Trinity Delta

Scancell

Update

SCOPE'ing out iSCIB1+ in advanced melanoma

4 August 2025

Data from SCOPE, examining Scancell's highly promising ImmunoBody "off-the-shelf" DNA cancer vaccine, appear to show that a meaningful, additional benefit can be achieved when added to standard-of-care (SoC) CPIs as a first-line treatment in advanced melanoma. iSCIB1+ has been selected as the candidate for further development; it works in a larger, and easily identifiable, patient group that represents 80% of all advanced melanomas, double that of SCIB1. The benefits of iSCIB1+ will need to be demonstrated in a controlled trial (SCOPE was an open-label, exploratory trial), and development plans for a Phase IIb/III registrational study are being accelerated. Our valuation is increased >10% to £373m, or 36p/share following the latest SCOPE data. Further SCOPE data are expected later this year, as well as early data from the renal cell carcinoma (RCC) cohort of the ModiFY study, with upside potential from both.

Year-end: April 30	2023	2024	2025E	2026E
Revenues (£m)	5.3	0.0	7.5	0.0
EBITDA (£m)	(11.0)	(17.3)	(11.0)	(9.6)
PBT (£m)	(14.3)	(9.1)	(12.7)	(11.1)
Net Income (£m)	(11.9)	(5.9)	(9.6)	(9.8)
EPS (p)	(1.46)	(0.68)	(0.98)	(0.95)
Cash (£m)	19.9	14.8	20.5	14.8

Source: Trinity Delta Note: Adjusted numbers exclude share-based payments and exceptionals.

- **SCOPE objectives achieved** SCOPE is a Phase II, translational, open-label study assessing safety and efficacy of SCIB1/iSCIB1+ in advanced melanoma in combination with checkpoint inhibitors (CPIs). Other key aims were to select the optimal candidate for future development and to define the target patient population. These have been met, with iSCIB1+ selected, and a clear understanding of the target patients, who can be easily identified with a readily available test.
- **iSCIB1+ working as predicted and in a larger population** SCIB1 efficacy is restricted to 30% to 40% of patients with the appropriate HLA type. iSCIB1+ incorporates a broader array of epitopes designed to address a wider HLA patient population; and ideally all patients. Latest SCOPE data have clarified that iSCIB1+ works as expected in the predicted HLA types, which represent 80% of melanoma patients, effectively double that of SCIB1, and broadening the opportunity.
- **SCOPE data have accelerated future development plans** SCOPE data for iSCIB1+ in the target HLA patients appear to show around a 20% improvement in several parameters, including objective response rate (ORR, a measure of tumour shrinkage) and PFS (progression-free survival), when benchmarked against historical SoC doublet CPI data. This has accelerated development plans for a potentially pivotal Phase IIb/III trial, with Scancell planning to meet with FDA later this year.
- **Valuation increased to £373m or 36p/share; cash through to H226** Our iSCIB1+ valuation is essentially doubled to 8p/share, largely on higher peak sales, together with a longer patent life and a modest de-risking. With all else being equal, this results in an uplift to our Scancell rNPV to £373m (from £330m), or 36p/share, with further upside on upcoming clinical news. The cash runway extends into H226.

Price	10.25p
Market Cap	£106.4m
Enterprise Value	£86.0m
Shares in issue	1037.8m
12 month range	7.26-19.75p
Free float	58.7%
Primary exchange	AIM London
Other exchanges	N/A
Sector	Healthcare
Company Code	SCLP.L
Corporate client	Yes

Company description

Scancell is a clinical-stage immuno-oncology specialist that has four broadly applicable technology platforms. Two are therapeutic vaccines, Moditope and ImmunoBody, and two are antibody based, GlyMab and AvidiMab.

Analysts

Lala Gregorek
lgregorek@trinitydelta.org
+44 (0) 20 3637 5043

Philippa Gardner
pgardner@trinitydelta.org
+44 (0) 20 3637 5042

Scancell: SCOPE success, and more data to come

Scancell is a clinical stage immunology specialist focused on oncology. It has two highly promising vaccine platforms (ImmunoBody and Moditope), and two antibody technologies (GlyMab and AvidiMab), with the potential to treat many solid cancers. Investor attention is on the vaccine platforms as lead programmes progress through key stages of clinical development. For ImmunoBody, iSCIB1+ has been selected as the optimal candidate to take into future melanoma trials, and development plans for a pivotal Phase IIb/III study are being accelerated; further data from the ongoing SCOPE Phase II trial are expected later this year. For lead Moditope asset Modi-1, interim data from the RCC cohort of the ModiFY study should provide valuable insights into its potential benefit when coupled with double CPI therapy. Meanwhile, GlyMab antibodies continue to generate exciting preclinical data and GlyMab Therapeutics has been formed as a new legal entity. Our risk-adjusted NPV valuation is increased to £373m or 36p/share, owing to a doubling of our iSCIB1+ rNPV following latest SCOPE data; there is further potential upside on upcoming clinical news.

Successful SCOPE outcome and iSCIB1+ selection; future development plans accelerated

Latest data from the translational Phase II SCOPE study of SCIB1/iSCIB1+ in advanced unresectable stage III/IV melanoma have enabled the selection of next generation iSCIB1+ for future development, and have defined a target patient population. The SCOPE study is evaluating SCIB1/iSCIB1+ in combination with CPIs (either standard of care doublet therapy ipilimumab/nivolumab, or pembrolizumab) and includes four cohorts (Exhibit 1). Our July 2025 Update provides more detail on study design. Plans for a potentially registrational Phase IIb/III trial are being accelerated based on the strength of the data.

Exhibit 1: SCOPE study of SCIB1 and iSCIB1+ in advanced melanoma

- **Cohort 1** is evaluating SCIB1 in 43 patients with a restricted HLA type (A2), in combination with SoC doublet therapy (nivolumab and ipilimumab), administered through a needle-free intra-muscular injection.
- **Cohort 2** is similarly investigating SCIB1, albeit combined with Keytruda (pembrolizumab). The low patient number enrolled (n=10) reflects how Keytruda has effectively been superseded as SoC in these indications.
- **Cohort 3** examines the next generation iSCIB1+ and SoC (nivolumab and ipilimumab), with 50 patients, including those with mixed haplotypes to reflect iSCIB1+'s broader activity profile.
- **Cohort 4** was added more recently, with a similar profile to Cohort 3 but employing a needle-free intra-dermal delivery and accelerated dosing; 24 patients have already been recruited to date and six are in screening.

Source: Trinity Delta

More SCOPE data to come this year, plus plans to meet FDA

Manufacturing has been optimised and is currently being scaled up in preparation for the planned Phase IIb/III trial. To expedite next steps, Scancell is planning to meet with FDA in coming months to discuss the clinical trial plans. Further SCOPE data are also anticipated this year, including Cohort 3 patients that have not yet had scans, longer-term PFS data, and, eventually, initial OS data. Furthermore, first data from Cohort 4, which has recruited very rapidly following inclusion of patients through the NHS Cancer Vaccine Launch Pad, are expected by year-end.

iSCIB1+ vaccine working as designed…

Efficacy with SCIB1, which was HLA restricted, prompted development of iSCIB1+…

The ImmunoBody SCIB1/iSCIB1+ DNA vaccines encode a modified human antibody, with the CDRs (complementarity determining regions) that normally bind to the target antigens replaced with carefully selected T-cell epitopes from a cancer antigen. First-generation SCIB1 includes three HLA.A2 epitopes from the proteins gp100 and TRP-2, enzymes which play key roles in the production of melanin in the skin. These were identified from T-cells of patients who achieved spontaneous recovery from melanoma skin cancers. Whilst effective, these epitopes limit SCIB1's applicability to patients with the appropriate HLA type (HLA.A2), restricting its use to around 30% to 40% of melanoma patients. Once SCIB1's efficacy was confirmed, an additional three melanoma-specific epitopes from the same gp100 and TRP-2 proteins were incorporated into second-generation iSCIB1+ with the aim of targeting a broader range of HLA types and therefore potentially a larger patient population. In addition, the AvidiMab platform was used to improve potency, and this also confers extended primary patent protection to iSCIB1+.

…which was predicted to work in a broader range of HLA types, representing 80% of all melanoma patients

It was predicted that iSCIB1+ would stimulate T-cells in the following HLA types: A2, A3, A31, A33, B35 and B44; a broader range of HLA types than SCIB1, hence expanding the target population. There was also an aspiration that by increasing the number of epitopes from gp100 and TRP-2, this could potentially lead to responses in all melanoma patients, given that both are expressed by all pigment producing melanomas. Whilst the latter is generally quite a rare outcome, iSCIB1+ was found to work in the predicted HLA types (as described below) which represent most, about 80%, of melanoma patients, achieving the goal of broadening the target patient population.

T-cell responses were assessed to provide insights into patient outcomes

T-cell responses were assessed in the SCOPE study to provide insights and an understanding of patient outcomes. In the 50 patients enrolled in Cohort 3, T-cell data so far are available for 31 patients, with nine patients pending (of the remaining ten patients, no bloods were received for five patients that were off study, and the five patients that progressed were excluded). Of these 31 subjects, 19 patients made a positive T-cell response, shown in Exhibit 2.

Exhibit 2: T-cell responses in Cohort 3

Clinical Response	N	Positive T-cell response	% positive
Complete/Partial Response	19	15	79%
Stable Disease	7	3	43%
Progressive Disease	5	1	20%
Total	**31**	**19**	

Source: Scancell, Trinity Delta

Positive T-cell responses led to an improved clinical outcome

The data show that a positive T-cell response correlates with a better clinical outcome, with very few T-cell responses in patients with progressive disease, vs the majority of patients with a complete or partial response (CR/PR) having a positive T-cell response. Scancell has also confirmed that positive T-cell responses correlated well with the predicted HLA types (data not shown) ie patients with the HLA type in which iSCIB1+ was predicted to stimulate a response were more likely to have a complete or partial response.

...in a clearly defined and identifiable population...

Best responses were seen in patients with the target HLA type with a CD8+ response

Additional data also demonstrate that all six epitopes included in iSCIB1+ induced antigen-specific T-cell responses, and that a CD8+ (killer T-cell) response was more likely to lead to a clinical response (measured by ORR, overall response rate, which refers to patients with a CR or PR), ie the best responses were observed in patients with the target HLA type with a CD8+ response:

- ORR if a positive T-cell response: 67% (12/18);
- ORR if a CD8+ T-cell response: 83% (10/12).

This could allow a readily available test to identify target patients and enrich the patient population in future trials

This observation could form the basis of a patient identification strategy to enrich the population for the planned Phase IIb/III trial. HLA typing, which assesses an individual's MHC (Major Histocompatibility Complex) class I and II alleles (with class I crucial for CD8+ T-cell responses) and identifies the specific HLA alleles present, could be used to identify patients more likely to respond. HLA typing is used frequently, for example to ensure compatibility in organ donation and transplantation. Whilst it is not a specific companion diagnostic or biomarker for iSCIB1+ *per se*, the readily available information from such a widely accepted test could be used to identify target patients in which iSCIB1+ would be expected to stimulate a positive response. This form of testing was used in the SCOPE trial in the UK and had a swift 48-hour turnaround.

...with durable patient responses...

SCOPE was an open-label, exploratory trial and findings will need to be confirmed in future trials

Patient outcomes in SCOPE were primarily assessed by overall response rate (ORR). PFS (progression-free survival) and OS (overall survival) are also being measured but data are not yet mature. As the trial was open-label, there are no directly comparable data, but historical data from other trials can be a useful and informative benchmark, with the usual caveats around the limitations of cross trial comparisons. In addition, as the trial was translational and exploratory in nature, identifying the patients which benefited, and understanding why, can help to provide insights into the potential magnitude of benefit that may be observed in further studies, and can help to enrich and optimise the design of future trials. Clearly any observations from a translational, open-label trial such as SCOPE will need to be fully evaluated in a larger randomised and controlled clinical trial.

Data have been presented based on the target patient group, and some patients have not yet been scanned

With the target patient group identified as those having certain HLA types (described above), Scancell has stratified the data from Cohort 3 (which was not HLA restricted) and has presented data in the target HLA type patients. We understand that this includes 39 patients of the recruited 50. Of these 39 target HLA patients, Scancell has confirmed that three were non-evaluable, and data from seven are still pending as they have not yet been scanned – we assume these data will be presented later this year. Hence, data are presented for 29 patients. Data in the remaining 11 patients have not been presented; we assume that these are non-target patients and, as such, little to no benefit was observed, over and above what may be expected with doublet CPI therapy. A summary of the patient responses in the target population in Cohorts 1 and 3 (SCIB1/iSCIB1+ with CPI doublet therapy ipilimumab/nivolumab), both separately and pooled, are shown in Exhibit 3.

Exhibit 3: Patient responses in Cohorts 1 and 3, and combined

	Cohort 1 (SCIB1)	Cohort 3 (iSCIB1+)	Cohort 1 and Cohort 3 (SCIB1/iSCIB1+)
N (evaluable patients)	38	29	67
Complete Reponse (CR)	8	4	12
Partial Response (PR)	18	16	34
Stable Disease (SD)	8	5	13
Progressive Disease (PD)	4	4	8
Objective Response Rate (ORR)	68.4% (26/38)	68.9% (20/29)	68.6% (46/67)
Disease Control Rate (DCR)	89.5% (34/38)	86.2% (25/29)	88.0% (59/67)
PFS (not yet mature)	64.6% at 22-months	80.8% at 11-months	69% at 22-months

Source: Scancell, Trinity Delta

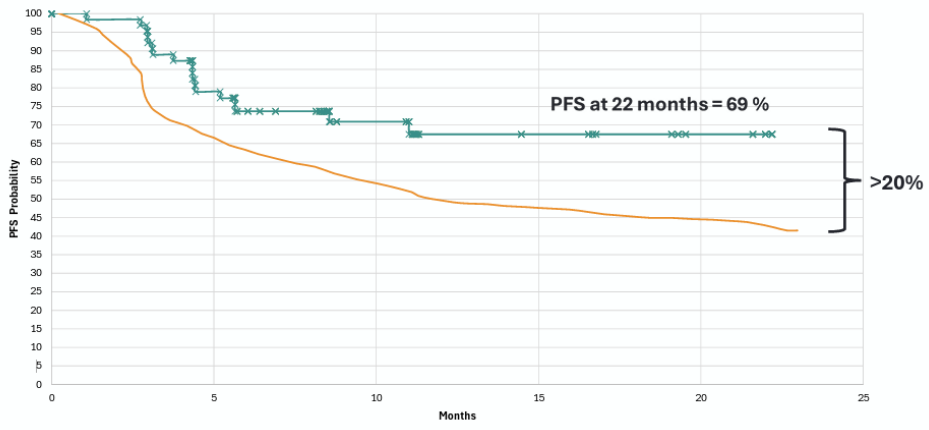
iSCIB1+ efficacy appears to be comparable to SCIB1

The ORR for iSCIB1+ in the target population in Cohort 3 was 68.9%. This was consistent with data from SCIB1 in Cohort 1 with a 68.4% ORR, for a combined ORR from the two cohorts of 68.6%. For context, the ORR with ipilimumab/ nivolumab CPI doublet therapy is 48% in the real-world setting (all-comer, advanced melanoma patients). We are not aware that data for doublet CPIs have been presented stratified by HLA-type, nor that there are any data to suggest certain HLA types may be more or less responsive to CPI doublet therapy. Hence, whilst not directly comparable, this does provide a useful benchmark, with the usual caveats and limitations of cross trial comparisons.

PFS will be key for regulators…

The primary efficacy endpoint in SCOPE was ORR, as is usual in earlier-phase studies, and hence to date this has been the main data presented. ORR is essentially a measure of tumour burden (it measures tumour shrinkage) and is a useful early indicator of anti-tumour activity. Regulators tend to prefer survival endpoints as a more robust measure of patient benefit, however data can be time consuming to collect, particularly for overall survival, and so are not always appropriate in early clinical development. Both progression-free (PFS) and overall survival (OS) are being assessed in SCOPE, although the data are not yet mature. To date, PFS at 22-months in Cohort 1 is 64.6%, whereas in Cohort 3 the PFS is 80.8% at 11-months, with the combined cohorts shown in Exhibit 4 plotted against SoC data for doublet CPIs ipilimumab/nivolumab (from Checkmate-067).

Exhibit 4: Cohort 1 & 3 PFS versus SoC (Checkmate-067, illustrative)



Source: Scancell Note: Green = Cohort 1 and 3 from SCOPE trial; Orange = doublet CPIs ipilimumab/nivolumab from Checkmate-067 trial.

...and data appear to show responses are highly durable, prompting acceleration of future development plans

These data appear to suggest that responses achieved are highly durable and that once a patient has a response, this is maintained – longer follow-up data will be important in this regard. This is perhaps due to the CD8+ killer T-cell responses observed in the majority of patients with a clinical response; these T-cells direct tumour cytotoxicity and promote memory T-cell formation, which contribute to a prolonged clinical benefit. If the effects of iSCIB1+ can be maintained (ie are durable) this is a positive outcome for patients as it means they can live for longer without their disease worsening (a perhaps more meaningful real-world patient benefit than tumour shrinkage, ORR). This compelling PFS benefit has accelerated development plans for a potentially pivotal Phase IIb/III trial, with Scancell planning to meet with FDA later this year.

Further SCOPE data are anticipated later this year

Patients enrolled in SCOPE remain in the study for two years, so survival data (OS and PFS) will continue to be monitored. We expect an update on PFS, with longer follow-up, in Q425, as well as potential initial OS data, in addition to early data from Cohort 4 which is examining intradermal administration (PharmaJet's Tropis) and an accelerated dosing regimen.

...and no additional toxicities

SCIB1/iSCIB1+ are well tolerated without additional toxicities on top of SoC

Available safety data from all Cohorts in SCOPE are shown in Exhibit 5. For SCIB1/iSCIB1+ there was a much lower incidence of Grade 3 and 4 treatment-related adverse events (AEs) compared to those related to the CPIs, and even fewer serious adverse events (SAE), which are generally defined as being fatal, life-threatening, requiring hospitalisation or prolonged hospitalisation, or causing disability. Hence, the addition of SCIB1/iSCIB1+ to CPIs does not appear to cause additional toxicities.

Exhibit 5: Safety data (TEAEs) from SCOPE across all Cohorts

	TOTAL EVENTS	EVENTS RELATED TO SCIB1 AND ISCIB1+	EVENTS RELATED TO CPI	EVENTS RELATED TO THE ADMINISTRATION PROCEDURE	NOT RELATED
All AEs (subjects)	1689	258	732	124	575
SAEs	123	11	92	0	20
AEs > G3	163	30	113	3	17
Grade Undefined	47	1	5	1	40

Source: Scancell Note: TEAE = Treatment emergent adverse event

Phase IIb/III plans accelerated

Phase IIb/III plans are being accelerated

Planning for a registrational Phase IIb/III was already underway, and the latest SCOPE data have accelerated this, with Scancell intending to discuss the trial design with FDA this year, ahead of Cohort 4 data. This is to ensure that the trial can start as soon as is practicable. Scancell also intends to discuss the clinical plans with multiple regulators (ie MHRA in UK and EMA in Europe) and will seek to apply for any relevant accelerated pathways that could be applicable, to try and make iSCIB1+ available to patients as swiftly as possible.

Registrational trials could potentially start in 2026

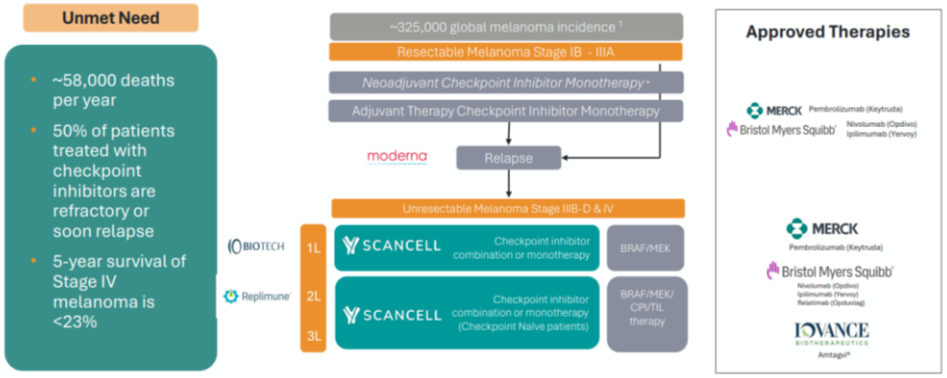
Irrespective of any accelerated approval pathways, a Phase III registrational trial will be needed to secure full approvals; our launch forecasts are based on this being fully completed. Scancell has previously outlined that the trial is likely to be

a multinational, multi-centre, blinded study (with key centres in the US, UK, and Europe), with an adaptive trial design. This means that at pre-specified points certain data can be assessed and reviewed as the trial is ongoing, which can then be used to modify and adapt the trial. As described earlier, the primary endpoint will likely be PFS as this is a focus for regulators. We expect the trial to initially use the intra-muscular route of administration, with the potential for intra-dermal accelerated dosing incorporated if Cohort 4 data are supportive. A smooth regulatory clearance could see the Phase IIb/III study start patient enrolment during 2026. The outcomes from SCOPE have clearly defined the target HLA population as described earlier.

Potential for iSCIB1+ to also have a place in earlier-stage melanomas

Whilst plans in the unresectable metastatic population are advanced, Scancell is at the very preliminary stages of exploring the potential to investigate iSCIB1+ in earlier stage neoadjuvant/adjuvant resectable melanoma. This is based on activity that has been observed in combination with pembrolizumab. Exhibit 6 shows how iSCIB1+ could be positioned as a central element within various melanoma treatment pathways.

Exhibit 6: iSCIB1+ could become part of new standard of care in melanoma



Source: Scancell

Significant market for iSCIB1+ in late-stage melanoma; potential to also address larger & earlier-stage markets

Based on the now clearly defined target patient population in advanced melanoma, management estimates that the addressable market size for iSCIB1+ in this indication is c $3bn. The opportunity is even larger in the earlier-stage neoadjuvant/adjuvant setting at around $6-9bn. Other opportunities for iSCIB1+ could also be as a preventative vaccine in certain high-risk groups. However, at present, our peak sales assumption for iSCIB1+ focuses only on the advanced melanoma indication. There remains an unmet need in this group of patients; despite CPIs improving patient outcomes, only around 50% of patients maintain a long-term benefit, with the remainder either relapsing or becoming refractory to CPI treatment.

Valuation and Financials

Increasing iSCIB1+ peak sales to reflect a broader patient target group

We value Scancell using a sum of the parts rNPV-based model (risk-adjusted net present value). Following initial SCOPE data, we have adjusted our assumptions for iSCIB1+, leaving assumptions for other Scancell assets unchanged. Given the broader melanoma patient population targeted by iSCIB1+, we increase our peak sales to $1.5bn (from $1bn). We acknowledge that there remains upside to this peak sales assumption as iSCIB1+ could potentially address 80% of melanoma patients (vs SCIB1 with 30-40%); however, at this stage, we take our usual conservative stance. Our iSCIB1+ peak sales do not include any potential in earlier neoadjuvant/adjuvant melanoma, nor in any other indications or opportunities.

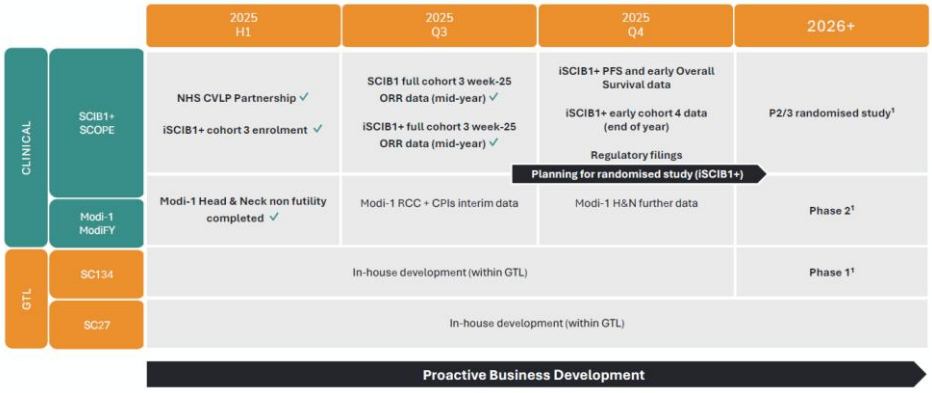
Peak sales increase, plus other changes, lead to our SCIB1+ valuation doubling to 8p/share

We also modestly increase our probability of success to 15% (from 10%) with further upside on additional data, particularly more mature survival data, and clarity from regulators regarding the planned trial design. We have also extended the lifecycle of iSCIB1+ to reflect the longer patent life; however, this is largely offset by now forecasting a slightly later, but more realistic 2030 launch (from 2029). Together, these result in an uplift to our iSCIB1+ rNPV to £84m (from £41m), equivalent to 8p/share (from 4p/share).

iSCIB1+ uplift results in an increased Scancell rNPV of £373m, or 36p/share, with all other elements unchanged

All other elements of our valuation are unchanged (more details on our valuation, and the main assumptions underpinning each rNPV, are provided in our October 2024 Update). Hence, the increase in our iSCIB1+ rNPV leads to an increase in our Scancell rNPV to £373m (from £330m), equivalent to 36p/share (from 32p/share). Several catalysts are expected over the next 12 months (Exhibit 7), notably additional SCOPE data and initial RCC data for Modi-1, with upside potential from successful outcomes.

Exhibit 7: Clinical progress should provide multiple value inflection points



Source: Scancell Note: CPI = Checkpoint inhibitor; RCC = Renal Cell Carcinoma; H&N = Head and Neck; [1] Subject to further out-licensing, partnering and/or further financing

Cash runway extends into H226, and could be extended with BD activity

Our financial forecasts are unchanged (Exhibit 8), with more detail available in our October 2024 Update. Current cash extends into H226, even with the planned acceleration of the potentially registrational iSCIB1+ Phase IIb/III trial. This cash runway could be extended by successful execution of any business development transaction(s), where Scancell is proactively exploring various options across the pipeline. This is also beyond the key near-term value inflection points for iSCIB1+ and Modi-1, providing Scancell with time to evaluate potential suitable out-licencing and partnering opportunities to optimally advance its assets from a position of strength.

Exhibit 8: Summary of financials

Year-end: April 30 £'000s	2022	2023	2024	2025E	2026E
INCOME STATEMENT					
Revenues	**0**	**5,271**	**0**	**7,500**	**0**
Cost of goods sold	0	(525)	0	(750)	0
Gross Profit	**0**	**4,746**	**0**	**6,750**	**0**
R&D expenses	(9,477)	(11,645)	(12,871)	(13,250)	(5,035)
General and administrative expenses	(4,787)	(5,021)	(5,396)	(5,504)	(5,614)
Other revenue/expenses	965	0	0	0	0
Operating Profit	**(13,299)**	**(11,920)**	**(18,267)**	**(12,004)**	**(10,649)**
EBITDA	**(12,559)**	**(11,018)**	**(17,301)**	**(11,011)**	**(9,618)**
Net Interest	(1,773)	(931)	(734)	(693)	(495)
Other financing costs/income	8,800	(1,453)	9,884	0	0
Profit Before Taxes	**(6,272)**	**(14,304)**	**(9,117)**	**(12,697)**	**(11,144)**
Adj. PBT	**(5,582)**	**(13,576)**	**(8,457)**	**(11,971)**	**(10,346)**
Current tax income	1,703	2,368	3,258	3,095	1,325
Net Income	**(4,569)**	**(11,936)**	**(5,859)**	**(9,601)**	**(9,819)**
EPS (p)	**(0.56)**	**(1.46)**	**(0.68)**	**(0.98)**	**(0.95)**
Adj. EPS (p)	**(0.48)**	**(1.37)**	**(0.60)**	**(0.90)**	**(0.87)**
Average no. of shares (m)	815.2	816.1	862.5	983.5	1,039.0
Gross margin	*N/A*	*90%*	*N/A*	*90%*	*N/A*
BALANCE SHEET					
Current assets	**32,362**	**24,606**	**21,867**	**24,475**	**18,935**
Cash and cash equivalents	28,725	19,920	14,817	20,463	14,798
Accounts receivable	647	538	1,378	1,240	1,364
Inventories	0	0	0	0	0
Other current assets	2,990	4,148	5,672	2,772	2,772
Non-current assets	**2,744**	**2,249**	**1,709**	**884**	**13**
Property, plant & equipment	2,744	2,249	1,709	884	13
Other non-current assets	0	0	0	0	0
Current liabilities	**(6,649)**	**(7,969)**	**(6,389)**	**(6,248)**	**(6,024)**
Short-term debt	(4,197)	(4,693)	(2,862)	(2,862)	(2,862)
Accounts payable	(2,137)	(2,970)	(3,099)	(2,920)	(3,162)
Other current liabilities	(315)	(306)	(428)	(466)	0
Non-current liabilities	**(27,063)**	**(28,534)**	**(20,692)**	**(19,776)**	**(19,776)**
Long-term debt	(26,207)	(27,788)	(20,226)	(19,776)	(19,776)
Other non-current liabilities	(856)	(746)	(466)	0	0
Equity	**1,394**	**(9,648)**	**(3,505)**	**(665)**	**(6,853)**
Share capital	61,348	61,514	72,856	83,322	83,322
Other	(59,954)	(71,162)	(76,361)	(83,987)	(90,175)
CASH FLOW STATEMENTS					
Operating cash flow	**(10,193)**	**(8,140)**	**(15,660)**	**(4,168)**	**(5,606)**
Profit before tax	(6,272)	(14,304)	(9,117)	(12,697)	(11,144)
Non-cash adjustments	(5,597)	4,014	(7,566)	2,412	2,325
Change in working capital	372	940	(711)	2,858	119
Interest paid	0	0	0	0	0
Taxes paid	1,304	1,210	1,734	3,258	3,095
Investing cash flow	**(1,264)**	**81**	**178**	**283**	**463**
CAPEX on tangible assets	(1,268)	(203)	(177)	(168)	(160)
Other investing cash flows	4	284	355	451	623
Financing cash flow	**(928)**	**(746)**	**10,390**	**9,531**	**(522)**
Proceeds from equity	0	166	11,342	10,466	0
Increase in loans	0	0	0	(450)	0
Other financing cash flow	(928)	(912)	(952)	(485)	(522)
Net increase in cash	**(12,385)**	**(8,805)**	**(5,103)**	**5,646**	**(5,664)**
Cash at start of year	41,110	28,725	19,920	14,817	20,463
Cash at end of year	**28,725**	**19,920**	**14,817**	**20,463**	**14,798**
Net cash at end of year	**(1,679)**	**(12,561)**	**(8,271)**	**(2,175)**	**(7,840)**

Source: Scancell, Trinity Delta Note: Adjusted numbers exclude share-based payments and exceptionals. FY26e R&D forecasts are largely illustrative pending development plans.

Philippa Gardner pgardner@trinitydelta.org
+44 (0) 20 3637 5042

Lala Gregorek lgregorek@trinitydelta.org
+44 (0) 20 3637 5043

Franc Gregori fgregori@trinitydelta.org
+44 (0) 20 3637 5041

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