National Institute for Health and Care Excellence

Multiple Technology Appraisal (MTA)

Erythropoiesis-stimulating agents (epoetin and darbepoetin) for treating cancer-treatment induced anaemia (including review of TA 142)

Response to consultee and commentator comments on the draft scope

Section	Consultees	Comments	Action
Background information	Amgen	Amgen suggest, for clarity, that the background section explicitly state that the interventions will be assessed under their licensed indications.	The background is only a brief description of the disease and how it is managed. The way the technologies will be assessed in the appraisal has already been defined in the remit, which is *To appraise the clinical and cost effectiveness of erythropoiesis-stimulating agents (epoetin and darbepoetin) within their licensed indications for the treatment of cancer-treatment induced anaemia.* It is also mentioned under 'other considerations'.
	NCRI/RCP/RCR/ACP/JCCO joint comment	This is accurate and mainly complete. However, our experts in gynaecological cancer feel there is no mention of the time frame for improvements in Hb level with the use of Epo products. This will have a bearing on when the treatment should be commenced. Cancer patients with a Haemoglobin level of 8 or less are likely to be very symptomatic. It may therefore be necessary to start treatment earlier.	NICE acknowledges the importance of this comment. However, the haemoglobin level necessary for treatment to commence or stop should be informed by the evidence base at the appraisal stage rather than at the scoping stage.
	Royal College of Pathologists and BSH	Acceptable	Comment noted.
	Myeloma UK	Myeloma UK considers the general information	Comment noted. The scope has been

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		provided about anaemia and erythropoiesis stimulating agents (ESAs) to be accurate. In myeloma, anaemia is normochromic and normocytic and attributed to either the myeloma itself (a more chronic form) and/or the myelosuppressive effect of the chemotherapy (a more acute form). As a consequence, it is often difficult for clinicians to determine the exact cause or causes of the anaemia. The British Committee for Standards in Haematology Guidelines for Supportive Care in Myeloma (BCSH/UKMF 2010) suggest that approximately 75% of myeloma patients present with anaemia, and a European-wide survey in myeloma patients suggested that the prevalence of anaemia during chemotherapy is around 85% (Birgegard et al, 2006). Myeloma UK agrees that the commonly experienced effect of anaemia in patients is a marked reduction in quality of life, such as debilitating fatigue, reduced exercise capacity and a decreased sense of wellbeing. These effects have a dramatic impact on the lives of patients and their families; this should not be underestimated by the appraisal committee. A patient's ability to fully benefit from often expensive anti-cancer treatment is often dependent on their ability to regain a quality of life that is worth living. Poorly managed anaemia can seriously impact patients' ability to do this. In a Myeloma UK survey conducted in 106 patients, 95% of patients reported that fatigue impacted on their personal and family life and on their emotional wellbeing. When asked about the tasks that became	updated to indicate that 75% of multiple myeloma patients present with anaemia at diagnosis.

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		the most difficult with fatigue: 62% stated walking, 62% stated taking exercise, 46% stated concentrating and 49% stated cleaning the house. Other symptoms of anaemia included breathlessness and weakness throughout the body, which impact on patients' mobility and ability to leave the house. It should be noted that whilst the NICE definition of anaemia is correct, the need to treat anaemia depends on whether a patient is symptomatic rather than just on their haemoglobin levels.	
	Healthcare Improvement Scotland and NCRN Haematological Oncology Study Group	Yes	Comment noted.
The technology/ intervention	Amgen	Amgen recommend an amendment to the wording to indicate route of administration for each intervention, i.e.that Darbepoetin alfa is administered by the subcutaneous route. Within the scope and subsequent guidance, Amgen feel it will be important to acknowledge the difference between originator and biosimilars interventions, specifically relating to the prescription of biological products and the regulatory position with respect to automatic substitution. The MHRA Drug Safety Update states that ''When prescribing biological products, it is good practice to use the brand name for several reasons''. Firstly, this will ensure that automatic substitution of a biosimilar product does not occur when the medicine is dispensed by the pharmacist, given that the products (biosimilar and reference) will have the	According to the summary of product characteristics all the EPO technologies are administered subcutaneously for chemotherapy induced anaemia. Comments noted. NICE will take into consideration any difference between the clinical and cost effectiveness for the individual products, where such evidence is available.

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		same international non-proprietary name (INN) but are not presumed identical. Secondly, to support pharmacovigilance monitoring requirements, as this will enable attribution of adverse drug reactions (ADRs) to the correct biological product. In the UK, this view is also broadly endorsed by the British National Formulary (BNF) in their general guidance on prescribing and by National Prescribing Centre (NPC).	
	Roche Products	Yes	Comment noted.
	NCRI/RCP/RCR/ACP/JCCO joint comment	Yes	Comment noted.
	Royal College of Pathologists and BSH	Yes, but there are 7 randomised studies in which an ESA has been combined with intravenous iron versus no iron. It is not clear to me from the list of interventions whether the combined treatment will be assessed. Combined treatment improves the number of responding patients.	NICE recognises that iron supplementation may be required for EPO treatment but iron supplementation is not the technology being appraised. NICE will be examining EPO based therapies taking account of any adjunctive therapies at the appraisal stage.
	Myeloma UK	We agree that the description of the technologies is accurate.	Comment noted.
	Healthcare Improvement Scotland and NCRN Haematological Oncology Study Group	Yes	Comment noted.
Population	Amgen	Amgen believe it is important to ensure that the population defined in the scope is aligned with the defined populations as licensed for treatment with all Erythropoiesis-stimulating agents (ESAs) in the UK	The technologies will be appraised in line with their respective marketing authorisations.

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		(i.e. patients with anaemia as a result of chemotherapy as well as those at risk of transfusion).	The appraisal will establish if 'being at risk of blood transfusions' defines a separate population.
	Hospira UK	In addition to the subgroups previously considered within TA142, (people with any type of cancer receiving platinum-based chemotherapy, women with ovarian cancer receiving platinum-based chemotherapy, people unable to receive blood transfusions) Hospira also recommend a further subgroup analysis for patients with lung cancer receiving chemotherapy. The incidence of anaemia in lung cancer patients undergoing chemotherapy is up to 83%, and is common in patients receiving platinum-based regimens, due to direct bone marrow damage and renal impairment with secondary deficiency in erythropoietin production. Recent meta-analyses suggest ESAs reduce transfusion requirements without increasing mortality or disease progression in lung cancer patients undergoing chemotherapy. One trial (EPO-CAN-20) reported an association between ESA use and increased mortality was conducted in NSCLC patients not receiving chemotherapy or radiotherapy. To date, no other controlled ESA trials in lung cancer have reported safety signals regarding ESA-associated survival and disease progression. [Ref: Vansteenkiste, J et al. Lung Cancer, 2012;76(3):478–485]	Comment noted. The wording of the scope has been amended to allow inclusion of other subgroups. The appraisal will determine which patients (according to cancer type, if evidence allows) are the most suitable and likely to benefit from the treatment.
	Roche Products	Yes the population is defined correctly	Comment noted

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		The subgroups identified in “other considerations” are appropriate but may be difficult to assess due to lack of available evidence.	
	NCRI/RCP/RCR/ACP/JCCO joint comment	Yes. Although, it might be appropriate to specifically address the issues of Jehovah Witness patients suffering from Cancer, as well as the generic group of ‘at risk from transfusion’	Comment noted. The wording of the scope has been amended to allow inclusion of other subgroups.
	Royal College of Pathologists and BSH	Yes	Comment noted.
	Myeloma UK	We consider that the population covered by the NICE appraisal scope is defined appropriately. We suggest that NICE further consider the idea of producing a combined or separate assessment of ESAs in patients with cancer-related anaemia. As mentioned in the background, approx. 75% of myeloma patients present with anaemia at diagnosis and it is often a more chronic form of the condition, leading to a prolonged impact on quality of life. ESAs form an important treatment option for this group of patients as well as those affected by cancer treatment-related anaemia. A recent Myeloma UK survey of 50 consultant haematologists asked them about their use of ESAs and how the NICE guidelines could be changed to improve the treatment of anaemia in myeloma. In total 84% believed that the guidelines could be broadened to improve the treatment of anaemia in myeloma patients. 35% of consultant haematologists specified that it would be beneficial for NICE to consider cancer-related anaemia as part of the current guidance or as a new piece of guidance. For	Comments noted. NICE can only appraise the technologies within their marketing authorisation. The technologies are currently licensed for people receiving chemotherapy; therefore an appraisal of cancer-related anaemia is beyond the remit for this appraisal.

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		example, one stated that NICE 'should recognise the value of erythropoietin in patients with cancer and anaemia, due to both chemotherapy and the underlying disease' and another expressed 'erythropoietin should be available for cancer-related anaemia if appropriate'. The BCSH guidelines for supportive care in myeloma does not make a distinction between cancer-related and cancer treatment-related anaemia in terms of whether or not a patient should receive an ESA. The guidelines state that ESA's should be considered in a patient with persistent symptomatic anaemia (typically haemoglobin concentration <10.0 g/dl) in whom haematinic deficiency has been excluded (Grade A recommendation; level 1b evidence)'. Other issues From our experience of the use of NICE TA142 to date, we believe that clause 1.3 is too restrictive. It states 'erythropoietin analogues in combination with intravenous iron may be considered for people who cannot be given blood transfusions and who have profound cancer treatment-related anaemia that is likely to have an impact on survival'. We know of a significant number of myeloma patients where the doctor has considered an ESA clinically relevant for their treatment, but that have been unable to secure funding from the local PCT due to the lack of information on the impact it will have on the patients overall survival. Given the severe impact of anaemia-related fatigue, overall survival quite clearly should not be the major endpoint. Myeloma UK believes that clinicians should be able	Comment noted. As with all recommendations made in this appraisal review, any recommendation equivalent to the current section 1.3 will be subject to consultation.

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		to prescribe erythropoietin where it is clinically relevant and where it will have a significant impact on quality of life. It might be beneficial for NICE to further specify the circumstances in which clinicians can use erythropoietin for patients in line with 1.3 and to take out the clause on overall survival as this is difficult to determine (perhaps replacing this with quality of life).	
	Healthcare Improvement Scotland and NCRN Haematological Oncology Study Group	It might be appropriate to specifically address the issues of Jehovah Witness patients suffering from Cancer, as well as the generic group of 'at risk from transfusion'	Comment noted. The wording of the scope has been amended to allow inclusion of other subgroups.
Comparators	Amgen	The scope states that 'interventions will be compared with each other'. However it is likely that there will be limited clinical evidence to inform the assessment of clinical effectiveness for the biosimilars comparators, since the European Medicines Agency (EMA) guidance for licensing biosimilars is generally granted on the basis of assumed bioequivalence.	Comment noted. Where evidence allows the interventions will be compared with each other in line with their marketing authorisations.
	Hospira UK	The most accurate comparator intervention to ESAs is red blood cell transfusion (RBCT) and as such this should be subject to the same outcome measures as ESAs, including potential adverse events (including transmission of infectious agents, transfusion-related acute lung injury, iron overload, and haemolytic reactions). It is important that the true overall cost per RBCT is transparent and excludes any subsidy, for example from other blood transfusion services.	Comment noted. All costs related to the interventions and the comparators will be included.
	Roche Products	Yes.	Comment noted.

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		We would define best alternative care as including: adjustment to the cancer treatment regimen, blood transfusion and iron supplementation.	
	NCRI/RCP/RCR/ACP/JCCO joint comment	Yes	Comment noted.
	Royal College of Pathologists and BSH	The comparators are fine. It is not clear whether no treatment or blood transfusion is the better alternative care. There are also some data on the use of intravenous iron alone in the management of cancer treatment related anaemia but these data are probably insufficient at present to draw meaningful conclusions.	Comment noted.
	Myeloma UK	We agree that the current treatment comparators for cancer-treatment related anaemia is dose reduction of the patient's chemotherapy, blood transfusions and iron supplements (either on its own or in combination).	Comment noted.
	Healthcare Improvement Scotland and NCRN Haematological Oncology Study Group	Yes	Comment noted.
Outcomes	Amgen	There have been a number of changes to the licensed indication for ESAs, regarding both treatment initiation, and target, Hb ranges. Consequently the majority of available clinical trial evidence relates to initiation of ESA treatment in patients with Hb levels > 10 g/dl and is not aligned with current ESA labels (which state that treatment should be initiated when haemoglobin concentration	Comments noted. Clinical input to the appraisal will inform the haemoglobin levels reflective of clinical practice in the NHS.

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		≤ 10 g/dl). Moreover, substantial clinical trial evidence has evaluated treatment to target Hb levels > 12 g/dl, and is similarly not aligned with current ESA labels (which state that the considered Hb target range should be 10-12g/dl and sustained haemoglobin level of greater than 12 g/dl should be avoided). As a consequence of this, Amgen believe that there is likely to be very limited clinical evidence available for this appraisal, where initiation and target Hb ranges are aligned with the revised, current ESA licence. Tumour response - It will be difficult to evaluate tumour response in many trials involving erythropoietin preventing chemotherapy induced anaemia (CIA). Often these trials involve numerous tumour types and overall response was not an endpoint measured. In addition, many tumour specific trials may not have included tumour response as an endpoint.	The wording of the scope has been amended.
	Roche Products	Yes If possible the definition of tumour response should be clarified in the scope (e.g. tumour response /progression).	Comment noted. The wording of the scope has been amended,

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	NCRI/RCP/RCR/ACP/JCCO joint comment	Yes. Adverse events should include thromboembolic disease and stroke. There is also a need to consider time frames of response to the intervention. Especially important for those groups of patients where blood transfusion is not an option based on religious and other beliefs. It is important to minimize adjustments to treatment regimen etc which may then have an impact on both response to treatment and survival.	Comments noted. The scope of the appraisal is not intended to specify outcome measures in detail. The adverse events will be more explicitly defined and discussed at the appraisal stage. The time frames of response are defined implicitly in the outcomes.
	Royal College of Pathologists and BSH	Possibly, depending on whether the combined treatment of ESA + IV iron is considered.	Comment noted. NICE will be examining EPO based therapies taking account of any adjunctive therapies at the appraisal stage.
	Myeloma UK	The outcomes considered in the appraisal scope do capture the important health-related benefits from ESA intervention in patients with cancer treatment-related anaemia. However, it should be noted that erythropoietin is considered a supportive care in myeloma and does not always affect a patients overall survival. Health-related quality of life and the haematological response to the treatment are the most important outcome measures for NICE to consider in this appraisal.	Comment noted.
	Healthcare Improvement Scotland and NCRN Haematological Oncology Study Group	Yes. Adverse events should include thromboembolic disease and stroke.	The scope of the appraisal is not intended to specify outcome measures in detail. The adverse events will be more explicitly defined and discussed at the appraisal stage.
Economic	Hospira UK	Cost-effectiveness comparisons based upon NHS	Any nationally available discounts can

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analysis		list price will fail to reflect significant real-world discounts in UK regional contract pricing. Published comparison across G5 countries show potentially significant savings from introduction of biosimilars. Under weight-based dosing, the average cost of a single Biosimilar epoetin α treatment across scenarios was €4726 with corresponding estimates: €5484 for originator Epoetin α, €5652 for Epoetin β, and €8465 for both darbepoetin once weekly and once every three weeks. [Ref: Aapro M, et al. Ther Adv Med Oncol. 2012;4(3):95-105]	be taken into consideration.
	Roche Products	NICE appraisal TA142 used a three year time horizon, this would appear to remain suitable	Comment noted.
	NCRI/RCP/RCR/ACP/JCCO joint statement	Given that some of the cancer therapies used with ESA are likely to be curative a long time horizon will be required.	Comment noted.
	Myeloma UK	The QALY, whilst a fair and uniform tool in the assessment of the clinical and cost-effectiveness of newly licensed medicines, favours outcome measures such as overall survival over other measures such as progression free survival and quality of life. As mentioned above, erythropoietin is a supportive treatment in myeloma and can significantly improve a patient's quality of life. We are concerned that the understandable lack of overall survival data with erythropoietin will be detrimental to the outcome of the appraisal. Myeloma UK therefore hopes that	Comment noted. The reference case specifies the methods considered by NICE to be the most appropriate for the Appraisal Committee's purpose and consistent with an NHS objective of maximising health gain from limited resources. (NICE Guide to the Methods of Technology Appraisal, section 5.2.2). The Committee will explore if there are any potential significant and substantial health-related benefits been identified

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		NICE will undertake a detailed consideration of the impact that erythropoietin has on a patient's quality of life, alongside the traditional QALY assessment. We are aware that the cost of erythropoietin has reduced since the publication of NICE TA142, supported by an increase of ESAs and biosimilars available on the market. We hope that this is favourable to the outcome of this NICE appraisal. Finally, as part of the cost-effectiveness assessment, NICE should take into account the fact that ESAs are increasingly self-administered by the patient in their home, thus reducing the costs associated with continuous hospital visits.	that were not included in the economic model? All costs related to administrations of the interventions and the comparators will be included appropriately.
	Healthcare Improvement Scotland and NCRN Haematological Oncology Study Group by	Given that some of the cancer therapies used with ESA are likely to be curative a long time horizon will be required.	Comment noted.
Equality	NCRI/RCP/RCR/ACP/JCCO joint comment	Jehovah Witness patients, as discussed above	NICE will take any equality issues into consideration
	Healthcare Improvement Scotland and NCRN Haematological Oncology Study Group	Jehovah Witness patients, as discussed above	NICE will take any equality issues into consideration
Other considerations	Amgen	Amgen believe that consideration should also be given to the level of evidence available regarding outcomes in patients on standard of care who do and do not receive blood transfusions during and post-chemotherapy.	Comment noted.
	NCRI/RCP/RCR/ACP/JCCO	Consider the timing of the intervention plus see	Comment noted.

Section	Consultees	Comments	Action
	joint comment	comments below	
	Royal College of Pathologists and BSH	As above	Comment noted.
	Myeloma UK	As mentioned above, Myeloma UK would urge NICE to further consider the possibility of assessing erythropoietin in the context of cancer-related anaemia. We would also ask that NICE undertake an assessment of how NICE TA142 has been implemented across the UK. Myeloma UK is aware of myeloma patients who have become intolerant to blood transfusions, being unable to access erythropoietin and this has had an extremely detrimental effect on their overall quality of life. From our experience and through undertaking a survey of consultant haematologists, we know that there is inequitable access of erythropoietin across England and Wales. In some areas, consultant haematologists reported being able to use erythropoietin whenever clinically relevant, whereas in other areas they can only access it in patients with renal problems, in line with NICE CG114. We know this is often due to locally arranged 'contracts' which in some cases have significantly reduced the costs of EPO, increasing the likelihood of the local PCT's approving funding. Myeloma UK hopes that the differential picture of access across England and Wales will be considered and discussed by NICE as part of this appraisal as well as the role that NICE guidance can play in ensuring that this difference is addressed.	NICE can only appraise the technologies within their marketing authorisation. The technologies are currently licensed for people receiving chemotherapy; therefore an appraisal of cancer-related anaemia is beyond the remit for this appraisal. Variation in the regional implementation of NICE recommendations cannot be addressed in a technology appraisal. .

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	Healthcare Improvement Scotland and NCRN Haematological Oncology Study Group	See below	Comment noted.
Innovation	Royal College of Pathologists and BSH	It is not innovative anymore. The combination of an ESA plus intravenous iron is rather newer.	Comment noted.
Questions for consultation	Hospira UK	Cost-effectiveness comparisons performed should be consistent with the current label and clinical guidance on target Hb levels which is likely to result in lower cumulative ESA doses. The risk of thromboembolic events and death reported with traditional ESA use in this population is less clear with the more conservative ESA use recommended by label changes made since the last appraisal. Indeed, Swedish experience based on the NICE model and ESA treatment target Hb of 12 g/dl in line with current guidelines yields a cost per QALY that is 40% lower than a Hb-target of 13 g/dl when comparing to RBCT. [Borg, S et al. Acta Oncologica, 2008; 47:1009-1017]	Comment noted.
	NCRI/RCP/RCR/ACP/JCCO joint comment	Yes, but the issues of poorer cancer related outcomes have made the issue of ESA in cancer patients very difficult in recent years and a key component of this MTA.	Comment noted
	Myeloma UK	Myeloma UK knows that ESAs have a significant and substantial impact on health-related benefits, particularly for patients who have symptomatic anaemia. This is demonstrated in a wide-range of randomised controlled trials covering both cancer-	Comment noted.

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		related and cancer treatment-related anaemia. Patients who receive ESAs report having an improved quality of life, reducing symptoms such as fatigue, breathlessness and overall weakness. They are also able to get on with normal day-to-day activities such as walking, exercising, shopping, cleaning and socialising. The BCSH, UKMF and American Society of Haematologists all consider ESAs as a good standard of care for patients with symptomatic anaemia. In addition, these clinical bodies do not consider there to be any detrimental impact to patient outcomes after being treated with an ESA, despite some reports that they can impact on mortality. Finally, we welcome the introduction of biosimilars onto the market as a way of improving patient access to treatments and increasing market competition. There is currently no evidence to suggest ESA biosimilars are any less effective or safe than the generic versions of the treatments.	
	Healthcare Improvement Scotland and NCRN Haematological Oncology Study Group	Yes, but the issues of poorer cancer related outcomes have made the issue of ESA in cancer patients very difficult in recent years and a key component of this MTA.	Comment noted.
Additional Comments on the draft scope	Roche Products	The epoetin market is highly commoditised, and as such the different treatments already compete on price. TA 142 states that in these circumstances the drug with the lowest acquisition cost should be used. It is unclear what benefit would be realised by the	A review of TA142 was because since the guidance was published, several new products have been introduced to the market products including 'biosimilars' referencing an epoetin alfa

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		NHS or patients were a review of these technologies carried out.	product (Eprex). As a result of this, the cheapest available erythropoietin analogue (Binocrit, epoetin alfa) costs £50.91 per 10,000-unit prefilled syringe versus £62.85 per 10,000-unit prefilled syringe, the price that was used in the later analyses for TA142. Also the appraisal has been scheduled to coordinate with the availability of results from the EVALUATE study.
	NCRI/RCP/RCR/ACP/JCCO joint comment	Despite its unlicensed status, ESA therapy is widely used (for more than 20 years) in the haematological malignancies known as Myelodysplastic Syndromes (MDS) and a trial of such therapy is recommended in British Committee for Standards in Haematology (BCSH) guidelines for some patients with low risk MDS (Update due first half of 2013) as well as many other guidelines around the World. The UK use of ESA in MDS is considerably less than many European Countries as recorded in the on-going EU LeukemiaNet MDS Prospective Registration Study. Furthermore, the availability of this therapy is variable across the UK despite guideline recommendations. Inclusion of this indication as in-scope, would be widely appreciated by haematologists across the UK and would help address a genuine therapeutic dilemma which has gone on for many years in many Centres.	NICE can only appraise the technologies within their marketing authorisation. The technologies are currently licensed for people receiving chemotherapy for non-myeloid malignancies; therefore the inclusion of myelodysplacic syndromes is beyond the remit of this appraisal.
	Healthcare Improvement Scotland and NCRN Haematological Oncology Study Group	Despite its unlicensed status, ESA therapy is widely used (for more than 20 years) in the haematological malignancies known as Myelodysplastic Syndromes (MDS) and a trial of such therapy is recommended in	NICE can only appraise the technologies within their marketing authorisation. The technologies are currently licensed for people receiving

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		British Committee for Standards in Haematology (BCSH) guidelines for some patients with low risk MDS (Update due first half of 2013) as well as many other guidelines around the World. The UK use of ESA in MDS is considerably less than many European Countries as recorded in the on-going EU LeukemiaNet MDS Prospective Registration Study. Furthermore, the availability of this therapy is variable across the UK despite guideline recommendations. Inclusion of this indication as in-scope, would be widely appreciated by haematologists across the UK and would help address a genuine therapeutic dilemma which has gone on for many years in many Centres. However, I appreciate that this is unlikely to happen!!	chemotherapy for non-myeloid malignancies; therefore the inclusion of myelodysplacic syndromes is beyond the remit of this appraisal.

The following consultees/commentators indicated that they had no comments on the draft remit and/or the draft scope

Department of Health
Royal College of Nursing
Medicines and Healthcare products Regulatory Agency

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE)

Health Technology Appraisal

Erythropoiesis-stimulating agents (epoetin and darbepoetin) for treating cancer-treatment induced anaemia (including review of TA 142)

Response to consultee and commentator comments on the provisional matrix of consultees and commentators (pre-referral)

Version of matrix of consultees and commentators reviewed: Provisional matrix of consultees and commentators sent for consultation					
Summary of comments, action taken, and justification of action:					
	Proposal:	*Proposal made by:*		*Action taken:* Removed/Added/Not included/Noted	*Justification:*
1.	Representatives from the Jehovah's witnesses group should be included.	Royal College of Physicians on behalf of the NCRI/RCP/RCR/ACP/JCCO		Added	Following a search of potential groups "Hospital Information Services" had been identified as a potential group and added to the matrix.