

Present:

Professor D Dodwell	Breast NSSG Representative
Dr D Jackson	Gynae NSSG Representative
Dr R Johnson	Haematology NSSG Representative
Dr M Snee	Lung NSSG Representative
Mr G Fell (Chair)	NHS Bradford & Airedale
Ms G Fox	NHS North Yorkshire and York
Ms D Tomlinson	
Mr P Allen	User Partnership Group
Ms M Allinson	
Mr P McManus	Yorkshire and The Humber SCG
Mr D Thomson	Yorkshire Cancer Network

Apologies

Ms J Craig, Dr J Dent, Ms A Johnson, Dr T Perren

1. Welcome and Apologies			
Log No	Action	Lead(s)	Deadline
94	G Fell welcomed the group and apologies were noted.	N/A	N/A
2. Action Log from the last meeting			
Log No	Action	Lead(s)	Deadline
95	The action log from the meeting held on 25th November 2009 was agreed as an accurate record.	N/A	N/A
3. Matters arising			
Log No	Action	Lead(s)	Deadline
96	Paul McManus gave an update on log no. 78. 'Sunitinib Post Trial'. P McManus informed the group that the issue has now been resolved via the SCG.	N/A	N/A
4. New topic proposals - Trastuzumab in HER2 Positive Gastric Cancer			
Log No	Action	Lead(s)	Deadline
97	For discussion under 'Tri-Network Forum' and 'Horizon Scanning'.	N/A	N/A

5. Topics under review			
5.1 Gefitinib in mutation positive NSCLC - 1st line			
Log No	Action	Lead(s)	Deadline
98	<p>M Snee reported that trials showed that gefitinib significantly increased progression-free survival (PFS) and objective response rate (ORR) compared with standard chemotherapy in the overall patient population but that this overall benefit was driven primarily by the patients with EGFR mutation positive tumours. D Thomson reported that responses to the clinical and safety data were received from 3 Trust Drug and Therapeutic Committees (DTC's) all of whom supported the use of the drug.</p> <p>D Thomson then explained that the use of gefitinib in this patient group instead of standard chemotherapy, when viewed in isolation, was estimated to result in an incremental cost per annum of £1.3 million across YCN. However the clinicians noted that if gefitinib was approved they would no longer use erlotinib as a second line agent in these patients and that this and other factors would reduce this figure. A budget impact model was developed to estimate the incremental cost for the new pathway versus the current pathway. Using this model the estimated incremental cost per annum for the new pathway was £307,000 across YCN.</p> <p>YHEC discussed the Health Economic model provided by the company. The group agreed that, assuming a willingness to pay of up to £30,000 a QALY, gefitinib may be judged cost effective compared to gemcitabine plus carboplatin and pemetrexed plus cisplatin.</p> <p>The group therefore agreed that Gefitinib (Iressa) is recommended for use in the Yorkshire Cancer Network for the treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with activating mutations of EGFR-TK. This recommendation will be sent to the YCN Management Board meeting taking place on the 3rd February 2010.</p>	D Thomson	03/02/2010

5. Topics under review			
5.2 Herceptin beyond progression in metastatic breast cancer			
Log No	Action	Lead(s)	Deadline
99	<p>The YCN Gateway Group considered the London Cancer New Drugs Group (LCNDG) clinical review of trastuzumab in this indication. The group agreed that the clinical evidence presented would not normally result in a positive recommendation from the group.</p> <p>York Health Economic Consortium (YHEC) discussed their review of the health economic model supplied by the manufacturer. The group agreed that trastuzumab and capecitabine used to treat post progression breast cancer should not be considered to be cost effective at a willingness to pay threshold of £30,000 per QALY.</p> <p>D Thomson outlined the budget impact was difficult to estimate given the specific subgroup and small patient numbers. An estimate of £11,000 to £21,000 per 100,000 population per annum was agreed.</p> <p>Despite these facts the group found it very difficult to agree upon a recommendation. A number of other factors were felt to strongly influence possible recommendations:</p> <ol style="list-style-type: none"> 1. Clinicians locally, regionally, nationally and internationally firmly consider that this is their standard practice based on their clinical interpretation of the evidence. 2. This has been standard practice in YCN for many years and would involve a de-commissioning decision and the associated political and practical implementation issues this would raise. 3. That it appeared that neither of the other cancer networks in the SHA were reviewing this topic although trastuzumab was in use beyond progression in those networks. 3. The National Institute for Clinical Excellence (NICE) do not consider unlicensed indications. Trastuzumab beyond progression meets all the NICE end of life criteria apart from being unlicensed. 4. The NICE Advanced Breast Cancer Guidance does not recommend the use of trastuzumab. 5. That a recommendation in support of trastuzumab may set a precedent allowing the approval of Lapatinib. <p>However the group then considered recent discussions at NICE over it's appraisal of Lapatinib. This has been a difficult, long running appraisal and much of this difficulty has been over whether trastuzumab beyond progression is standard practice in the NHS England. The appraisal committee released an ACD in October 2009 which did not recommend the use of Lapatinib due in large part to the fact they did not consider that trastuzumab, the comparator, was standard practice in the NHS.</p> <p>In January 2010 the Guidance Executive asked the appraisal committee to reconsider this position due to "the fact that evidence, from the sponsor, other consultees and in the view of the National Cancer Director, trastuzumab is being used extensively post-progression". Their reason was stated as that whilst normally they would expect "NICE guidance to recommend practice which an advisory body knows to be cost effective, there may be circumstances in which an intervention might represent an improvement in the effectiveness with which NHS funds are being used, even though those NHS funds themselves may not necessarily represent the most cost effective use of resources."</p> <p>The YCN Gateway Group therefore considered it's difficulty in agreeing a recommendation on this topic that takes account of all the other considerations outlined. They further considered the fact that NICE appears</p>	D Thomson	03/02/2010

5. Topics under review			
5.2 Herceptin beyond progression in metastatic breast cancer			
Log No	Action	Lead(s)	Deadline
	to be having a similar difficulty and is better resourced and qualified to suggest a solution. In light of this the group agreed to make recommendation to allow current practice to continue and await an answer to this difficult issue from NICE. This recommendation will be sent to the YCN Management Board meeting taking place on the 3rd February 2010.		
100	D Dodwell agreed to forward the minutes to D Thomson from the breast Tri-Network meeting held on 4th January 2010.	D Dodwell	11/02/2010
5.3 Updated Health Economic analysis for Everolimus in metastatic RCC – 2nd line			
Log No	Action	Lead(s)	Deadline
101	As item 6.1.	N/A	N/A
6. Topics at N3/SCG			
6.1 Everolimus in metastatic RCC - 2nd line			
Log No	Action	Lead(s)	Deadline
102	<p>The YCN Gateway Group agreed in its meeting on 30th September 2009 that everolimus was a safe and effective option for the treatment of this group of patients offering a median progression free survival improvement of 3 months. In terms of budget impact across the YCN, the procurement costs of everolimus would be estimated to require additional funding of £451,440 - £712,800 per year dependent on the use of the patient access scheme and the number of eligible patients. Independent work carried out by YHEC in September 2009 led the group to not consider everolimus to be cost effective for use in YCN. An initial recommendation was made by the Gateway Group, and supported by the YCN Management board in its meeting of the 7th October 2009, not to recommend the use of the drug in this indication.</p> <p>After this decision was made the manufacturer subsequently agreed to share their health economic model with YHEC who reviewed this on our behalf. This second review was then discussed by the Gateway Group in January 2010. The key differences between the two models were:</p> <p>The methods used to estimate survival benefit. A lower price being applied to the Novartis model in accordance with DH approved patient access scheme approved in October 2009. The group agreed that Everoilimus would be very unlikely to fall within a cost-effectiveness threshold of £30,000 per QALY and additionally, given uncertainty over the estimated survival benefit in the health economic model, the groups did not feel sufficiently assured that the additional cost would fall within an “end of life” cost-effectiveness threshold.</p> <p>The group therefore agreed that Everolimus (Afinitor) remains not recommended for use in the Yorkshire Cancer Network for the second-line treatment of patients with metastatic renal cell cancer (mRCC) who are intolerant of or whose disease has progressed despite any prior VEGF receptor tyrosine kinase inhibitor therapy following a review of updated health economic evidence. This recommendation will be sent to the YCN Management Board meeting taking place on the 3rd February 2010.</p>	D Thomson	03/02/2010

6. Topics at N3/SCG			
6.2 Bevacizumab in metastatic breast cancer - 1st line			
Log No	Action	Lead(s)	Deadline
103	P McManus informed the group that North Trent Cancer Network still need to respond. Humber and Yorkshire Coast Cancer Network are discussing Bevacizumab at their Management Board meeting next week.	N/A	N/A
7. N3 Tri-Network Forum update			
Log No	Action	Lead(s)	Deadline
104	P McManus informed the group that the next Tri-Network Forum meeting is taking place next week. A proposal has been sent to the 3 Cancer Networks to formalise the group as a forum for agreeing commissioning priorities and policies across the 3 Networks. The group would act as an expert clinical panel for specialist services and would provide the SCG with technical and clinical advice.	N/A	N/A
8. Specialist Commissioning Group update			
Log No	Action	Lead(s)	Deadline
105	As item 7.	N/A	N/A
9. NICE update			
Log No	Action	Lead(s)	Deadline
106	D Thomson gave an update regarding recent recommendations from NICE and discussed recent published guidance.	N/A	N/A
10. Horizon scanning			
Log No	Action	Lead(s)	Deadline
107	D Thomson discussed the tabled paper produced from the horizon scanning presentations presented at the Gateway Launch Event on 16th October 2009. D Thomson to circulate to the group with the action log.	D Thomson	05/02/2010
11. AOB			
Log No	Action	Lead(s)	Deadline
108	D Thomson informed the group that the regimen list had now been finalised and will be sent to the YCN Commissioning Group for comments. The list will be compared across the 3 Networks.	N/A	N/A

Date of Next Meeting(s)

Wednesday 17th March 2010 2:00pm

Level 4, CRUK Meeting Room, Bexley Wing, St James's University Hospital, Beckett Street, Leeds, LS9 7TF

Wednesday 19th May 2010 2:00pm

Seminar Room 2, Cookridge Suite, Level 7, Bexley Wing, St James's University Hospital

Wednesday 21st July 2010 2:00pm

Level 4, CRUK Meeting Room, Bexley Wing, St James's University Hospital, Beckett Street, Leeds, LS9 7TF

Wednesday 22nd September 2010 2:00pm

Committee Room 1, Trust HQ, Ground Floor, St James's University Hospital

Wednesday 17th November 2010 2:00pm

Seminar Room 2, Cookridge Suite, Level 7, Bexley Wing, St James's University Hospital