Engagement Report

Topic details

Title of policy or policy statement:	Clinical Commissioning Policy Statement Abatacept for treatment of severe treatment-resistant morphoea (localised scleroderma) (adults and children 2 years and over)
Programme of Care:	Internal Medicine
Clinical Reference Group:	Specialised Rheumatology
URN:	1921

1. Summary

This report summarises the feedback NHS England and NHS Improvement received from engagement during the development of this policy proposition, and how this feedback has been considered. In summary all respondents were supportive of the proposition, but some identified additional evidence and guidance that has been considered by the Public Health member of the Policy Working Group.

2. Background

Abatacept belongs to a group of medicines called biological therapies. It is a protein which interrupts the interaction between T cells, a type of white blood cell involved in inflammation, and the other immune cells which activate these T cells. This results in decreased T cell activation, and therefore decreased inflammation, a key process of the disease activity in morphoea (localised scleroderma). Abatacept is currently widely used for rheumatoid arthritis as an approved biologic treatment. It may be administered intravenously or subcutaneously, self-injected by trained patients or their carers following their initial dose. Some patients with severe disease may require initial intravenous loading dose(s). Most patients will receive the treatment as subcutaneous injections.

Morphoea (localised scleroderma) is an idiopathic inflammatory disorder that causes sclerotic changes in the skin and soft tissues. Whilst typically limited to skin and subcutaneous tissues, it may affect deeper tissues including the muscular fascia, muscles, tendons, joints and bone. Though the exact trigger and disease process is not fully understood, it is thought that excessive T cell activation plays a key role. This leads to increased release of pro-inflammatory and pro-fibrotic mediators ultimately leading to increased collagen deposition.

The term morphoea covers a wide spectrum of clinical manifestations, which varies significantly in terms of its severity, depending on the extent, depth of involvement and activity of disease. Subtypes include a limited form of morphoea, a disseminated plaque form, a pansclerotic form and linear morphoea. There is no formal published definition of severe disease although it is widely agreed that it is based on site, extent, depth of involvement and potential to develop damage including functional and psychological

impairment (Li et al., 2012, Orteu, 2016). Specifically, sub-types with disease crossing joints thus limiting mobility and those occurring at multiple body sites (greater than 3 sites) or circumferentially constitute the severe phenotype. Patients with severe disease of deep disseminated plaque, pansclerotic and linear subtypes are the focus of this policy proposition. The linear and pansclerotic forms are the most likely to involve structures below the skin such as fascia, muscle and bone and require systemic therapies (Knobler 2017, Orteu 2016, Albuquerque 2019). Linear disease can cause significant limb length and girth asymmetry, flexion contractures and impaired mobility. Linear head and neck disease can cause facial asymmetry, scarring alopecia, ocular and dental problems and neurological complications including migraine and epilepsy. These apply to both juvenile onset and adult forms of morphoea.

NHS England and NHS Improvement have concluded that there is sufficient evidence to support the routine commissioning of this treatment for the indication.

This policy proposition has been developed by a Policy Working Group consisting of Consultant Rheumatologists, a Consultant Dermatologist, Paediatric Rheumatologists, a Public Health Consultant, a Pharmacist and a Patient Representative.

3. Engagement

NHS England and NHS Improvement has a duty under Section 13Q of the NHS Act 2006 (as amended) to 'make arrangements' to involve the public in commissioning. Full guidance is available in the Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning. In addition, NHS England and NHS Improvement has a legal duty to promote equality under the Equality Act (2010) and reduce health inequalities under the Health and Social Care Act (2012).
The policy proposition was sent for stakeholder testing for 2 weeks from 19th August to 2nd September 2020. The comments have then been shared with the Policy Working Group to enable full consideration of feedback and to support a decision on whether any changes to the proposition might be recommended.

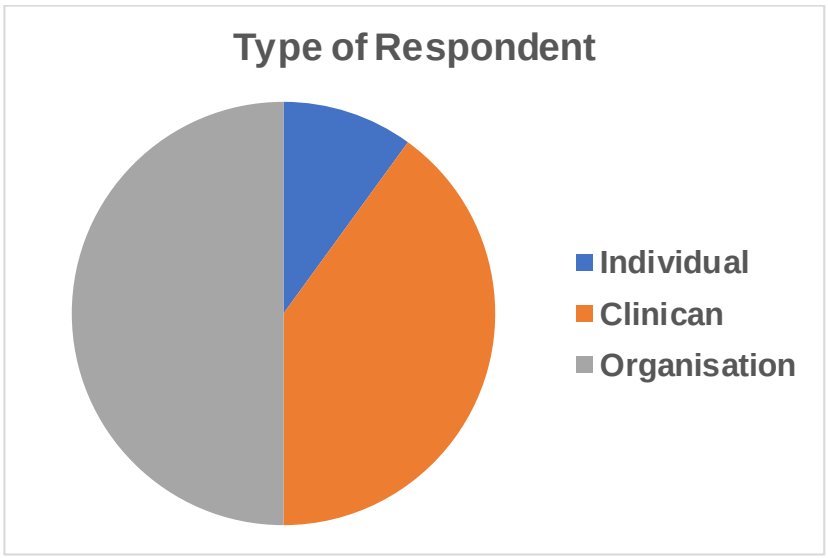
Respondents were asked the following questions:

- Do you support the proposal that Abatacept for treatment of severe treatment-resistant morphoea (localised scleroderma) (adults and children 2 years and over) will be routinely commissioned based on the evidence review and the criteria set out in this document?
- Do you believe that there is any additional information that we should have considered in the evidence review?
- Do you believe that there are any potential positive and/or negative impacts on patient care as a result of not making this treatment option available?
- Do you support the Equality and Health Inequalities Impact Assessment?
- Do you have any further comments on the proposal?
- Please declare any conflict of interests relating to this document or service area.

A 13Q assessment has been completed following stakeholder testing. The Internal Medicine Programme of Care has decided that the proposition offers a clear and positive impact on patient treatment, by potentially making a new treatment available which widens the range of treatment options without disrupting current care or limiting patient choice, and therefore further public consultation was not required. This decision has been assured by the Patient and Public Voice Advisory Group.

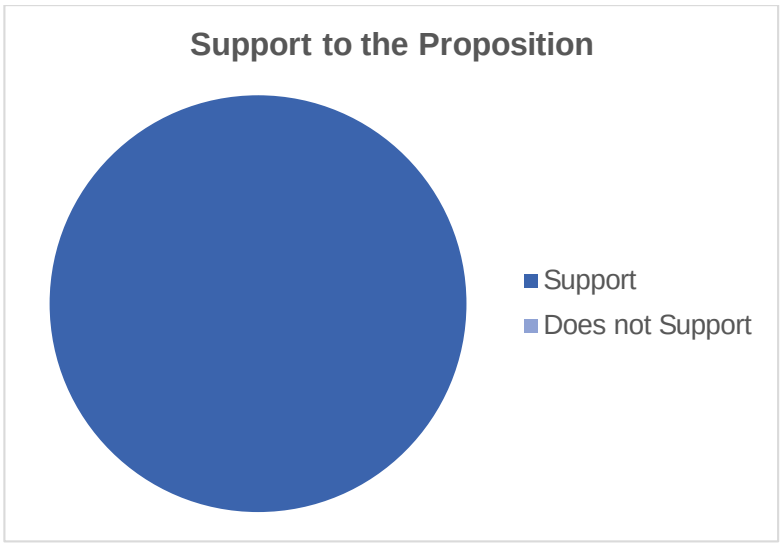
4. Engagement Results

There were 10 respondents in total: 1 individual, 4 clinicians and 5 organisations comprising 1 NHS Trust; British Association of Dermatologists; Scleroderma and Raynaud's UK; British Society for Rheumatology.



5. How has feedback been considered?

Responses to engagement have been reviewed by the Policy Working Group and the Internal Medicine PoC. All 10 respondents supported the routine commissioning proposition.



The following themes were raised during engagement:

Keys themes in feedback	NHS England Response
Relevant Evidence	
New evidence that has not been considered: Recent published retrospective paediatric case series and systematic literature review	*Kalampokis I, Yi BY, Smidt AC. Abatacept in the treatment of localized scleroderma: A pediatric case series and systematic literature review.*

(Kalampokis I et al. Sem Arth Rheum, Aug 2020, pg 645-656).	*Semin Arthritis Rheum. 2020 Aug;50(4):645-656.* The reported clinical outcomes from this case series of eight cases are consistent with that of the three studies on adult localised scleroderma: abatacept was effective in combination with disease modifying agents up to 30 months and it was well tolerated. It also supported the utility of LoSCAT in assessment of disease activity in paediatric cohort. Some of the subjects may have pansclerotic morphoea but the depth of the lesional sites was not described. 2 cases were not treated with disease modifying agents (MTX, MMF) before commencement of Abatacept but these were considered to be sufficiently severe enough to justify Abatacept. This paper was not available for review during the process. It can be considered to be included in Clinical trial evidence for paediatric cohort. *Knopfel N. LI, Schwieger-Briel A., Schroeder-Kohler S., Theiler M., Weibel L. Successful treatment of childhood localized scleroderma with abatacept: a case series. Pediatr Dermatol. 2019;36, Supplement 1 (S44).* The clinical outcomes on three paediatric cases were presented as conference abstract. Positive outcomes with improvement in disease activity were reported but insufficient details were available to assess robustness of response. Due to limitation of evidence from abstract, this is not included.
7 different published standards of care/consensus guidelines, is for systemic treatment with corticosteroids and methotrexate for all but very mild disease (Zulian 2019, Asano 2018, Constantin 2018, Knobler 2017, Kreuter 2016, Fett 2012, Li 2012. A UK multi-centre audit performed in 2016 of 149 patients showed that 143/149 (96%) met criteria for systemic treatment (Lythgoe et al, Ped Rheum 2018).	This supports that a majority of these patients with significant disease require systemic disease modifying agents. Noted and no further action.
Impact Assessment	
There were no comments on the impact assessment	Noted and no further action.
Potential impact on equality and health inequalities	
All of the respondents supported the Equality and Health Inequalities Impact Assessment and Patient Impact Assessment (PIA). All of the respondents agreed the proposition had positive impacts.	Noted and no further action.
Changes/addition to policy	
Comments on the stopping criteria were raised.	The text has been amended to clarify the stopping criteria.
There was a query on the number of DMARDS that need to have been used on a patient for the eligibility criteria	The text has been amended to clarify that at least 2 DMARDS have been tried.

6. Has anything been changed in the policy proposition as a result of the stakeholder testing and consultation?

The following changes based on the engagement responses have been made to the policy proposition:

- Considered Kalampokis et al (2020) that was highlighted as new evidence during stakeholder testing and the Implementation section has been amended accordingly.
- The eligibility criteria have been amended to clarify that at least 2 DMARDS should have been tried by the patient.
- The dosage for children has been amended to include reference to the Summary of Product Characteristics and to clarify the dosages.
- The monitoring and stopping criteria have been amended to include at any affected site after the modified Rodnan skin score (mRSS) is applied.
- The patient and clinical outcomes have been updated in the mandatory data collection section.
- The patient pathway has been updated to include paediatric centres.

7. Are there any remaining concerns outstanding following the consultation that have not been resolved in the final policy proposition?

No.