Northern, Eastern and Western Devon Clinical Commissioning Group
South Devon and Torbay Clinical Commissioning Group

Clinical Policy Committee (CPC)
Minutes

Wednesday 4th September 2013, 10.00 - 12 noon

Committee Suite, County Hall, Exeter

Present:

Dr Jo Roberts* (Chair)	GP Clinical Commissioner	South Devon & Torbay CCG
Dr Mick Braddick*	GP Clinical Commissioner	NEW Devon CCG
Dr Andrew Craig*	GP Clinical Commissioner	NEW Devon CCG
Richard Croker	Head of Medicines Optimisation	NEW Devon CCG
Dr Tawfique Daneshmend	Consultant Gastroenterologist & Hepatologist	RD&E NHS FT
Paul Foster	Chief Pharmacist	SDHC NHS FT
Niall Ferguson	Director of Pharmacy	NDHC NHS Trust
Barbara Jones	Head of Locality Contracting	NEW Devon CCG
Andrew Kingsley	Patient Safety and Quality	NEW Devon CCG
Dr Phil Melluish*	GP Clinical Commissioner	South Devon and Torbay CCG
Tracey Polak	Assistant Director/Consultant of Public Health	Devon County Council
Chris Roome	Head of Clinical Effectiveness	NEW Devon CCG
Dr Alison Round*	GP Clinical Commissioner	NEW Devon CCG
Dr Darunee Whiting*	GP Clinical Commissioner	NEW Devon CCG

Guests:

Dr Richard Haigh	Consultant Rheumatologist & Honorary Senior Clinical Lecturer	RD&E NHS FT
Dr Jon King	Consultant Rheumatologist	PHT NHS Trust
Dr Stuart Kyle	Consultant Rheumatologist	NDHC NHS Trust
Sanjay Verma	Clinical Evidence Pharmacist (Observer)	NEW Devon CCG
Hilary Pearce	Clinical Effectiveness Pharmacist	NEW Devon CCG
Dr Nick Viner	Consultant Rheumatologist	SDHC NHS FT

In attendance:

Fiona Dyroff	Clinical Effectiveness Governance Support Officer	NEW Devon CCG
Rebecca Heayn	Clinical Effectiveness Governance Manager	NEW Devon CCG

* Denotes voting members

1. Welcome and announcements

Attendees were welcomed to the meeting and the group introduced themselves.
Barbara Jones joined the meeting as deputy for Alison Wilkinson.

1.1 Apologies

Keith Gillespie	GP Clinical Commissioner	NEW Devon CCG
Andrew Gunatilleke	Consultant in Pain Management and Anaesthesia	SDHC NHS Foundation Trust
Stephen Hunt	GP Clinical Commissioner	NEW Devon CCG
Mac Merrett	Lay Member	
Alison Wilkinson	Contracting /Finance	NEW Devon CCG

1.2 Confirmation of voting members and declarations of interest

The six voting members present were noted. One voting member left the meeting prior to the decision on DAS scores: Initiation of biological treatment for rheumatoid arthritis being taken.

Declaration of interest forms were collected. The chair informed the committee that declarations of interest had been made by the rheumatology specialists present. These would be detailed in the minutes.

DRUG/TECHNOLOGY TO BE CONSIDERED	PHARMACEUTICAL COMPANY / MANUFACTURER / SERVICE PROVIDER
abatacept (Orencia®)	**Bristol-Myers Squibb**
tocilizumab (RoActemra®)	**Roche**
rituximab (Mabthera®)	**Roche**
Other drugs which can be used in rheumatoid arthritis: **adalimumab** (Humira®), **belimumab** (Benlysta®), **certolizumab** (Cimzia®), **etanercept** (Enbrel®), **golimumab** (Simponi®), **infliximab** (Remicade®)	**AbbVie, GlaxoSmithKline,** **UCB Pharma, Pfizer,** **Merck Sharp & Dohme**

NAME OF ATTENDEE	ROLE	
Dr Stuart Kyle	Consultant Rheumatologist	Received gifts, benefits or sponsorship of any kind, whether refused or accepted worth over £25 or several small gifts worth a total of over £100 from the above or closely related pharmaceutical/ manufacturing company/companies. Received honoraria from Abbvie, UCB and Chugai Roche
Dr Jon King	Consultant Rheumatologist	Have taken part in drug trial for the above drug/s device. Currently involved in multiple clinical trials involving all of the above apart from belimumab. Received gifts, benefits or sponsorship of any kind, whether refused or accepted worth over £25 or several small gifts worth a total of over £100 from the above or closely related pharmaceutical/ manufacturing company/companies. Sponsorship from UCB to attend EULAR 2011 London and Roche for EULAR 2012
Dr Richard Haigh	Consultant Rheumatologist & Honorary Senior Clinical Lecturer	Work as paid adviser to above pharmaceutical /manufacturing company/companies. UCB representative training on what NHS wants from companies selling biologic drugs, 2011. In receipt of payment/gift for transport and hospitality to attend national or international meetings or symposia. Roche paid registration and travel to attend EULAR annual scientific meeting, Berlin. Pharmaceutical trials – no personal payment to me, RD&E FT gains income. Have taken part in drug trial for the above drug/s/devices. Roche (Tocilizumab) trials - SUMMACTA trial complete 2012 (2 patients); ACT-TAPER currently recruiting (2 patients). Bristol-Myers Squibb: ASCORE observational study – just about to start recruitment.

1.3 Notification of any other business (AOB)

The chair asked the committee if there were any items to be discussed under AOB. The committee members confirmed that there were not.

2. Minutes of meeting held on 31st July 2013 and matters/actions arising

The minutes from the meeting held on 31st July were approved.

Actions from previous meeting:

13/20 *Options appraisal for declaration of interests to be brought to future meeting*

This will be brought to the meeting due to take place on 9th October 2013.

13/21 *NHS Devon, NHS Plymouth and Torbay Care Trust policies on circumcision to be reissued as joint NEW Devon CCG and South Devon and Torbay CCG commissioning policy*

Action complete

13/22 *NHS Devon and NHS Plymouth policies on Planned Treatment Abroad to be removed from NEW Devon CCG website. Website to indicate that funding of planned treatment aboard is the responsibility of NHS England and a link to NHS Choices to be provided.*

Action complete

13/23 *South Devon and Torbay CCG to be informed that their policy planned treatment abroad is no longer valid.*

Action complete

13/24 *Lixisenatide commissioning policy to be published*

Action complete

13/25 *Flutiform commissioning policy to be published*

Action complete

13/26 *Renavit commissioning policy to be published*

Action complete

13/27 *Details of future CPC meetings to be circulated with meeting minutes*

Action complete

13/28 *Appeals procedure to be considered and report brought to future CPC meeting*

3. Subcutaneous abatacept for rheumatoid arthritis

The committee were asked to consider evidence for commissioning the subcutaneous formulation of abatacept for the treatment of rheumatoid arthritis. Hilary Pearce – Clinical Effectiveness Pharmacist, NEW Devon CCG presented an evidence review. Dr Richard Haigh, Consultant Rheumatologist, Dr Jon King Consultant Rheumatologist, Dr Stuart Kyle Consultant Rheumatologist, and Dr Nick Viner Consultant Rheumatologist were present for this item.

Abatacept is a selective T cell co-stimulation modulator and has a different mechanism of action to the anti-TNFs and rituximab and tocilizumab. Abatacept is licensed in combination with methotrexate. NICE guidance on the use of the subcutaneous (sc) formulation is not expected until at least May 2014. Subcutaneous abatacept would offer a more convenient method of administration for patients and increase the range of NICE recommended drugs available for subcutaneous administration.

The committee reviewed the clinical evidence for subcutaneous abatacept. The results of four randomised controlled trials (RCT) evaluating subcutaneous abatacept have been published. The key trials are a comparison of the intravenous (iv) and subcutaneous formulations of abatacept and a comparison of the subcutaneous formulations of abatacept and adalimumab.

The subcutaneous and intravenous formulations of abatacept in combination with methotrexate were compared in a phase III randomised double-blind, double-dummy non-inferiority study of 1457

patients. An intravenous loading dose was given before initiating treatment with subcutaneous abatacept. The primary endpoint was achievement of ACR20 response at 6 months. Non-inferiority of subcutaneous abatacept versus the intravenous formulation was demonstrated. No conclusions were drawn on the impact of giving an IV loading before the first sc injection.

A two year phase III open-label non-inferiority RCT compared subcutaneous formulations of abatacept and adalimumab, both drugs were given in combination with methotrexate and no intravenous loading dose was given. The first year's results have been published and the study demonstrated non-inferiority of abatacept and adalimumab. The primary end-point was achievement of ACR20 response at 6 months. Outcomes for remission rate and proportion of responders using disease activity indices were similar for the two treatment groups.

Safety outcomes were comparable or more favourable for the subcutaneous formulation of abatacept to that of the intravenous formulation.

Anti-TNFs are excluded from the Payment by Results Tariff and pass-through arrangements for payment have been made between acute trusts and the CCGs. NICE has approved a patient access scheme for abatacept, the details of which are confidential. The total annual cost of the subcutaneous formulation of abatacept is approximately 50% lower than the total annual cost of the intravenous formulation taking into account drug cost, administration cost and VAT.

The committee discussed a range of issues pertinent to this therapy:

- Abatacept subcutaneous injection offers patients a more convenient method of administration.
- Cost savings could be made in the healthcare community if subcutaneous injections were used in place of intravenous therapy.

The committee voted unanimously in favour of commissioning the subcutaneous formulation of abatacept for the treatment of rheumatoid arthritis.

ACTION: Commissioning policy to be published.

4. Rituximab with methotrexate for rheumatoid arthritis

Local specialists have expressed an interest in using rituximab in combination with methotrexate for patients with an inadequate response to conventional DMARDs for whom anti-TNFs are not clinically appropriate because of co-morbidities which raise medical concerns. The committee were asked to consider the evidence for commissioning rituximab with methotrexate for rheumatoid arthritis as a first line biological agent for some patients. Hilary Pearce – Clinical Effectiveness Pharmacist, NEW Devon CCG presented an evidence review. Dr Richard Haigh, Consultant Rheumatologist, Dr Jon King Consultant Rheumatologist, Dr Stuart Kyle Consultant Rheumatologist, and Dr Nick Viner Consultant Rheumatologist were present for this item.

Rituximab with methotrexate is licensed for treating patients with severe active rheumatoid arthritis who have had an inadequate response or are intolerant to other disease-modifying anti-rheumatic drugs (DMARD) including one or more anti-TNF. Rituximab is an anti-CD20 monoclonal antibody which acts by selectively depleting CD20+B cells. NICE TA195 recommends rituximab as a second line biologic in line with licensed indication. Currently abatacept and tocilizumab are the two NICE options for patients requiring a first line biologic in combination with methotrexate wishing to avoid use of anti-TNFs.

The committee reviewed the evidence for rituximab with methotrexate. Two randomised control trials have been undertaken to investigate Rituximab as a first line biologic in combination with methotrexate for the treatment of rheumatoid arthritis. SERENE, a phase III RCT with a primary endpoint of the proportion of patients with an ACR20 response at week 24 demonstrated significantly greater efficacy of rituximab plus methotrexate compared to methotrexate plus placebo. It was also

shown that significantly higher proportions of patients receiving rituximab plus methotrexate achieved EULAR responses and low disease activity and remission compared with patients receiving methotrexate plus placebo. A phase II trial by Edwards et al with a primary endpoint of the ACR50 response at 24 weeks found a significant difference in the proportion of patients achieving an ACR50 response in favour of the rituximab plus methotrexate group. There are no head to head comparisons between rituximab and abatacept or tocilizumab. Evidence for comparative efficacy in from a meta-analysis of RCT data for abatacept, rituximab and tocilizumab indicates that the efficacy for rituximab lies between that of abatacept and tocilizumab. The trial also found that the rate of serious adverse events and of serious infection were comparable or lower than the rates for the control group. Comparative evidence suggested that the rate of serious infections for rituximab is higher than observed for abatacept but lower than observed for tocilizumab.

The latest evidence on the influence of rheumatoid factor and anti-CCP antibody status on response to rituximab suggests that the influence of these factors on response is not uniform across all patient populations receiving rituximab. Two analyses of rituximab trial data and patient characteristics indicate that seropositivity for rheumatoid factor and/or anti-CCP antibody at baseline has at most a modest effect on response to rituximab for patients who have no history of biologic use. Assuming that all patients are treated at the minimum dosing interval for rituximab it is estimated that cost would be 50% lower than intravenous formulations of abatacept or tocilizumab and comparable to sc abatacept injection. Review of extension phases to clinical trials and case series indicated that retreatment time for patients receiving rituximab ranged from 9 to 12 months. Therefore cost differences between intravenous formulations of abatacept and tocilizumab and sc abatacept injection are expected to be greater than the estimates given.

The committee discussed a number of issues pertinent to this therapy:

- Current options for these patients were limited to intravenous formulations of abatacept and tocilizumab given every four weeks. The commissioning of sc abatacept provides an alternative method of administration but sc administration is not suitable for all patients.
- Specialists confirmed that in clinical practice the retreatment interval for rituximab is significantly greater than six months for the majority of patients.
- Rituximab with methotrexate if offered as a first line biologic would provide an additional treatment option for patients for whom anti-TNFs were not suitable for clinical reasons.
- No capacity issues are expected, this therapy requires a longer infusion time but retreatment is required less often. Cost savings could be made.

The committee voted unanimously in favour of commissioning rituximab with methotrexate for rheumatoid arthritis.

ACTION: Commissioning policy to be published.

5. Tocilizumab without methotrexate for rheumatoid arthritis

There are no NICE recommended options for patients who require a biologic without concomitant methotrexate and for whom anti-TNFs are not clinically appropriate due to comorbidities which give rise to medical concerns. Local clinicians have asked for tocilizumab and rituximab to be considered as treatment options for this group of patients. Tocilizumab is licensed for use as monotherapy as a first line biologic. There is some support for this therapy from the British Society for Rheumatology. The committee were asked to consider the evidence for commissioning tocilizumab without methotrexate for rheumatoid arthritis as a first line treatment for patients for whom anti-TNFs are not clinically approved. Hilary Pearce – Clinical Effectiveness Pharmacist, NEW Devon CCG presented an evidence review. Dr Richard Haigh, Consultant Rheumatologist, Dr Jon King Consultant Rheumatologist, Dr Stuart Kyle Consultant Rheumatologist, and Dr Nick Viner Consultant Rheumatologist were present for this item.

The committee considered the evidence for tocilizumab without methotrexate. The evidence for tocilizumab as monotherapy comes from three double-blind, placebo-controlled RCTs including one phase IV RCT (ADACTA), one phase III RCT (ACT-RAY) and one small phase II RCT (CHARISMA). No comparative data from meta-analyses or indirect comparisons are available to compare tocilizumab monotherapy with rituximab monotherapy.

The CHARISMA trial demonstrated that significantly more patients receiving tocilizumab monotherapy achieved an ACR20 response than patients receiving methotrexate plus placebo. The ACT-RAY trial which compared tocilizumab monotherapy with tocilizumab plus methotrexate found similar outcomes for the two treatment regimens. In the ADACTA trial tocilizumab monotherapy demonstrated superior efficacy to a NICE approved treatment option, namely adalimumab. The safety profile of tocilizumab monotherapy is similar to or better than that of tocilizumab plus methotrexate. Rates of serious adverse events and serious infections reported by the ACT-RAY trial were comparable for tocilizumab monotherapy and tocilizumab plus methotrexate. Fewer treatment discontinuations and dose modifications for safety reasons were reported for tocilizumab monotherapy versus the combination therapy. It was reported that SMC had recommended tocilizumab without methotrexate and found the cost-effectiveness case to be demonstrated. However, the cost-effectiveness analysis addressed the use of tocilizumab versus anti-TNFs therefore it was not applicable to this patient group.

The committee discussed a range of issues pertinent to this therapy:

- Currently, there is no NICE recommended treatment option for patients who require a biologic without methotrexate and for whom anti-TNFs are not clinically appropriate.
- Some members of the committee were concerned that there was no formal cost-effectiveness analysis of tocilizumab without methotrexate for this patient group. NICE consider tocilizumab in combination with methotrexate to be cost-effective as a first line biologic. Similar health gains are anticipated with the use of tocilizumab monotherapy at a cost which would not be higher than the cost of combination treatment..
- It was noted that the commissioning decision on tocilizumab would be reconsidered when the NICE MTA on first line use of biologics was issued.
- A relatively low number of patients are expected to receive this therapy.
- A patient access scheme is in place for this drug.
- NICE - formal guidance on tocilizumab without methotrexate as a first line treatment is expected in 2014; some members felt the committee should wait for NICE. However it was acknowledged that publication of MTAs is frequently delayed.

The committee voted four to two in favour of commissioning tocilizumab without methotrexate for rheumatoid arthritis.

ACTION: Commissioning policy to be published.

6. Rituximab without methotrexate for rheumatoid arthritis

There are no NICE recommended options for patients who require a biologic without concomitant methotrexate and for whom anti-TNFs are not clinically appropriate due to comorbidities which give rise to medical concerns. Local specialists have asked for rituximab and tocilizumab to be considered as treatment options for patients who require a biologic without methotrexate and for whom anti-TNFs are not clinically appropriate. Use of rituximab as a first line biologic without methotrexate would fall outside of its licensed indications. The committee were asked to consider the evidence for commissioning rituximab without methotrexate for rheumatoid arthritis as a first line treatment for these patients. Hilary Pearce – Clinical Effectiveness Pharmacist, NEW Devon CCG presented an evidence review. Dr Richard Haigh, Consultant Rheumatologist, Dr Jon King Consultant Rheumatologist, Dr Stuart Kyle Consultant Rheumatologist, and Dr Nick Viner Consultant Rheumatologist were present for this item.

The committee reviewed the evidence for commissioning rituximab without methotrexate for rheumatoid arthritis. Efficacy for rituximab without methotrexate is based on one small double-blind

placebo controlled phase II RCT (Edwards et al). Two arms were of direct relevance to this review: rituximab plus placebo and methotrexate plus placebo (control). Evidence from this trial has shown that significantly more patients receiving rituximab plus placebo achieved an ACR20 response than patients receiving methotrexate plus placebo. More patients receiving rituximab plus placebo achieved an ACR50 response (primary end-point) and ACR70 response but the treatment differences compared with control were not significant. The rituximab plus placebo group failed to meet the primary endpoint of ACR50 because the placebo group achieved a higher than expected response. Data from the Edwards trial suggest that the efficacy of rituximab monotherapy is slightly lower than achieved with rituximab plus methotrexate as a first line biologic.

There are no head-to-head trials of rituximab monotherapy and tocilizumab monotherapy. There is no data from comparative analyses including meta-analyses and indirect comparisons comparing the two drugs. The British Society of Rheumatology (BSR) register of biologics includes a cohort of 106 patients who received rituximab, were anti-TNF naïve and in whom 75% of patients were receiving rituximab as monotherapy or with conventional DMARDs other than methotrexate. Response to rituximab six months after starting treatment were reported as the mean change from baseline in DAS28 of -1.71, a moderate EULAR response was reported for 47.17% of patients and a good EULAR response for 22.64% of patients. Disease remission was achieved for 14.15% of patients. Data from case series are also suggestive of benefit. There is limited evidence on the safety profile of rituximab monotherapy however it would be reasonable to assume that it would be similar or better than that or rituximab plus methotrexate.

The committee considered a range of issues pertinent to this therapy:

- The lack of evidence from large clinical trials was noted. Rituximab plus placebo failed the primary end-point of the Edwards trial because the control group achieved a higher then estimated response. It was noted that significantly more patients receiving rituximab plus placebo achieved an ACR20 response, which is an end-point commonly used in many of the larger clinical trials.
- Rituximab monotherapy would provide an alternative treatment option to tocilizumab for patients with no NICE approved option including less frequent treatment intervals than tocilizumab.
- The aim of the specialists is to be able to provide patients with the right treatment at an early stage. Clinical judgement is used to identify appropriate treatment and the likely response of patients.
- The stage at which treatment would be stopped if a patient had not responded.

The committee voted unanimously in favour of commissioning rituximab without methotrexate for rheumatoid arthritis.

ACTION: Commissioning policy to be published.

7. DAS scores for initiation of biologics for rheumatoid arthritis

Local specialists have requested that the requirement to assess at least two DAS scores >5.1 or one month apart, for determining eligibility for treatment with a biologic for rheumatoid arthritis be amended. They consider that the delay in treating patients is unnecessary, in light of a published analysis from UK clinical practice, and that this results in patients with on-going active disease waiting for a further month before a biological therapy is started. Dr Richard Haigh, Consultant Rheumatologist, Dr Jon King Consultant Rheumatologist, Dr Stuart Kyle Consultant Rheumatologist, and Dr Nick Viner Consultant Rheumatologist were present for this item. Hilary Pearce – Clinical Effectiveness Pharmacist – NEW Devon CCG presented an evidence review.

The committee were asked to consider the evidence for NICE criteria for at least two DAS scores of >5.1 or more measured one month apart for determining eligibility for treatment. NICE guidance is

based on eligibility criteria for biological therapy first issued by the British Society for Rheumatology (BSR) in 2001. BSR issued updated guidance in 2010 in which the requirement for two DAS readings, one month apart, has been removed.

The British Society for Rheumatology guidance on biologics (2010) refers to two publications addressing the minimum number of repeated measures of DAS score required to determine eligibility for biological therapies. These papers appear to indicate that the number of assessment visits will not completely eliminate the variability in disease activity between one assessment and another. The papers also indicate that the impact of this variability on treatment costs would appear to be minimal. There is no clear rationale for a specific number of DAS scores being taken. It is important that the DAS score selected by the clinician is an accurate reflection of the patient's condition as this will have an important impact on determining continuation of treatment.

The committee discussed a range of issues pertinent to this request:

- The rationale behind the NICE guideline and access to treatment. NICE are reviewing DAS28 scores and access to biologics; any CPC decision may have to be reviewed in light of any new guidance.
- The role of professional clinical judgement in identifying patients who require treatment with a biologic. Not all patients with a DAS28 score of more than 5.1 are treated with a biologic.
- In many cases, DAS scores are measured regularly at monthly intervals.
- The health and social costs of an unnecessary delay in treatment.

The committee voted unanimously in favour of commissioning the initiation of biologic agents for rheumatoid arthritis based upon the treating clinician's judgement that a baseline DAS score in excess of the NICE threshold for eligibility has been obtained which reflects the patient's condition, but that the requirement to determine eligibility with two scores taken one month apart be amended.

ACTION: Commissioning policy to be published.

8. Multiple chemical sensitivity

As part of the work being undertaken to align commissioning policies across Devon consideration had been given to the treatment of multiple chemical sensitivity. Hilary Pearce – Clinical Effectiveness Pharmacist, NEW Devon CCG presented a paper.

NHS Devon and Torbay Care Trust did not have policies for this condition. NHS Plymouth Clinical Commissioning Group agreed a policy in November 2010. The key points from the previous NHS Plymouth policy were:

- lack of consensus amongst clinicians that multiple chemical sensitivity is a recognised clinical syndrome;
- lack of trial evidence for specialist interventions and services should not be commissioned;
- recognition that this group of patients have health needs that should be treated by local NHS services.

The NHS Plymouth policy does not refer to any specific specialist interventions for multiple chemical sensitivity and a search of guidance from multiple professional bodies has not identified any specialist interventions with an evidence base for treating this condition. Information from the Royal College of Psychiatrists and the Royal College of General Practitioner's report and the British Society of Allergy and Clinical Immunology suggests that symptoms attributed to multiple chemical sensitivity would be expected to be managed through routinely commissioned NHS services. Therefore the development of a CCG policy on multiple chemical sensitivity is not required and it is proposed that the existing NHS Plymouth policy will be removed from the NEW Devon CCG website.

The committee considered issues pertinent to the need or otherwise for the development of a CCG policy on multiple chemical sensitivity, including;

- that the NHS Plymouth policy did not refer to any specific interventions and stated that patients should be managed locally;

The committee voted unanimously in favour of removing the existing NHS Plymouth policy.

ACTION: NHS Plymouth policy on the treatment of multiple chemical sensitivity to be removed from NEW Devon CCG website.

The chair expressed the thanks of the committee to Hilary Pearce for the phenomenal amount of work she had put into producing the committee papers.

9. Update from NICE Planning, Quality and Assurance Group (NPAG)

The committee received an update on the NPAG meeting held on 23 July.

- Tobacco - NICE support the harm reduction model, however it was felt that there is a lack of clarity on cost effectives and health benefits of smoking reduction. Locally the smoking cession model is currently used and work is being undertaken to work up a common position for the three public health teams in Devon.
- A representative from NHS England will attend the NPAG meeting taking place on Tuesday 22nd October 2013

10. Any other business

There was no other business to report. The chairman noted that the later than expected finish time reflected the volume and complexity of the issues considered. Discussion had been well focused.

Meeting closed at 12.40 pm

Summary of actions		
	Action	**Lead**
13/20	Options appraisal for declaration of interests to be brought to October meeting	Rebecca Heayn /Chris Roome
13/28	Appeals procedure to be considered and report brought to future CPC meeting	Chris Roome /Jo Roberts
13/29	Abatacept commissioning policy to be published.	Rebecca Heayn
13/30	Rituximab with methotrexate commissioning policy to be published	Rebecca Heayn
13/31	Tocilizumab without methotrexate commissioning policy to be published	Rebecca Heayn
13/32	Rituximab without methotrexate commissioning policy to be published	Rebecca Heayn
13/33	DAS scores for initiation of biologics for rheumatoid arthritis commissioning policy to be published	Rebecca Heayn
13/34	Multiple chemical sensitivity policy to be removed from NEW Devon CCG website	Rebecca Heayn