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Regional Medicines Optimisation Committees

Operating Model

Version 1, November 2021

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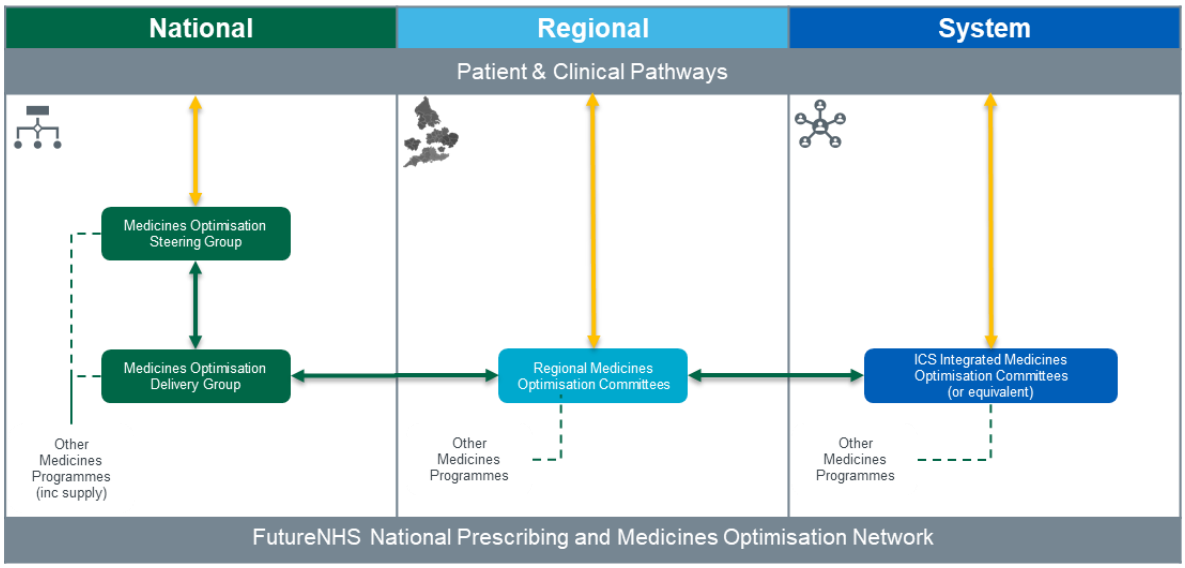
April 2022; then every two years by the Medicines Optimisation Delivery Group (MODG)

Contents

Vision

1. Medicines are the most common therapeutic intervention and the second biggest expenditure after workforce. Our (NHS England and NHS Improvement) vision for medicines is, therefore, to have a framework of policy, clinical leadership, and governance to ensure all aspects of medicines optimisation are integrated and coordinated to support system delivery within and across the NHS.



2. The Medicines Optimisation Steering Group (MOSG) acts as the most senior national group to bring all medicines workstreams together, the national point of support for medicines optimisation and ensures alignment on medicines optimisation policy and strategy.

3. The MOSG delegates responsibility to the Medicines Optimisation Delivery Group (MODG) to translate the national medicines policy and strategy into a delivery programme and work collaboratively with national, regional and system representatives to oversee the development of national recommendations and implementation guidance to support regions and systems in delivering medicines optimisation priorities.

4. Regional medicines optimisation committees (RMOCs) have delegated responsibility from the MODG to provide a strong link between national and/or regional policy/priorities/programmes and local system implementation.

5. Given the wide-ranging use of medicines in patient and clinical pathways, medicines optimisation is a critical enabler to supporting improvements in population health management and transformation of pathways of care and RMOCs are expected to support integrated care systems (ICSs) in optimising medicines usage to help achieve their triple aim of:

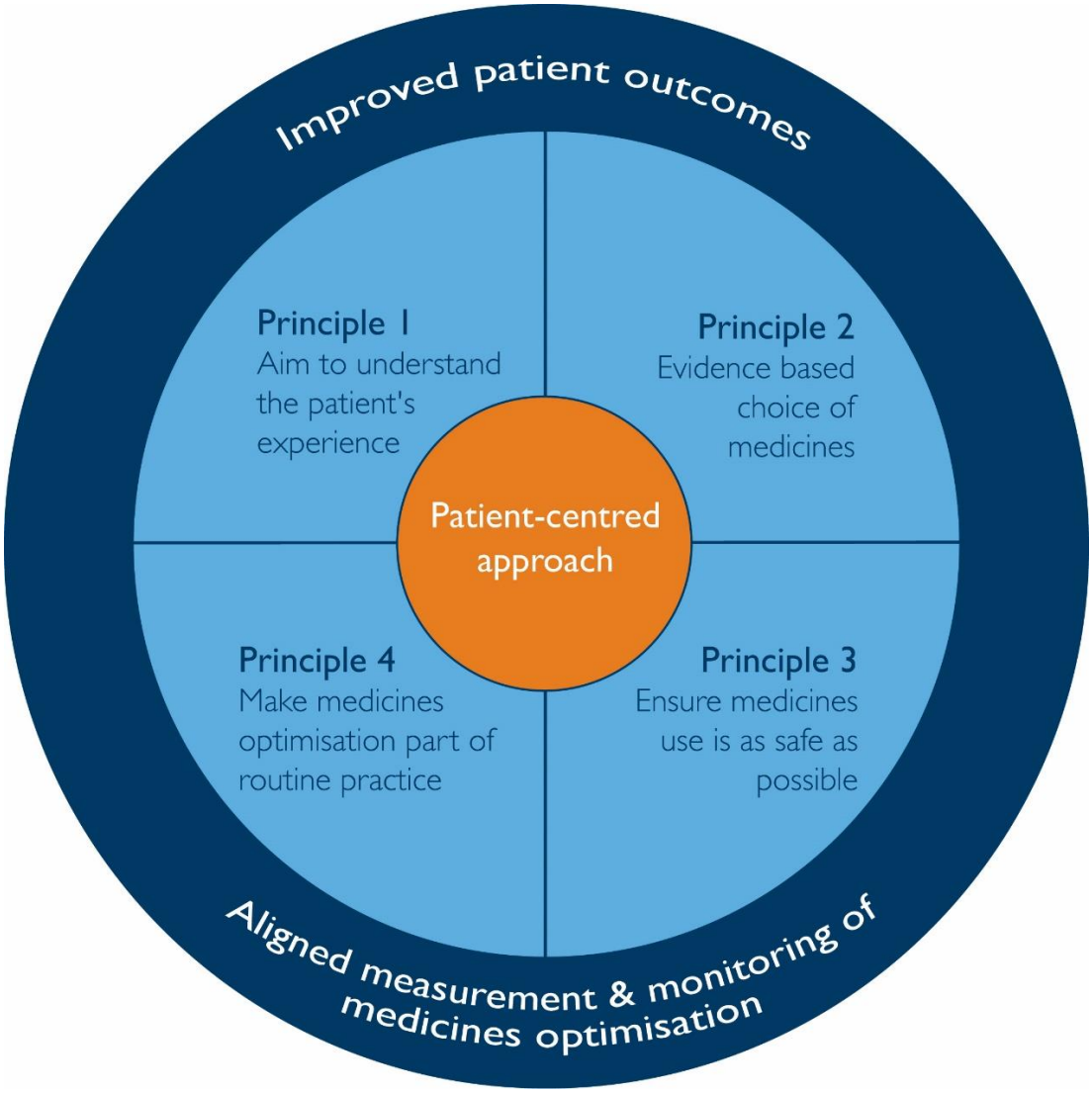
   - better health for everyone
   - better care for all
   - efficient use of NHS resources.

6. RMOCs are expected to embed a supportive and collaborative approach working closely with ICSs and other relevant stakeholders within and outside their region as required.

7. To deliver the NHS vision and priorities across England in a clear, consistent and coherent way, there will be seven RMOCs covering East of England, London, Midlands, North East and Yorkshire, North West, South East and South West. Their membership will be constituted to ensure representation from all ICSs in their region.

Aims and objectives

8. RMOCs have been established to optimise the use of medicines for the benefit of patients and the NHS, in line with the principles set out in the following diagram. They bring together decision-makers, healthcare professionals and patient representatives to share best practice, understand the evidence base and patient perspective to support the coordination of action to reduce unwarranted variation in clinical practice and improve equity of access to effective medicines.



9. The remit of the RMOCs will span the optimisation of medicines in all care settings and all parts of the integrated care system (primary care, secondary care, and tertiary care).

10. RMOCs have the following key aims and objectives:

- To support best patient outcomes through the safe, clinically effective, and cost-effective use of medicines while ensuring the NHS gets the best value for the taxpayer. This is achieved through the provision of timely and credible recommendations on medicines optimisation issues, for use and implementation by local decision-makers.

- To advise on and share best evidence-based practice across the region, supporting integrated care systems with identification and implementation

of medicines optimisation priorities while minimising duplication of effort and resources.

- To identify and then reduce unwarranted variation across the region by encouraging and facilitating consistent best practice across local and regional organisations.

- To promote awareness and support local implementation of regional and national policies and initiatives relating to medicines, including supporting implementation of national guidance, research and the adoption of proven innovation in medicines including those medicines that are part of the Accelerated Access Collaborative's 'Rapid Uptake Products' programme.

- To regularly feed up into the MODG any issues, risks and regional or system priorities that would benefit from a national approach or resolution led by NHS England and NHS Improvement, the Department of Health and Social Care (DHSC) or NICE.

- To inform development of, and where appropriate, lead regional delivery of the national medicines strategy. Overarching ownership of the national medicines strategy and national medicines optimisation priorities will be led by the MOSG and MODG, but RMOCs may be asked to support refinement or testing of the strategy and/or national medicines optimisation priorities.

- To collaborate where there are issues of common concern and/or the potential for duplication of effort or inconsistent implementation of policy.

11. To achieve these aims, RMOCs should:

- provide senior, authoritative, strategic medicines leadership and expertise based on best practice and best available evidence.
- consult and engage with stakeholders within their regions to inform development of the annual medicines optimisation delivery plan, and RMOC outputs, decisions, and recommendations where appropriate.
- safeguard appropriate use of anti-microbials by engaging with the national Antimicrobial Resistance (AMR) programme.
- support our statutory function in securing the safe management and use of controlled drugs.

- act as the regional point of contact for medicines optimisation expertise and guidance eg to review medicines within pathways of care.
- act as the channel through which regional issues, successes, and medicines optimisation priorities can be referred to national team(s) and governance infrastructure for national review, action, and potential national implementation.
- support ICSs in implementing national policies and guidance consistently across the region.
- support national teams and governance forums in the identification and delivery of national workstreams and invite members/regional representatives to join national working groups and sub-committees.
- share learning and understanding, identify best practice and disseminate research and innovation across the region, supporting the adoption and spread of proven innovations in medicines.
- promote equity in access, optimisation of use and the clinically effective and cost-efficient integration of medicines into patient and clinical pathways.
- promote inter- and intra-professional collaborative working across organisations.
- improve patient safety and reduce medication errors, working with other stakeholders as needed.
- take a strategic view of medicines optimisation, coordinating cross-sector support and engagement with the public, patients, commissioners, providers and clinicians to improve outcomes, reduce harm, and encourage a longer-term, patient-centred approach to medicines optimisation focusing on the effective investment in improving health and wellbeing.
- support ICS strategic and operational planning where relevant to medicines optimisation.
- inform and influence national policy and strategy for medicines optimisation including incentives for delivery through national contracts.
- be mindful of and support ICSs to follow the 2012 NHS Constitution in their work, which states that patients "have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you", and "have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides

not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you."

Outputs

12. Outputs could be in the form of:

- Advice, guidance, recommendations, tools, and other resources to support regional and local delivery.
- Newsletters, bulletins, and online resources to inform and engage with stakeholders.
- Regional guidance and recommendations to support NICE outputs, and wider national policy and strategy development and implementation.

13. RMOC outputs should:

- aim to achieve the best outcomes and experience for patients and regional populations taking into account the resources available in the region and at individual ICS level.
- have due consideration to NICE outputs.
- aim to support delivery of NHS strategic and operational priorities, the NHS Long Term Plan, the People Plan, the NHS Patient Safety Strategy, reduce health inequalities, and maximise environmental sustainability.

14. RMOCs should develop a region-wide vision and annual delivery plan (with specific, measurable, attainable, relevant and time-based [SMART] objectives wherever possible) for medicines optimisation. This should focus on the actions of the RMOCs to support ICSs in improving safety, outcomes, value and delivery of national and regional medicines optimisation priorities, including use of antimicrobials in line with the National AMR strategy. The delivery plan should be actively shared across the region before the start of each financial year and with the national team on a six-monthly basis. The delivery plan may need to evolve throughout the course of a year, so will need to be flexible and able to respond to emerging national, regional, and local priorities.

15. RMOCs should consider how best to implement the delivery plan which may include, for example, leveraging resource available within ICSs, submitting business cases to commission additional resource or expertise and/or creating

opportunities for interested individuals across the region to support delivery of priorities eg pre-registration pharmacists.

16. Annual delivery plans should reflect a balance between national, regional and local priorities with clear measures of success and key performance indicators (where appropriate) to measure the impact of the RMOC's work to demonstrate its contribution to its aims, those of the national programmes and those of the ICSs in their region.

17. RMOC operational guidance will not routinely be subject to public consultation outside the NHS.

Delegated authority

18. The RMOCs have been delegated responsibility by our MODG to lead, support and report on activities related to medicines optimisation strategy, policies, and guidelines across their region.

19. The RMOCs have no executive powers, other than those specifically delegated in this document. While RMOC outputs will be advisory and do not affect the statutory legal responsibilities and duties of NHS bodies, they are based on best practice and on the best available evidence and there is an expectation that local integrated care systems will have regard to implementation of RMOC recommendations.

Accountability

20. As the governance link between national policy and local system implementation as well as being a key point of contact for regional medicines optimisation expertise and guidance (in addition to the regional chief pharmacists), RMOCs are accountable to both the MODG and to our regional senior leadership, and should report in to appropriate regional structures.

21. The MODG is responsible for translating the national medicines policy and strategy into a delivery programme. Working collaboratively with national, regional and system representatives to oversee the development of national recommendations/implementation guidance to support regions and systems in delivering medicines optimisation priorities. The MODG is responsible for the governance and oversight of RMOC processes and the RMOC system to

ensure consistency in principles of operation and a set of measures by which each RMOC expects to demonstrate success.

22. While each RMOC has accountability and responsibility for delivery of its workplan and priorities, the MODG will play a key role in overseeing delivery across all the RMOCs, assessing the timeliness of delivery and the impact of RMOC outputs on reducing variation and improving quality.

23. Regular communication and feedback to the MODG will be carried out:

- Through reports on decisions and key actions, areas of high risk, safety issues or those that may be politically sensitive.
- Through presentation of significant decisions and/or project updates.

24. Engagement with the MODG will be facilitated by regional medical directors and regional chief pharmacists having seats on the MODG.

Membership

25. The chair of each RMOC will be the relevant regional medical director.

26. Other positions will be nominated from within the region to represent the range of clinical and non-clinical professions working in medicines optimisation and prescribing at senior ICS level to ensure representation of local drug decision making processes on the committee.

27. Members should have the necessary experience and seniority to make decisions on behalf of their organisation.

28. The core membership should consist of:

- at least one nominated representative of each ICS within the RMOC region. Where ICSs have, in the main, nominated representatives from one profession (eg mainly pharmacists), the RMOC chair has the authority to allow more than one representative per ICS from a different profession if this is deemed to be practical and appropriate
- Regional chief pharmacist (or their appointed deputy)
- Regional finance director (or their appointed deputy)
- Regional nursing and allied healthcare professional representative

- Regional antimicrobial pharmacy and prescribing lead
- Regional public health representative
- Regional medicines safety officer representative
- Regional specialised commissioning pharmacy representative
- Regional representative of NICE
- Regional representative(s) of the academic health sciences network
- Patient and public voice representative(s) with experience of working in partnership with healthcare organisations or programmes.

29. Each RMOC will determine whether any additional membership is required to ensure the provision of credible and implementable outputs by the RMOC. For example, expanding membership (where appropriate) to early grade clinicians or more junior representatives of ICS staff may be appropriate to ensure recommendations are practical for those responsible for delivering the recommendations on a day-to-day basis.

30. RMOC membership should be multidisciplinary and include clinicians in the broadest sense (including representatives of prescribing professions), and particularly medical practitioners and pharmacists. Regional professional roles will be expected to engage their system counterparts to increase awareness and understanding of the RMOC and facilitate local delivery and implementation in local organisations and systems.

31. The chair will provide input to ensure, as much as possible, that a balanced representative, diverse and inclusive membership from across the RMOCs region is achieved.

32. Membership shall be reviewed and updated regularly to ensure the above principles are maintained.

33. Open, transparent, and fair processes to securing broad but appropriate membership should be in place to ensure true representation of the make-up of each region. This includes considering how opportunities to become an RMOC member are cascaded across and within the region and giving due regard to patient equality, health inequalities, workforce equality, diversity, and inclusion eg alignment with ‘Inclusive Pharmacy Practice'.

Deputy arrangements

34. When not able to attend, members should send a deputy to participate and vote on their behalf. Deputies must have similar expertise and be of similar level of seniority as the member they substitute. Where a member is representing an organisation then the deputy would also need to be from the same organisation. Where a member is representing the public, a sector, or a professional group then the deputy would also need to be from the public, the same sector, or the same professional group but not necessarily the same organisation.

In attendance (no voting rights)

35. Experts, mostly with clinical or academic backgrounds or representatives of professional bodies, may be invited to meetings or sessions of meetings on a regular or ad-hoc basis to provide opinion, information, and evidence on specific matters. They may participate in discussions but shall not be entitled to vote at RMOC meetings.

36. Representatives from the secretariat/support function may be present to provide support to the committee. They will be non-voting attendees.

Role of the chair

37. The chair has responsibility for providing effective leadership of meetings. In addition, the chair is responsible for ensuring that the decision and action logs, produced by the secretariat/support function, and any reports accurately record the decisions taken, and, where appropriate, that the views of individual members have been taken into account.

38. If the chair is unavoidably absent or is not able to chair the meeting due to conflict of interest for specific items on the agenda a deputy will be appointed and will be responsible for chairing the RMOC meetings and providing leadership.

Role of members (and deputies)

39. RMOC members and deputies should:

- work in the interests of all the ICSs within the RMOC's region.

- actively contribute at and between meetings to ensure delivery of the agreed work programme.
- represent the views of their organisation, sector or professional group.
- communicate decisions taken by the RMOC and share best practice highlighted by the RMOC to their organisation, sector or professional group.
- provide feedback from their organisation, sector or professional group to the RMOC, including any specific medicines optimisation issues or other practical considerations.
- highlight to the RMOC any areas of best practice which could be shared regionally or nationally.
- commit to work outside meetings where required, including training to assure competency and membership of RMOC sub-committees or working groups (where applicable).
- attend meetings prepared, having read all circulated documents, liaised with others prior to the meeting and ready to contribute to the debate.
- embrace authentic allyship to improve their engagement with equality, diversity, and inclusion.
- proactively ensure the voices of colleagues of Black, Asian, and Minority Ethnic origin are heard, valued, included as equal and considered when decisions are being taken in meetings, networks, and committees.
- review the operating model at least once every two years.

40. An internal annual membership review may take place and the chair may request members to stand down if they are no longer compliant with the role requirements.

Role of the secretariat/support function

41. Specialist pharmacy service (SPS) will provide/appoint a secretariat/support function who will coordinate the agenda, decisions and actions and ensure that governance processes are adhered to. The secretariat/support function is responsible for ensuring that the RMOC works within this operating model.

42. A professional lead from SPS will support each RMOC in the delivery of their work programme including liaison with other organisations commissioned to lead on specific pieces of work.

43. Communications between the RMOC and stakeholders in relation to outputs will generally be through the secretariat/support function, except where it has been agreed that an individual member should act on the RMOC's behalf.

Sub-committees and short-life working groups

44. The RMOC may choose to establish/adopt permanent or temporary sub-committees and short-life working groups to manage identified workstreams or specific programmes of work and they may also choose to delegate such work to existing groups or committees.

45. Members of sub-committees and short-life working groups need not be members of the RMOC.

46. Each sub-committee and short-life working group should have its own terms of reference, ratified by the RMOC and report regularly to the RMOC.

Stakeholder network

47. The RMOC may choose to work with existing stakeholder networks or establish new stakeholder networks to facilitate wider communications and engagement across its region. Members of any stakeholder network may be consulted to inform outputs, decisions and recommendations but are not members of the RMOC.

Confidentiality

48. All members and attendees agree to keep detailed discussions confidential to allow free and full debate. Minutes should be sufficient to record that confidential discussions had taken place but not disclose any confidential matters.

49. Discretion should be used when discussing meetings with non-attendees but, in principle, members may share papers with colleagues unless specifically advised otherwise.

Admission of members of the public

50. Meetings are not open to members of the public other than those appointed as a patient and public voice representative or their deputy. RMOCs may choose to invite observers for personal professional development purposes.

Declaration of interests

51. A conflict of interest is a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring tax payer funded health and care services is, or could be, impaired or influenced by another interest they hold. All RMOC members should ensure that they are not placed in a position that risks, or appears to risk, compromising their role or the NHS public and statutory duties or reputation.

52. Members of the RMOC must declare any actual, potential, or perceived interests at least annually and adhere to our declarations of interest policy. An interest is relevant if it has occurred in the last twelve months or if it is planned to occur. Members are asked to inform the chair and/or secretariat/support function prior to each meeting of any change in their relevant interests and any conflict arising due to an agenda item. If a member has an interest, they will not be allowed to participate in discussions and decision making. They may also be asked to leave the meeting during particular discussions, and this will be recorded in the minutes. An annual register of interests will be maintained by the chair and/or secretariat/support function with a copy available at each meeting.

53. The chair should not have an interest in any agenda item under discussion. If the chair has an interest in a matter under discussion, they will absent themselves from discussions and decision making, and nominate a deputy for that agenda item.

Quorum arrangements

54. The quorum is reached when at least half of the members with the chair are present.

55. A meeting that starts with a quorum present shall be not be deemed to have a continuing quorum in the event of the departure of members, therefore making it less than quorate. In the event of a challenge, the remaining members may choose to adjourn the meeting or to continue the meeting and ratify the decisions in the next meeting. The final judgement on whether the meeting is quorate will reside with the chair.

Decision making

56. Discussions at the RMOC will consider factors such as prescribing data, national guidance, patient outcomes, clinical outcomes, clinical evidence, available resources, an overview of likely financial impact and any feedback from stakeholder groups.

57. Members should normally arrive at decisions by a consensus. Where consensus cannot be reached, the decision will be made by a majority vote - defined as more than 50% of members present at the meeting. Abstentions are not considered when determining the majority.

Frequency of meetings

58. It is anticipated that each RMOC will meet every two months but quarterly as a minimum. The chair has the right to convene extraordinary meetings when considered necessary, to remain flexible to regional requirements, and take chair's action in exceptional circumstances.

59. Members may attend meetings in person or, where appropriate facilities exist, by telephone or video conference. It is the role of the chair to ensure that members attending virtually have full opportunity to participate in the business of the meeting.

60. An attendance log will record members' or their delegates attendance at each meeting. Members or their named deputies should attend (in person or virtually) at least 75% of RMOC meetings each year.

Agenda setting and topic submission

61. Items for the agenda and topics (including potential priorities) for review will be proposed by the RMOC members or fed in directly from systems (preferably via their nominated ICS member if applicable) via the RMOC secretariat/support function.

62. There should be a focussed exercise to collate relevant topics across the region as part of annual business planning processes to inform development of the RMOC's annual workplan.

63. Urgent topics or those that emerge due to unforeseen circumstances can be submitted for consideration at any point in the financial year via the RMOC secretariat/support function.

64. All items will be prioritised and assessed for suitability and relevance to the RMOC by the chair and/or secretariat/support function prior to them being discussed by the RMOC. This should include consideration of a number of factors including whether the topic submitted has relevance in other parts of the region or is a specific ICS issue and /or whether the topic requires escalation to the national team.

Publication of agenda, decisions and actions

65. The chair and/or secretariat/support function should make agendas and papers available to members at least two weeks prior to meetings.

66. The decision and action log should be circulated to members within two weeks of the meeting and ratified at the subsequent meeting.

Publication of minutes and other outputs

67. Draft minutes of meetings should be circulated to members within two weeks of the meeting and ratified at the subsequent meeting.

68. The secretariat/support function should share ratified minutes with the RMOC regional network within two weeks of being approved.

69. RMOCs may share individual outputs as soon as they are approved for publication and they need not be delayed waiting on ratification of minutes.