Regional Medicines Optimisation Committees Operating Model

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NHS England and NHS Improvement

Contents

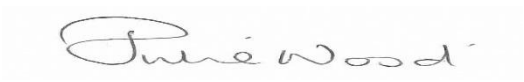
Foreword

We would like to recognise and acknowledge the excellent work of the Regional Medicines Optimisation Committees (RMOCs) since their inception and the valuable contributions of their members. RMOCs have developed advice on topics as diverse as free of charge medicines schemes and prescribing of Liothyronine, helping to support local decision makers with their commissioning decisions and assisting with delivery against national priorities such as improving the uptake of best value adalimumab biological medicines.

Much has changed in the two years since the first iteration of the RMOC Operating Model was published in 2017. Sustainability and Transformation Partnerships (STPs), initially established to bring local health and care leaders together to plan around the long-term needs of local communities, have begun transitioning to Integrated Care Systems by 2021. These local partnerships will take shared responsibility to improve the health and care system for their local population and will align with the seven new regions established under the NHS England and NHS Improvement operational model. The number of RMOCs will therefore need to increase from four to potentially seven, and we must ensure that STP and ICS members are appropriately represented on them. In addition, the agreement of the Voluntary Scheme for Branded Medicines Pricing and Access will have implications for the role of RMOCs in respect of new and existing medicines evaluations.

This revised operating model sets clearly sets out the refined aims and objectives for the RMOCs and their expected ways of working. One of the main changes set out in this model is a desire to move towards a more balanced work programme for each RMOC with a focus on regional oversight and implementation of national medicines priorities, with the ability for each RMOC to identify and oversee the implementation of local and regional medicines optimisation priorities. RMOCs will continue to operate nationally to develop advice that will be of use and relevance to all regions and to coordinate activity between each committee, however, individual RMOCs will be able to review what this advice may mean for their respective region. There is also a role for RMOCs in reviewing medicines usage within pathways of care and within a medicine optimisation context. NICE will share its work plan on a regular basis to reduce the risk of duplication of work between NICE and the RMOCs.

We are committed to working closely with stakeholders and we recognise the importance of ongoing engagement with CCGs, STPs/ICSs and others to strengthen system-wide support for the RMOCs. This is crucial to achieving the ambition of the RMOCs to improve patient outcomes and ensure the NHS gets the best value for the taxpayer through the provision of timely and credible advice.



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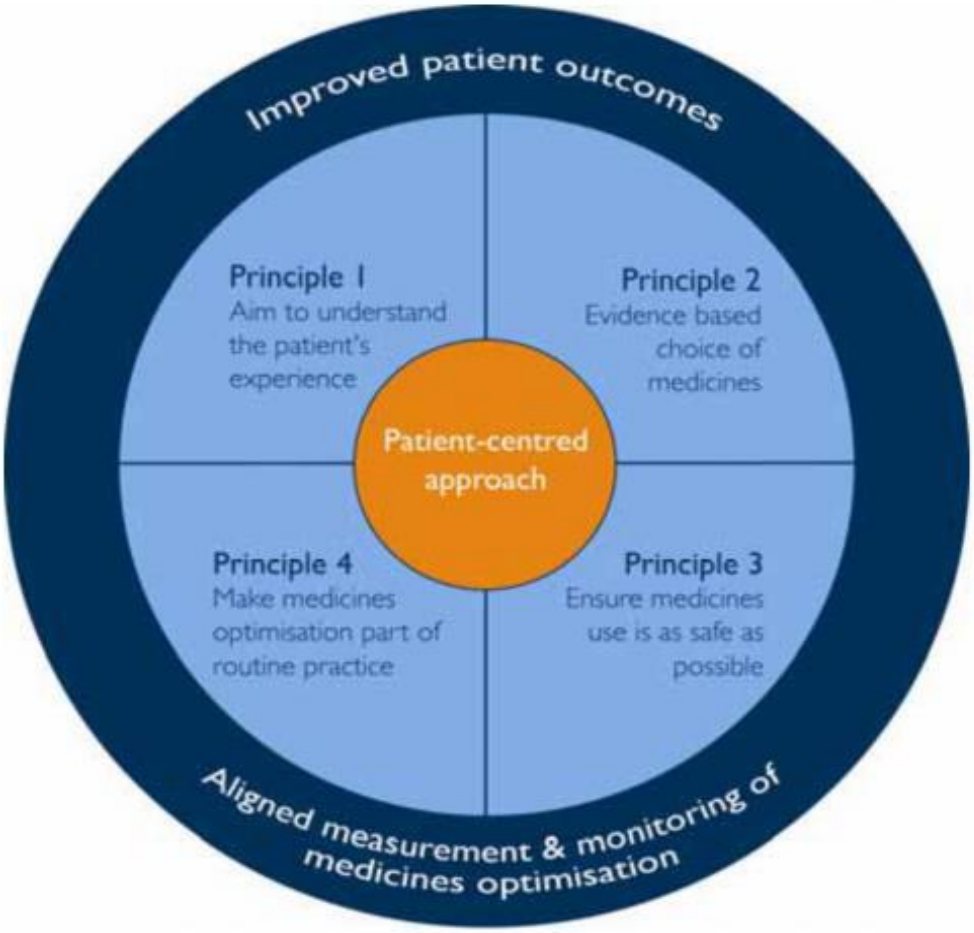
Aims and Objectives

1. Regional Medicines Optimisation Committees (RMOCs) have been established to optimise the use of medicines for the benefit of patients and the NHS[1], in line with the principles set out in the diagram below. They bring together decision-makers and healthcare professionals to share best practice, understand the evidence base and coordinate action to reduce unwarranted variation and improve outcomes and value.



2. RMOCs have three aims:

    - To improve patient outcomes and ensure the NHS gets the best value for the taxpayer through the provision of timely and credible advice on

[1] In 2012, the Royal Pharmaceutical Society produced a Medicines Optimisation Framework, working with patient representatives, the professions, the NHS and the pharmaceutical industry, which sets out an approach to medicines use that is patient centred, value driven, and outcome based.

medicines optimisation issues, for use and implementation by local decision-makers;

- To reduce local and regional duplication and variation through identifying challenges and issues related to medicines optimisation that would benefit from a coordinated approach; and

- To promote awareness and support regional implementation of national policies and initiatives relating to medicines, including supporting national guidance.

3. There are currently four RMOCs (South, London, Midlands and East and North) aligned to the four previous NHS England and NHS Improvement regions. In light of the new NHS England and NHS Improvement regional landscape, there is an expectation that seven RMOCs will be operational by autumn 2020, however, this is subject to agreement within the regions.

4. RMOCs are an integral part of the NHS England and NHS Improvement regional infrastructure and are expected to work with and support colleagues operating in commissioner and provider organisations (including primary care) and other relevant stakeholders.

5. RMOCs have three specific objectives:

   - Co-ordinate nationally to develop advice that will be of use and relevance to all regions and, acting as a single medicines optimisation system across England, aligning activity between each committee. However, individual RMOCs will be able to review what this advice may mean for implementation within systems across their respective region;

   - Regional oversight of the implementation of national medicines optimisation priorities, including the Medicines Value Programme, Medicines Safety Programme, Public Health England's Prescribed Medicines Review, Antimicrobial Stewardship in line with the Antimicrobial Resistance National Action Plan, Shared Care and uptake of Accelerated Access Collaborative products; and

   - Identification and oversight of implementation of local and regional medicines optimisation priorities to support improvements in clinical quality and value and reduction in variation.

Role of RMOCs

6. The role of RMOCs is to improve patient outcomes through supporting and optimising local prescribing practice and reduce unwarranted variation throughout the region and nationally. They will promote collaboration and help reduce duplication on issues related to medicines optimisation across the English healthcare system.

7. RMOCs work in support of NHS England and NHS Improvement Regional Medical Directors and NHS England and NHS Improvement Regional Chief Pharmacists, who are the named individuals responsible for overseeing the delivery and implementation of medicines optimisation priorities at a regional level.

8. **The status of RMOC outputs are advisory**. They do not affect the statutory legal responsibilities and duties of NHS organisations. However, there is an expectation that both commissioners and providers of NHS healthcare will have regard to implementation of RMOC advice, working with the ambition to reduce duplication of the development of advice across systems.

Operation of RMOCs

9. RMOC agendas will be informed by both regional and national priorities. To facilitate this, RMOC Chairs and the Regional Chief Pharmacists will determine which topics will be prioritised for discussion at their respective committee meetings, taking into account the national RMOC work programme.

10. Meeting frequency should be determined by the needs of the relevant region and the RMOC Chair, but there is a guiding principle that each RMOC should aim to meet every three months as a minimum.

11. RMOCs will be mindful of 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."*

12. NICE technology appraisals, highly specialised technology evaluations and guidelines take precedence over regional or local guidance. The work of the RMOCs will not seek to duplicate or undermine this activity, whilst recognising the freedom of individual clinicians to prescribe as they see most appropriate for individual patients.

13. Under the terms of *the 2019 Voluntary Scheme for Branded Medicines Pricing and Access (ref)* agreed between the Department of Health and Social Care, NHS England, the Association of British Pharmaceutical Industry and voluntary scheme members, it was agreed that **all new medicines and significant new indications** would undergo an appropriate NICE appraisal from that point onwards. NICE expects to have achieved full coverage of all such medicines and indications by April 2020. RMOCs will not evaluate new medicines and significant new indications.

14. For **existing medicines where significant new evidence becomes available**, NICE already has a clear process and timelines for reviewing guidance and is in the process of updating this to improve efficiency. Therefore, RMOCs will make use of this process to inform NICE if they believe technology appraisal guidance should be updated when significant new evidence becomes available.

15. RMOCs may however have a role in **reviewing medicines use within pathways of care.** Any advice made would be framed within a medicines optimisation context and would not seek to duplicate any work already being undertaken by NICE. Further detail is included in **Annex A**.

16. NICE will share its work plan on a regular basis (6 monthly) with the Medicines Optimisation Priorities Panel. This will enable the RMOCs to plan their work programme efficiently and reduce the risk of duplication of work between NICE and RMOCs. RMOCs will not work on topics where NICE plans to publish guidance or advice.

RMOC Governance

RMOC Membership

18. Each RMOC is chaired by a Regional Medical Director. In a scenario where RMOCs do not transition to seven by 2021 (e.g. one RMOC covers two NHS England and NHS Improvement Regions), it is for the Regional Medical Directors to agree arrangements across regional boundaries.

19. RMOCs are supported by the Regional Chief Pharmacist, with the secretariat support provided by the NHS England commissioned Specialist Pharmacy Service or a commissioning support service.

20. The Regional Chief Pharmacists provide system-wide leadership on medicines optimisation and pharmacy services. Their role includes the provision of professional support and specialist pharmaceutical expertise alongside the Chair of the RMOC. Through liaison with the RMOC secretariat, Regional Chief Pharmacists will help to facilitate local engagement and implementation of the committee's advice.

21. Each RMOC is free to determine its own membership locally to reflect the needs of the region and its constituent organisations. However, due regard must be given to ensuring RMOC membership is reflective and representative. To ensure some consistency across the RMOCs, membership should include clinicians (in the broadest sense as relevant, but medical practitioners and pharmacists in particular), commissioners, provider trust and patient and public voice representatives. Each RMOC Chair must be satisfied that there is appropriate representation to ensure the provision of credible and implementable advice by the RMOC.

22. From April 2020, the case is being made for each Integrated Care Systems (ICS) to appoint a Chief Pharmacist who will be expected to nominate a peer representative to sit on their local RMOC, and all ICS Chief Pharmacists will be expected to have regard to RMOC outputs.

23. RMOC members are expected to actively contribute at and between meetings, to ensure delivery of the agreed work programme.

24. Membership of each RMOC is published on the RMOC web presence on the Specialist Pharmacy Service website. Further detail on the principles for appointing members is set out in **Annex B**.

25. A code of conduct for RMOC members[2] is published on the Specialist Pharmacy Service website.

Specialists in attendance

26. With the Chair's agreement, specialist technical expertise may be requested for specific agenda items, but the specialist will not be involved in agreeing RMOC decisions or developing RMOC advice. Specialists should be experts in their field and be able to provide a balanced view on the issue under consideration.

RMOC Oversight

27. The RMOC system is overseen by the Medicines Optimisation Oversight Group (MOOG), and is supported and sponsored by NHS England and NHS Improvement. National Priorities for the RMOCs are reviewed by the Medicines Optimisation Priorities Panel (MOPP) in advance of the MOOG ratifying them for inclusion on the RMOC work programme.

Role of the MOOG

28. The Medicines Optimisation Oversight Group 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.

29. The MOOG is co-chaired by the Chief Pharmaceutical Officer for NHS England and the Chief Executive of NHS Clinical Commissioners.

30. Membership of the MOOG comprises commissioner and provider representatives, representatives from each RMOC, NHS England and NHS Improvement and NICE. Observers from the trade bodies representing the branded and generics pharmaceutical industry are also invited to attend meetings.

31. The MOOG is responsible for regularly reviewing delivery of each RMOC work programme and monitoring achievement against clearly defined success measures. MOOG will monitor the impact of RMOC recommendations and implementation, and feedback into the prioritisation process. It is also responsible for ensuring that the work programme priorities at a national level can be delivered within the scope of resources identified.

32. The outputs of MOOG will be reported to the NHS England and NHS Improvement Medicines Value Programme Board.

[2] https://www.sps.nhs.uk/networks/rmoc-medicines-optimisation-oversight-group/

33. Terms of reference for MOOG members are published on the Specialist Pharmacy Service website. [3]

Role of the MOPP

34. The role of the Medicines Optimisation Priorities Panel (MOPP), supported by the Specialist Pharmacy Service Coordinating Hub, is to review national topic submissions put forward by the regions and agree whether the topic should progress to the national RMOC work programme.

35. The MOPP is chaired by a Regional Medical Director and/or Regional Chief Pharmacist and meets quarterly, with the option to meet more regularly if needed. The frequency of meetings will be determined by the number of topics requiring review and the emerging RMOC work programme.

36. The Chair will be awarded delegated authority from MOOG to make decisions relating to the RMOC work programme, but the outputs will be reported to the MOOG at each meeting. MOPP will be chaired by each region on a rotational basis.

37. MOPP membership comprises RMOC members, patient and public representation, PrescQIPP and NHS England and NHS Improvement representatives. A health economist and public health representative may be co-opted and utilised to help inform priorities where appropriate, as determined by the Chair.

38. Topics put forward by an RMOC for consideration as a national priority will include (as part of the process of gathering evidence) commissioner input, prior to consideration by the MOPP. Topics approved for inclusion on the work programme will be allocated to an RMOC and subsequently published on the Specialist Pharmacy Service website.

39. In a scenario where a topic is not deemed appropriate for inclusion on the RMOC work programme at that time but may be suitable at a later date, feedback will be provided as to when a topic may be included in work plans. In any case, feedback will be given as to why a topic has not been selected for consideration by the RMOCs.

40. Where submissions to MOPP focus on other issues outside of the remit of RMOCs, these may, if appropriate, be referred to other established groups to develop advice. Where this occurs, applicants will be notified and advised how to contribute further to the process.

[3] https://www.sps.nhs.uk/networks/rmoc-medicines-optimisation-priorities-panel/

41. NICE will share its work plan with MOPP every six months to enable RMOCs to plan their work efficiently and reduce the risk of duplication of work between RMOCs and NICE.

42. To ensure transparency, the MOPP membership[4] and code of conduct are published on the RMOC web presence. MOPP decisions are published following ratification by the MOOG.

[4] https://www.sps.nhs.uk/networks/rmoc-medicines-optimisation-priorities-panel/

Development of the RMOC work programme

43. Each individual RMOC work programme will consist of:

    - Nationally-set medicines optimisation priorities; and
    - Local/regional medicines optimisation priorities topics.

44. Stakeholders including CCGs, NHS Trusts, STPs/ICSs, Clinical Reference Groups, Area Prescribing Committees, Drug and Therapeutic Committees Prescribing Committees, Primary Care Networks, Providers, Academic Health Science Networks (AHSNs), Professional Leadership Bodies, relevant trade Bodies, individual patients and patient groups can all submit topics.

45. APCs, CCGs, STPs and ICSs have a key role in helping to set the regional RMOC work programme and are encouraged to work together across local geographies to submit topics/priorities to their RMOC, via the online submission tool.

46. Submitted topics via the website are assigned to the Specialist Pharmacy Service Coordinating Hub to undergo an initial triage process (see **Annex C**) and provide the supporting evidence for presentation to the MOPP and then subsequently an RMOC. In determining how topics are allocated to an RMOC, regional topics will be submitted based on the location of the topic submitter and corresponding region.

47. Topics identified by an RMOC Chair as a regional priority will go straight onto the relevant RMOC work programme and be reported to MOPP. Any topics identified as national priorities via either the online submission tool or an RMOC Chair will be put forward for consideration at the next MOPP meeting. Regional Chief Pharmacists will coordinate with each other to avoid duplication.

48. The process from submitting a topic through to assessment by an RMOC, is expected to be completed within three months.

49. If a topic raised in a region has been considered by another RMOC and advice developed, the advice generated by the lead RMOC can be shared with other committees but done so with an understanding that it may require local interpretation to support implementation. Individual RMOCs will be expected to review what it means for their respective region.

50. Topics not selected will be published with a rationale for why the topic was not considered appropriate for inclusion on the RMOC work programme.

51. Each RMOC work programme and a set of success measures will be published on the Specialist Pharmacy Service website https://www.sps.nhs.uk/ .

Outputs from the RMOCs

52. Outputs may be in the form of:

    - Advice to support local commissioners and providers (including primary care); or
    - Recommendations to support national policy implementation.

53. Examples of published RMOC advice can be accessed via the following link - https://www.sps.nhs.uk/category/rmoc-recommendation-or-resource/

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

55. Two weeks prior to an RMOC discussion, and to help inform the development of advice, any supporting evidence will be shared with the membership of the relevant RMOC.

56. Following an initial RMOC discussion, it is expected that between meetings, members will work up draft advice in preparation for publication and feedback.

57. Emerging advice will be made available on the Specialist Pharmacy Service website for comment, within a four-week timeframe. Stakeholders such as APCs/CCGs and any relevant Professional Bodies and Patient Groups will be notified when draft advice is out for comment.

58. Comments will be reviewed and considered by members when tabling a final draft for sign-off at the next scheduled meeting. Comments will be summarised and made available in the public domain. It is acknowledged that for complex issues, preparation of advice may take longer.

59. RMOC advice and the supporting evidence base will be published on the RMOC website. A direct email will be issued to APCs and registered users to inform them that new content has been posted on the website.

60. RMOCs are expected to clearly set out and publish a work programme at the start of every financial year, but with an understanding that each RMOC work programme will evolve throughout the course of a year and so will need to be flexible and able to respond to emerging national and regional priorities.

61. Each RMOC will set out measures by which they expect to demonstrate success. These success measures, which will align to their work programme, can be

determined regionally but in principle are expected to align with national priorities and demonstrate how they can support local systems to improve.

Annex A – Framework for discussions

- The purpose of the framework is to provide a consistent and equitable structure for discussion and consideration of topics within RMOC meetings.

- It is intended to promote good practice with respect to patient safety and clinical and cost effectiveness.

- It is intended to ensure that the rationale applied to any guidance issued is open and transparent. However, it is important to note that all outputs are advisory in nature.

- This framework is complementary to any requirements outlined under the NHS constitution.

Core Principles

- Core principles that should be applied to any discussions are the need for decisions to be rational, equitable, take account of economic factors and must balance the needs of an individual with needs of the wider community.

- The NHS is committed to evidence-based healthcare. Advice will therefore need to be based on the best evidence of clinical effectiveness. This will normally already be defined within national standards or NICE guidance and the RMOC will not seek to replicate these. However, where there is little difference in clinical effectiveness, then other factors may be considered. These are:

    - Patient safety;

    - Patient factors such as formulation, dosing and outcome measures;

    - Cost/affordability i.e. how much does the drug cost per item, how does the NHS pay for the drug, and what is the anticipated budget impact? e.g. potential for cost saving, low impact, medium impact, high impact;

    - Equalities and Health Inequalities: i.e. whether there are groups of people who would be disproportionately affected;

    - Commissioning pathway: any commissioning issues that need to be considered before the medicine can be used;

- Healthcare resource utilisation i.e. what NHS resources would be required to implement a change;

- Shared care: is the medicine suitable for shared care? If so, can a standard template be produced? Is a RAG/traffic light status advisable?; and/or

- The wider context in which treatments can be provided, including implications for service delivery and any future horizon scanning.

- The process for decision making will be fully documented in the minutes, and any accompanying documents used by the committee will be published for consultation alongside any advice.

Annex B(i) – RMOC Membership: Person Specification

1. Representatives are to reflect the role and capacity in which they are appointed and the geographical population in which they practice. They should therefore be in a senior position and have a minimum of three years' experience in that role/capacity.

    - Hospital Medical Specialist Consultants and/or Consultant Pharmacists: All must be current or recent members of new drugs panels, Area Prescribing Committees, Drug & Therapeutics Committees or equivalent. At least one must be a clinical pharmacologist.

    - At least one APC chair – to represent other APC chairs in the region

    - CCG Prescribing Leads: All must be current or recent members of new drugs panels, Area Prescribing Committees, or equivalent.

    - Senior Hospital Pharmacists: All must be current or recent members of new drugs panels, Area Prescribing Committees, Drug & Therapeutics Committees or equivalent.

    - CCG Senior Medicines Optimisation Pharmacists: All must be current or recent members of new drugs panels, Area Prescribing Committees, or equivalent.

    - ICS Chief Pharmacists: currently a member of a new drugs panel, Area Prescribing Committees, Drug & Therapeutics Committees, or equivalent.

    - AHSN Lead – must be currently working on medicines optimisation activities, with an understanding of national priorities e.g. AAC.

    - At least two Patient and public voice members: Must have experience of working in partnership with healthcare organisations or programmes.

    - Observer from the national institute for health and care excellence (NICE) with a detailed knowledge of medicines optimisation principles.

    - Observers from the trade bodies representing the branded and generics pharmaceutical industry with a detailed knowledge of medicines optimisation principles.

2. Representatives may cover more than one of the membership categories e.g. a CCG Clinical Lead may also be a practicing GP and therefore could be classed as both for the purposes of RMOC membership.

3. CCG roles in relation to APC representation must include active Chairs or Secretaries to ensure the work of RMOCs is recognised both on APC agendas and communicated to their peers.

4. Membership may include an observer role for an ‘early career’ clinician of any discipline or a Clinical Fellow; as a professional and personal development opportunity to be agreed by the RMOC Chair.

Annex B(ii) – Appointment of members

1. The appointment process for membership of RMOCs is undertaken in each region, supported by NHS England and NHS Improvement and the Specialist Pharmacy Service. A 'call for members' is communicated through national and regional networks and expressions of interest sought via an application process. Application forms are reviewed by the Regional Medical Director, Regional Chief Pharmacists and an agreed set of 'virtual' panel members.

2. Where application numbers for any specific profession/role exceed the membership proposed regionally, or where a clear judgment cannot be made from the application form review process alone, an interview will be held. The interview process will be overseen by the appropriate Regional Medical Director as Chair. Proper consideration will be paid to the provisions of the Equality Act 2010 with respect to recruitment.

3. RMOC members will be appointed on a two to four-year tenure. Following appointment members will undertake an SPS-led induction, facilitated by the RMOC secretariat, to help them fulfil the role. The induction process sets out expectations in terms of individual members, and the importance of communicating and feeding RMOC publications back via their local networks.

4. There is an expectation that the host organisation for appointed members will cover the cost of attending meetings. It is acknowledged that there may be exceptions to this for certain professional groups, e.g. primary care contractors where attending meetings is not legitimately part of their day job, and lay members, who will be managed in accordance with NHS England and NHS Improvement policy.

5. NHS England and NHS Improvement regions are expected to cover venue costs for their respective committee meetings.

6. Individuals appointed must adhere to the seven principles of public life as set down by Lord Nolan - honesty, integrity, accountability, leadership, openness, selflessness and objectivity. They must also complete a register of interests form on an annual basis as requested by the RMOC secretariat.

Annex C – Assessing medicines optimisation topics

1. RMOCs are expected to work on programmes that are of regional and national importance and which are likely to have a significant impact on patient outcomes, value, patient safety or the commissioning decisions of a majority of CCGs or STP/ICSs in the region or in England. Consequently, a topic will be given higher priority where it can be shown to:

    - Have the potential to generate significant improvements in quality and value across the regional health system;
    - Have significant implications for patient safety if not addressed (e.g. reducing medication-related harm, infection prevention and control); and/or
    - Have a major impact on operational efficiency (i.e. has been requested for consideration by a broad range of CCGs or has clear and significant implications for the commissioning decisions of the majority of CCGs in the region).

2. Topics submitted via the online tool are assigned to the Specialist Pharmacy Service to undergo an initial triage process, and to work up supporting evidence for presentation to an RMOC.

3. Regional Medical Directors and Regional Chief Pharmacists will use the criteria below to assess whether a topic is a regional or national issue.

Triage Q/*SPS site notes*
Tangible patient benefit *Does resolution of the issue have potential to result in real, tangible benefits to patients?*
Medicines safety *Is there the potential for harm or risk to patients and their use of medicines resultant from not addressing the issue?*
Patients and their care *To what extent is patients' access to and ability to receive high-quality care or preventative care currently affected by the issue raised? For example, is there unacceptable variation currently, or would resolution of the issue increase accessibility or quality of care?*
Achievable and measurable *Could potential strategies to address the issue be developed which are achievable and measurable?*
Policy alignment *Does the issue and its resolution align with other high-level MO and medicines value programme policies and priorities?*
Already covered through existing work *To what extent is the topic raised unique and not addressed currently by existing national work programmes? E.g. Specialised Commissioning, NICE, the Medicines Optimisation dashboard*
Clear and logical rationale *Is the suggested rationale for why the issue should be considered by the RMOC clear and logical?*

Triage Q/*SPS site notes*
Local, regional, and national *Does the issue, and its resolution, currently have local and regional components? I.e. does it lend itself to the RMOC approach?*
Productivity risks *Is there the potential for financial risk to the NHS resultant from leaving the issue unaddressed?*
Quantifiable benefit *Does resolution of the issue have the potential to provide quantifiable benefits to the NHS?*

Glossary

AAC	Accelerated Access Collaboration
AHSN	Academic Health Science Network
APC	Area Prescribing Committee
CCG	Clinical Commissioning Group
DTC	Drug and Therapeutic Committee
ICS	Integrated Care System
NHS I	NHS Improvement
NICE	National Institute for Health and Care Excellence
RMD	Regional Medical Director
RMOC	Regional Medicines Optimisation Committee
SPS	Specialised Pharmacy Service
STP	Sustainability and Transformation Partnership