Medicines Optimisation Oversight Group (MOOG)
Minutes of Meeting

Thursday, 19 March 2019
12.45pm - 14:30pm

NHSCC Office, Floor 15, Portland House, London, SW1E 5BH.

Attendees	
Keith Ridge (Chair)	NHS England
Julie Wood (dialed in)	NHS Clinical Commissioners
Richard Seal (dialed in)	NHSE/NHSI Regional Pharmacist (Midlands & East)
Stephen Brown	NHSE/NHSI Regional Pharmacist (South)
Richard Goodman	NHSE/NHSI (Interim) Regional Pharmacist (London)
Christopher Corfield	Central London, Hammersmith & Fulham, Hounslow and West London CCGs
Paul Fleming	British Generics Manufacturers Association
Collette Goldrick	Association of British Pharmaceutical Industry
Ben Rehman	Specialist Pharmacy Service
Alex Williams	NHS England
Jonathan Underhill	National Institute of Health and Care Excellence
Eileen Callaghan	NHS Hastings and Rother CCG, NHS Eastbourne, Hailsham and Seaford CCG
Heather Marshall	NHS England
Phil Thomas	NHS England
Sue Dickinson	Specialist Pharmacy Service (Observer)

Apologies	
Malcolm Qualie	NHS England
Vin Diwaker	NHS England Medical Director (London)
David Levy	NHS England Medical Director (Midlands and East)
Slakahan Dhadli	NHS Southern Derbyshire CCG
Mike Prentice	NHS England Medical Director (North)
Richard Croker	East and North Hertfordshire CCG

ACTION LOG

No.	Decision or Action	Owner	Status
1.	Process document – draft easy read version with tracked changes – by end of March	PT	Closed
2.	Criteria document – to be re-distributed to MOOG	BR	Closed
3.	Criteria document – to be re-visited by MOOG for reflection and comments. Also, to be put in new process document	All MOOG members PT	Ongoing
4.	Medicines optimisation topics – List to be prioritised and include detail under each one to allow comments back	BR & JS	Closed
5.	Revised draft operating model to be tabled at next MOOG on 12th June 2018	All MOOG members	Closed
6.	RMOC memberships to include an AHSN representative	All Regions	Closed
7.	Early Clinicians gaps in RMOC membership to be filled	Midlands & East and North	Ongoing
8	AHSNs and RMOCs MOU to be circulated	SB	Closed
9	Formalise stronger working relationships between the RMOCs and PRESQUIPP	WR	Closed
10	Annual RMOC report – ready for 1-year anniversary in June	PT	Closed
11	Operating Model – provide any further comments	All	Ongoing
12	Develop a plan for functioning of the RMOCs in relation to big programmes of work and additional resources required.	Regional Pharmacists	Ongoing
13	Membership – recruit CCG members to RMOCs and additional representatives to MOOG.	NHSCC/PT	Closed
14	Re-circulate Operating Model for comments.	PT	Ongoing
15	Share further iteration of evidence summary with APCs for comment.	SPS	Closed
16	Revisit at next meeting what it means to be a lead RMOC – in relation to shared care.	PT	Closed
18	Revisit comms plan at next meeting	PT	Closed
19	Comments on proposed topics for inclusion on the RMOC work programme.	All	Complete
20	Comments on operational group terms of reference.	All	Complete
21	Members to feedback on stakeholder mapping	All	Complete

Item	
1	**Welcome, introduction and apologies** • The Chair welcomed colleagues to the meeting of the Medicines Optimisation Oversight Group (MOOG) and invited around the table introductions. • Apologies were noted.
	Meeting Objectives To convene the group and: • Listen to reflections from round the table following the latest round of RMOC meetings and overview of current workplans. • Hear about next steps to strengthen links between NHS England's Medicines Value Programme, the MOOG and RMOCs. • Get feedback from the last two MOPP meetings and ratify topics for inclusion on RMOC work programme. • Have an update from the latest Operational Group meeting. • Discuss RMOC Communications Plan.
2	**Minutes from the last meeting** Members proposed the following amendments to the minutes: • Action No 8 – typo noted for AHSNs
3	**Reflections of the last round of RMOC meetings and overview of current work plans** • Prior to hearing reflections following the last round of RMOC meeting, the Chair reiterated NHS England's commitment to making RMOCs succeed but acknowledged at this moment in time there are some important issues to think through at a policy level. **South** • Committee met in January with New Regional Medical Director chairing their first meeting. It was suggested a central standardised briefing would be helpful for new Medical Directors setting out expectations in the role of Chair. • Meeting was well attended with good engagement. • Liothyronine guidance well received. Since then House of Lords dossier (highlighting massive variation amongst CCGs) published. This presented new evidence around patient which fed into a review, not amend advice/guidance but to clarity. • In the process of finalising wording with a view to circulating to all RMOCs for feedback by the end of next week. Further House of Lords debate (no date set yet) will take place, therefore important to get advice as good as it can be. Guidance aimed at addressing variation and Lords hear and recognise that is its intended purpose. • In contact with CE of one patient group to continue ongoing dialogue. • In relation to Low Priority Prescribing the role of an RMOC is to set out guidance to support the policy aims and a reduction in routine prescribing.

- It was noted the interest from the House of Lords is likely to reopen debate about implementation of guidance – focus on CCG variation. Heather to support from a comms perspective.
- Botox – come through MOPP – real value in this piece of work. Big programme of work that will benefit the system from a standard national position.
- Continued focus on biosimilar medicines as specialist topic. CSU collaborative supporting a piece of work in relation to biosimilars insulin. Opportunity to review what next area of focus could be and insulin identified as most appropriate to work on. CSU looking at evidence, meeting with stakeholders, gathering intelligence on barriers/issues. Recognition uptake of biosimilars insulin is low – what's the opportunity, toolkit to be produced at end of work.
- Raised at MOPP – biosimilars tool developed to identify best value biologic for an individual patient. Raised a question on where now – take back to MVP Board. Question for MOOG – where there is a good innovation, how do we progress further? Chair advised an internal discussion at NHSE would be a first step, with a view to taking to the Board via policy team.
- Update on compassionate free of charge – dispensing routes guidance published
- Best value biologics group has changed into MVP subgroup – South Productivity Efficiency Board

London

- Met on 6 March with a focus on 2 substantive pieces of work.
- Hydrocortisone granules – new formulation. Conversation akin to APC discussion about product and appropriateness for prescribing. ABPI raised concerns about process for new medicines when discussing at an RMOC. Didn't conclude whether advice should be provided. Interesting dress rehearsal. License versus unlicensed, plan in therapy against not. Appetite that appropriate conversation to have – unwarranted variation and duplication.
- Inappropriate polypharmacy/over prescribing – priority area for London RMOC. Planning national stakeholder event in May – bring together experts in May to explore overprescribing – and put in place action plan.
- Multicompartment compliance aids – prioritised through MOPP – falls into polypharmacy arena. Appetite in healthcare to review when should and should not be used – over used and not always helpful to patients.
- Deprescribing – agreement at RMOC to do it as part of international collaborative. NICE have already endorsed Canadian guidance.
- In response to a question on whether there is an intention to develop a UK position. Canadians and Australia have developed robust guidelines. Medicines is an international collaborative approach. 70k and 7/8 months to develop new guidelines. Logical to do collaboratively across the world that meets the needs of all those countries. RMOC to consider appropriate endorsement of guidance.
- Membership wise – struggling with membership and attendance. Reviewed attendance – pattern so exploring trends in membership and whether people are still.

Midlands and East

- Last meeting in December – usual standard agenda items.

- Substantive clinical items – prescribing of sodium oxybate - patients with sleep disorders and in particular pediatrics. Widened to look at adults – drifted into territory of commissioning pathways. With this condition, pathways not clear. Spec comm colleagues looking at clarifying pathways of entry for these rare conditions. No consistent referral pathway.
- TL1 new metrics – new piece of evidence. Two Diabetes bodies in the states issues a statement following a trial. Helpful presentation given by clinical specialist – this is also being looked at as part of diabetes national programme. Looking at in form of formulary choices. NICE unlikely to produce anything until more substantial trials taking place – does the RMOC issue a holding statement for now? Quantifying number of patient's eligibility criteria.
- Next meeting on 4 April.

North

- Full attendance at meeting on 7 March. In a position when someone resigns, two people coming forward to fill the vacancy.
- Substantive items – brought back STOMP and STAMP work – asked for principles in managing patients with learning difficulties for patients. Will go on SPS website.
- Main item on shared care – short life working group comprised consisting of membership from all 4 RMOCs – some early deliverables identified – defining shared care, exploring variation. No surprises from the early findings – needs to be some in depth analysis to understand variation.
- Had an underspend from the first bit of funding and now looking for commitment of ongoing funding for this work.
- Other 2 items – more clinical – rivoroxiban and sodium docusate. No appetite to address docusate – draft advice not to encourage deprescribing – part of wider deprescribing piece on opioids. Rivaroxaban – came through topic selection. Controversial given links to NICE guidance, individual APCs looking for guidance – appropriate discussion to have.
- AMR and biosimilars discussed as standard topics.

General comment

- It was noted London and North meetings touched on deprescribing of opioids. The PHE review was mentioned with a report expected in late Summer. In addition, MHRA have launched a programme of work with a similar timescale.
- Chair commented that discussions are ongoing on what the role of RMOCs will be in supporting implementation of the recommendations which will come out of the review.

Shard Care Proposal

- Chair commented having reviewed the shared care paper, putting resources to one side, it set out a good way forward.

	• CCG representative on the group were asked to comment. There was general support and a shared view it's good that its bottom up approach. Main issues captured and sets off on right footing. Incentivisation also an issue so good that was picked up. • Chair requested any substantive comments to be fed back to the North Regional Pharmacist. It was added this is a topic RMOCs should be covering and asked what the next steps were? • Next steps focus on reconvening short life working group to set out programme of work and timelines – small set of discrete guidelines to be developed starting in topical areas. Consistency and monitoring aspects are important, and outputs need to be patient focused. Important to get principles right in the first instance to ensure we get it right. • NICE already developed some guidance and could be some potential quick wins in sharing those. **New medicines workstream** • Chair asked for a policy view on the new medicines. It was acknowledged the pitch has changed slightly in light of new PPRs arrangements - expected to be fully operational in April 2020. Timely for policy team and MOOG to determine what we do on new meds. Is there an interim position for RMOCs that will subsequently help APCs and alleviate some of the existing pressure? • A point of clarity – NICE took on responsibility from 1st January. Gearing up to April 2020 when NICE are expected to be fully operational. • It was noted a discussion at the last MOOG meeting about the expected content of evidence reviews and that nothing has been shared subsequently. • It was reiterated to the group that the evidence review content will not mirror NICE TAs and dialogue is ongoing. RMOCs were in part set up as NICE don't cover every medicine so they have a role to play. Any drug coming to market authorisation/new indication could be applicable. • In regard to the new voluntary pricing and access scheme, discussions are ongoing on a range of offerings from NICE. Wording all new meds/major indications will have options of funding TA. Industry is funding this and from their perspective, want to see it happen and accelerated. • Point was made that the majority of time at APCs is not spent on new drugs. Focus on implementation and operationalising available guidance. If a clinician wants to use a new approved NICE drug, it comes to an APC. Majority covered – most won't be of interest. It's confusing about how it's going to work in practice. • Quality assessment will be undertaken, not a full TA, applying NICE methodology. Discussions ongoing to ensure process is up and running from April. • Secondary care drugs can often end up in primary care which results in duplication of effort and variation. A year feels like a long period of time and there could be a role for RMOCs. • RMOC member expected to pick up new drugs they have been alerted to. From April 2020, understand NICE arrangements will kick in. Need to be clear and explain to RMOC members what the situation is. • Crucial element is what the status of NICE output is. Same as TAG then requirement for NHS to fund it, if something else, to do with timelines for delivery so maybe an interim role for RMOCs.

	• Range of products expected out of NICE, some TAs, some not. • Chair concluded that ultimately a decision on whether the new medicines workstream commences is for the medicines policy unit and not MOOG.
4	**RMOC agendas and MVP topics** • Deputy Director, Medicines and Diagnostics Policy Team, NHS England was invited to set the context in relation to the content of the paper provided on RMOC agendas and MVP topics. • Conscious work on a revised operating model has been ongoing. Part of hold up due to change in NHS landscape - commitment to bring revised iteration to the group in June. In the meantime, intention is to seek feedback on emerging content by correspondence. Trying to focus on bread and butter on what RMOCs were set up to do – reducing variation and duplication in the system. • Also need to think about four or seven committees going forward - aligned to this is an opportunity to review membership and expectations. • Paper on MVP topics asks for MOOGs permission to have standing agenda items on biosimilars, LPP and antimicrobial resistance. Role of RMOC is to review data. It is not about performance managing but understanding variation and to think through rationale/reasoning for it, which can be feedback to MOOG. • Chair added we have been talking about this for a while, but ensuring RMOCs supported with data, to take on a bit of an improvement role in the same vein as GIRTH for example – feels to us there are some standard items the RMOCs should be taking on. • From a CCG perspective supportive with a focus on improvement and not performance managing. • It was noted there is a fine line between improvement and performance management. Some concern amongst members in the South that this isn't what they signed up to do • Concerns raised about enough resources to facilitate seven. Given impending delivery though regions, not everyone needs one, but everyone might want one. Mood music is heading in that direction. • Reality of managing an RMOC across a geography is a challenge around local engagement – easier when dealing with a smaller patch. Whether 4 or 5, its one national system which could benefit representation across all regions. • The agenda item closed, and the chair concluded there was broad support for the MVP proposal.
5	**Medicines Optimisation Priorities Panel (MOPP)** • Joint NHSE/NHSI Regional Pharmacist (South) was invited to provide an update following January and March meetings. • Connecting into other systems like Presqipp and MO CRG in a much better way – looking at their agenda as well as RMOCs. • Topic submissions slowing down. • Question raised about when there are RMOC issues that are not agreed, do they go back to MOPP? Chair responded that a discussion with medicine policy team should happen in the first instance and brought back to MOOG if an issue can't be resolved. • PSC inhibitors – overlap with Accelerated Access Collaborative (ACCO– thought required on what is the future role for RMOC in supporting the aims of the ACC.

	• Linked to comms – recognition MOPP items need to be clearly communicated ala NICE. • Proposed topics to be added to the work plan were reviewed. **Action: Chair asked for any concerns to be raised by the end of the week** **Operational Group** • As part of the agenda item, members were asked to sign off the terms of reference for the SPS led operational group. Any issues arising from the group meetings are feedback to MOOG. • A question was raised about membership of the group and whether a CCG representative was required. The role of the group was explained, and it was agreed no CCG representative was required. • In addition to the terms of reference, a disclaimer was tabled for sign-off. Members agreed the statement should be shared with legal colleagues before sign-off. **Action: Comments on terms of reference by the end of the week**
6	**RMOC Communications and Engagement Plan** • Heather Marshall, Communications and Engagement Manager, NHSE, was invited to talk through the content of the RMOC communications and engagement plan. • The plan was drafted before Christmas and shared with SPS and NHSCC for comment. Key focus of the plan is set in the context about how we engage with professional bodies and patient groups. Paper sets out table of roles and responsibilities: - RMOC members - SPS - What we can do nationally • In terms of next steps, members views/comments on plan would be appreciated additional help required with stakeholder mapping as topics are added to workplan to ensure engagement with the right cohort of people/groups. **Action: Members to feedback on stakeholder mapping** • Initial feedback from around the table: - Industry absence – Industry fully supportive of RMOCs - Additional messages required providers - Comment on way RMOCs will contribute to delivery of the Long-Term Plan. This needs to be a dynamic document that's updated when new landscape plays out – STPs/ICS for example.

	- Idea of regional events to coincide with republishing operating model supported. - Important to work with the right specialists and patient groups for a given topic. Lay some of the ground work now. - 3 MVP priorities could be focus of relaunch to bring people on board with the work of committees, set out in the context of long-term plan. - engage with committee lay members – access into local groups and build them in as a key resource. Getting links to STPs important. Can build on the work already taken place with patient groups. Chair in bringing the agenda item to a close highlighted a need for broader engagement with industry, messages for providers, messages on long term plan, STP/ICSs, regional engagement with bodies and patient groups - working closely with RMDs.
7	**Conclusion** • Chair brought the meeting to a close, and thanked members for a helpful discussion. We all want RMOCs to fly and whilst PPRS implications are noted – there is a lot of work to do elsewhere on things other than new medicines.

Next Meeting:
17 September 2019
14.00 – 16.00