Medicines Optimisation Oversight Group (MOOG)
Minutes of Meeting

Tuesday, 17 September 2019
14:00pm - 16:00pm

Astor Court Hotel Meeting Rooms, Fitzrovia W1W, 20 Hallam Street, London, W1W 6JQ

Attendees	
Julie Wood (Chair)	NHS Clinical Commissioners
Keith Ridge	NHS Clinical England
Michele Cossey (dialed in)	NHSE/NHSI Regional Pharmacist (North)
Richard Seal	NHSE/NHSI Regional Pharmacist (Midlands & East)
Stephen Brown	NHSE/NHSI Regional Pharmacist (South)
Richard Goodman	NHSE/NHSI 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
Justine Scanlan	Specialist Pharmacy Service
Jonathan Underhill	National Institute of Health and Care Excellence
Eileen Callaghan	NHS Hastings and Rother CCG, NHS Eastbourne, Hailsham and Seaford CCG
Sarah Crotty	NHS HERTS VALLEYS CCG
Phil Thomas	NHS England
Sue Dickinson	Specialist Pharmacy Service (Observer)
Richard Croker	NHS Devon Clinical Commissioning Group
Gareth Arthur	NHS England

Apologies	
Vin Diwaker	NHS England Medical Director (London)
Malcolm Qualie	NHS England
Slakahan Dhadli	NHS Southern Derbyshire CCG

Action log – live actions[1]

No.	Decision or Action	Date	Owner	Status
7.	Early Clinicians gaps in RMOC membership to be filled	June 2019	Midlands & East and North	Ongoing
22	Recruit an early career clinician to MOOG	June 2019	PT	Ongoing
24	Operating Model - NHS England to make agreed changes and circulate to group members for comment with a quick turn-around.	Sept 2019	PT	Close
25	Ven diagram might be useful to set out how NICE and RMOCs will work together to avoid any potential duplication.	Sept 2019	NICE/SPS	Ongoing

[1] A full action log is set out in Annex A

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, about RMOC workplans and progress updates on national priorities. • Discuss and sign off the Operating Model. • Hear about the NICE Connect project and medicines pathways. • Get feedback from the last MOPP meeting and ratify topics for inclusion on RMOC work programme. • Hear an update from the latest Operational Group meeting. • Hear an overview on the Accelerated Access Collaboration. • Review the agenda for the national RMOC event on 8th October.
2	**Minutes from the last meeting** The chair reviewed the minutes with group members. The following amendments to the minutes were proposed: • Date needs changing on the first page to 19 March 2019. At the end of the minutes, the meeting date for the next meeting also needs amending.
3	**Reflections of the last round of RMOC meetings and overview of current work plans** The chair invited the Regional Chief Pharmacists to provide updates from the last round of RMOC meeting and to give members an overview of current work plans. **South** • Talked a lot about Liothyronine at the meeting. • Revisions to the Free of Charge policy has been out for consultation. As a result, advice expected to be issued soon. • Hydroxychloroquine – two parts of south could not implement screening to ensure patients don't lost their sight. RMOCs asked to kite-mark. Uncomfortable doing that. Part of role of RMOC is to raise awareness of the work. Giving patients drugs that could harm, exploring with other RMOCs. • AAC. Presentation to this group is on the agenda for later. Key RMOC role with supporting the uptake of AAC RUP is one of monitoring uptake and unwarranted variation. • Botox – work been happening for six months and made progress. Available evidence is sketchy in parts, but clearer in others. Need MOOG to agree next steps and needs appropriate resources to support. Botox is an important topic but to do it

justice, more than current capacity required to ensure delivery. Change in use is likely given now on NHS tariff. Will pick this up again at the end of the update.

- Biosimilar insulin work is on-going with CSU support. Alongside doing some with the Commercial Medicines Unit at NHS England to explore commercial opportunities. At the very least, this work is about raising awareness to the system.
- Blueteq approvals – RMOC role with endorsing but the underpinning principles is to keep things simple.
- Safety update feedback provided.
- Regional assurance group is up and running looking at BVB, LPP and OTC.
- Biosimilar cost comparator tool – RMOC felt it was useful but needs some work to make it available across the country. AHSN on board but needs resourcing to support its spread.
- Legal advice on sequencial use of biologics was sought. Advice provided put into a paper and approved by an RMOC. Helpful position for CCGs in the context of NHS Constitution – setting out restricting the number of options per patient isn't aligned.
- Subcutaneous infliximab – not being looked at by NICE so right for RMOC to pick this up.
- Depot Buprenorphine – need some expertise in the form of a short life working group to come together for a small amount of money to help develop advice.

A paper on Botox was tabled setting out recommendations and next steps. The group were asked for a view on how far we take Botox given the size of the issue. The following points were raised:

- Something RMOCs should look at. Alternative is we leave every APC and Trust to address locally. Do we leave it for every APC and Trust to address locally and take an independent view, or do it once nationally as the RMOC system was set up.
- Recognition that when a product is on tariff, advice is more likely to be implemented.
- Suggested an option is to request Botox is added to NICE work programme – however the issue is number of indications.
- NICE clinical guidelines include evidence summary on off-licence use. Key thing is about avoiding duplication of effort and a need for a robust process.
- On the issue about the use off label/unlicensed medicines. No process or output from NICE that serves that purpose yet. One solution would be the RMOCs.

Given spend continues to increase, general consensus amongst members is it seems sensible for RMOCs to look at Botox and be given some funding to deliver advice, which would cover 'grey areas' where the evidence is sketchy. Recognised a need to be clear on the status of advice i.e. not to the same standard of NICE.

London

- Tidy up meeting held in July.

- Committee continues to work on polypharmacy and deprescribing agendas.
- Deprescribing event took place earlier in the year and looking to adopt Canadian deprescribing guidance – one submitted to NICE and endorsed. Four others to work on.
- Multi-compliance aids – published piece of work to signpost health and social care professionals.
- Feedback from MOPP – discussion on operating model and share model
- National overprescribing review. Work kicks off in earnest next week with first meeting of a short life working group. London RMOC leading with the NHSE/NHSI Chief Pharmaceutical Office as Senior Responsible Officer.
- Big piece of work looking at national antidotes audit. Working with the medicines policy team and getting a meeting in the diary to conclude.
- Two key subgroups on AMR and BVB – second meeting of latter group to take place tomorrow.

Midlands and East

- First meeting chaired by Nigel Sturrock and had a good turn-out.
- Members were unhappy with the length of time to publish the refreshed RMOC Operating Model.
- NHSE/I presented on AMR which set out the policy direction of travel and links to RMOCs.
- Discussion about the NHSE & NHSI merger.
- Dr Lewelyan – MHRA funded. RMOC decision to endorse suspended.
- Antibiotic pack sizes. OOH and Walk in Centers.
- PGD development – Tracy Rogers gave an update on the work on AMR and sexual health.
- Sodium Oxybate – following up next steps with NHSE/I medicines policy team.

North

- Met in June.
- Presentation given to members on draft Operating Model setting the proposed direction of travel.
- CSU scope discussed, and MOU agreed on shared care work.
- High level antimicrobial stewardship presentation to members.
- Next meeting to take place in October.

RMOC Operating Model

A revised draft of the Operating Model, following the one issued to members in August, was circulated for comments last week. The main changes were made following consultation with ABPI and NICE. The main concerns fed back continued to focus on the role of RMOCs with new and existing medicines.

The chair opened up a group discussion on the latest draft and the following points were made by members:

	• Working assumption is there will be one RMOC North as there are 7 STPs. One RMOC relating to three and a bit STPs is cumbersome, and whether a meeting is held in the North West or North East, it's a day out for members however it is organised. • Disappointment on new drugs being out of scope – going to get drop off in membership from clinicians in particular. Recognise the difficulties in arriving at the decision. Anything NHSE/I involved in almost becomes a national decision. Might do something in the North that's separate i.e. APC type agenda funded by APCs, but in a slightly different way to RMOC and owned by STPs/ICSs. • Arriving at a policy decision on new medicines has been quite tricky. There is still a role for RMOCs where no NICE guidance is expected within eighteen months. Don't know what the list looks like? Really important role within region, done by RMOC on behalf of APCs. Something here about doing things once. • From 1 Jan 2019, NICE primed to take on new medicines and indications. NICE processes have changed – Industry funded to ensure medicines are reviewed in a timely fashion. Not going to be a situation where 2 years go by without guidance. NICE will decide on what's appropriate for use and will be of mandatory use. TA for most new meds expected given the need for evidence when a medicine enters the UK market. No backlog and process in place. • Operating Model needs to reflect what's in the current pipeline. Need to avoid performance management, about clinical engagement. NICE FAQ on local formularies on NICE approved treatment and place in pathway – important role for NICE and gives RMOCs some principles. • RMOCs need to remain clinically led and not about performance management. Important role for RMOCs moving forward working with ICS/STPs. • Three layers to an RMOC work programme – national MVP MO priorities, regional priorities and things locally to reduce variation. • It was highlighted the presentation on LPP at North RMOC caused some disgruntlement with clinicians as being told rather an opportunity to influence. This is helpful feedback not to develop things in a national bubble and recongnise a need to engage clinicians along the way. • Needs to be a reference to resources and providing assurance. need to be supported to give them enough to deliver what is required for the system. • SPS highlighted supporting 6 or 7 RMOCs is undeliverable without additional resources. • A no nonsense document. Multiple indications/unlicensed evidence sketchy and getting into position of legal challenge with a company. • Teams are needed to engage with local movers and shakers in the same way as run local APCs. Secretariat is worth their weight in gold and ensure work up is done in time for consideration at a meeting. Is there already duplication in the system. • Concern of doing away with doing once nationally element. First two bullet points of objectives are fine. Needs to be a further one on doing things once. If only got oversight of national priorities and regional/local priority, risk of losing clinical buy in. Don't therefore need MOOG and MOPP as 7 rather than 1 national system. Stuff that local systems needs doing, need RMOCs to do once and reduce duplication. Enables focus to be on implementation. • There continues to be some reservations about the role of RMOCs and regional versus national approach. The underlying principle of a lead RMOC producing advice across the RMOC system remains, albeit with an understanding there may be regional implications when applying advice that require consideration. • With the revised Operating Model, we recognise there is an element of seeing how it plays out in terms of regional ownership and topics for inclusion on work programmes. The guiding principle of RMOCs reducing duplication in the system

	still stands and a coordination function is required to ensure we avoid a scenario of RMOCs looking at the same topics. • If RMOCs are part of the regional infrastructure, need to be funded by regional architect, access to analyst, programme management. Some funding to support national priorities. In terms of other 2 priorities, much more powerful getting. RMOCs linked into regional infrastructure and whether there is resource/capacity. Part of the job of the Medicines Policy Unit is to inform NHSE Regional Directors. **Consensus that a national medicines optimsation system with the objective of doing things once. Principle since day one and made good progress. RMOCs were set up to reduce unwanted variation. That's why a single national model on policy issues is important. Dismantling the national model would add to variation.** ***Action: NHS England to make agreed changes and circulate to group members for comment with a quick turn-around.***
4 **5**	**NICE Connect Project** The chair invited Jonathan Underhill to provide members with an overview of the NICE Connect project. • Recognition NICE are good at what they do, but sometimes difficult to find information easily on website. Need to get more agile at meeting demand. To help people access the information they need quickly and easily, NICE are reviewing how they produce and present guidance. • The work will be driven by pathways that reflect the organisation and delivery of prevention, treatment and care. These pathways will be the way NICE prepare and present advice on effectiveness, safety and value for money. The pathways will link across and within topics. This allows users to access underpinning evidence and practical support. • NICE will provide clearer, more accessible, and up to date information and recommendations on treatment, care and support. This includes advice on the order of interventions to be used • Other thing NICE are looking at is where a NICE TA sits within a pathway. If there are several TAs and guidance, provide information on where a medicine would fit within a pathway and include recommendations. • Often evidence isn't there to give a hard and fast recommendation. Take a pragmatic approach to support a pertinent decision. Input into clinical system – determines what medicines not to use. • Plan – process of looking at methods and processes. Underpinned by scope, including stakeholder engagement to understand what issues are and how to improve. 1. Look at fundamental overhaul and in depth look at how to develop future recommendations 2. How its presented – working up timeline – a year or 2 in the making before anything fundamentally changes. May be some interim presentations along the way. ***Action: suggestion a Ven diagram might be useful to set out how NICE and RMOCs will work together to avoid any potential duplication. Wording in the operating model is important and a need to work hard on maintaining relationships.***

	Accelerated Access Collaborative The Chair invited Sam Roberts, NHS England's Director of Innovation and Life Science, to provide members with an overview of the Accelerated Access Collaborative (AAC. • The AAC was constituted in May and came out of the Accelerated Access Review. • All Chief Exec's across multiple NHS organisations have signed up to the aims/implementation of the AAC. • New SofS requested more authority with delivering the AAC aims. Leadership arm now in NHSE/I and much more connected into our world. • AAC cover 3 things: 1. Pre-NICE approval to support product uptake (top pg 4) 2. Developing elements of innovation eco system 3. Commission a number of innovation programmes, including AHSNs, patient groups, pharma, to support implementation of RUPs. • First wave identified seven RUP of which two are medicines - PSCK1 inhibitors and cladribine. PSCK in particular aligns to RMOCs as commissioned by CCGs. Cladribine Specialised Commissioning in NHSE/I. • PSCK1 inhibitors – engagement workshop earlier in the year to understand barriers. NICE, AHSNs, patient groups in attendance. NHS creates barriers – prior approval process for example. Some mirrors NICE process, some several pages. Can take up to 12 months for a patient to receive treatment through use of algorithms. • Taken our eye of cholesterol across the country. Dropped off Right Care for example, approach as working group, was how do we get peoples focus on raising awareness • PCSK9 inhibitors good for patients and good for the NHS as saves money. Right for the RMOCs as clinically led groups to pick this up • What is the role of AHSNs - North East and North Cumbria lead - education/communication side of things. GPs don't identify patients for use on a product. AHSN to educate GPs • Important to ensure RMOCs don't duplicate work being undertaken by other parts of the system. • Governance – standing agenda item on each RMOC agenda.
6	**MOPP** The chair invited Steve Brown, chair of the last MOPP, to provide a quick overview from the last meeting. • Discussion about the principles around MVP and write out to the system. • Focus on tools for acquisitioned costs. • Vitamin B – went to London RMOC – felt it didn't meet criteria. First one put through that got pushed back. More about diagnostics – ask about endorsing guidelines and reviewing diagnostic pathways – pushed back as didn't have the expertise and didn't think appropriate to look at. RG will draft a letter to send out to system. • Discussed the benefit of inserting a status column on the work plan, including information on timescale for topics going to an RMOC.

	• Focus at on the 'No's' (topics not put forward to the at next meeting. **Operational Group Meeting** The Chair invited Ben Rehman to provide a headline piece of feedback. • Main discussion around operationalising the Operating Model.
7	**National RMOC Event – 8 October 2019** A draft agenda was circulated to the group in advance of the meeting. Due to the meeting over running, comments were requested back to Phil Thomas. The chair provided some quick feedback to say the content of the agenda for day looked good.
8	**Conclusion** • Chair brought the meeting to a close, and thanked members for a helpful discussion.

Next Meeting:
26 November 2019
11.00 – 13.00

Annex A

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	Closed
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	Closed
12	Develop a plan for functioning of the RMOCs in relation to big programmes of work and additional resources required.	Regional Pharmacists	Closed
13	Membership – recruit CCG members to RMOCs and additional representatives to MOOG.	NHSCC/PT	Closed
14	Re-circulate Operating Model for comments.	PT	Closed
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	Closed
20	Comments on operational group terms of reference.	All	Closed
21	Members to feedback on stakeholder mapping	All	Closed
22	Recruit an early career clinician to MOOG	PT	Ongoing
23	FreeStyle Libra policy document – chase their publication	PT	Complete
24	Revised iteration of the Operating Model to be circulated to members in July.	PT	Ongoing