GHP Guild of Healthcare Pharmacists

19th September 2016

Medicines, Diagnostics and Personalised Medicines Policy Unit
Quarry House
Quarry Hill
Leeds
LS2 7UE

Regional Medicines Optimisation Committees-
Proposals for Establishment

Response from the Guild of Healthcare Pharmacists

Thank you for the opportunity to respond to this consultation. The Guild of Healthcare Pharmacists represents UK wide around 4,500 pharmacists including the majority of hospital pharmacists, pharmacists employed by NHS Primary Care organisations and pharmacists employed by other public bodies such as Prisons and the Care Quality Commission. The Guild is part of the health sector of the union Unite.

Consultation Comments

Overarching Comments

- The proposals do lack detail, some of which is important in developing the responses to the consultation.
- Is there a need for 4 RMOCs or is the real requirement around the evaluation process?
- If the purpose is to draw together all of the evidence review bodies (e.g. MTRAC, ERNM, NETAG, UKMi) and co-ordinate the workplans, is there a need for 4 committees?
- By introducing the RMOCs, are you introducing another layer of bureaucracy? Is it anticipated that advice from the RMOC will still need to be adopted at local level through the existing APC structures?
- The proposals are very primary care focussed

4. What is the core purpose of RMOCs?
Questions

4.1 Do you agree that the points above clearly outline the proposed role for the RMOCs? If not, please list and explain the specific points about which you disagree.

4.2 Is there anything additional that you feel should be included in the role of the RMOC?

We agree with the intention to reduce duplication and streamline introduction of new medicines into clinical practice. Identifying unproven therapies would be a valuable role but guidance would need to be very clear if prescribing habits and patient acceptance of the guidance are to be achieved.

However, there are concerns that RMOCs will slow down the process of publishing reviews as the workload is likely to be high if a national perspective is taken. Some APCs will undertake local evaluations and uptake of medicines that are in the NICE workplan but are more than 6 months away from planned publication. If these drugs are not picked up by the RMOC, significant delays will be introduced. There is mention of a case by case stance being taken on such drugs but the document lacks any detail as to the rigor of any such decisions.

Rather than developing four committees to pick up new drugs not on the NICE workplan, would it be more appropriate to further develop the role NICE to include the activities proposed by the four RMOCs?

What will the degree of advice be? Summary of evidence/options paper/single recommendation which APCs expected to ratify? Not knowing this affects the ability to comment on the proposal. Also there is a risk that by providing this advice from a regional level may lose local 'buy in' to the proposals.

There is a need to clarify if the purpose of the RMOC is to simply review/evaluate new medicines in isolation or, in some instances, as part of an overall treatment pathway. Many new medicines are introduced each year that can be described as me too drugs. What is not helpful is an isolated statement about the new drug. What would be very useful in this situation is where the new drug may or may not fit into existing pathways/guidelines. If this is not the purpose of the RMOC, this work is likely to be duplicated across many APCs and defeats the purpose of the establishment of the RMOC.

5 What are the operational governance principles under which RMOCs will operate?
Questions:
5.1 Do you agree with the operational governance principles outlined above?
If NO, please list and explain the specific points about which you disagree.

5.2 Is there anything additional which you feel should be made explicit in the governance arrangements outlined?

5.3 Please comment on issues around conflict of interest. Should members be free from conflicts of interest or should members be able to hold conflicting interests and declare them?

We agree with the operational governance principles outlined in the document. However we would welcome information on what the Terms of Reference are and how you plan to engage the statutory NHS bodies – NHS England CCGs and secondary/tertiary care organisations into the process.

It is unlikely that members of the RMOC will be totally free from any form of Conflict of Interest so it would be appropriate to have clear arrangements for how members with conflicts should participate in discussions/votes. We would suggest adopting the same principles that

are in use for participation in NICE working groups.

One governance element that is missing is around a robust and clear appeals process against decisions around prioritisation or actual advice produced.

6 What should RMOC membership look like?
Questions

6.1 Do you agree with the proposed core membership outlined above? If not, please explain.

6.2 Do you think there should be any additional members not listed that need to be included? If so, please list with a brief explanation of why.

6.3 Should the additional membership as outlined above be part of the core membership or co-opted when required?

6.4 Should pharmaceutical industry / manufacturers representation be included as part of the core membership? If so, how should this be managed?

Further detail is needed e.g. how many representatives from each membership category will there be and what would the selection process be for membership? How will individual members be truly representative of the group they are meant to be representing? There is a danger that to be truly representative the Committee is likely to be far too large. The potential geographical spread of members needs to be considered.

LMC and LPC should be involved, however the points made above would also apply.

We feel that secondary care clinicians or DTC Chairs should be core members of the RMOC as prescribing in secondary care has a major influence on prescribing in primary care and therefore engagement in the process by secondary care would be vital.

Pharma should not be included in the core membership or have voting rights. They should have an opportunity to submit information, view the workplan and comment on consultations (if they are planned), however they should not be allowed to speak at meetings of the RMOC.

As stated previously, there is a risk that regional committees will lose local acceptance of decisions made without the involvement of the NHS commissioning bodies

7 How will RMOC work plans be determined?
Question

7.1 Do you agree with the proposal for determining the work plan of the RMOCs? If not, please explain how you think this should be approached and why.

There is a lack of detail within this section. There needs to be information on how the prioritisation will be undertaken. As stated previously, there needs to be a robust appeals process developed.

We are unclear why the pharmaceutical industry are involved in the development of the workplan.

Will the process look at medicines that are only likely to be used in secondary care for example vernakalent? This would not impact on primary care so is unlikely to be fed into the process by an APC but every secondary care Trust is likely to have to undergo a review process. Therefore should secondary care or local DTCs be able to feed into the workplan?

NHS England has a process for commissioning new drugs and procedures which they are the responsible commissioner. It would be helpful if this was considered as part of the work plan and role of RMOC

8 What is the status of outputs from RMOCs?
Question:

8.1 RMOC outputs will be framed as advice - do you agree? If not, please explain your rationale.

We would agree with this and would suggest advice and recommendations similar to those of the SMC.
The links with the commissioning bodies would be vital to implement any recommendations

We hope these comments are of assistance. Our reply may be made freely available.

Yours faithfully

Dave Thornton
Immediate Past Chair (Immediate Past President) &
Head of International Delegation
Guild of Healthcare Pharmacists

Barry Corbett
Professional Secretary
Guild of Healthcare Pharmacists