Greater Manchester Medicines Management Group (GMMMG)

Terms of Reference

Issue date: September 2020
Version number: 1.1

REVISION DATE	ACTIONED BY	SUMMARY OF CHANGES	VERSION
January 2020	RDTC M Mason	Final version approved by GMMMG	1 (FNL/DOCJan2020)
August 2020	RDTC D Newsome	Version 1.1 - Amended to reflect temporary merger of PaGDSG / FMESG to form MGSG in response to GMMMG COVID recovery restart plan and priorities for 2020/21.	1.1

1 Vision

'To make Greater Manchester the safest, most effective place to receive medicines and treatments'

2 Aims and objectives

The aim of the Greater Manchester Medicines Management Group (GMMMG) is to lead medicines excellence across Greater Manchester supporting the commissioning of patient orientated outcomes by viewing medicines and treatments as an investment in improving health and wellbeing rather than a cost.

GMMMG will:

Promote the most efficient and cost effective use of medicines to support Clinical and financial sustainability. This should always include the consideration and promotion of non-medicine options as appropriate e.g. education, lifestyle changes as the start point.

Provide advice and make recommendations on the optimal and safe use of medicines for the benefit of the GM Health economy.

Provide strategic leadership to Greater Manchester CCGs and Trusts on the commissioning or decommissioning of medicines and devices.

Scope new and innovative ways of working to achieve improvements in medicines optimisation.

Support and engage with the public, patients, commissioners and clinicians to support the implementation of GMMMG recommendation. In the absence of a lay member GMMMG will seek to communicate with patient groups through "Health watch" via its GM wide consultations.

Set high quality outcomes standards; monitor and report against standards with the aim of to reducing unwarranted clinical variation

GMMMG will promote quality improvement with better utilisation of data and analytics and sharing of best practice between organisations.

Improve the quality and safety of medicines and device use across the Greater Manchester region by highlighting variation in patient outcomes attributable to medicines and devices to both commissioners and providers. Setting standards to reduce variation and improve patient outcomes identified as requiring improvement and supporting GM organisations to identify unwarranted variation locally.

Promote local implementation and monitor adoption of GMMMG guidance and escalate to GM Directors of Commissioning if further action is required.

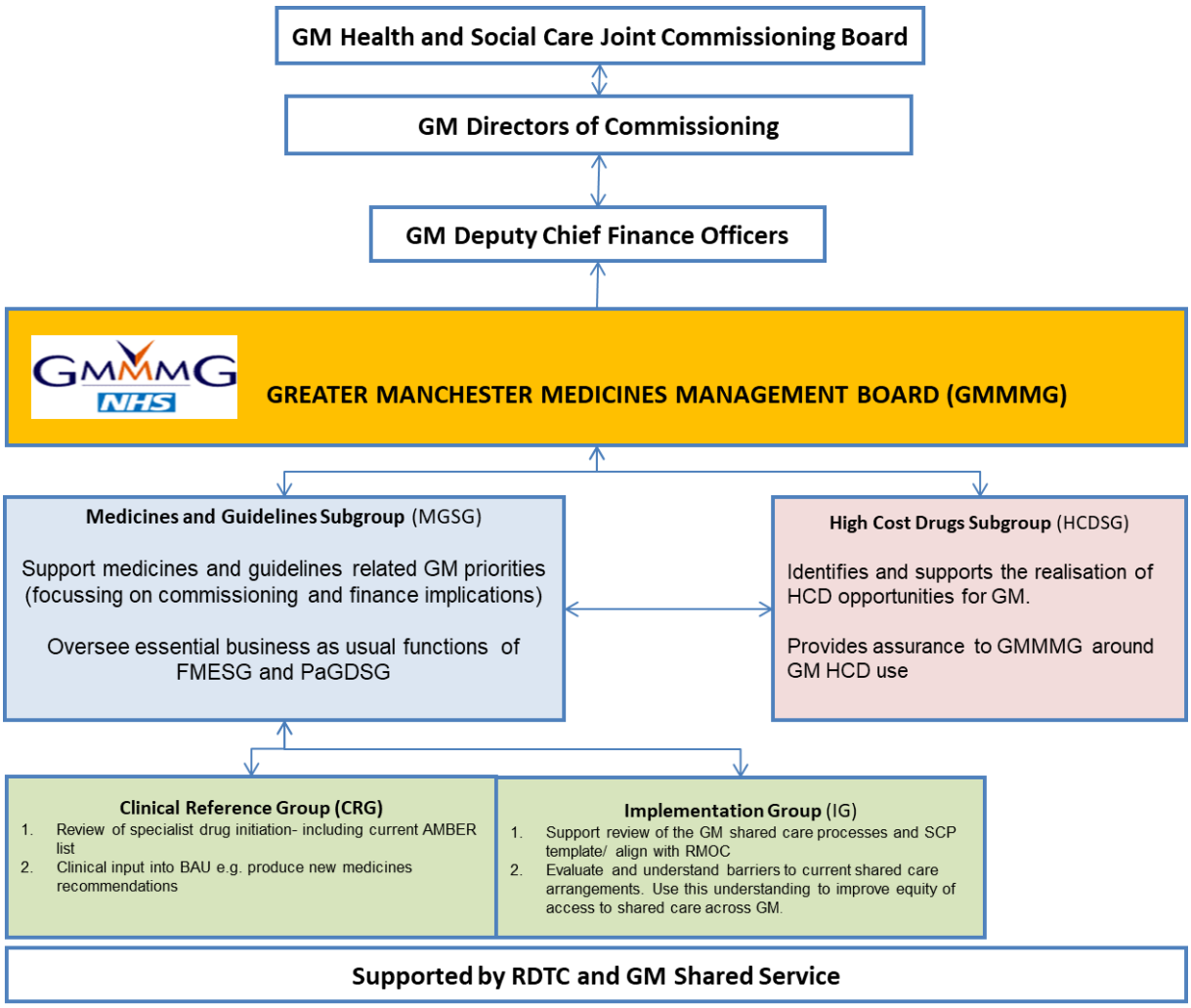
Oversee, set direction and ratify outputs from the GMMMG subgroups.

3 Accountability

GMMMG will be accountable to the GM Directors of Commissioning (DoCs)

The following subgroups will be accountable to GMMMG

- Medicines and Guidelines Subgroup
- High Cost Drugs Subgroup



4 Delegated Authority

GMMMG has been delegated authority by GM Directors of Commissioning to make recommendations around the use of medicines and devices across GM providing that the financial threshold of such a recommendation does not exceed £200K per year across GM in any of years one to five. Any recommendation exceeding this threshold will need to be approved to proceed by GM Chief Finance Officers, prior to submission to GM Directors of Commissioning in the first instance.

Table 1 illustrates the routes of decision making by GMMMG

Subgroup recommend-ation	GM Financial impact[1]	GM commissioning impact	GMMMG	DFCOs	DoCs	Output
Low clinical risk	Low	Nil	ratification	-	-	Formulary
High clinical risk	Low	Nil	decision	-	-	
Low clinical risk	High	Nil	Recommend-ation to DFCOs	Recommend-ation to DoCs	Decision	DoCs report + Formulary + assurance monitor
High clinical risk	High	Nil				
Low clinical risk	Low	Yes	Recommendation to DoCs	-	Decision	DoCs report + Formulary
High clinical risk	Low	Yes		-		
Low clinical risk	High	Yes	Recommendation to DFCOs	Recommend-ation to DoCs	Decision	DoCs report + Formulary
High clinical risk	High	Yes				

[1]Low financial impact is considered to be <£200K/year across GM in any of years one to five

[2] High financial impact is considered to be >£200K/year across GM in any of years one to five

[3] High clinical risk is deemed to be use of agents where a significant point needs to be considered e.g. use of the agent outside of license, or where use of more established unlicensed agents may be recommended ahead of the use of a newer licensed agent

5 Decision Making Criteria

GMMMG believes that health care should be allocated justly and fairly, according to need and the capacity to benefit, such that the health of the population is maximised within the resources available. GMMMG and its subgroups will consider which medicines or treatments should be prioritised for investment as defined by clinical effectiveness, cost effectiveness, affordability and clinical need. Recommendations will be made using the decision making criteria outlined alongside the ethical framework (appendix A). This is to ensure a consistent, equitable and transparent approach to all aspects of medicines management throughout the local health system ensuring compliance with the principles of the NHS Constitution.

Any item brought for a decision to the group will need to undergo an equality impact assessment; this will ensure that any decision made will not impact on those who are already disadvantaged or vulnerable. A set front page or template will be available for use (appendix B)

If a treatment is of unproven effectiveness, poor cost effectiveness or of low overall priority to

the Greater Manchester population, the group will advise under what circumstances the treatment should be made available to patients, and will also recommend decommissioning of treatments where appropriate.

The process of priority setting by the GMMMG should be designed to be open, transparent and consistent. It will use systematic methodology, an evidence-based approach and wider engagement within the process (and in accord with legislation and regulations) using the GMMMG prioritisation criteria (appendix C) Any submission to GMMMG which is not completed in full as described in appendix B will not be considered by GMMMG, and the professional secretary has been delegated the authority to reject incomplete applications.

Annual horizon scanning of new medicines and technologies expected and possible savings due to availability of biosimilar or generic products will be utilised by the group to aid work planning. The GMMMG work plan will be agreed annually, and an annual report will be prepared to demonstrate the success and progress made by GMMMG at the end of each financial year.

6 Membership

The GMMMG membership is drawn from across the Greater Manchester Health Economy, and is structured so as to provide a balanced group representative of the whole economy and its population. Nominees will be sought and approved by the Chair to ensure maximum health economy representation and as far as possible a mix of pharmacists, Directors and Clinicians including CCG prescribing leads and Acute Provider Medical Directors or Clinicians. All positions will be reviewed on three year tenure.
Current membership is listed in appendix D

6.1 Role of the Chair and Vice Chair

The Chair is appointed through a stakeholder nominations process and has particular responsibility for providing effective leadership. The Chair is responsible for ensuring that the minutes of meetings, produced by the Secretariat, and any reports to DoCs accurately record the decisions taken, and, where appropriate, the views of individual Committee members have been taken into account.

The Chair will provide input to ensure that a fair representation on the committee from across GM is achieved whenever possible.

Membership will nominate a Vice Chair who will be responsible for chairing the committee meetings and providing leadership 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.

An additional 17 to 20 positions will be available the majority of these positions will need to be nominated by organisations from within local health economies.

Those nominated will need to include the following roles:

- GP Prescribing lead
- Head of Medicines Optimisation
- Director of Commissioning or a deputy
- CCG Chief Finance Officer or a deputy
- Secondary Care Clinician
- Chief Pharmacist
- Public Health representative
- Mental Health representative (nominated member from Mental Health Trusts)
- Provider Board representative
- A council representative for Social Services
- Regional Chief Pharmacist
- Joint Commissioning Board Clinical Lead for Medicines Optimisation
- Medical Director
- NHSE Specialised Commissioning Representative
- Chair or vice chair of each GMMMG subgroup
- Lay representative
- LPC or Community Pharmacy Representative

NB where possible membership of the GMMMG and its subgroups should not overlap significantly in order to ensure a fair decision making and appeals process however it is recognised that this may not always be possible.

6.2 In Attendance (no voting rights)

Non-voting members may be invited on a regular or ad hoc basis from the following groups or any other groups as required.

- Experts, mostly with clinical or academic background, may be invited to meetings or sessions of meetings on an ad-hoc basis to provide opinion, information and evidence on specific matters.
- GM Communications lead
- Representative from the AHSN (Health Innovation Manchester), Strategic Clinical Networks, the LPN

Representatives from the Regional Drug and Therapeutics Centre (RDTC) and the GM Joint Commissioning Team (JCT) will be present to provide support to the group. They will be non-voting members.

6.3 Expected behaviours of members

All members attending GMMMG or subgroups to represent an organisation or present a paper do so in a professional capacity, and all participants should be treated with courtesy, respect and consideration.

Participants should only speak when they are invited to by the Chair and should raise a hand to be recognised as having something to say. A person should not be interrupted while speaking or asking a question.

All speakers are asked to be clear and concise, as GMMMG and its subgroups have busy

agendas, and are required to work within the allocated agenda time.

6.4 Deputy Arrangements

When not able to attend, members must send a deputy to participate and vote on their behalf, with the exception of Patient and Public Voice members. Each member must nominate a deputy at the start of the appointment period. Deputies must have similar expertise and be of similar level of seniority as the member they substitute. Where a member is representing a professional group (e.g. Medical Director) then the deputy would also need to be from the same professional group but not necessarily the same organisation.

6.5 Role of Individual Members (and deputies)

- Represent the views of their constituent organisations and/or professional groups
- Have authority to make clinical recommendations/decisions on behalf of their constituent organisations and professional groups.
- Ensure that decisions taken by committee are communicated to their organisation and local health economy.
- Ensure feedback from constituent organisations is received by the committee, including any specific concerns regarding patient safety, commissioning issues or other practical considerations.
- Commit to attend meetings regularly and liaise with the nominated deputy to ensure consistent attendance.
- Commit to work outside meeting where required, including training to assure competency in line with NICE local decision making competency framework.
- Attend meetings prepared having read all documents and having liaised with others prior to the meeting, and ready to contribute to the debate.
- Declare any financial or personal conflicts of interest at the start of each meeting and adhere to the GMMMG declarations of interest policy.
- Review the terms of reference bi-annually
- An internal annual membership review may take place and the chair may request members to stand down in the event that they are no longer compliant with the role requirements.

6.6 Role of the secretariat/support function

The RDTC and GM JCT will coordinate the agenda, minutes and actions and ensure that governance processes are adhered to. The Secretariat will be provided by the Regional Drug and Therapeutics Centre (RDTC) and is responsible for ensuring that the committee does not exceed its terms of reference.

Communications between the committee and stakeholders in relation to outputs will generally be through either the Secretariat or GM Joint Commissioning Team (JCT), except where it has been agreed that an individual member should act on the committee's behalf.

7 Confidentiality

All members and attendees agree to keep detailed discussions confidential to allow free and full debate to inform unencumbered decision making.
Discretion should be used when discussing meetings with non-attendees and papers should not be shared without agreement of the chair or professional secretary, to ensure confidentiality is maintained.

8 Declaration of interests

Members of the committee must declare their relevant personal and non-personal interests in line with NHSE guidance (Managing Conflicts of Interest in the NHS). Members are asked to inform the Secretariat and Chair prior to each meeting of any change in their relevant interests. The minutes of each meeting will record declarations of interest, and whether members took part in the discussion and decision making. An annual register of interests will be published on the GMMMG website. (This is in addition to any registers published by organisations)

The Chair or Vice Chair should not have a personal interest in any agenda item under discussion. If the chair or vice chair have an interest in a matter under discussion they will absent themselves from discussions and nominate another chair for that agenda item.

9 Quorum arrangements

The quorum is reached when at least two thirds of voting members are present. An appropriate spread of members' interests is also required for the quorum to be valid. It is advisable that, at least one Provider member, one commissioner member, one deputy chief financial officer and a sufficient presence of members with an appropriate clinical knowledge need to be present.

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 voting members, therefore making it less than two thirds 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.

10 Voting arrangements

Members should normally aim to arrive at decisions by a consensus. Where consensus cannot be reached, a majority vote - defined as a 75% majority of represented (quorate) members. Abstentions are not considered when determining the majority.

11 Frequency of meetings

In order to maximise attendance the GMMMG will meet a minimum of bi-monthly, however the Chair has the right to convene extraordinary meetings when considered necessary, to remain

flexible to clinical and service requirements, and take chairs action in exceptional circumstances. A record will be kept of members' attendance at the meeting via the minutes. The GMMMG and subgroup Chairs will meet virtually and informally in the intervening months.

12 Agenda Setting

Items for the agenda will be proposed by membership or through applications received from the GM health economy. A work plan will be agreed by the group at the start of each financial year. All items will be prioritised and assessed for suitability and relevance to the group by the professional secretary and the Chair prior to them being discussed by the subgroup. Only items that have the support of a majority (6 out of 10 health economies) will be considered at a GM level. Prescribing or other data may be consulted to evaluate relevance.

13 Publishing of agenda and minutes

The committee will make agendas and papers available one week prior to meetings to membership either via email or on GMMMG website.

Meeting notes and actions from the meeting will be sent to members for final approval within two weeks of the meeting, after which and following Chairs approval they will be published to the GMMMG website.

14 Publishing of statements and recommendations

All outputs will be shared on the GMMMG website, and will be reflected in the GMMMG formulary, PbRE list, DNP lists or RAG lists and associated guidance. Final decisions made by GMMMG will be published to the website and shared through a bulletin to CCG MO leads, Trust Chief Pharmacists and GMMMG members for onward dissemination within their organisations within three weeks of the meeting.

This bulletin will be shared with Docs in addition to any formal papers for submission at the next DoC's meeting.

The GMMMG twitter account will be used to further disseminate the outputs of GMMMG and to raise awareness and encourage participation in GMMMG consultations.

15 Appeals

All appeals must comply with the **GMMMG appeals policy** available from the GMMMG website. The grounds on which an appeal can be made are outlined within this document. Appeals will in the first instance be sent to the professional secretary of the GMMMG who will forward them on to the relevant subgroup. Appeals can only be made by NHS Healthcare Professionals within the region covered by the GMMMG or by a clinician outside of the region who has responsibility for a patient registered within the above region and for the indication or use for which the GMMMG or its subgroups considered the treatment.

16 Pharmaceutical Industry

The GMMMG will not accept requests from the pharmaceutical industry to attend meetings or to present information to group members. Ways in which the group will engage with the Industry are defined within the **GMMMG pharmaceutical engagement policy**.

Applications for review, from the pharmaceutical industry cannot be accepted as all appeals must come from health care professionals working within Greater Manchester to ensure that they are in line with the needs of the local population.

Date TOR Agreed:

Review Date:

Appendix A: GMMMG decision making framework

Framework for agreeing policies at GMMMG through the ethical framework

The purpose of an ethical framework is to:

•Provide a coherent structure for discussion, ensuring all important aspects of each issue are considered

• Promote fairness and consistency in decision making from meeting to meeting and with regard to different clinical topics

• Provide a means of expressing the reasons behind the decisions made.

The Ethical Framework is especially concerned with the following:

1.1 Equity

GMMMG believes that health care should be allocated justly and fairly on the basis of clinical need and the capacity of a cohort of patients to benefit from a proposed treatment and in such a way that seeks to maximise the welfare of patients generally within the budget available.

GMMMG will assess health needs according to patients' capacity to benefit from health care. Thus, it will not be bound to achieve equal shares but will distribute resources within the population according to need, and the imperative to reduce health inequalities. Treatment will not be recommended solely because a patient or clinician requests it. Similarly, a treatment of very little benefit will not be commissioned on the sole ground that it is the only treatment available. This is necessary to ensure that resources are used to provide the greatest health benefit to the population of Greater Manchester as a whole.

1.2 Evidence of clinical and cost effectiveness

GMMMG will seek to obtain the best available evidence of clinical and cost effectiveness. It will promote treatments for which there is good evidence of clinical effectiveness in improving the health status of patients. It will not recommend treatment that is shown to be ineffective or which cannot be shown to be effective i.e. where evidence is lacking or inconclusive. Patient support for a treatment will not necessarily be taken as evidence of clinical effectiveness. Expert opinion, on its own and without supporting evidence, is unlikely to constitute sufficient evidence to justify recommending a new treatment. The quality of any studies will be considered in giving weight to their recommendations. Reliable evidence will

usually be required from good quality, rigorously appraised studies and where possible will only published information will be used, however on occasion it may be necessary to consider evidence from other sources.

GMMMG will compare the cost of a new treatment to the existing care provided and to its overall benefit, to the Greater Manchester population.

1.3 Cost of treatment

1.3.1 Affordability

GMMMG is required to consider the budgets of the GM health economy and not to exceed this, therefore the cost impact of recommendations must be considered in all cases.

1.3.2 Rarity

GMMMG primarily considers the healthcare of the majority population of Greater Manchester. Conditions affecting a small number of people or individual patients will be considered by the individual CCG responsible for the care of those patients.

1.3.3 Opportunity Costs

The cost of treatment is also important because investing in one area of health care inevitably diverts resources from other uses (opportunity costs). Thus independent decisions will be made about cost, cost-effectiveness and opportunity costs.

3.4 Needs of the community

Public health is an important concern of GMMMG and it will seek to make decisions which promote the health of the entire community. Whilst GMMMG is primarily concerned with recommendations relating to medicines and technologies it will always include the consideration and promotion of non-medicine options as appropriate e.g. education, lifestyle changes as the start point. GMMMG will support effective policies to promote preventive medicine across GM.

3.5 National Standards and GM devo

The Department of Health issues guidance and directions to NHS bodies which may give priority to some categories of patient, or treatment. These may affect the way in which health service resources are allocated. GMMMG will consider National Recommendation and implement as appropriate. GMMMG will also work to support those priorities identified by the GM HSCP under the devo agenda.

Appendix B: GMMMG submission template

Name of Meeting:	GMMMG	
Date of Meeting:		
Author of paper and contact details		
Declarations of Interest of authors of this report:		
Title of paper:		
Aims of this proposal and how this will be measured:	☐ **prevent ill health by:**	
	☐ **reduce known health inequalities by:**	
	☐ **improve healthcare quality (safety, experience, effectiveness) by:**	
	☐ **improve health and wellbeing outcomes by:**	
Executive Summary **(please provide no more than a one page summary and include key points)**		
This item is presented to CSB for	☐	***Decision***
	☐	***Discussion***
	☐	***Information***
CSB is asked to:		
Financial implications **The financial implications**	☐Yes	☐No

summary must be submitted with this application (appendix 1)		
Commissioning implications	☐Yes Please provide details	☐No
Does this proposal pose any inequality **An equality impact assessment must be submitted with this application (appendix 2)**	☐Yes	☐No
This proposal has the support of all ten GM CCGs	☐Yes	☐No Please list any CCG who has not confirmed support (additional information as to why should be provided within the exec summary)
This proposal has the support of all GM provider Trusts	☐Yes	☐No Please list any Trust who has not confirmed support (additional information as to why should be provided within the exec summary)

Appendix 1: GMMMG Financial implications summary

Please provide details of any financial implications of this proposal *Fill in section 1 OR section 2. Note any proposal with a cost or saving equating to >£200K across the GM economy requires support from DCFOs. Please state the date and route this has been confirmed.*		
Is this intervention a like for like switch?	Yes ☐ Please fill in **section 1**	No ☐ Please go to **section 2**
1a) what are the costs of the drugs involved?		
1b) Will this intervention benefit primary care/ secondary care/both – please provide detail (eg. patient experience/ process/clinical outcomes)		

2. Is this a "spend to save" initiative?	Yes ☐ Please fill in **section 2**	No ☐ Please go to next section
2a) Detail the source of funds and the anticipated payback period		
2b) Will this intervention benefit primary care/ secondary care/both – please provide detail (eg. patient experience/ process/clinical outcomes)		
2c) Will this intervention present as an activity saving or a reduction in prescribing costs – please provide detail		
2d) What are the anticipated implementation costs of this intervention – please include a costed estimate impact for GM and per CCG.		
2e) Provide a costed model of savings over the full payback period		

Appendix 2: GMMMG Equality Impact assessment

Equality Impact Assessment
Please advise whether the decision has a positive or negative effect on any of the groups of people with protected equality characteristics and on Human Rights

Protected Equality Characteristic	Positive (Yes/No)	Negative (Yes/No)	Explanation
Age			
Disability			
Gender			
Pregnancy or maternity			
Race			
Religion and belief			
Sexual orientation			

Other vulnerable group			
Human Rights			
If you have answered that there is a negative impact to any one of the questions above, please explain what you have done or will do to mitigate this.			

Appendix C: GMMMG prioritisation framework (adapted from the Bristol and Birmingham CCGs prioritisation matrix)

	Scoring Description						Description
	0	1	2	3	4	33	
Mandatory	Not Mandatory or considered High Risk					Mandatory and/or high risk	
National alignment	Not a national requirement or NHS target	Addresses one target or national requirement	Addresses two targets or national requirements	Addresses three targets or national requirements	Addresses four or more targets or national requirements		Aligns to: National outcomes framework Key policy document(s) and/or performance target
Local Alignment	This proposal / area is not identified as a local priority	Tactical alignment - enabler scheme	Initiative / area aligns with Bristol priorities	Initiative features in Bristol CCG or partner plans	Initiative contributes significantly to Bristol priorities		Addresses identified: Health and well being board CCG strategic priorities and/or needs assessment including patient and public feedback
Quality of evidence of effectiveness including transferability	No evidence will have intended impact	Limited amount of emerging evidence predominantly from descriptive case studies, surveys or expert opinion	Some evidence from non-comparative cross-sectional or before and after studies	Moderate evidence from non-randomised comparative studies	Strong evidence of effectiveness (Well-conducted SRs/meta-analyses or RCTs)		Increasing robustness of underpinning evidence of effectiveness increases level of certainty in the validity of the findings. Study populations and settings must be examined to ensure generalisability/transferability to a Bristol population. Length of follow-up needs to be considered in order to assess likelihood of longer-term benefits
Outcomes - clinical benefit	No impact	Improvement in outcomes of unknown significance	Small improvement in important patient health and/or healthcare utilisation outcomes	Moderate improvements in important patient health and/or healthcare utilisation outcomes	Significant improvements in important patient health and/or healthcare utilisation outcomes		Outcomes assessed by studies should be important to patients and/or healthcare utilisation
Scale of impact	No Impact	Limited Impact - less than 100 patients	Moderate Impact - 100 - 1,000 patients	Significant Impact - 1,001 - 5,000 patients	High Impact - over 5,000 patients		
Health inequalities	No impact	Small evidence that narrows gap in life expectancy for	medium evidence and larger group	good evidence and large group	Very good evidence and over 1000 patients		Gap in life expectancy here is estimated by the population affected and likely
Process	unikely to be feasible/several barriers to delivery/ does not support	Long (over 1 year) implementation, significant barriers to	less than one year, significant barriers, some integrated working	no significant implementation issues, within 1 year and some integrated working	Proposal ready to go with clear opportunities for integrated working and		An assessment as to the "doability" of this proposal
Sustainability	Does not support CCG sustainability objectives	no score	Partially supports acheivement	no score	Fully supports achievement of CCG sustainability		including impact on other services and the overall health and social care system

Appendix D: Current GMMMG membership

Name	Title	Organisation	Representing
Dr Helen Burgess (HB)	GP MO Prescribing lead	NHS Manchester CCGs	Chair/GPs
Petra Brown (PeB) Or Jane Wilson (JW)	Chief Pharmacist Associate Director of Pharmacy	Pennine care NHS FT GM Mental Health NHS FT	GM Mental Health Organisations
Dr Pete Budden (PB) Or Robert Hallworth (RH) Or Dr Richard Darling (RD)	GP Prescribing Lead GP Prescribing Lead GP Prescribing Lead	Heywood, Middleton and Rochdale CCG	MGSG
Kate Rigden (KR)	Deputy Chief Finance Officer	NHS Oldham CCG	CCG finance leads
Jay Hamilton (JH) Or Ruth Dales (RuD)	Program Development Lead Lead Pharmacist	GM AHSN	Health Innovation Manchester (HIM)
Dr Ann Harrison (AH)	GP MO Prescribing lead	Trafford CCG	GPs
Robert Hallworth (RH)	Specialist Cancer Pharmacist	NHSE	NHSE Specialised Commissioning
Peter Howarth (PH)	Head of Medicines Management	Tameside & Glossop CCG	CCG MO leads
Dr Daljit Saroya (DS)	Consultant Anaesthetist and Chair of MO committee at Stockport FT	Stockport FT	GM Secondary Care Clincians
Leigh Lord (LL)	Locality Lead Pharmacist	NHS Trafford CCG	CCG MO leads
Peter Marks (PM)	LPC Board Member	GM LPC	Community Pharmacy
Fiona Meadowcroft (FC)	Interim Deputy Director Strategy – Integrated Care	MHCC	CCG Commissioning lead
Karen O'Brien (KO'B)	Regional Pharmacist	NHSEI	NHSEI
Dr Jeff Schryer	JCB clinical lead for MO	The GM Joint Commissioning Board (MO)	JCB

Steve Simpson (SS)	Chief Pharmacist	Bolton FT	Chief pharmacists
Charlotte Skitterall (CS)	Chief Pharmacist	Manchester FT	HCDSG
Claire Vaughan (CV)	Head of MO	Salford CCG	HCDSG
Dr Sanjay Wahie (SW)	Clinical Director	NHS Wigan CCG	GPs
Dr Peter Elton (PE)	SCN representatives	Strategic Clinical Network	Strateic Clinical Network
Vacant seat			Provider Board representative
Vacant seat			Council representative for GM Social Services
Vacant seat			GM Medical Directors
Vacant seat			Lay representative
Vacant seat			GM Public Health
Sue Dickinson (SD)	Director of Pharmacy	RDTC	SPS
Monica Mason (MM)	Head of Prescribing Support	RDTC	Professional secretary
Andrew Martin Kathryn Griffiths/	MO Pharmacist	GM Joint Commissioning team	GMMMG support
Andrew White (AW)	Head of MO	GM Joint Commissioning team	GMMMG support
Dan Newsome (DN)	Principal pharmacist	RDTC	GMMMG support