



Regional Medicines Optimisation Committees

Operating Model

First Edition, April 2017

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

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FOREWORD

There is much to be done to help patients, public and society more broadly get the best outcomes from medicines. From patients receiving insufficient information about their medicines to hospital admissions caused by the adverse effects of medicines which could have been prevented, professionals and patients need to work much closer together to improve the quality of medicines use.

Working in partnership with NHS Clinical Commissioners, NHS England has responded to requests for better coordination, collaboration and alignment across health economies and nationally, by joining up vital medicines optimisation activity through the establishment of four Regional Medicines Optimisation Committees (RMOCs) - which will operate together as part of a single system to eliminate duplication of activity across England.

RMOCs will provide advice and make recommendations on the optimal use of medicines for the benefit of patients and the NHS. They will bring together decision makers and clinicians across the four regions of England, to share best practice, understand the evidence base, coordinate action and so reduce variation thus improving outcomes and value.

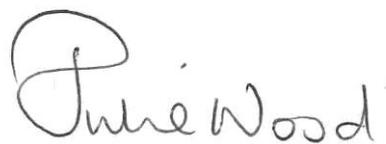
Delivery activity for RMOCs will commence in April 2017, with all four RMOCs expected to have held their inaugural meeting by the end of June 2017. Over the coming twelve months, they will establish themselves and begin to take on the functions described in this operating model.

Given that medicines remain the most common therapeutic intervention in healthcare, and colleagues in research and the broad pharmaceutical industry have worked hard to discover and develop safe and effective medicines, we must all work even harder together to ensure that individual patients and society gets as much value out of that effort as possible, and resources are used wisely and effectively.

We would like to take this opportunity to thank members of the RMOC Steering Group for their strategic direction and advice during the RMOC set up process. In addition, we would also like to thank everyone who has contributed to the RMOC establishment process during the course of the past twelve months.



Dr Keith Ridge
Chief Pharmaceutical Officer
NHS England

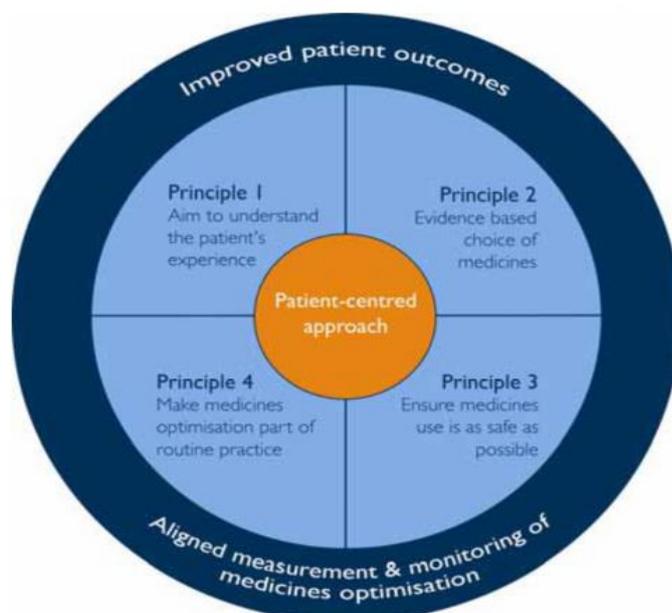


Julie Wood
Chief Executive
NHS Clinical Commissioners

INTRODUCTION

1. Patients depend on medicines to help maintain health, prevent illness, manage chronic conditions and treat disease. Medicines are an important part of what the NHS does to help patients and they are a precious resource. The NHS spends over £15bn each year on medicines, which is second only to staff costs. With people living longer, with multiple and more complex conditions, and research and development leading to new and more expensive medicines being available, that amount is set to continually rise.
2. At the same time, we know that people do not always use their medicines as intended, some medicines have little or no effect on certain people, and medicines can have adverse reactions which result in people needing hospital care.
3. 'Medicines optimisation' is about making sure that the right patients get the right choice of medicine at the right time. By focusing on patients and their experiences, the goal is to:
 - improve health outcomes;
 - help people take their medicines correctly;
 - avoid people taking unnecessary medicines;
 - reduce wastage of medicines; and
 - improve medicines safety.
4. 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. This framework is set out at Figure 1.

Figure 1: Medicines Optimisation Framework



5. Healthcare professionals across the NHS have been working in their clinical teams, through their Area Prescribing Committees (APC), and Drug and Therapeutic Committees (DCT), to implement this framework and secure improved outcomes for patients, and value for the NHS. NHS England is supportive of this agenda, and has responded to requests for better coordination, collaboration

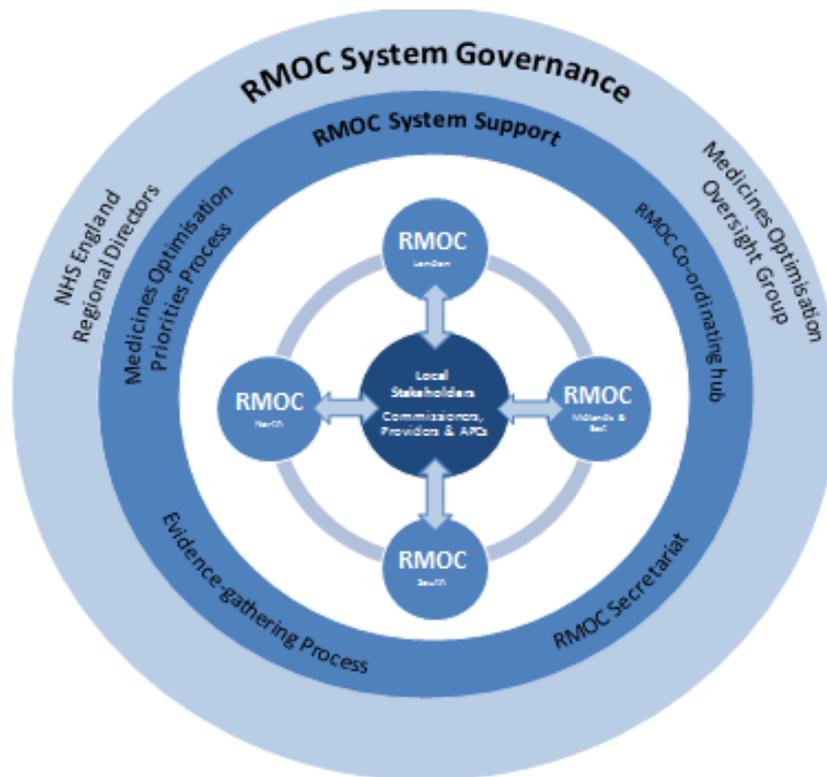
and alignment across health economies and nationally, by joining up this vital activity through the establishment of **Regional Medicines Optimisation Committees (RMOCs)**.

6. The intended role and function of RMOCs has been co-developed by NHS England and NHS Clinical Commissioners on behalf of Clinical Commissioning Groups, in partnership with NHS hospital representatives, the National Institute for Health and Care Excellence (NICE), NHS Improvement and representative bodies of the branded and generic pharmaceutical industry.
7. RMOCs will provide advice and make recommendations on the optimal use of medicines for the benefit of patients and the NHS. They will bring together decision makers and clinicians across the four regions of England, to share best practice, understand the evidence base, coordinate action in order to reduce variation and improve outcomes and value.

PURPOSE AND SCOPE

8. The four RMOCs - in London, the South, the North, and in the Midlands and East of England - will operate as a single, strategic medicines optimisation system for England as illustrated in Figure 2. The purpose of the RMOC system is to:
 - provide a credible source of consistent and reliable advice on medicines optimisation activities, making pragmatic recommendations for use by local decision-makers;
 - promote awareness and support implementation of national policies and initiatives relating to medicines (e.g. NHS Right Care, NHS Improvement's Hospital Pharmacy Transformation programme, CQUINs);
 - provide and disseminate resources to support and accelerate the uptake of advice and implementation of medicines optimisation activities;
 - monitor the implementation of advice and guidance across the four regions of England;
 - identify challenges and emerging issues related to medicines that would benefit from a co-ordinated, system-wide approach;
 - consider the implications of new ways of working and technological innovations;
 - undertake a collaborative horizon-scanning role to identify potential topics for consideration by liaising and collaborating with existing national and regional bodies and organisations including NICE and the Specialist Pharmacy Service; and
 - improve productivity and efficiency by reducing the unnecessary duplication of medicines optimisation activities at local level.
 - in fulfilling this purpose due regard will be paid to the requirements of the public sector Equality Duty and regard will also be paid to the requirements of the duties to reduce health inequalities.

Figure 2 – System Governance for Medicines Optimisation Committees in the NHS in England

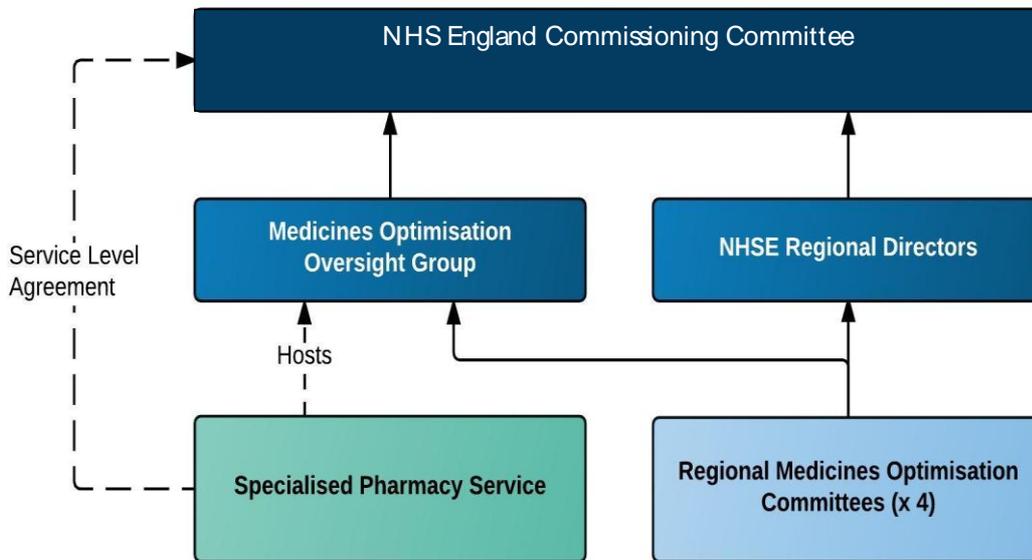


9. The RMOC system will be overseen by the Medicines Optimisation Oversight Group, and will be supported by the NHS England Specialist Pharmacy Service (SPS). A set of priorities will be developed to guide RMOC activities, by a Medicines Optimisation Prioritisation Panel. Roles and responsibilities of each element are explained in this operating model.
10. The status of RMOC recommendations and all other outputs are advisory. They do not affect the statutory legal responsibilities and duties of NHS organisations. RMOCs will connect into the wider assurance mechanisms and delivery systems in respect of commissioners and providers, and will help inform the use of local and national levers.
11. A twelve month plan for the RMOCs will be published on the Specialist Pharmacy Services (SPS) <https://www.sps.nhs.uk/>. Where priorities change in year, this will be reviewed and updated quarterly.

GOVERNANCE AND ACCOUNTABILITY

12. NHS England facilitates and supports the RMOC system on behalf of local commissioners, providers and the wider NHS. As part of this role, it provides system governance and a support function to the RMOCs. This support is provided by NHS England's Specialist Pharmacy Service, and includes:
 - a co-ordinating hub;
 - a national Medicines Optimisation Priorities Panel;
 - an evidence-gathering and evaluation process; and,
 - RMOC secretariat functions in each region as part of a regional medicines optimisation unit.
13. Figure 3 describes the key governance and accountability relationships that underpin the work of the RMOCs and the RMOC operating model.

Figure 3 - Governance and accountability framework



Role of the Medicines Optimisation Oversight Group (MOOG)

- 14. The Medicines Optimisation Oversight Group (MOOG) is responsible for the governance, oversight of RMOC processes and the new RMOC system to ensure consistency in operation and for ratifying the prioritised RMOC annual work programme.
- 15. The MOOG is co-chaired by the Chief Pharmaceutical Officer for NHS England and the Chief Executive of NHS Clinical Commissioners and reports its strategic plans to the NHS England Executive.
- 16. Membership of the MOOG comprises of Commissioner and Provider representatives, representatives from each RMOC, NHS England and NICE. Observers from the trade bodies representing the branded and generics pharmaceutical industry will attend meetings.
- 17. The MOOG has responsibility for managing the SLA with the NHS England Specialist Pharmacy Service, ratifying and overseeing implementation of the RMOC operating model and the overall RMOC work programme.
- 18. The MOOG will regularly review delivery of the work programme, including evaluating the impact of RMOC recommendations and implementation, and feedback into the prioritisation process. An annual report will be produced, agreed in the group and signed off by the co-Chairs to demonstrate that its own proceedings and those of the constituent RMOCs are appropriate and adequately governed and take proper account of relevant legal obligations including the public sector equality duty and the duties in relation to reducing health inequalities.
- 19. The MOOG Group has responsibility for managing a service level agreement with the NHS England Specialist Pharmacy Service, ratifying and overseeing implementation of the RMOC operating model and the overall RMOC work programme.

SUPPORTING RMOCs

Medicines Optimisation Priorities Panel (MOPP)

20. The Medicines Optimisation Priorities Panel (MOPP) determines the priority medicine optimisation topics which are to be addressed through the RMOCs. Prioritisation plans will be informed by evidence gathering and horizon scanning, stakeholder engagement, and suggestions from RMOCs. The MOPP will develop and publish transparent methodology to guide its prioritisation, which will distinguish between issues that are suitable for a national approach via RMOCs versus those best considered locally.
21. The MOPP will consider priorities against a set of criteria, which could include: the scale of the opportunities, potential impact on patient care and outcomes, the likelihood of implementation, the extent of unwarranted variation, and fit with NHS priorities. These criteria will be developed by the MOPP and published as part of its prioritisation methodology.
22. The MOPP will undertake a medicines optimisation analysis of potential priorities using these criteria, and will draw on intelligence from a range of sources including APCs, DTCs, Clinical Reference Groups in Specialised Commissioning, NICE, NHS Improvement, RightCare, AHSNs and patients and patient groups. It will make recommendations which will be agreed by the MOOG, and taken forward by the RMOCs. From time to time, there may be issues which arise outside the routine prioritisation process which require a RMOC to consider and advise. It will be the role of the MOPP to allocate such issues to a particular RMOC.
23. The MOPP will be chaired by a member of the Medicines Optimisation Oversight Group and hosted by the RMOC coordinating hub. MOPP membership will comprise of RMOC members, NHS England and NICE. A Health Economist and Public Health representative will also be utilised to help inform priorities.

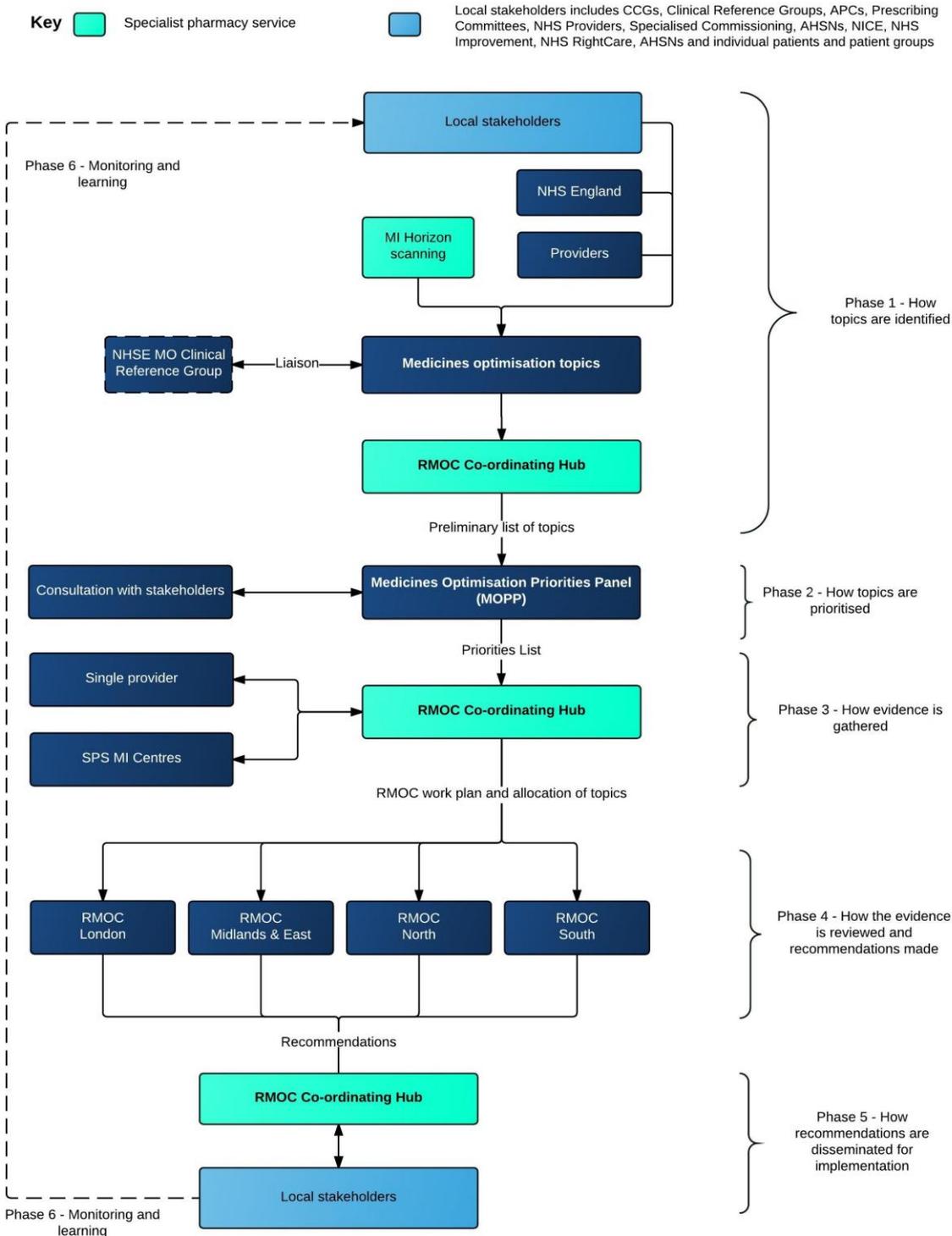
RMOC Coordinating Hub

24. The RMOC coordinating hub will be run by the NHS Specialist Pharmacy Service and will undertake the following key activities:
 - coordinating the RMOC prioritisation process including gathering evidence and requests received via each of the four RMOCs or via stakeholders;
 - hosting and coordinating the work of the Medicines Optimisation Priorities Panel (MOPP);
 - developing and publicising the RMOC work programme, informed by the Medicines Optimisation Prioritisation Panel (MOPP), and responding to ad-hoc requests for support;
 - implementing the agreed RMOC work programme including the scheduling and allocation of work to individual RMOCs;
 - preparing the papers for discussion at the RMOCs (including providing access to any necessary evidence summaries);
 - identifying, endorsing and promoting tools and other resources to support implementation of RMOC recommendations;
 - monitoring implementation of RMOC advice and guidance by local areas and reporting this to RMOCs;
 - providing quarterly updates to the Medicines Optimisation Oversight Group on national implementation of advice and guidance issued by the RMOCs

WAYS OF WORKING

25. As set out in Figure 4, the RMOCs operate collaboratively as a single system supported by the NHS England Specialist Pharmacy Service. The operational processes can be explained considering six distinct phases. Further information on the six phases can be found in **Appendix A**.

Figure 4 – RMOC Operational Process Map



RMOC MEMBERSHIP

26. Each RMOC will be chaired by the NHS England Regional Medical Director for that region and the secretariat support will be provided by NHS England Specialist Pharmacy Services (SPS) Medicines Information Service.
27. Membership will be drawn from the list of proposed members set out in the schematic in **Appendix D**. RMOC membership recruitment will be conducted in an equitable manner to ensure a balanced and consistent approach across the four RMOCs, ensuring an appropriate number of CCG and provider representatives. Specific numbers may vary according to regional requirements but the Medicines Optimisation Oversight Group would ensure overall consistency and balance at the outset and over time. Membership will be reviewed at regular intervals.

Appointment of members

28. The appointment process for membership of RMOCs will be undertaken via the four regions of NHS England (London, North, South, Midlands & East). A 'call for members' will be communicated through national and regional networks and expressions of interest sought via an application process. Application forms will be reviewed by the Regional Medical Director and an agreed set of virtual 'panel members'.
29. Where application numbers for any specific profession/role exceed the proposed membership outlined above or where a clear judgement 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.
30. Following appointment, RMOC members will undertake an induction to help them fulfil the role. There is a working assumption that the host (NHS) organisation for appointed members will cover the cost for attending meetings. It's acknowledged there may be exceptions for example, primary care contractors and lay members who will be managed in accordance with NHS England policy.

Specialists in attendance

31. With the Chair's agreement, specialist expertise may be invited onto the RMOCs as required to provide specific specialist input to meetings. They should be experts in their specific field and be able to provide a balanced view on the issue considered and review the evidence provided. This will be defined by the secretariat as the work programme is developed. Additional members should be agreed by RMOCs before the required meeting. If appropriate, consideration will be given to securing specialist expertise to assist the RMOCs to address the public sector Equality Duty and the duties in relation to reducing health inequalities.

WORKING WITH STAKEHOLDERS AND PARTNERS

Patients and the Public

32. The network of RMOCs will need the input of patients and the public to ensure that they are focussing on topics that matter to them, and that their advice and recommendations are considered. Therefore each RMOC will have two dedicated patient and public representatives and there will be a lay member on the Oversight Group and MOPP. Patients and the public will have a role to play in terms of putting forward suggestions for consideration by the MOPP.

Local and national stakeholders

33. Stakeholders including CCGs, Clinical Reference Groups, APCs, Prescribing Committees, Providers, Specialised Commissioning, AHSNs, NICE, NHS Improvement, RightCare, and individual patients and patient groups will provide a source of intelligence to inform the work of the RMOCs. This will include groups that will contribute to assisting compliance with the public sector Equality Duty and the duties in relation to reducing health inequalities.

Sustainability and Transformation Plan (STP) footprints

34. It is expected that each RMOC will be actively involved with all commissioners (including specialised commissioners and Clinical Commissioning Groups) and providers of NHS services in their region, and RMOC business should be communicated across STP footprints. Involvement with RMOCs will assist health and care economies to work together towards optimising medicines use and improved outcomes in line with the NHS Five Year Forward View.

NEXT STEPS

35. Delivery activity for RMOCs will commence in April 2017, with all four RMOCs expected to have had their inaugural meeting by end June 2017. Over the coming 12 months, they will establish themselves and begin to take on all the functions described in this operating model.

36. Initial priorities for the RMOCs will be identified by the Medicines Optimisation Oversight Group, so that RMOCs are able to focus on the key issues facing the NHS locally and nationally from the outset.

37. The MOPP will be established during 2017 and will be the vehicle for prioritising RMOC activity going forwards. Its first task will be to develop its prioritisation methodology and criteria to guide its considerations.

38. A 12 month period of evolution & refinement is planned, which will include the iteration of this operating model, informed by learning from the first year of operation.

Appendix A – Six phases of RMOc Operational Process

Phase 1 – Topic identification

1. Potential topics for consideration by RMOcs are identified through routine horizon-scanning by the Specialist Pharmacy Service and by consultation with NHS commissioners, providers and area prescribing committees. There is liaison with the NHS England's Specialised Commissioning Medicines Optimisation Clinical Reference Group to ensure that topics areas identified are not duplicated.
2. The output of phase 1 is a preliminary "long list" of medicines optimisation topics collated by the RMOc co-ordinating hub.

Phase 2 – Topic prioritisation

3. During phase 2, the preliminary list of medicines optimisation topics is considered by the Medicines Optimisation Priorities Panel (MOPP). The panel uses agreed criteria to prioritise topics for consideration by the RMOcs in consultation with stakeholders including commissioners and providers.
4. The output of phase 2 is a prioritised list of topics which is thereafter managed by the RMOc co-ordinating hub.

Phase 3 – Evidence-gathering

5. During phase 3, the RMOc co-ordinating hub commissions the gathering of any evidence that is required to help RMOcs to make their recommendations.
6. During this phase, the RMOc co-ordinating hub also converts the priorities list into the RMOc work programme and allocates topics and schedules the work to the four RMOcs. The evidence gathered to support the discussion of each topic is also forwarded to the relevant RMOc.
7. The output of phase 3 is the annual RMOc work programme, which is ratified by the Medicines Optimisation Oversight Group, and published on the SPS website <https://www.sps.nhs.uk/>.

Phase 4 – Review of evidence and recommendations

8. Each RMOc considers the evidence for the topics that have been allocated to them according to agreed principles and makes a recommendation. Each RMOc acts as part of a single system and recommendations made by one are made on behalf of all four RMOcs. The recommendations from each RMOc are passed back to the RMOc co-ordinating hub for collation and dissemination across all four regions.

Phase 5 – Dissemination and implementation

9. The RMOc co-ordinating hub publishes and disseminates the recommendations to stakeholders for local decision-making and implementation. The key audiences will be local Area Prescribing Committees and Drug and Therapeutic Committees.

Phase 6 - Monitoring and Learning

10. The Medicines Optimisation Oversight Group will regularly review delivery of the work programme, including evaluating the impact of RMOG recommendations and implementation and feedback into the prioritisation process.

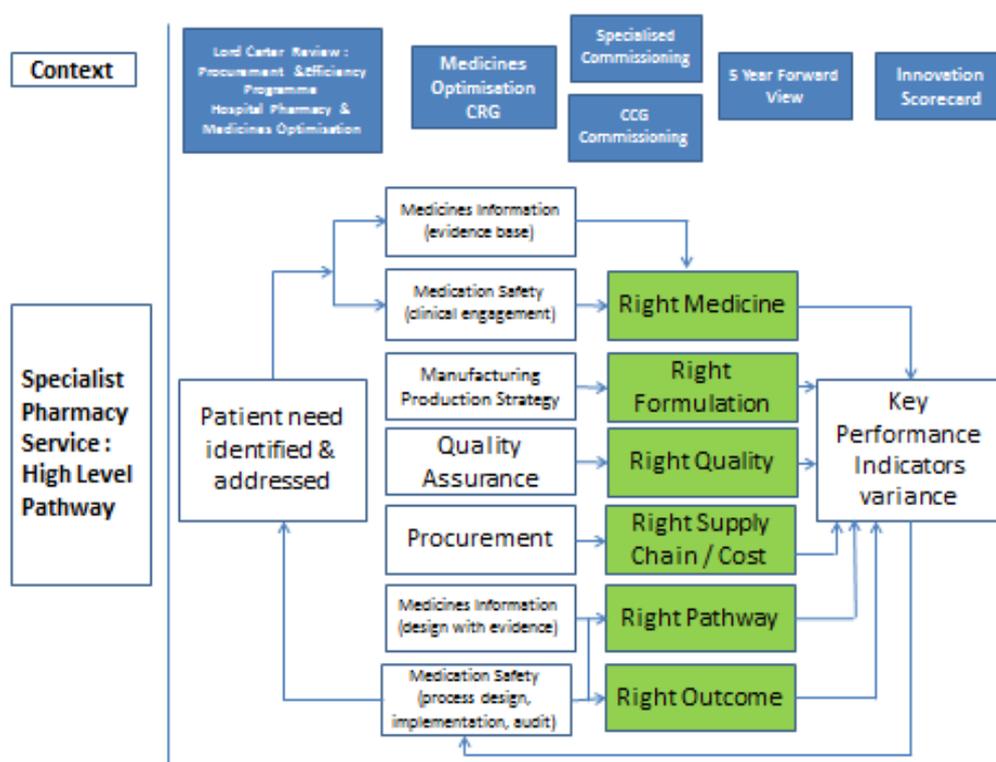
Appendix B – RMOG Resources

1. Specialist Pharmacy Service

The Specialist Pharmacy Service (SPS) consists of senior, experienced pharmacists who provide an invaluable support to the NHS. These pharmacists deliver services which focus on medicines information and evaluation, medicines procurement, pharmaceutical quality assurance and preparation and clinical pharmacy.

The Review of Specialist Pharmacy Services in England (2014) proposed that to ensure access to necessary expertise across England and achieve value-for-money, the Service should be provided at a level of organisation greater than a local health economy and that the service should be directly commissioned by NHS England against a national specification. The commissioning intention being that there should be a consistent and system wide service for England. The functional groupings of the service are designed collectively to underpin the optimisation of medicines usage across England. **Figure 1** depicts a high level plan of delivery for SPS.

Figure 1: A Specialist Pharmacy Service



SPS will provide operational support to RMOGs, which includes:

- a co-ordinating hub;
- a national Medicines Optimisation Priorities Panel;
- an evidence-gathering and evaluation process; and,
- RMOG secretariat functions in each region as part of a regional medicines optimisation unit.

Appendix C- RMOc Membership Terms of Reference

General

1. The four RMOcs - in London, the South, the North, and in the Midlands and East of England - will operate as a single, strategic medicines optimisation system for England. Each RMOc serves the whole country by improving the safe and effective use of medicines, and improving cost effectiveness. It does this by supporting the implementation of evidence based advice on the best use of medicines.
2. RMOcs will provide advice and make recommendations on the optimal use of medicines for the benefit of patients and the NHS. They will bring together decision makers and clinicians across the four regions of England, to share best practice, understand the evidence base, coordinate action and so reduce variation thus improving outcomes and value.
3. A set of priorities will be developed to guide RMOc activities, by a Medicines Optimisation Prioritisation Panel. The RMOc network will be overseen by the Medicines Optimisation Oversight Group, and will be supported by the NHS England Specialist Pharmacy Service (SPS).

Membership

4. Core membership of each RMOc is set out in the schematic (pg 28). The professional secretariat to the RMOcs will be provided by the NHS England Specialist Pharmacy Services (SPS) Medicines Information Service.
5. Individual RMOc members will have a responsibility to:
 - Promote two-way communication between the RMOc and relevant NHS colleagues / organisations.
 - Communicate decisions from the RMOc to NHS organisations in their region for implementation.
 - Undertake work as necessary between meetings.
 - Commit to regular attendance of RMOc meetings to ensure continuity into decision-making.
 - represent their peers (from the role/profession category for which they are appointed) and as such should not bring their local organisational issues to bear on the RMOc discussions.
 - gather views and opinions from their peers (within any confidential arrangements that RMOcs have in place e.g. sharing of papers etc.)
 - **must read** relevant papers / discussion documents as supplied for the meeting **prior to attendance** at the RMOc meeting so that discussions can be informed and as concise as possible, and agreement can be reached.
 - Declare prior to each meeting any outside interests, which might have a bearing on their actions, views and involvement in discussions within the RMOc.

Specialist in attendance

6. With the Chair's agreement, specialist expertise may be invited onto the RMOCs as required to provide specific specialist input to meetings. They should be experts in their specific field and be able to provide a balanced view on the issue considered and review the provided evidence.

Nominated deputy

7. A deputy can be nominated by members, but must be agreed by the Chair on appointment to the RMOC.

Standing Orders - General

8. Members of the RMOC shall be bound by these standing orders and will be expected to abide by the seven principles for the conduct of public life as recommended by the Nolan Committee which are:

- selflessness
- integrity
- objectivity
- accountability
- openness
- honesty
- leadership

Membership

9. All RMOC members will be appointed for a minimum term of one year with the option to extend for a further year. Regular review points on membership will take place and members will also be able to re-apply at the end of their tenure. The removal or substitution of members and the general constitution of the RMOC shall be at the discretion of the chair(s).
10. All reasonable facilities shall be provided for members to ensure they have the opportunity to participate fully and equitably in the business of the RMOC.

Interpretation

11. Statements of RMOC members made at meetings shall be relevant to the matter under discussion at the time and the decision of the chair on questions of order, relevancy, and interpretation (including conflicts of interest) shall be final.
12. Meetings will be conducted by the chair. On the occasion(s) where the chair(s) is absent, another member of the committee can be used as proxy to fulfil the role. The proxy vice chair of the meeting will be appointed by the chair of the meeting.
13. The chair(s) may take action on behalf of the RMOC outside of the scheduled RMOC cycle when urgent decisions are required and it is impracticable to convene a special meeting of the RMOC.

Quorum

14. The RMOCs will meet monthly and is deemed to be quorate if there is a minimum of 50% attendance from both clinical commissioning group colleagues and NHS England representatives.
15. No business should be transacted unless the meeting is quorate with the exception of urgent business. If a member is excluded due to a conflict of interest or a member is unable to attend at short notice and membership falls below the quorum, business may be transacted at the Chairs discretion with the understanding that any RMOC decisions will be ratified by email at the earliest opportunity by the appropriate number of members before being accepted.
16. The quorum must be achieved for the meeting to proceed. Or an agreement reached to ratify decisions by email as above. However, the needs of the RMOC are such that even if the meeting is quorate, an appropriate spread of members' interests should be represented at each meeting. If, in the view of the chair, the spread of interests is insufficient for the business under consideration, the meeting may be suspended or adjourned until a later date.
17. Invited experts and observers in attendance at RMOC meetings will not count towards the quorum.

Collective responsibility

18. All members of the RMOC shall abide by the principle of collective responsibility, and not speak against them in public.

Arrangements for meetings

19. NHS England Specialist Pharmacy Services (SPS) Medicines Information Service, will ensure that RMOC meetings will take place in venues that are accessible to, and have facilities for, persons with disabilities.

20. Meetings of the RMOCs shall be held at such times and places as SPS may determine to facilitate the conduct of its business.
21. NHS England Specialist Pharmacy Services (SPS) Medicines Information Service, shall determine what matters shall appear on every agenda in advance of each meeting.
22. Members will be expected to attend for the full meeting unless agreed in advance with the chair or where they have declared a conflict of interest to one or more relevant discussions.
23. RMOC meetings will be held on a monthly basis and run in sequential order i.e. a different RMOC meeting every month throughout the course of a financial year. Members are expected to attend all meetings of their RMOC. Where necessary, apologies for absence must be given at least one working week prior to the RMOC meeting date (unless illness or mitigating issue is noted).
24. NHS England Specialist Pharmacy Services (SPS) Medicines Information Service, will make all reasonable attempts to agree each meeting date in advance and members are expected to keep these dates free until they are released.

Admission of members of the public

25. These meetings are not open to the public.

Minutes

26. The draft minutes of the RMOC proceedings shall be drawn up and submitted to the next meeting for approval.
27. The approved minutes will be published on SPSs website.

Declarations of Interest

28. All members must make a declaration of any potential conflicts of interest that may require their withdrawal in advance of each meeting. This declaration will be reaffirmed again at the start of each meeting. Declarations of interest will be recorded in the minutes and published on the SPS website.
29. During the course of the meeting, if a conflict of interest arises with matters under consideration, the member concerned must withdraw from the meeting, or part thereof, as appropriate.
30. Experts invited to provide expert testimony will make a declaration of interest in advance of RMOC meetings and in accordance with NHS England's Conflict of Interest policy. This declaration will be reaffirmed again at the start of each

meeting. These will be recorded in the minutes and published on the SPS website.

Terms of reference

31. RMOC members must comply with the terms of reference which set out the scope of the RMOCs work and its authority.

Record of attendance

32. A record will be kept of members' attendance at RMOC meetings via the minutes.

Members are expected:

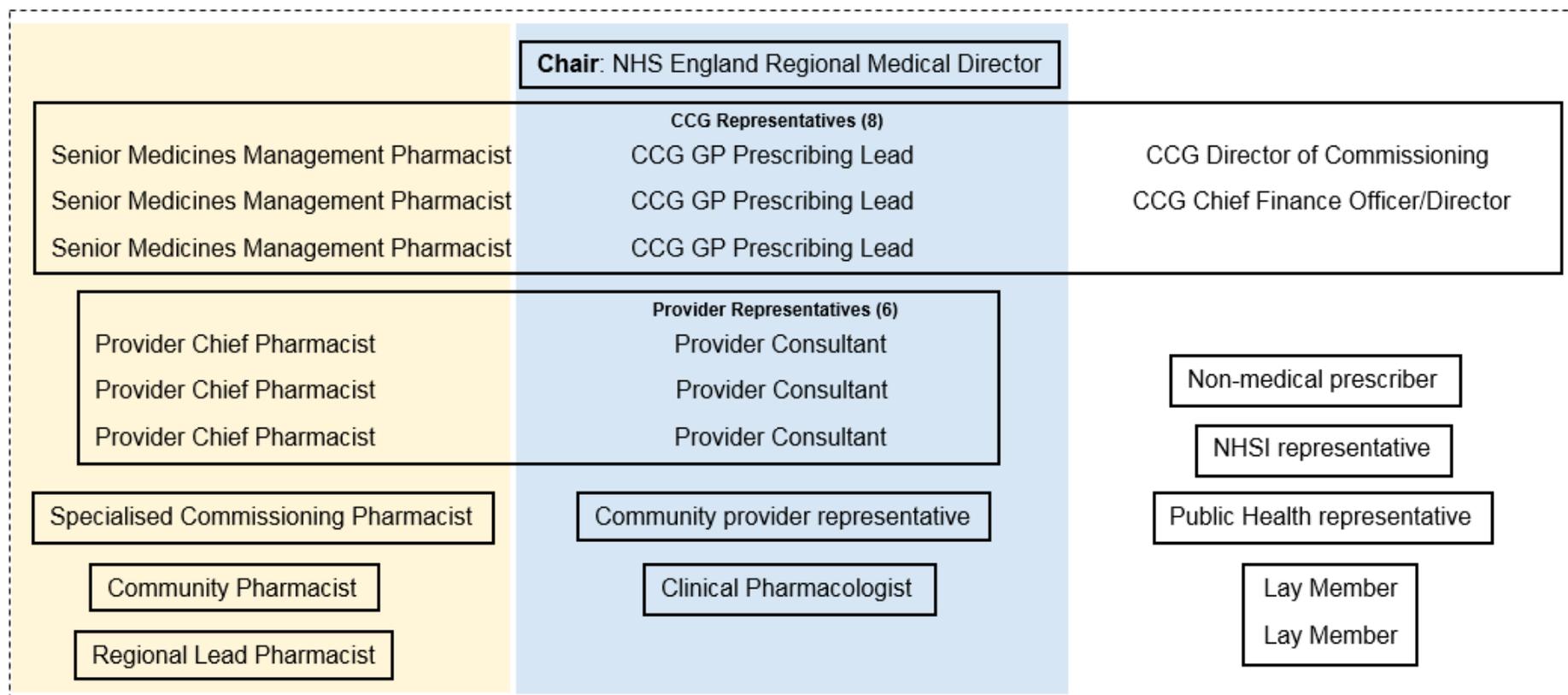
- to attend at least 50% of RMOC meetings during a 12-month period.
- not to miss more than 1 consecutive RMOC meeting.

33. Members who are unable to meet either of these expectations may be asked to stand down from the RMOC in accordance with SO [see paragraph 9].

Review of terms of reference and standing orders

34. These terms of reference and standing orders will be reviewed every year.

RMOC Membership Schematic (numbers are indicative and a matrix system of skill set will be considered)



Total: 29

- Secretariat: SPS Representative
- Observer: NICE Representative
- Observer: ABPI/BGMA Officer
- Observer: Early Career Clinician

At least one member should have:

- A nursing background;
- Expertise in Mental Health;
- Expertise in paediatrics.

RMOC Member Person Specifications

- Representatives are to reflect the role and capacity in which they are appointed rather than to represent the geographical population in which they practice. They should therefore be in a senior position and have a minimum of 3 years experience in that role /capacity.
- Hospital Consultants: 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.
- CCG Prescribing Leads: All must be current or recent members of new drugs panels Area Prescribing Committees, or equivalent.
- Hospital Pharmacists: All must be current or recent members of new drugs panels, Area Prescribing Committees, Drug & Therapeutics Committees or equivalent.
- CCG Senior Medicines Management Pharmacists: All must be current or recent members of new drugs panels, Area Prescribing Committees, or equivalent.
- Public Health representative – Must have experience in population decision making regarding the use of medicines, appliances or devices.

Please note there is recognition that representatives may cover more than one of the proposed membership categories outlined below (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).

An observer role to be made available at all Committee meetings for an 'early career' clinician of any discipline as a professional and personal development opportunity (to be agreed by the RMOC Chair ahead of each meeting (An attendee should attend at least three consecutive meetings to gain learning and experience).

Appendix D - Glossary

ABPI	Association of British Pharmaceutical Industry
AHSN	Academic Health Science Network
APCs	Area Prescribing Committee
BGMA	British Generic Manufacturing Association
CCG	Clinical Commissioner Groups
CQUINs	Commissioning for Quality and Innovation payments
CRG	Clinical Reference Group
DTCs	Drug and Therapeutic Committee
FT	Foundation Trust
MOOG	Medicines Optimisation Oversight Group
MOPP	Medicines Optimisation Priorities Panel
NHS I	NHS Improvement
NICE	the National Institute for Health and Care Excellence
RMD	Regional Medical Director
RMOC	Regional Medicines Optimisation Committees
SLA	Service Level Agreement
SPS	Specialised Pharmacy Service
SPS MI	Specialised Pharmacy Service Medicines Information
STP	Sustainable Transformation Plan