

# **NHS Kent and Medway INTEGRATED MEDICINES OPTIMISATION COMMITTEE (IMOC)**

Terms of Reference  
Version 6.0

## Definitions

1. For the purpose of these terms of reference and other ICB corporate documents including but not limited to: the ICB Standing Financial Instructions, ICB Scheme of Reservation and Delegation, and ICB Scheme of Matters Reserved to Officers; the term '**Integrated Medicines Optimisation Committee**' (**IMOC**) shall have the same meaning as the '**ICB Joint Prescribing Committee**' (**JPC**), including where any delegated limits of authority have been approved.

## Introduction

2. The Integrated Medicines Optimisation Committee (IMOC) is established in accordance with the Regional Medicines Optimisation Committee (RMOC) recommendations and the NHS Kent and Medway Integrated Care Board (ICB) Constitution, Standing Orders and Scheme of Reservation (SoRD) and Delegation. These Terms of Reference set out the remit, responsibilities, delegated authority, membership, and reporting arrangements of the IMOC.
3. The IMOC is authorised by the ICB Executive Management Team to act within its Terms of Reference. All employees and individuals appointed by the ICB are directed to co-operate with any request made by the IMOC.
4. The remit of the IMOC is to provide oversight and direction to deliver a shared medicines optimisation vision for improving population health, preventing ill health, reducing health inequality, and promoting physical and mental health and wellbeing across Kent and Medway. Working together as a single system, strategies will be aligned to achieve the strategic objectives and outcomes. The Committee will also review performance of the above areas and ensure appropriate action plans are in place and delivery is effectively monitored.
5. The remit of the Kent and Medway IMOC will include considering the recommendations made by the RMOC system and, where appropriate, supporting implementation in line with the Kent and Medway IMOC processes.
6. The IMOC is accountable to the ICB Executive Management Team who in turn are accountable to the ICB Board. The IMOC will also report to the ICB Improving Outcomes and Experience Committee (IOEC) for assurance purposes.
7. The remit of the IMOC is outlined below. The nature of how these are delivered will be determined by the IMOC Chair who is also the lead executive officer to the IMOC.

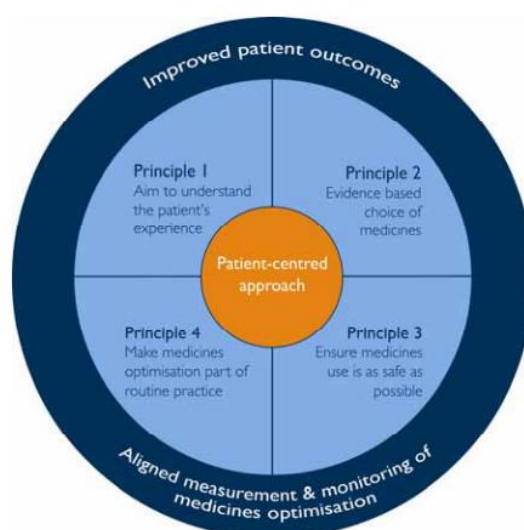
## Purpose:

8. The IMOC has been established to provide the ICB with assurance that is delivering its medicines optimisation functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality

set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care.

9. The IMOC exists to scrutinise the robustness of, and gain and provide assurance to the Executive Management Team and the IOEC, that there is an effective system of quality medicines governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care.
10. The IMOC will provide regular assurance updates, as requested, to the Executive Management Team and IOEC in relation to activities and items within its remit.
11. Medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease. In an era of significant economic, demographic and technological challenge it is crucial that patients get the best quality outcomes from medicines. However, there is a growing body of evidence that shows us that there is an urgent need to get the fundamentals of medicines use right. Medicines optimisation represents that step change. It is a patient-focused approach to getting the best from investment in and use of medicines that requires a holistic approach, an enhanced level of patient centred professionalism, and partnership between clinical professionals and a patient. Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time.
12. The IMOC key purpose is to optimise the use of medicines for the benefit of patients and the NHS, in line with the four guiding principles described by the [Royal Pharmaceutical Society](#) (set out in figure 1) below by bringing together decision-makers, healthcare professionals and patient representatives to share best practice, understand the evidence base and patient perspective to support the coordination of action to reduce unwarranted variation in clinical practice and improve equity of access to effective medicines.

Figure 1. Summary of the four principles of medicines optimisation.



National RMOCs were launched by NHS England in July 2017. Although there are seven committees, the RMOCs operate against a single framework, with each group being part of a greater national system. The RMOCs make recommendations,

*pursue actions, and co-ordinate activities related to any aspect of Medicines Optimisation. The remit of the Kent and Medway IMOC will include considering the recommendations made by the RMOC system and, where appropriate, supporting implementation in line with the Kent and Medway IMOC processes.*

### 13. To achieve this, the IMOC will:

- Ensure strategic alignment with health and care priorities across Kent and Medway with consideration to patient needs from medicines optimisation services to support delivery of NHS strategic and operational priorities, the NHS Long Term Plan, reduce health inequalities and maximise environmental sustainability.
- Provide strategic medicines leadership and expertise based on best practice and best available evidence e.g. approval of guidance, recommendations, tools and other resources to support local delivery including Patient Group Directions, Shared Care Protocols, Formulary Applications.
- Provide oversight of Medicines Optimisation functions across Kent and Medway providing assurance in all elements and monitor associated risks, maintaining a risk register / issues log.
- Make decisions within agreed delegated authority limits (or make recommendations outside of this to the Chief Medical Officer and Executive Management Team), using a prioritisation approach, taking account of cost of the medicine and impact of the investment.
- Consult and engage with place-based partners within Kent and Medway to inform development of the annual medicine's delivery plan, outputs, decisions and recommendations where appropriate e.g. Horizon scan (NICE/NHSEI outputs) and understand potential cost pressures and clinical risks from future prescribing.
- Promote and develop strategies for equity in access, optimisation of use and cost-effective integration of medicines into patient and clinical pathways e.g. direct oversight of work conducted at scale across Kent and Medway implementation of national policies and strategic workstreams.
- Promote inter- and intra-professional collaborative working across organisations e.g. sharing best practice in relation medicines optimisation across Kent and Medway
- Improve patient safety and reduce medication errors, working with other stakeholders as needed.
- Take a strategic view of medicines optimisation, co-ordinating cross-sector support and engagement with the public, patients, providers and clinicians to improve outcomes, reduce harm, and encourage a longer-term, patient-centred approach to medicines optimisation focusing on the effective investment in improving health and wellbeing to achieve the best outcomes and experience for patients and local populations.
- Support place based strategic and operational planning where relevant to medicines optimisation. Directing priority areas of work to streamline production/delivery thereby avoiding duplication.
- Inform and influence policy and strategy for medicines optimisation across Kent and Medway.
- Review/oversight of governance decisions from equivalent committees within the provider collaborative.

14. The IMOC will develop a system-wide vision, strategy and annual delivery plan (with specific, measurable, attainable, relevant and time-based (SMART) objectives wherever possible) for medicines optimisation focusing on improving safety, outcomes, value and delivery of national and regional medicines optimisation priorities. The delivery plan should be actively shared across the ICS before the start of each financial year. The delivery plan may need to evolve throughout the course of a year, so will need to be flexible and able to respond to emerging national, regional, and local priorities.
15. The IMOC will consider how best to implement the delivery plan which may include, for example, leveraging resource available within place base, commissioning additional resource or expertise and/or expanding provision of opportunities for interested individuals across the region to support delivery of priorities.
16. Annual delivery plans should reflect a balance between national, regional and local priorities with clear measures of success and key performance indicators (where appropriate) to measure the impact of the committees work in order to demonstrate its contribution to its aims and those of the national programmes.

### **Delegated Authority**

17. The IMOC has delegated authority as set out in the ICB Standing Financial instructions (SFI's) Scheme of Reservation and Delegation (SoRD) and the Schedule of Matters Delegated to Officers and Committees.
18. Above this threshold, authorisation will be by the ICB Chief Medical Officer and ICB Executive Management Team on the recommendation of the IMOC. The IMOC will seek input in advance from finance leads for items that near the financial threshold.

### **Reporting**

19. Regular communication and feedback to the Executive Management Team and IOEC will be carried out as requested:
  - Through reports on decisions and key actions, areas of high risk, safety issues or those that may be politically sensitive;
  - Through presentation of significant decisions and/or project updates;

and facilitated through representation by the IMOC chair/ICB Chief Pharmacist.

### **Finance and Planning:**

20. The IMOC will use a prioritisation approach, taking account of cost of the medicine and impact of the investment. The committee will consider the financial position of its stakeholder constituent organisations and the extent to which it is feasible to absorb any cost impact or if additional funding is required, also accounting for any substitution impact.

21. The overall approach will be to incorporate robust horizon scanning as part of the ICB annual planning process a possible exception to this being national guidance which wasn't anticipated. In an exceptional case where a medicine is felt to require additional funding, the committee will seek advice from the ICB Chief Finance Officer or deputy on the best way to secure the committee's recommendation.
22. In line with the recent Innovation report, the committee would not seek to duplicate NICE assessments or challenge an appraisal recommendation. It would support timely and planned implementation of NICE Technology Appraisals and to avoid duplication of workload it would consider recommendations from other national bodies e.g. RMOG, Medicines and Healthcare products Regulatory Agency (MHRA).
23. Cancer drugs and those commissioned by NHS E/I would not be considered by the Committee unless there is an impact on other locally commissioned services or medicines. At time of update, it is expected that some clinical services may move from NHSE/I specialised commissioning to ICB's, and this would be expected to include any related medicines. These will be considered on a case by case basis as the changes are confirmed.

## **Membership**

24. The Chair will be the appointed Chief Medical Officer for NHS Kent and Medway ICB.
25. The Deputy Chief Medical Officer or the ICB Chief Pharmacist, will have deputising functions when appointed in the absence of the chair.
26. Other positions will be nominated from within the ICS to represent the range of clinical and non-clinical professions working in medicines optimisation and prescribing to ensure representation of local drug decision making processes on the Committee.
27. Members should have the necessary experience and seniority to make decisions on behalf of their organisation.
28. Membership should be multi-disciplinary and include clinicians in the broadest sense (including representatives of prescribing professions), and particularly medical practitioners and pharmacists. ICS professional roles will be expected to engage their place base counterparts to increase awareness and understanding of the ICS and facilitate local delivery and implementation in each locality.
29. The Chair will provide input to ensure, as much as possible, that a balanced representative, diverse and inclusive membership from across the ICS is achieved.
30. Membership shall be reviewed and updated regularly to ensure the above principles are maintained.

31. The membership shall consist of:

- One nominated representative from each of the four health and care partnerships (H&CP), with suitable knowledge and experience of the IMOC agenda
- One senior clinical acute provider system representative
- One senior clinical community provider system representative
- One acute provider chief pharmacist system representative
- One senior clinical mental health provider system representative
- One senior clinical primary care system representative
- ICB Chief Finance Officer (or their appointed deputy)
- ICB Chief Nurse (or their appointed representative)
- One senior Public Health representative
- Patient and Public Voice representative(s) with experience of working in partnership with healthcare organisations or programmes (non-voting)
- Local Pharmaceutical Committee (LPC) representation (non-voting)
- Local Medical Committee (LMC) representation (non-voting)

### **In Attendance (no voting rights)**

32. Non-voting attendees may be invited on a regular or ad hoc basis as required.

33. Representatives from the pharmaceutical industry, medical device manufacturers/suppliers and any other supplier will not be permitted to attend IMOC meetings.

### **Deputy Arrangements**

34. Members should make every effort to attend all meetings. Members may nominate a deputy to represent them in their absence, as long as it is not another member of the IMOC. Deputies attending will be expected to have the same level of delegated authority as the permanent member to effectively participate and make decisions.

### **Role of the Chair**

35. The Chair has responsibility for providing effective leadership of meetings. In addition, the Chair is responsible for ensuring that the decision and action logs, produced by the support function, and any reports accurately record the decisions taken, and, where appropriate, that the views of individual members have been considered.

36. 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 a deputy will be appointed and will be responsible for chairing the meetings and providing leadership.

### **Role of Members (and Deputies)**

37. Members and deputies should:

- work in the interests of all the place-based partnerships within the ICB.
- actively contribute at and between meetings to ensure delivery of the agreed work programme.
- represent the views of their organisation, sector or professional group.
- communicate decisions taken by the ICB and share best practice highlighted by the committee to their place base and ensure these are implemented with the provision of assurance to the IMOC where appropriate.
- provide feedback from their place base, organisation, sector or professional group to the committee, including any specific medicines optimisation issues or other practical considerations.
- highlight to the committee any areas of best practice which could be shared locally.
- attend meetings prepared; having read all circulated documents, liaised with others prior to the meeting and ready to contribute to the debate.
- embrace authentic allyship to improve their engagement with equality, diversity and inclusion.
- proactively ensure the voices of colleagues of Black, Asian and Minority Ethnic origin are heard, valued, included as equal and considered when decisions are being taken in meetings, networks and committees.

### **Sub-Committees and Working Groups**

38. The Integrated Medicines Optimisation Steering Group (IMOSG) is a permanent forum with direct responsibility to support the IMOC to manage the functions of the working groups and provide the final assurance papers for decision review by IMOC.
39. The IMOSG may choose to establish/adopt permanent or temporary working groups to manage identified workstreams or specific programmes of work and they may also choose to delegate such work to existing groups or committees. This will include Formulary, High-Cost Drugs, Patient Group Direction working groups and various clinical networks.
40. The Integrated Pharmacy Medicines Optimisation Programme Board (IPMO-PB) group is a permanent forum with direct responsibility to support the IMOC with assurance in the following strategic areas: Medicines Safety, Medicines Value, Overprescribing, Mental Health, Workforce and Digital.
41. The IMOSG and IPMO-PB groups will have their own terms of reference, ratified by the IMOC and will submit recommendation reports/applications for decisions/approval/ratification to the IMOC.

### **Individuals in Attendance**

42. Experts, mostly with clinical or academic backgrounds or representatives of professional bodies, may be invited to meetings or sessions of meetings on an ad-hoc basis to provide opinion, information, and evidence on specific matters. They may participate in discussions but shall not be entitled to vote at meetings.

## Confidentiality

43. All members and attendees agree to keep detailed discussions confidential to allow free and full debate. Minutes should be sufficient to record those confidential discussions had taken place but not disclose any confidential matters.
44. Discretion should be used when discussing meetings with non-attendees but, in principle, members may share papers with colleagues unless specifically advised otherwise.

## Declaration of Interests

45. A conflict of interest is a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold. All members should ensure that they are not placed in a position that risks, or appears to risk, compromising their role or the NHS public and statutory duties or reputation.
46. Members must declare any actual, potential, or perceived interests at least annually and adhere to the NHSEI declarations of interest policy. An interest is relevant if it has occurred in the last twelve months or if it is planned to occur. Members are asked to inform the Chair and/or support function prior to each meeting of any change in their relevant interests and any conflict arising due to an agenda item. If a member has an interest, they will not be allowed to participate in discussions and decision making. They may also be asked to leave the meeting during particular discussions, and this will be recorded in the minutes. An annual register of interests will be maintained by the support function with a copy available at each meeting.
47. The Chair should not have an interest in any agenda item under discussion. If the Chair has an interest in a matter under discussion, they will absent themselves from discussions and decision making, and nominate a deputy for that agenda item.

## Equality and diversity

48. All recommendations considered and decisions made by the IMOC should aim to improve equality, diversity and or inclusion (EDI) outcomes. This should be evidenced through the relevant equality impact assessment. Where this is not possible, any proposal and impact assessment must demonstrate that all reasonable alternative options have been appropriately considered and articulate why they have been ruled out.

## Quorum Arrangements

49. The quorum is reached when at least half of the members with voting rights plus the Chair are present. A minimum of:
  - 2 health and care partnership representatives,
  - The senior clinical acute provider system representative

- The senior clinical community provider system representative
- One ICB Member in addition to the chair

50. A meeting that starts with a quorum present shall not be deemed to have a continuing quorum in the event of the departure of members, therefore making it less than 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.

## **Decision Making**

51. Discussions at the IMOC will consider factors such as prescribing data, national guidance, patient outcomes, clinical outcomes, clinical evidence, available resources, an overview of likely financial impact and any feedback from stakeholder groups.

52. It is expected that members will arrive at decisions by a consensus. Where consensus cannot be initially reached, further work should be attempted to reach consensus. If there is no possibility of achieving consensus a vote may take place. A proposal shall be considered approved as long as 75% of voting members present vote in favour.

53. Recommendations will be recorded via the IMOC minutes. Proposals put forward for decision will be defined by a multi-criteria decision-making tool which is agreed by IMOC members and shared with applicants.

54. The committee will continually review its decision-making processes based on the DH guiding principles and best practice as defined by the National Institute for Health and Care Excellence (NICE) and the NHS Constitution.

55. Note: Directions issued by the Secretary of State for Health (2010) make it a statutory obligation for commissioners to make funding available within 3 months for medicines that have been recommended by a NICE technology appraisal, unless they are directed otherwise by the Secretary of State for Health.

## **Frequency of Meetings**

56. It is anticipated that the IMOC will meet bi-monthly and may meet more frequently as agreed by the committee members. The Chair has the right to convene extraordinary meetings when considered necessary.

57. Members may attend meetings in person or, where appropriate facilities exist, by telephone or video conference. It is the role of the Chair to ensure that members attending virtually have full opportunity to participate in the business of the meeting.

58. An attendance log will record members' or their delegates attendance at each meeting. Members or their named deputies should attend (in person or virtually) at least 66% of the meetings each year.

59. Notice of any Committee meeting must indicate:

- a. Its proposed date and time, which must be at least five (5) working days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given)
- b. Where it is to take place
- c. An agenda of the items to be discussed at the meeting and any supporting papers
- d. If it is anticipated that members of the Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting will be agreed by the Chair.

### **Agenda Setting and Topic Submission**

60. Items for the agenda and topics (including potential priorities) for review will be proposed by the members or fed in directly from place base (preferably via their nominated place base member if applicable) via the committee's support function and a decision on priority will form the annual delivery plan.
61. There should be a focussed exercise to collate relevant topics across the ICS as part of annual business planning processes to inform development of the ICS's annual work plan.
62. Urgent topics that may emerge in exceptional circumstances can be submitted for consideration at any point in the financial year via the appropriate sub-committee e.g. IMOSG or IPMO-PB.
63. All items will be prioritised and assessed for suitability and relevance to the ICS by the committee. This should include consideration of a number of factors including whether the topic submitted has relevance in other parts of the ICS or is a specific place base issue.

### **Publication of Agenda, Decisions and Actions**

64. The support function should make agendas and papers available to members at least one week prior to meetings.
65. The decision and action log should be circulated to members within two weeks of the meeting and ratified at the subsequent meeting.

### **Publication of Minutes and Other Outputs**

66. Draft minutes of meetings should be circulated to members within two weeks of the meeting and ratified at the subsequent meeting.
67. The support function should share ratified minutes with the relevant Assurance Committees within two weeks of being approved.

## Stakeholder engagement

68. Membership of the Committee's sub-groups to include a patient representative (sourced via local Healthwatch organisations).
69. Engagement with clinical groups and networks, especially if a formulary decision needs specific knowledge and expertise or has direct implications for a clinical practice area will be undertaken as required with:
- patients or patient representative groups
  - local people and communities
  - local clinical specialists
  - relevant manufacturers of medicines, for example, when the company can offer additional evidence and insight that can assist with decision-making
  - other relevant decision-making groups.
70. The Committee will ensure stakeholder engagement is proportionate to the type of decision being made and the medicine being considered.

## Public Communications

71. The IMOC will develop a local communication framework, in consultation with stakeholders, reviewed annually, to:
- disseminate targeted, concise information to other decision-making groups and key stakeholders, including patients and the public who need to know about the decision
  - routinely communicate with neighbouring local formulary decision-making groups to share practice, particularly when there are cross-boundary patient flows
  - anticipate media response to decisions.
72. IMOC documents will be published on the NHS Kent and Medway ICB website, in a clear, simple and transparent way, so that patients, the public and stakeholders can easily understand it. This includes minutes of IMOC meetings, decision outcomes and associated decision outputs.

## Appeals Process

73. Any appeals against IMOC decisions should be directed to the ICB Chief Medical Officer who will convene an appeal panel as required. The make-up of the Appeal Panel shall be determined by the ICB Chief Medical Officer but will consist of no less than three duly qualified persons. The Appeal Panel will be accountable to the Executive Management Team through the ICB Chief Medical Officer.

74. The Appeal Panel will be supported to discharge its responsibilities administratively through the ICB medicines optimisation function. Appeal requests must be submitted in writing to the Chair within 30 days of the date of issue of the decision.
75. The appeals process gives applicants the right to appeal an IMOC decision if they feel that the process leading to the decision being made was not followed correctly.
76. The Appeal Panel does not consider whether the decision was clinically right or wrong and cannot change the assessment criteria agreed by the ICB.
77. The Grounds for an appeal against decisions made by the IMOC are:
- In reaching the original decision, the IMOC did not follow its agreed decision-making process as outlined in the Terms of Reference.
  - The applicant can demonstrate that not all relevant evidence available at the time of review was taken into consideration at the time of the decision for whatever reason.

**Notes:**

*1. The applicant cannot appeal against a decision just because they do not agree with the decision or because new evidence has come to light since the original decision was made. If new evidence is provided following a decision made by the IMOC, the correct procedure is to resubmit for reconsideration of the decision by the committee.*

*2. The applicant cannot appeal against a decision because a neighbouring IMOC (or equivalent Committee) came to a different decision.*

*3. The applicant will not be able to lodge an appeal if they did not attend the meeting where the application was considered.*

*The appeal panel will assess if the IMOC has followed its own processes accurately. The results of this appeal will be communicated directly to the appealing clinician and the IMOC, who will review the decision if required.*

**Review**

78. The Terms of Reference for the IMOC shall be reviewed by members of the Committee annually, or as required in line with any developments or changes to the ICB's constitution, national guidance or feedback from auditors, with recommendations made to ICB for approval.

**Date TOR Agreed: February 2023**

**Review Date: February 2024**

### Version Control:

Version Number	Amendment	Amendment Owner	Date of Amendment
1.0	Original Version	Associate Director for Medicines Governance & Pharmacy Education	July 2022
2.0	V1.0 stakeholder consultation and engagement feedback log	Associate Director for Medicines Governance & Pharmacy Education	July 2022
3.0	V2.0 stakeholder consultation and engagement feedback log	Associate Director for Medicines Governance & Pharmacy Education	August 2022
4.0	V3.0 Executive governance/finance feedback meeting	Associate Director for Medicines Governance & Pharmacy Education	August 2022
5.0	V4.0 Executive Director of Corporate Governance feedback meeting	Executive Director of Corporate Governance	August 2022
5.0	V5.0 Inequalities Prevention and Population Health Committee	Approval of new medicines optimisation governance structure and IMOC ToR	September 2022
6.0	Change of accountability and reporting arrangements	ICB Executive Director of Corporate Governance	October 2022
6.0	Approval	Executive Management Team	March 2023

# New Medicines Optimisation Governance Pathway Proposal

