**South Yorkshire Integrated Medicines Optimisation Committee**

**Prescribing guideline/shared care protocol (New or updated) Proposal Form**

All prescribing guidelines and share care protocols (SCP) to be discussed at the South Yorkshire integrated Medicines Optimisation Committee should be accompanied by this form. It should be completed by the main author of the guidelines/SCP and [appendix 2](#appendix2) - declarations of interests, must be completed by the main author/s **and**, if different the person presenting the proposal to the IMOC.

|  |  |
| --- | --- |
| **Applicant name** |  |
| **Applicant organisation** |  |
| **Applicant role** |  |
| **Applicant e-mail**  |  |
| **Has Declaration of Interest form been completed (see** [**appendix 2**](#appendix2)**)** |  |

|  |  |
| --- | --- |
| **Summary of Proposal/Recommendation** |  |
| **List manufacturer(s) of the preparation(s) recommended in the guideline / protocol / application** |  |
| **Alternatives in Use/Changes from the current situation or document**  |  |
| **Advantages of Proposal** |  |
| **Clinical risks / safety concerns?** **Include exclusion criteria / contraindications** |  |
| **Monitoring requirements and responsibility for these** |  |
| **Does the guideline/SCP include expected duration of treatment/criteria for stopping?** |  |
| **Financial and Resource Implications** *(for primary & secondary care)***Use** [**NICE resource impact tools**](https://www.nice.org.uk/about/what-we-do/into-practice/resource-impact-assessment) **where available)****Please include the following where relevant.** **Estimated;*** **patient numbers**
* **any work load and costs in primary care**
* **any work load and cost in secondary care**

**Also consider any offset/reduction in use of alternative medicines/ procedures/pathways** |  |
| **Environmental impact** (*Does this proposal have a* ***positive****,* ***negative*** *or* ***neutral*** *environmental impact?)* *(consider waste, efficiency, and carbon footprint of the product. Please indicate if this information is not readily available).* |  |
| **State whether there are any** [**equality or diversity**](http://www.intranet.sheffieldccg.nhs.uk/new_page_9.htm) **implications.**[***Appendix 1***](#appendix1) ***needs to be completed****(Could this application help* ***reduce*** *or* ***enhance*** *health inequalities? Consider if there are any specific patient group including those with protected characteristics who may be adversely or positively affected by this change (see appendix 1). Also consider whether any specific patient group needs additional support to when implementing change).*  |  |
| **Clinical system changes** *(Are there any changes that could be made to the GP clinical systems to support the embedment of this recommendation if approved?)* *E.g. Optimise Rx, Script Switch, Ardens, local clinical system functions* |  |
| **References/Evidence/Quality Standards to support proposal or changes** |  |
| **Opinion of provider trust colleagues** |  |
| **Opinion of primary care colleagues.** |  |
| **Opinion of LMC colleagues** |  |
| **Is any public engagement needed to;** * **support decision making process or**
* **to embed implementation if approved.**

**Liaise with communications and engagement department, as appropriate.** |  |
| **Commissioning implications?** *Are there significant financial implications or shift in workload from secondary to primary care.*  |  |

**Please return completed forms to**: syicb-doncaster.imoc@nhs.net

**Appendix 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **(Please complete****each area**[**[1]**](https://ukc-word-edit.officeapps.live.com/we/wordeditorframe.aspx?ui=en-gb&rs=en-GB&wopisrc=https%3A%2F%2Fnhs.sharepoint.com%2Fsites%2Fmsteams_acf35c%2F_vti_bin%2Fwopi.ashx%2Ffiles%2Fba077bfdcc2348f58a717de6374d9084&wdenableroaming=1&mscc=1&hid=e00c2ea6-e4fe-40d3-ba41-4001b7192250.0&uih=teams&uiembed=1&jsapi=1&jsapiver=v2&corrid=fac2465e-1d8b-4547-bb2b-c407ea3da8f9&usid=fac2465e-1d8b-4547-bb2b-c407ea3da8f9&newsession=1&sftc=1&uihit=UnifiedUiHostTeams&muv=v1&accloop=1&sdr=6&scnd=1&sat=1&rat=1&sams=1&mtf=1&sfp=1&halh=1&hch=1&hmh=1&hsh=1&hwfh=1&hsth=1&sih=1&unh=1&onw=1&dchat=1&sc=%7B%22pmo%22%3A%22https%3A%2F%2Fwww.office.com%22%2C%22pmshare%22%3Atrue%7D&wdlcid=en-gb&ctp=LeastProtected&rct=Normal&wdorigin=TEAMS.UNIFIEDUIHOST.REBOOT&wdhostclicktime=1672222960954&wdprevioussession=1df50c07-18c9-4f97-b233-34c717170e97&instantedit=1&wopicomplete=1&wdredirectionreason=Unified_SingleFlush#_ftn1)**)** | **What key impact have you identified at this stage?** | **Explain any positive or negative impact below. What action, if any, has been taken to address these issues?** | **Further action required?** |
| **Positive****Impact**  | **Neutral****impact** | **Negative****Impact** |
| **Age** | ☐ | ☐ | ☐ |   |   |
| **Disability** | ☐ | ☐ | ☐ |   |   |
| **Gender reassignment** | ☐ | ☐ | ☐ |   |   |
| **Marriage and civil partnership** | ☐ | ☐ | ☐ |   |   |
| **Pregnancy and maternity**  | ☐ | ☐ | ☐ |   |   |
| **Race** | ☐ | ☐ | ☐ |    |   |
| **Religion or belief** | ☐ | ☐ | ☐ |    |   |
| **Sex** | ☐ | ☐ | ☐ |    |   |
| **Sexual orientation** | ☐ | ☐ | ☐ |   |   |

**Does a** [**Quality and Equality Impact Assessment**](https://www.intranet.sheffieldccg.nhs.uk/Downloads/equality%20and%20diversity/QEIA%202020.xlsm) **need to be carried out?**

[[1]](https://ukc-word-edit.officeapps.live.com/we/wordeditorframe.aspx?ui=en-gb&rs=en-GB&wopisrc=https%3A%2F%2Fnhs.sharepoint.com%2Fsites%2Fmsteams_acf35c%2F_vti_bin%2Fwopi.ashx%2Ffiles%2Fba077bfdcc2348f58a717de6374d9084&wdenableroaming=1&mscc=1&hid=e00c2ea6-e4fe-40d3-ba41-4001b7192250.0&uih=teams&uiembed=1&jsapi=1&jsapiver=v2&corrid=fac2465e-1d8b-4547-bb2b-c407ea3da8f9&usid=fac2465e-1d8b-4547-bb2b-c407ea3da8f9&newsession=1&sftc=1&uihit=UnifiedUiHostTeams&muv=v1&accloop=1&sdr=6&scnd=1&sat=1&rat=1&sams=1&mtf=1&sfp=1&halh=1&hch=1&hmh=1&hsh=1&hwfh=1&hsth=1&sih=1&unh=1&onw=1&dchat=1&sc=%7B%22pmo%22%3A%22https%3A%2F%2Fwww.office.com%22%2C%22pmshare%22%3Atrue%7D&wdlcid=en-gb&ctp=LeastProtected&rct=Normal&wdorigin=TEAMS.UNIFIEDUIHOST.REBOOT&wdhostclicktime=1672222960954&wdprevioussession=1df50c07-18c9-4f97-b233-34c717170e97&instantedit=1&wopicomplete=1&wdredirectionreason=Unified_SingleFlush#_ftnref1) **Positive Impact:** will actively promote the values of SY ICB and ensure equity of access to services;

 **Neutral Impact:** where there are no notable consequences for any group;

 **Negative Impact:** negative or adverse impact for any group. If such an impact is identified, you should ensure, that as far as possible, it is eliminated, minimised or counter-balanced by other measures.

**Appendix 2**

Declaration of interest

This section should be completed by the author/s of the document being presented.

Please declare all interests that are relevant and material (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) and which have occurred in the last two years and/or are planned or anticipated in the next twelve months.

|  |  |
| --- | --- |
| **Presenter / Author****Job Title****Organisation** |  |

Have you, or anyone in your immediate family, any financial or other interest in any pharmaceutical manufacturer or supplier, community pharmacy dispensing or retail interest, and which may constitute a real, potential or apparent conflict of interest?

**Please tick: Yes No**

Have you had, during the past year, any employment or other professional relationship with any organisation that is a pharmaceutical manufacturer or supplier or represents such organisations?

**Please tick:** **Yes No**

If you answered ‘yes’ to either question, please give details in the box below. (Continue on new sheet if required)

|  |  |  |  |
| --- | --- | --- | --- |
| Type of interest, eg. shares, employment, association, payment\* | Name of commercial entity | Belongs to you, your family or work unit? | Current interest or interest ceased? |
|  |  |  |  |

\* Amounts do not have to be declared.

|  |  |
| --- | --- |
| **If applicable. in your opinion, could any of these declarations reduce your objectivity in relation to this application**  |  |

 **Reference**

For ICS use only

|  |  |  |  |
| --- | --- | --- | --- |
| Request Clinically approved(Please tick) |  Yes |  No |  |
| Referred for financial approval | Yes | No | Not required |

If request is not approved please indicate rationale for decision: