Title	Standards for Clinical Document Management Clinical Policies, Procedures, Protocols, Guidelines and Standard Operating Procedures
Document Type	Policy
Version Number	V7
CGQ & RDS ID Number	CG003/07.1
Approval/Issue date	September 2022
Review date	September 2025
Owner/Responsible Person	Laura Jones, Director of Quality and Improvement
Developed by	Group listed on page 9 (2008)
Reviewed by	Clinical Governance Steering Group (2010) Associate Directors of Nursing and Clinical Governance & Quality Facilitator – Clinical Effectiveness (2013) Review/Consultation Group 2015 Review/Consultation Group 2018 Review/Consultation Group 2021 Review/Consultation Group 2022 Slight amendments to approval route made Sept 2024
Approved by	Clinical Executive Operational Group (awaiting approval)
Health Inequality Impact Assessment (HIIA) **(statutory for policies)**	September 2022

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Intent

The aim of this policy is to ensure all NHS Borders clinical policies, protocols, procedures and guidelines (referred to hereafter as clinical documents) are:

- developed using a systematic and co-ordinated approach
- revised and updated by the identified review date
- reviewed and updated by the appropriate person(s)
- approved by the appropriate group
- logged on a central register held by Clinical Governance & Quality
- published on the Right Decision Service (RDS) app/website
- fully implemented with all relevant staff being made aware of the clinical documents and where to access them as required
- compliant with the requirements of the Public Records (Scotland) Act 2011

This policy is designed to provide a framework for the development and review of all clinical documents within NHS Borders. The policy applies to all staff employed by NHS Borders or contracted to work with NHS Borders on a fixed term or temporary basis.

Introduction

The development and implementation of clinical documents is a process of continuous improvement. NHS Borders recognises the importance of locally developed clinical documents. These provide a framework within which staff will work to ensure high standards of clinical practice and the delivery of safe, effective and person centred care to all NHS Borders' patients.

In taking control of clinical documents NHS Borders is demonstrating a proactive approach to risk management principles as outlined in the NHS Borders Risk Management Policy (located on NHS Borders intranet) ensuring systems are in place to monitor and assure the effectiveness of implementation of locally developed clinical documents.

Definitions

Clinical Document	Any publication that provides direction, evidence and/or patient documentation relating to the assessment, treatment and care of patients. A clinical document can be a policy, procedure, protocol or guideline, for example: ○ Public Protection Policy ○ Remote/telephone Prescribing Procedure ○ Medical Infusion Device Protocol ○ Vitamin D deficiency Guideline	
Policy	• written statement that conveys the general intentions, approach and objectives of an organisation • enables management and staff to make appropriate decisions and administer and comply with relevant legislation, organisational rules and good working practices • not open to interpretation or professional judgement and is non-negotiable • policies often reflect statutory legislation and or NHS mandatory objectives	Mandatory
Procedure	• detailed steps/instructions that describe the official or accepted way something is to be done, with deviations from the procedure being required to be recorded • may be attached to a policy or stand alone	Mandatory
Protocol	• defines the rules, expected behaviour and method for managing a particular situation or may form an arrangement between partners • when implemented, ensures uniformity of standards • used to translate national guidelines into local practice	Mandatory
Guideline	• provides advice on how something should be done, i.e. is a recommended approach, parameter, for undertaking a task or activity, using a product or equipment , etc • designed to help practitioners assimilate, evaluate and implement the ever increasing volume of evidence and opinion on current best practice	Good Practice

Standards

1 Clinical Document Register

1.1 A central register of all locally developed clinical documents will be maintained by Clinical Governance & Quality.

1.2 The owner/lead for the development/review of a clinical document is responsible for registering it with Clinical Governance & Quality.

1.3 Review reminders will be issued to the identified owner of the clinical document, by Clinical Governance & Quality, three months in advance of the review date, when the document is due and then when document is out of date.

1.4 Clinical Governance & Quality will provide clinical document status reports to the Clinical Board Governance groups to enable operational management; the reports will identify all clinical documents on the register that are due for review within three months and those which have exceeded their review date.

2 Format of Clinical Documents

2.1 All approved clinical documents will be on the appropriate template and have a uniform front cover page (*Appendix 1).*

2.2 Clinical documents will contain all necessary information in a concise format.

2.3 A statement about the purpose of the clinical document will be included.

2.4 UK English spellings, plain English and the active rather than passive voice, will be used, as far as possible, ensuring wording is clear and easily understood.

2.5 Do not use jargon and abbreviations; any abbreviations used should be written in full in the first instance with the abbreviation in brackets.

2.6 Sources of evidence and good practice must be listed in the references/supporting evidence section these should be in Vancouver style, including web addresses and/or the Digital Object Identifier (DOI) of articles. Evidence can be provided by the Clinical Librarian (*Appendix 2)*

2.7 Where appropriate, clinical documents will be cross-referenced to other clinical/non-clinical documents.

2.8 Only use images owned by NHS Borders or by other copyright owners with written permission. (Images to be provided to Clinical Governance & Quality as separate high quality files for upload to RDS).

2.9 Break up text into chunks so that RDS users will be able to navigate quickly to relevant content.

3 Clinical Document Development and Review

3.1 Clinical documents must be developed and reviewed by a group of staff, both clinical and non-clinical, with the appropriate level of knowledge and experience, and be representative of the range of groups/individuals involved in the delivery of patient care.

3.2 Evidence to support clinical documents can be obtained from the Clinical Librarian. (*Appendix 2*)

3.3 Representation should be sought, as appropriate, from partner organisations e.g. social work and voluntary sector as required for clinical document development and review.

3.4 Health Inequality Impact Assessment (HIIA) for all new and substantial revisions to existing public sector policies as a legal requirement for all public bodies must be undertaken. This assessment is necessary to ensure that all clinical policies meet statutory requirements in relation to equality and diversity. Please refer to the Equality and Diversity microsite on NHS Borders intranet.

3.5 The owner/lead for the development/ review will be able to make changes to their content on RDS. Consultation should be sought as appropriate (see paragraph 4 Consultation)

- content with no changes will be re-published on RDS with new review dates without further consultation / approval
- content with minor changes not affecting working practice, such as:
    - spelling corrections
    - update of job titles
    - update to links/references
    - additional text to provide clarity which does not affect overall intention/process of document

  Will be re-published on RDS without further consultation / approval
- content with minor changes which may affect working practice will trigger a consultation, before re-publication on RDS
- substantial changes to an existing document will trigger a consultation, before re-publication on RDS
- documents that exceed their review date must be reviewed but may remain on RDS for up to one year, an automatic warning will appear against overdue documents showing how many days past the review date it is.

4 Consultation

4.1 All new clinical documents must be consulted on prior to approval.

4.2 Reviewed clinical documents should be consulted on if there has been a full re-write or substantial changes made.

4.3 A timescale for consultation must be identified and made known to all individuals and groups being invited to provide comment/feedback on the draft document;

- **four** weeks minimum period of consultation for all new clinical documents
- **two** weeks consultation where there are substantial changes to existing document
- **one** week to allow agreement from stakeholders/topic specialists where any minor amendments made

4.4 The owner/lead for the development/review is responsible for ensuring all areas, departments and staff groups, to whom the clinical document is relevant, are given the opportunity to contribute to the consultation.

4.5 The development/review group will agree and make changes to the clinical document that reflect comments received during the consultation, prior to the clinical document going to the appropriate group or individual for approval.

5 Approval

5.1 The owner/lead for the development/review group is responsible for ensuring that appropriate approval is sought prior to a new or reviewed clinical document being implemented.

5.2 All clinical documents requiring approval will be sent to the appropriate group as follows:

- **NHS Borders Operational Planning Group (OPG)** – where implementation will be organisation wide or where at clinical board or service level there is considered a budgetary or reputational risk to the organisation. All clinical policies should be signed off through OPG or a designated sub-group of OPG
- **Clinical Board Clinical Governance Group** – where implementation is within a single clinical board area
- **Departmental Group/Clinical Director/Head of Department** - where implementation is within a single specialty or department

5.3 All clinical documents relating to medication/pharmacy should be sent to **Area Drugs and Therapeutics Committee (ADTC)** for approval. Appendix 3

6 Dissemination/Implementation of Clinical Documents

6.1 Following approval and/or upload of the clinical document, the owner/lead for the development/review is responsible for ensuring the appropriate persons are notified that the document is to be implemented; this information is for dissemination to all relevant staff. The process for notification is as follows:

- applicable across the organisation - communication sent to the General Managers, Associate Medical Directors, Associate Nurse Directors and Associate Director of AHPs for the Clinical Boards and relevant Heads of Corporate Services
- specific to a Clinical Board - communication sent to the General Manager(s), Associate Medical Directors, Associate Nurse Directors, Associate Director of AHP's and the Director of Pharmacy
- departmental/clinical speciality/clinical area – communication sent to the Clinical Directors, Operational Managers, Clinical Service Managers, Heads of Departments, Clinical Nurse Managers, Senior Charge Nurses, and relevant AHP Professional Leads

7 Document Control

7.1 All clinical documents must be version controlled:

- clinical document must be clearly marked as 'draft' preferably using a watermark throughout the document until it is approved. All approved clinical documents will have a version number clearly marked on the front cover, for example the first version of the document may be numbered 01, first review 02, second review 03 and so on
- the version number will be amended each time the clinical document is reviewed and /or updated
- Clinical Governance & Quality will provide a unique identifier that will include the version number at point of registration

7.2 The owner/lead for the development/review will ensure that the final approved version of the clinical document for implementation is sent to Clinical Governance & Quality to be uploaded to the NHS Borders Right Decision Service (RDS) app and website.

7.3 Clinical Governance & Quality will send a link to the clinical document on the RDS to the owner/lead for the development/review. Required/desired access to the clinical document from other microsites should be made via this link to the master version on RDS.

7.4 Clinical Governance and Quality will ensure that any previous version is removed from RDS and archived, confirmation of this will be sent to the owner/lead for the development/ review with a copy of document for departmental archive.

7.5 The owner/lead for the development/review will be responsible for ensuring that the previous version of the approved clinical document is retained in a file on a network shared drive.

7.6 Clinical documents will be retained by person/department responsible in line with retention periods as per the Scottish Government Records Management: Health & Social Care Code of Practice (Scotland) 2020 & NHS Borders Records Management Policy (found on NHSB Information Governance intranet site.

References/ Supporting Evidence

1. Public Records (Scotland) Act 2011
   https://www.legislation.gov.uk/asp/2011/12/contents/enacted

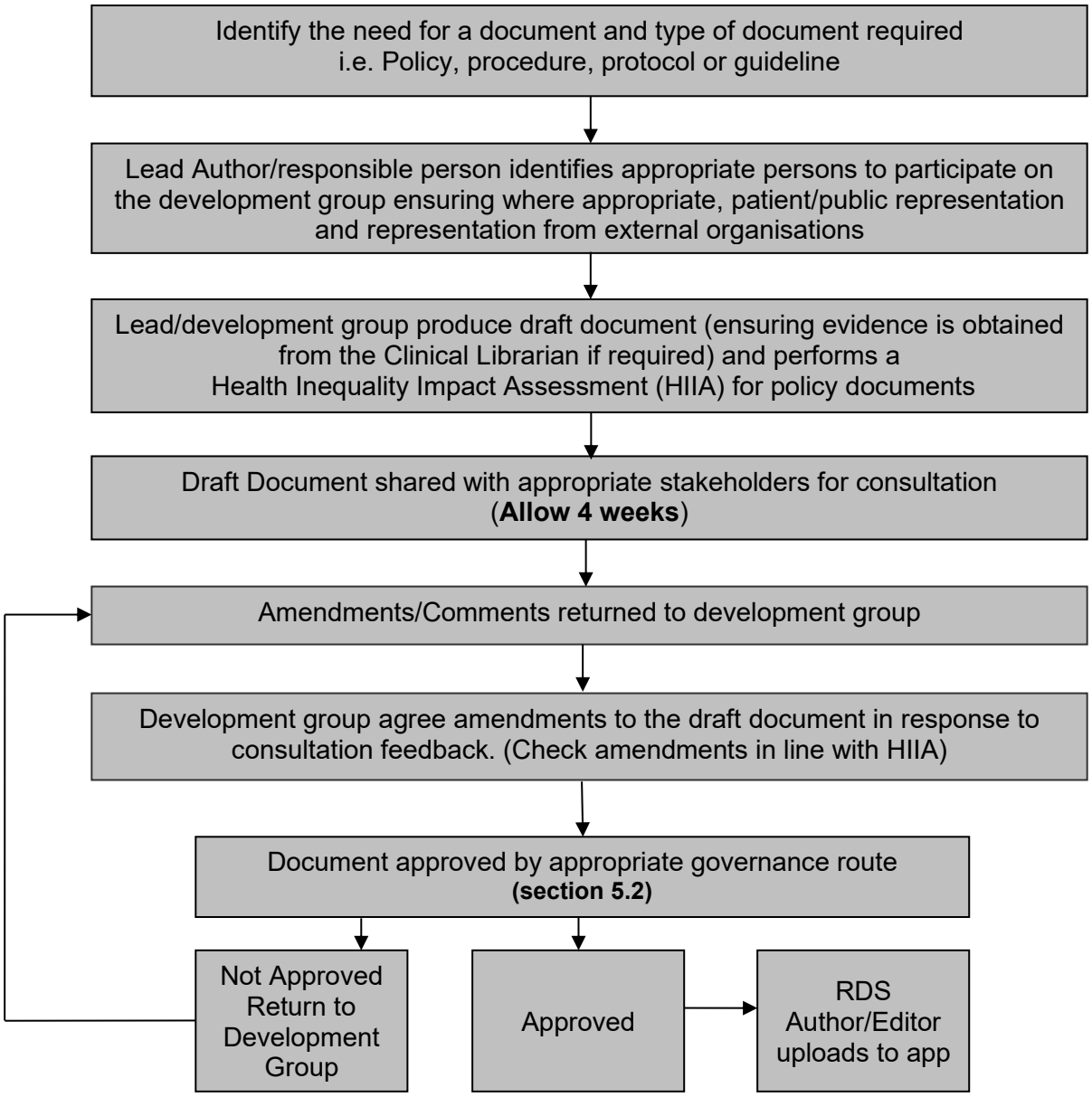
2. NHS Borders Risk Management Policy http://intranet/resource.asp?uid=30000

3. Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/contents

4. Scottish Government Records Management: Health & Social Care Code of Practice (Scotland) 2020
   https://www.informationgovernance.scot.nhs.uk/wp-content/uploads/2020/06/SG-HSC-Scotland-Records-Management-Code-of-Practice-2020-v20200602.pdf

5. Scottish Intercollegiate Guidelines Network (2015), SIGN 50 A guideline developers' handbook
   https://www.sign.ac.uk/assets/sign50_2015.pdf

Process for New Clinical Document Development



Clinical Librarian will:
Support Lead for development group to ensure evidence is relevant and up to date as appropriate

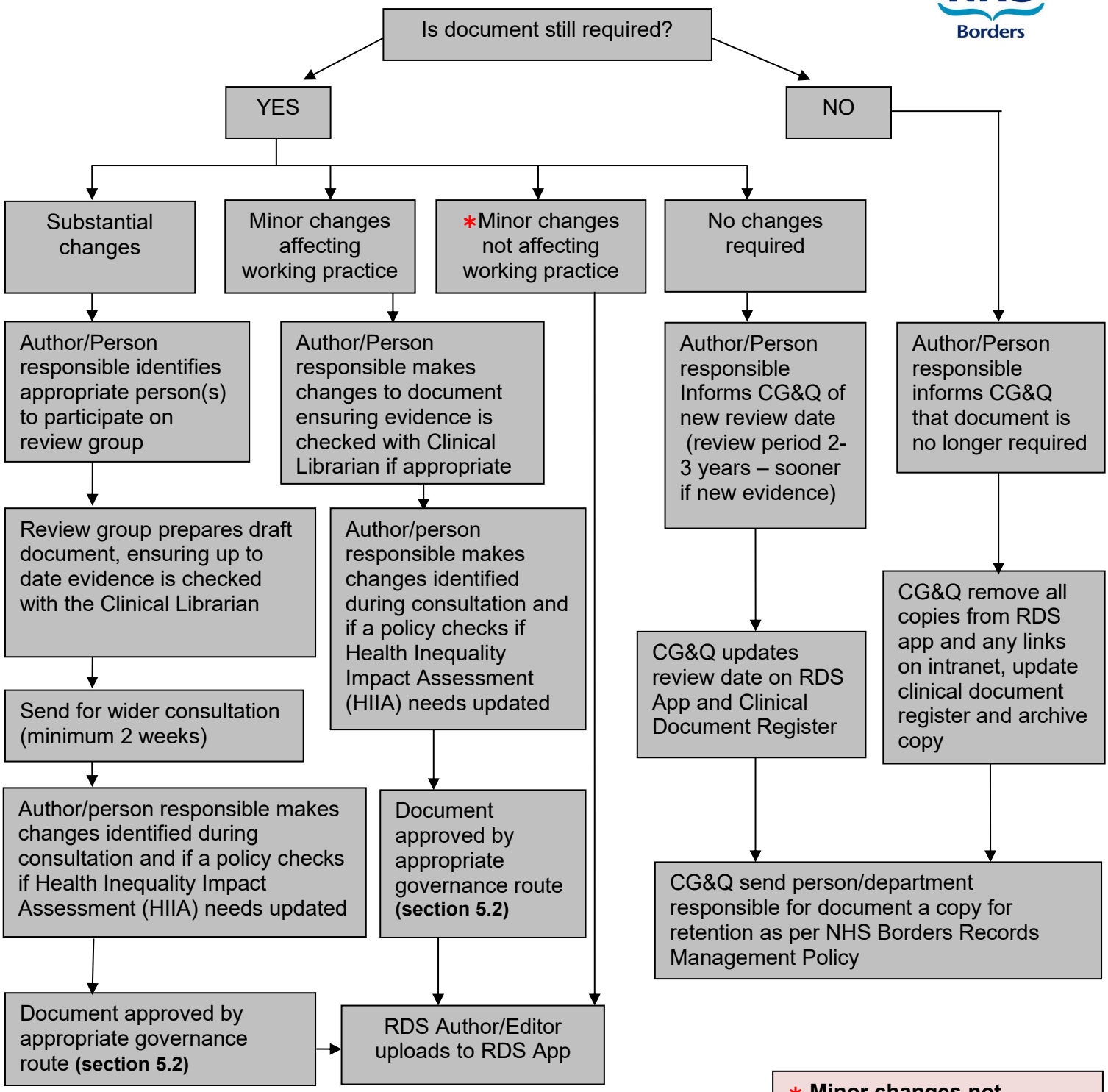
CG&Q will:

- check document formatting and readability
- perform quality checks on RDS app vs RDS style guide
- add RDS ID number to document cover sheet
- add to clinical document register
- publish to RDS app
- provide link if required to be added to NHS Borders microsites
- retain copy of document on RDS shared drive

Owner/lead for the development will:

- ensure appropriate persons are notified that the document is available on the RDS app
- ensure document is implemented and disseminated to all relevant staff

Process for Clinical Document Review



Clinical Librarian will:
Check evidence in document is up to date and amend as appropriate

Clinical Governance & Quality (CG&Q) will:

- check document formatting and readability
- perform quality checks on RDS app vs RDS style guide
- add RDS ID number to document cover sheet
- add to clinical document register
- publish to RDS app
- provide link if required to be added to NHS Borders microsites
- retain copy of document on RDS shared drive

*** Minor changes not affecting working practice:**

- spelling corrections
- update of job titles
- update to links/references
- additional text to provide clarity which does not affect overall intention/ process of document

Development Group (2008)

Ross Cameron	Medical Director
Elaine Cockburn	Head of Midwifery
Tom Cripps	Associate Medical Director Clinical Governance
Sandra Little	Ward Manager, Kelso Hospital
Bruce Low	Consultant Psychiatrist
Heather Maughan	Director of Nursing & Midwifery
Beverly Meins	Senior Nurse Community Hospitals
Irene Morris	Director of Organisational Change
Erica Nisbet	Head of Clinical Governance & Quality
Marion Paterson	Manager of Assessment & Treatment, Learning Disability Service
Alasdair Pattison	Lead Clinician Podiatry/Lead AHP
Andrew Riley	Director of Public Health
Leonie Smith	Associate Director of Nursing
Isabel Swan	Lead Nurse, Mental Health
Jim Torrance	Chair of Primary and Community Services Partnership

Review/Consultation Group (2015)

Katie Buckle	General Manager Planned Care and Commissioning
Simon Burt	General Manager Mental Health and Learning Disability Services
Jonathan Kirk	Associate Medical Director Primary and Community Services
David Love	Associate Medical Director Clinical Governance
Philip Lunts	General Manger Unscheduled Care
Sheena MacDonald	Medical Director
Karen McNicoll	Associate Director AHP
Hamish McRitchie	Associate Medical Director Acute Services
Alasdair Pattinson	General Manager Primary and Community Services
Evelyn Rodger	Director of Nursing and Midwifery
Cliff Sharp	Associate Medical Director Mental Health and Learning Disability Services
Charlie Sinclair	Associate Director of Nursing Acute, Primary, Acute and Community Services
David Thomson	Associate Director of Nursing Mental Health and Learning Disability Services

Review/Consultation Group (2018)

Janet Bennison	Associate Medical Director BGH
Nicky Berry	Associate Director of Nursing BGH and Head of Midwifery
Simon Burt	General Manager Mental Health and Learning Disabilities
Amanda Cotton	Associate Medical Director Mental Health
Ros Gray	Head of Quality & Clinical Governance
Annabel Howell	Associate Medical Director Clinical Governance
Laura Jones	General Manager Planned Care and Commissioning
Peter Lerpiniere	Associate Director of Nursing Mental Health, Learning Disabilities and Older People

Nicola Lowdon	Associate Medical Director Primary and Community Services
Phillip Lunts	General Manager Unscheduled Care
Kenny Mitchell	General Manager Primary and Community Services
Claire Pearce	Director of Nursing, Midwifery and Acute Services
Sandra Pratt	Associate Director Strategic Change
Erica Reid	Lead Nurse Primary and Community Services
Cliff Sharp	Medical Director

Review Group (2021) – minor amendments – addition of flow charts

Laura Jones	Head of Clinical Governance & Quality
Justin Wilson	Quality Improvement Facilitator, Effective
Diane Laing	Clinical Effectiveness Administrator

Review Group (2022) – following introduction of RDS app

Laura Jones	Director of Quality and Improvement
Justin Wilson	Quality Improvement Facilitator, Effective
Diane Laing	Clinical Effectiveness Administrator
Olive Herlihy	Associate Medical Director Clinical Governance
Moira Mitchell	Clinical Librarian
Suzy Cuthbert	Assistant Librarian
Kath Liddington	Knowledge Management Co-ordinator
Brian Magowan	Consultant Gynaecologist

Roles and Responsibilities

Role	Responsibilities
Medical Director, Director of Nursing, Midwifery and AHPs	Will secure agreement on the process for development, approval and review of clinical documents.
General Managers and Heads of Corporate Services supported by Associate Directors of Nursing/ Associate Medical Directors/ Associate Director of AHPs	Will ensure dissemination of policy within the Clinical Boards/Directorates and seek assurance adherence to the process for the development, approval and review of clinical documents.
Service and Operational Managers/Clinical Directors	Will support implementation and compliance with this policy and where applicable audit implementation and compliance. Will ensure clinical documents for their areas of responsibility remain up to date within review timescales.
Clinical Governance and Quality	Will support the document management process in relation to policy: • log documents on central register with a unique ID and version number • publish documents on the Right Decision Service (RDS) app and send a link to the owner/lead • send review reminders to the owner/lead • remove previous versions from RDS; retain copy of document on RDS shared folder; confirm with owner/lead and provide a copy for the departmental archive • provide clinical document status reports to the four Clinical Board Governance groups • Obtain high quality image files from the owner/lead
Owner/lead for the development/review	Will • oversee the development / review group • ensure effective consultation • ensure appropriate approval prior to implementation • make / propose changes to the content on RDS • send the final approved version of the clinical document to Clinical Governance & Quality for upload to the RDS app/website and inclusion on Clinical Document register. • notify appropriate persons of implementation • retain a Departmental archive of previous versions
Clinical Librarian	Will provide up to date evidence to support document development/review
RDS Author/Editor	Will upload clinical documents to RDS, adhering to RDS style guide
Ward/Departmental Managers	Will ensure that all staff who are involved in clinical document development/review are familiar with policy and support compliance.
Individual Clinical Staff	All clinical staff involved in the development and review of clinical documents will comply with policy.

Appendix 1 Clinical Document Template

Title	
Document Type	*e.g. Policy/guideline/procedure/protocol*
Version Number	*Current version of document*
Developed by	*May be a group – membership should be included in document – this applies to the original version of the document and should include the original approval/issue date – mm/yyyy*
Approved by	*Group/Committee*
Approval/Issue date	*Date of approval/issue of current version – mm/yyyy*
Owner/Responsible Person	*Person responsible for the document (this should be a named individual/post not a group) – using format Smith JC (no full stops) accompanied by e-mail address*
Review date	*Date next review due to be completed – mm/yyyy*
Reviewed by *(not applicable if version 1)*	*May be a group – membership should be included in document – all reviews should be listed either here or in separate table within the document – mm/yyyy*
Significant resource implications (financial/workload/ climate)	*Please indicated any significant resource or climate impacts*
Health Inequality Impact Assessment (HIIA) (only statutory for policies)	*If your document is a policy then HIIA will need to be completed – Paperwork can be found on Equality & Diversity Intranet site* *Date impact assessment completed – mm/yyyy*
ID Number	*Clinical Governance & Quality Use only*

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Objectives - *(optional) overall objective(s) of the guideline. The expected health benefits from the guideline are to be specific to the clinical problem or health topic.*

Scope - *(optional) Report the health question(s) covered by the guideline, particularly for the key recommendations.*

Audience - *(optional)The target users and/or those persons who should be aware of this guidance.*

Guideline Body – *Use for short guideline or introduction if longer*

Contents – *if your guideline is longer than one page then provide content list.*

List Appendices: *(if appropriate please send these separately if possible)*

Guideline Text – *The main body of guideline information, for guidance longer than one page*

Editorial Information

What's New – *include any significant changes or updates (not applicable to new guidance)*

What's new expiry date:

Authors & Co-Authors - *List stakeholders who contributed to development of document (please include email addresses)*

Review Group – *List stakeholders who contributed to review (not applicable for Version 1)*

Are elements of this guidelines printable *i.e referral forms etc* **Yes** ☐ **No** ☐

Keywords - *Specify up to five keywords to be used to help users when searching for this resource.*

Supporting Evidence/References *Remember to link as appropriate throughout text. (**Do not link to NHS Borders Intranet either send link or document separately**)*

References *Specify any links to any evidence and/or supporting information applicable to the development.*

Evidence Method *(optional) Describe the methods and approach to the development of this guideline.*

Related Resources *(optional) Specify links and/or references to further useful resources or tools to support the evidence.*

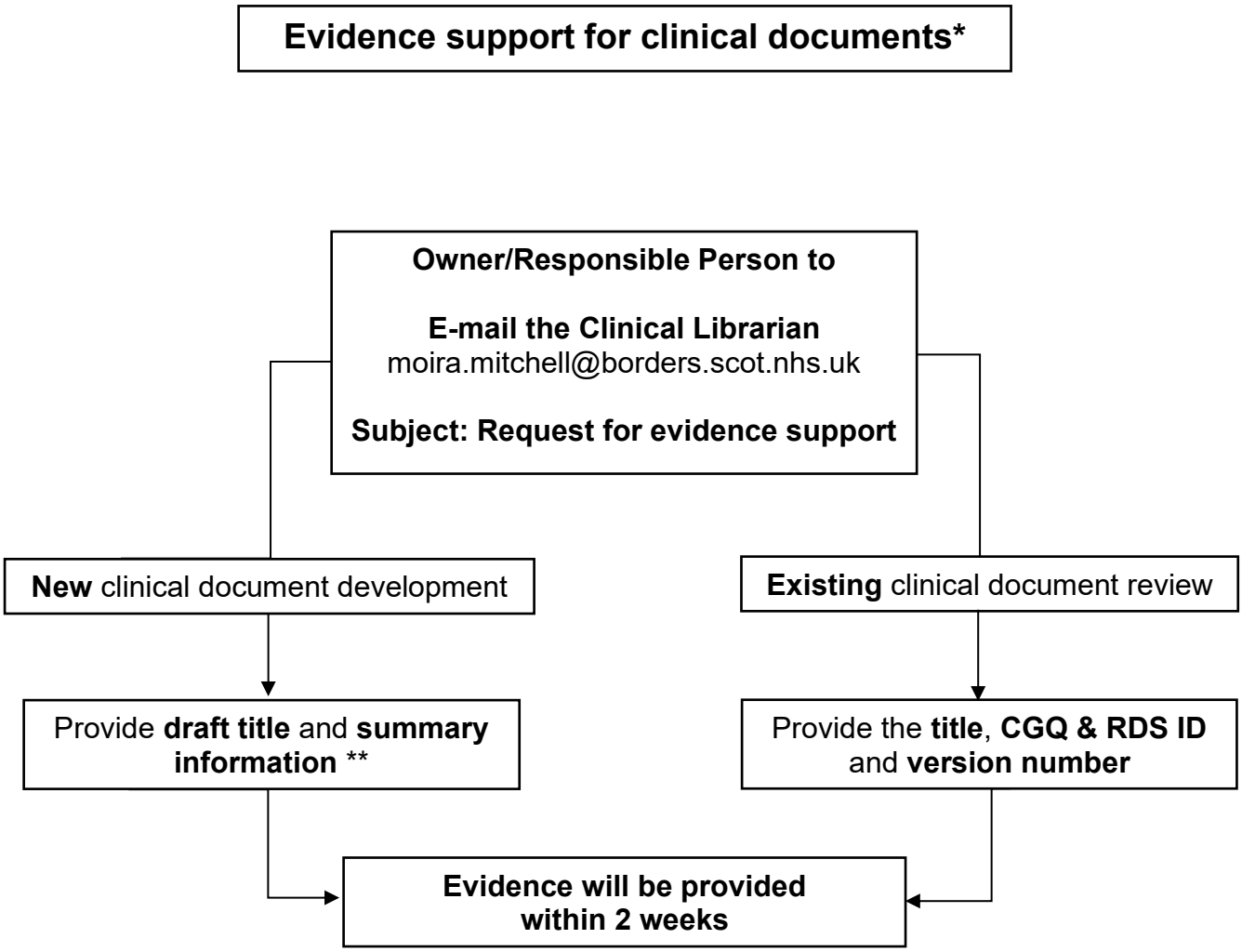
Related guidelines *(optional) Specify any links to related Guidelines within the content.*

For policies only

Roles & Responsibilities *(for policies only)*

Roles	Responsibilities

Appendix 2 – Evidence Support from Clinical Librarian



* step 3 of Process for New Clinical Document Development algorithm
step 4 of the Process for Clinical Document Review algorithm

** relevant medical subject headings may be helpful
https://meshb-prev.nlm.nih.gov/treeView

Appendix 3

PRODUCTION OF GUIDELINES AND PROTOCOLS INVOLVING MEDICINES

GUIDANCE ON THE PRODUCTION OF GUIDELINES AND PROTOCOLS INVOLVING MEDICINES

INTRODUCTION

This document aims to set out the processes involved in the preparation and ratification of therapeutic guidelines and protocols involving medicines intended for use by healthcare professionals within NHS Borders.

APPROVAL OF THERAPEUTIC GUIDELINES AND PROTOCOLS

Only guidelines that fulfil specific criteria will be presented for a formal Area Drugs and Therapeutics Committee (ADTC) review and ratification process.

Guidelines and protocols to be considered by ADTC should conform to the NHS Borders Clinical Document Policy Development Framework and be prepared in a format to upload to the Right Decision Service.

Policies to be considered by ADTC must be accompanied by a Equality Impact Assessment.

Not all protocols and guidelines require individual review by the Area Drugs and Therapeutics committee, and the criteria at Appendix 1 indicate those that will be reviewed.

The purpose of the ADTC review is:

- To confirm that all appropriate stakeholders have been fully consulted
- To ensure that any implications for service delivery have been considered.
- To ensure that any significant impact on prescribing and workload in Primary Care or Secondary care has been considered.
- To ensure that any potentially significant cost or service implications are highlighted to the Medicines Resource Group.
- To facilitate the publication of the policy or protocol on to the Right Decision Service website as appropriate. For support see Appendix 3 Flowchart.
- To endorse the use of specific disease management guidelines for use in NHS Borders.

In certain situations, e.g. NPSA alert or MSAN, ADTC may also commission the production of guidelines or protocols in order to define the circumstances in which certain drugs may be used.

NEW GUIDELINE OR PROTOCOL NOT REQUIRING ADTC REVIEW

All other NHS Borders medicines-related guidelines and protocols not fulfilling the criteria in Appendix 1 should be reviewed and approved for use within the appropriate directorate by its senior clinical / management team through the relevant CMT. However, there will be an expectation that guideline groups will follow a number of principles set down by ADTC.

These principles are:

1. Guidelines and protocols should conform to the NHS Borders Clinical Document Policy Development Framework and be prepared in a format to upload to the Right Decision Service.
2. There should be a clear description of the process for development of the guideline, the membership of the group involved and those consulted, together with any relevant 'declarations of interest'.
3. Guideline development groups should ensure that they have included a pharmacist and representation from all other relevant healthcare professionals' groups.
4. All appropriate stakeholders must be fully consulted; consideration could be given to design guidelines across the East region.
5. Consultation should take place throughout NHS Borders, where appropriate, to ensure that the guideline is applicable across the Health Board area. Discussion at Clinical Interface Group should be considered.
6. Where the therapeutic protocol or policy has significant implications for Primary Care, a representative sample of general practitioners should be involved in the development group.
7. For such guidelines, the Local Medical Committee and the Associate Director of Pharmacy for Primary and Community Care should be consulted for advice.
8. Consideration should be given to the involvement of patients or their support groups where appropriate.
9. All medicines included in NHS Borders therapeutic guidelines and protocols must already be included in the East Region Formulary.
10. Clinical specialists involved in the production of the guideline or protocol will be responsible for ensuring that the content is accurate and up-to-date and is based on current published evidence or best practice.
11. The guideline must give full details of the individuals involved in its production
12. The guideline must contain a date of preparation and a date of review.
13. Consideration should be given on how best to facilitate access to the guideline e.g. Right Decision Service and/or Primary Care circulation.

INCLUSION OF GUIDELINES OR PROTOCOLS IN THE EAST REGION FORMULARY GUIDANCE

In some instances, it may be appropriate for a protocol or guideline to be included on the East Region Formulary website. This website is intended to be a reference source for prescribers across NHS Borders. Please contact the Director of Pharmacy to ask about this hosting.

SUBMITTING A NEW GUIDELINE OR PROTOCOL FOR APPROVAL BY ADTC

The “Request for a protocol or guideline to reviewed by ADTC” meeting cover paper (Appendix 2) should be submitted to ADTC with all protocols or guidelines. The purpose of this form is to ensure that all information required for ADTC and its subcommittee to make an informed decision about the protocol is available. The form includes a section requesting declarations of interest to be completed by the chair of the group. This is essential in order to ensure that the process is transparent and not open to challenge about bias.

In addition, the ADTC Cover Paper (Appendix 2 of this document) should also be submitted.

All guidelines for ADTC review should be submitted to the ADTC secretariat at the address in the flowchart at Appendix 3.

APPENDIX 1:

CRITERIA FOR THERAPEUTIC PROTOCOLS/ GUIDELINES REFERRAL TO ADTC

Guidelines fulfilling one or more of the following criteria should be referred for review by ADTC.

1. The guideline protocol or policy has clinical implications for multiple directorates within Acute, Mental Health and/or Primary Care.
2. There are significant new cost implications beyond a single directorate or speciality.
3. There are significant new service implications beyond a single directorate or speciality.
4. The guideline, protocol or policy includes non-Formulary medicines.

Where there is uncertainty about whether the policy or guideline fits the above criteria the guideline group may contact the Associate Director of Medicines Governance and Digital Development or the Chair of ADTC for specific advice.

APPENDIX 2:

NHS Borders Area Drug & Therapeutics Committee – Cover Paper

Request for paper to be reviewed by NHS Borders ADTC

Meeting:	Area Drug & Therapeutics Committee
Meeting Date:	*To be completed by ADTC administrator*
Title:	Name of Document
Document Author:	Full name and title of author
Email contact:	Email address of author

Purpose:

This document is presented to ADTC for: (please select from drop down)	Choose an item.
This document is a: (please select from drop down)	Choose an item.
This document is New or an Update: (please select from drop down)	Choose an item.
Name of the Protocol/Guideline/Policy:	Name of Protocol/Guideline/Policy
Details of changes provided/attached:	☐
Other, please note other document type:	Other document type
Is feedback required after meeting?	Choose an item.

Route to ADTC:

The following staff members and/or groups have considered this document as part of its development. They have either supported the content, or their feedback has informed the content presented in this document.

- Peer Review – contact Name, date written as dd/mm/yyyy
- Clinical Pharmacist Review – contact name, date written as dd/mm/yyyy

- Committee/Group/Meeting Name, date written as dd/mm/yyyy
- Committee/Group/Meeting Name, date written as dd/mm/yyyy

SBAR – Document Summary:

Situation:	Concise statement of situation – why is this being brought to ADTC?
Background:	Relevant information leading to the situation; summarise issues of significance.
Assessment:	Analysis of the situation and considerations; assess current position, identify any organisational risks, stakeholder considerations and evidence base to help inform decision. Include any positive/negative impact on quality of care; staffing resources; financial impacts; risk assessment and any other impacts.
Recommendation:	State the action being requested, e.g., for Approval.

Implications for Primary Care – for ACUTE PROTOCOLS

Are there any implications for prescribing practices of resources in Primary Care?	YES/NO (delete as appropriate)
Have General Practitioners been fully consulted?	YES/NO (delete as appropriate)
Please give details of consultation including dates:	
Are there any cost implications associated with the introduction of this protocol or guideline (e.g. increased prescribing costs)?	YES/NO (delete as appropriate)
If YES, please give details:	

Are Medicines Resource Group aware?	YES/NO (delete as appropriate)
Are there any service implications associated with the use of the drug therapy (e.g. diagnostic tests, monitoring, additional drug therapy, etc)?	YES/NO (delete as appropriate)
If YES, please give details:	

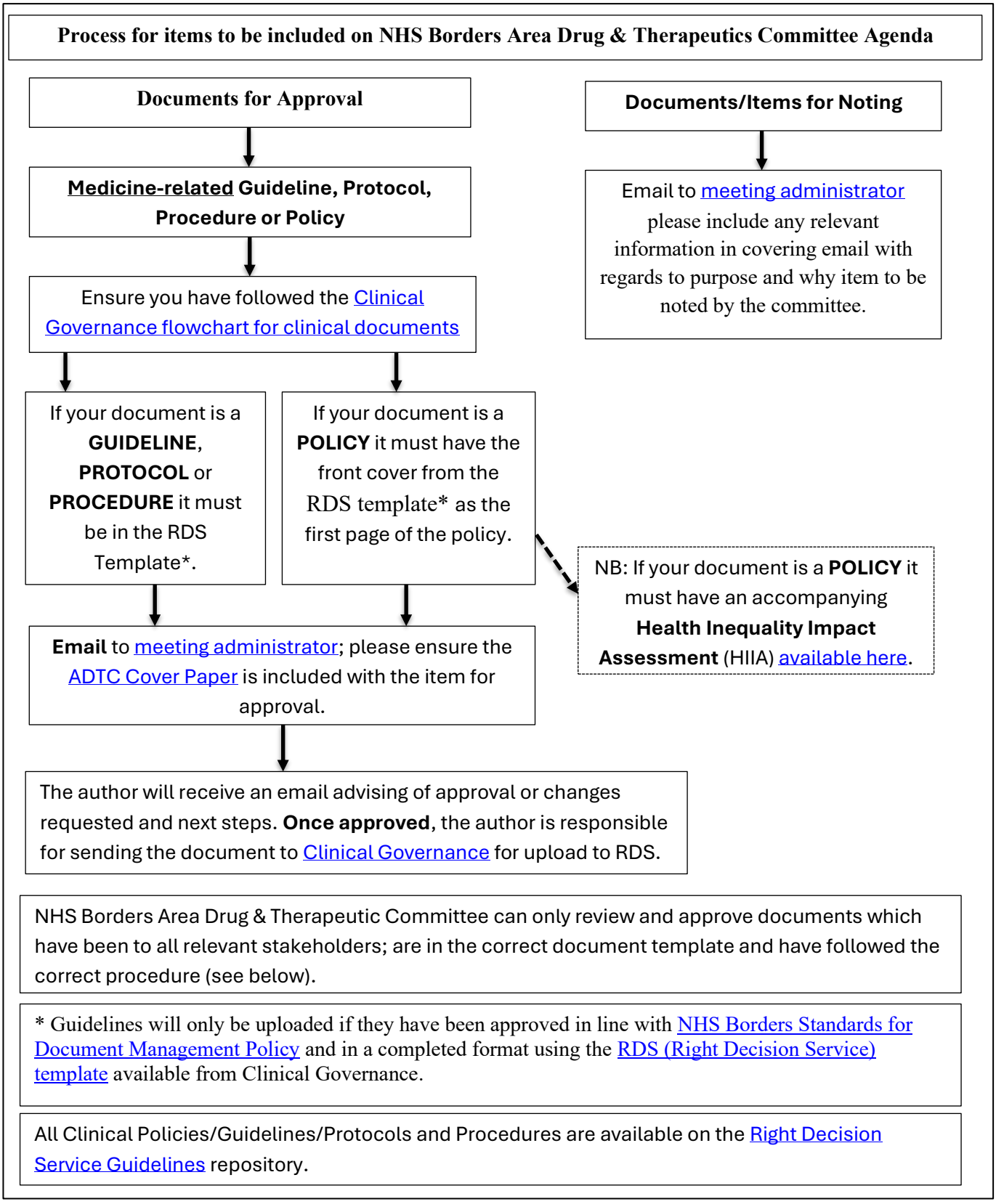
Declaration of Interest

Please note any declarations of interest:	

Health Inequality Impact Assessment (HIIA) – for POLICY only

Date of Health Inequality Impact Assessment:	DD/MM/YYYY
Health Inequality Impact Assessment attached with document:	☐

APPENDIX 3:


Process for items to be included on NHS Borders Area Drug & Therapeutics Committee Agenda
Documents for Approval
Documents/Items for Noting
Medicine-related Guideline, Protocol, Procedure or Policy
Email to meeting administrator please include any relevant information in covering email with regards to purpose and why item to be noted by the committee.
Ensure you have followed the Clinical Governance flowchart for clinical documents
If your document is a GUIDELINE, PROTOCOL or PROCEDURE it must be in the RDS Template*.
If your document is a POLICY it must have the front cover from the RDS template* as the first page of the policy.
NB: If your document is a POLICY it must have an accompanying Health Inequality Impact Assessment (HIIA) available here.
Email to meeting administrator; please ensure the ADTC Cover Paper is included with the item for approval.
The author will receive an email advising of approval or changes requested and next steps. Once approved, the author is responsible for sending the document to Clinical Governance for upload to RDS.
NHS Borders Area Drug & Therapeutic Committee can only review and approve documents which have been to all relevant stakeholders; are in the correct document template and have followed the correct procedure (see below).
* Guidelines will only be uploaded if they have been approved in line with NHS Borders Standards for Document Management Policy and in a completed format using the RDS (Right Decision Service) template available from Clinical Governance.
All Clinical Policies/Guidelines/Protocols and Procedures are available on the Right Decision Service Guidelines repository.