**Distribution and dissemination of new/updated
SIGN guidelines within boards**

SIGN

27 August 2014

Purpose:

To establish current distribution/dissemination procedures used by SIGN Distribution Co-ordinators within boards and to share this information amongst them.

This will allow best practice to be shared amongst boards and will also allow SIGN to identify what happens once a new/updated guideline is disseminated to the Boards.

As a result of this report, SIGN will create a specific section on its website containing information about distribution/dissemination to assist Distribution Co-ordinators.
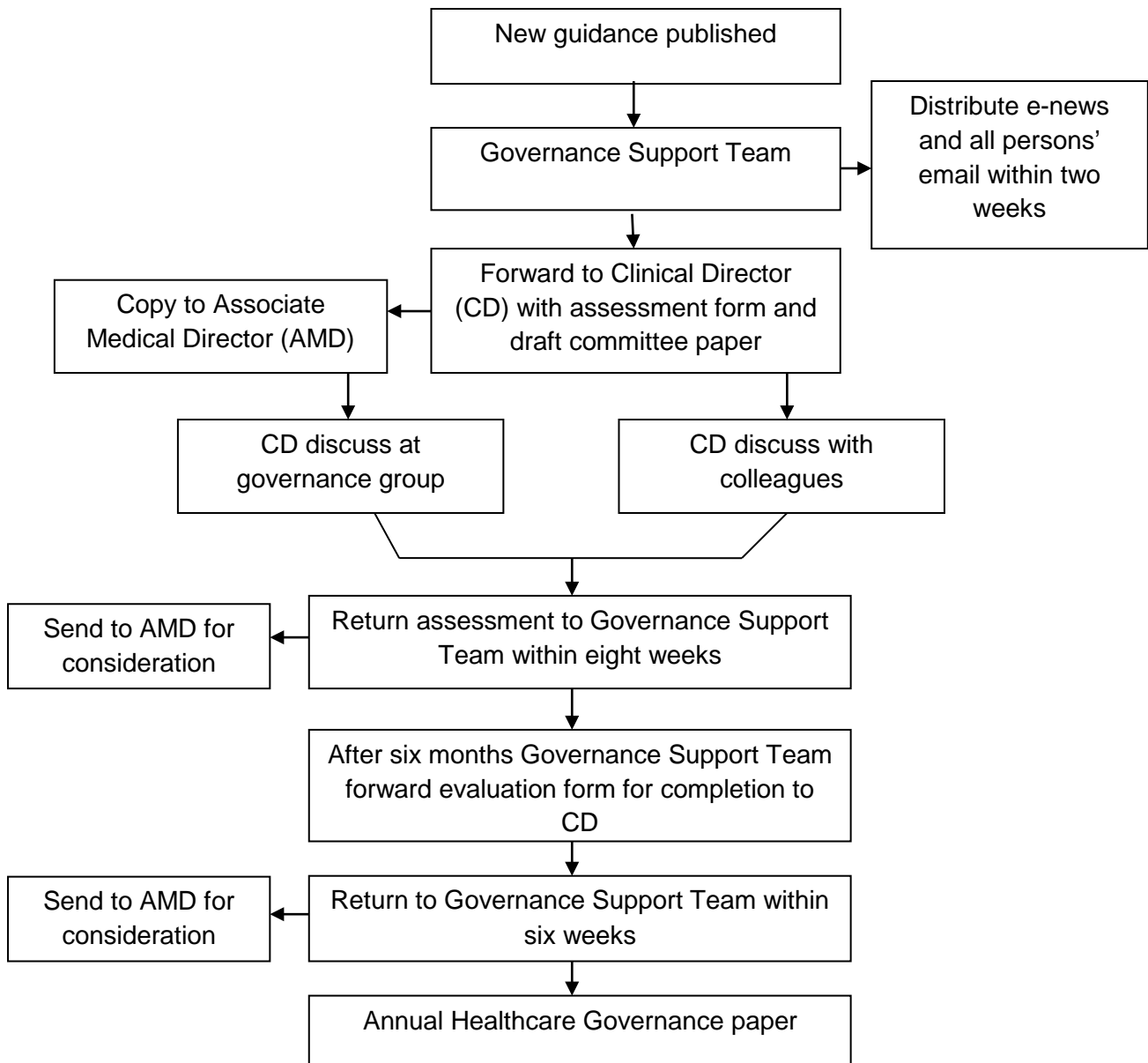
Findings:

The findings detailed below are very encouraging and demonstrate that there are some excellent processes for dissemination within boards.

1. NHS Ayrshire and Arran

- The Governance Support Team will electronically distribute the guidance via e-news and all persons' email within 2 weeks of publication.
- The appropriate Clinical Director (or Service Lead) will be identified and the guideline will be forwarded with the associated documentation by the Governance Support Team. As part of this process, a draft Committee report will also be forwarded ready for submission to the appropriate Committee which will usually be either a governance committee or a managed clinical network committee. The standards section within the assessment form will also be populated prior to issue.
- The Clinical Director will initially consider the guideline and will complete his/her assessment. This may be undertaken in collaboration with colleagues or through the respective governance committee.
- The Clinical Director will return the documentation to the Governance Support Team within eight weeks of receipt.
- The Governance Support Team will forward the assessment to the designated Associate Medical Director for consideration.
- After six months the Governance Support Team will request an evaluation of implementation of the guidance with the response to be returned within six weeks.
- Upon receipt this will be forwarded to the Associate Medical Director for consideration.
- If at any point there is no response in relation to requests for information the Governance Support Team will send three reminders, one month apart, and if there remains no response the appropriate Associate Medical Director will be advised.
- The Governance Support Team will prepare an annual report for the Healthcare Governance Committee outlining all guidelines received and implementation progress.

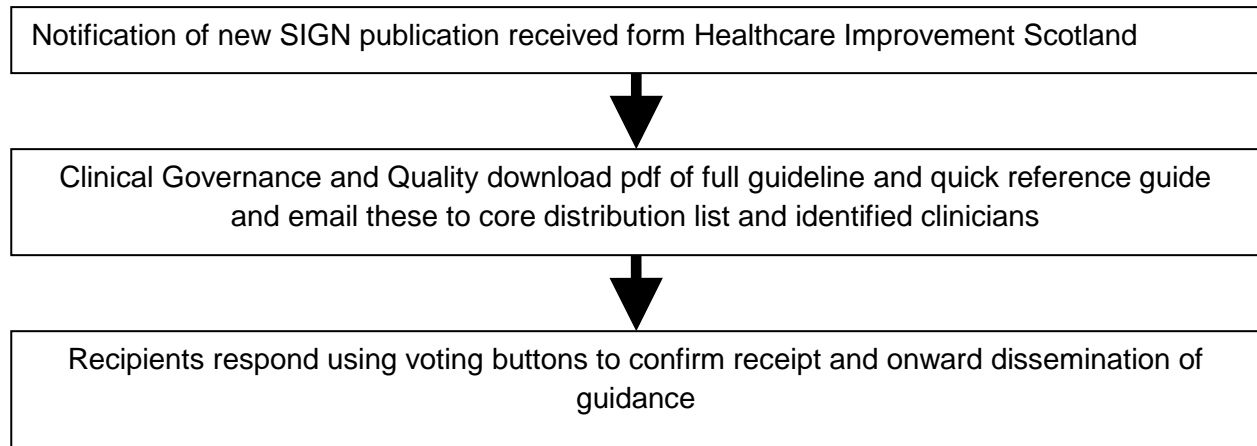The flowchart below demonstrates this process.

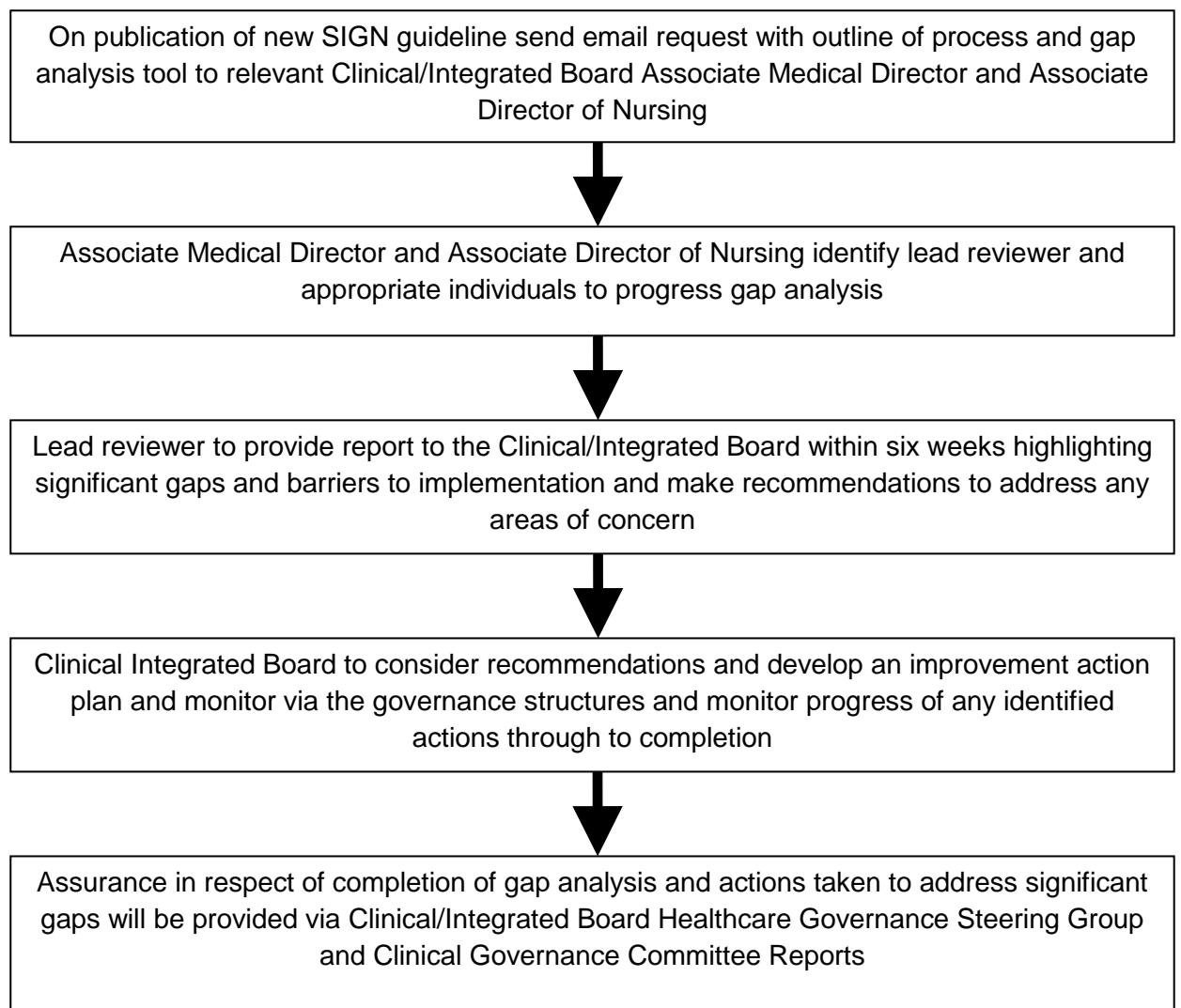**Guideline Distribution, Review, Implementation and Monitoring**

```
                    ┌─────────────────────────┐
                    │  New guidance published │
                    └─────────────────────────┘
                                 │
                                 ▼
                    ┌─────────────────────────┐      ┌─────────────────────┐
                    │ Governance Support Team │─────▶│ Distribute e-news   │
                    └─────────────────────────┘      │ and all persons'    │
                                 │                    │ email within two    │
                                 │                    │ weeks               │
                                 ▼                    └─────────────────────┘
┌─────────────────┐   ┌─────────────────────────┐
│ Copy to         │◀──│ Forward to Clinical      │
│ Associate       │   │ Director (CD) with       │
│ Medical         │   │ assessment form and      │
│ Director (AMD)  │   │ draft committee paper    │
└─────────────────┘   └─────────────────────────┘
        │                    │               │
        ▼                    ▼               ▼
┌─────────────────┐   ┌──────────────┐  ┌──────────────┐
│ CD discuss at   │   │ CD discuss   │  │ CD discuss   │
│ governance      │   │ with         │  │ with         │
│ group           │   │ colleagues   │  │ colleagues   │
└─────────────────┘   └──────────────┘  └──────────────┘
```

New guidance published

Governance Support Team → Distribute e-news and all persons' email within two weeks

Copy to Associate Medical Director (AMD) ← Forward to Clinical Director (CD) with assessment form and draft committee paper

CD discuss at governance group

CD discuss with colleagues

Send to AMD for consideration ← Return assessment to Governance Support Team within eight weeks

After six months Governance Support Team forward evaluation form for completion to CD

Send to AMD for consideration ← Return to Governance Support Team within six weeks

Annual Healthcare Governance paper

2. NHS Borders

SIGN Guideline Dissemination and Review (DRAFT)

Dissemination

Notification of new SIGN publication received form Healthcare Improvement Scotland

↓

Clinical Governance and Quality download pdf of full guideline and quick reference guide and email these to core distribution list and identified clinicians

↓

Recipients respond using voting buttons to confirm receipt and onward dissemination of guidance

Review

On publication of new SIGN guideline send email request with outline of process and gap analysis tool to relevant Clinical/Integrated Board Associate Medical Director and Associate Director of Nursing

↓

Associate Medical Director and Associate Director of Nursing identify lead reviewer and appropriate individuals to progress gap analysis

↓

Lead reviewer to provide report to the Clinical/Integrated Board within six weeks highlighting significant gaps and barriers to implementation and make recommendations to address any areas of concern

↓

Clinical Integrated Board to consider recommendations and develop an improvement action plan and monitor via the governance structures and monitor progress of any identified actions through to completion

↓

Assurance in respect of completion of gap analysis and actions taken to address significant gaps will be provided via Clinical/Integrated Board Healthcare Governance Steering Group and Clinical Governance Committee Reports

3. NHS Dumfries and Galloway

SIGN implementation process

- Guideline comes in new or has been updated from SIGN

↓

- A clinical lead reviews, ensures electronic dissemination around the Directorates and determines who should be asked to respond with the Dumfries and Galloway position.

↓

- Returns include assurance around current practice, any gaps associated with the guideline, action plan to address gaps and a timescale to respond and are reviewed at a Guideline Assurance Group (GAG) before being recorded on the electronic database

↓

- The GAG would accept or question the assurance and look for an update on the action plan in 3-6 months (depending on the gaps or action)

↓

- GAG would submit an assurance paper to Healthcare Governance Committee twice a year.

4. NHS Fife

NHS Fife follow the same process for all new and updated guidelines.

The Executive Lead for Clinical Governance nominates a clinician to lead the review of the guideline.

An email is then sent to the lead clinician asking them to establish and chair an NHS Fife-wide group to review the guideline and make recommendations to the NHS Fife Quality, Safety and Governance Group regarding its implementation across NHS Fife.

The remit of the review group is to deliver advice on:

- the applicability of the guideline across NHS Fife
- the relative priority for full implementation in NHS Fife
- any resource or redesign issues
- an overall recommendation as to whether or not the guideline should be implemented fully
- other guidance material, which may affect or influence any subsequent action plan.

Copies of the full guideline, summary matrix and reporting matrix are then sent to the lead clinician.

A letter is also distributed to all relevant staff with a copy of the quick reference guide for their information. We use the SIGN suggested distribution list as a guide.

Finally the completed matrix and summary report with any recommendations comes back to the NHS Fife Quality Safety and Governance Group for discussion.

Within the final report the lead would recommend if the guideline should be fully adopted across Fife, in doing this there may or may not be some low cost/high cost resource involved.

NHS Fife has used this process now for at least 12 years and it works well.

5. NHS Grampian

Process for Implementation of SIGN Guidelines

Notification of published guidelines received at *QGRU*	NHSG Global Email organised by *QGRU*

Formal contact by *QGRU* made with

Senior Clinical Directors/Managers

requesting/suggesting identified **CL/Manager**

Links to:
• Performance
• Clinical Quality Indicators
• Clinical Guidelines Intranet
• Local Documents/Guidelines
• GPs
• Standard improvement programme/modernisation
• CE Strategy and Audits
• Clinical Governance Committees
• Medicines Policy Group and Processes

Identified **CL/Manager** and *QGRU* complete:
- Gap Analysis Document
- Risk Assessment
- Summary Sheet

CL/Manager/*QGRU* submits the completed Gap Analysis document and Summary back to, e.g.

Senior Clinical Directors/Managers

for decision on whether to take forward

Recommendations submitted to:

COMT/CGC Groups/Other
(Performance/Local Sector routes)

YES
Implementation agreed by **COMT & CL/Manager** *Supported by QGRU*

NO
QGRU record reasons why on QGRU External Database

CL/Manager identifies/leads 'improvement' team to take forward implementation programme. *Supported by QGRU*

All stages of process recorded on QGRU External Database

CL/Manager reports findings to provide assurance to **COMT/CGC Groups/Other**
(Performance/Local Sector routes)

QGRU supports **CL/Manager** with future audit & improvement planning

6. NHS Greater Glasgow and Clyde

1. An email is sent to key individuals across NHSGGC to alert them that a new SIGN guideline has been published. The expectation is that this information is cascaded across the board when appropriate to do so.

2. A monthly newsletter is also produced, which contains this information, and is distributed widely across NHSGGC.

3. The newsletter is also made available on the NHSGGC intranet.

4. Within three months of publication, an Impact Assessment (IA) of the implications of the SIGN guidelines is carried out. The output of this IA is tabled at key groups and committees across NHSGGC. Below is a template developed in July 2014; this is being tested at present.

NHS Greater Glasgow and Clyde | Acute Services Division

SIGN Guidelines Impact Assessment Tool

Implementation of national clinical guidelines is the responsibility of each NHS Board and is an essential part of clinical governance. It is acknowledged that every Board cannot implement every guideline immediately on publication, but mechanisms should be in place to ensure that the care provided is reviewed against the guideline recommendations and the reasons for any differences assessed and, where appropriate, addressed.

Guidance (include name of guidance and which organisation/body produced the guidance)

Reviewer

Name:	
Job title:	
Department:	
Directorate/Other:	

Please consider the recommendations/criteria within the guidance and answer the following questions:

1. Are there any local guidelines/policies already in place to support the guidance?
Yes ☐   No ☐
If Yes, please identify local guidelines/policies below

2. Are the guideline recommendations already implemented in current practice?

Fully ☐   Partially ☐   Not at all ☐

Please identify the recommendations that are not implemented and specify if implementation of these recommendations will lead to improvement in patient care.

Recommendation not implemented	Would implementation lead to improved patient care?	Would you recommend implementation?	Please specify reason (if recommending partial or no implementation)
	Significant improvement ☐ Moderate improvement ☐ Minimal improvement ☐ No improvement ☐	Fully ☐ Partially ☐ No ☐	
	Significant improvement ☐ Moderate improvement ☐ Minimal improvement ☐ No improvement ☐	Fully ☐ Partially ☐ No ☐	
	Significant improvement ☐ Moderate improvement ☐ Minimal improvement ☐ No improvement ☐	Fully ☐ Partially ☐ No ☐	

	Significant improvement ☐	Fully ☐
	Moderate improvement ☐	Partially ☐
	Minimal improvement ☐	No ☐
	No improvement ☐	

3. Please detail the implications of not implementing the recommendations of the guideline?

4. What are the barriers to implementation/compliance with this guideline? e.g. cost implications

5. Please identify the recommendations that are not implemented and specify if implementation of these recommendations will have resource implications for NHSGGC.

Recommendation not implemented	Can the cost of implementation be absorbed within existing resource allocations?				If yes, does this require a change in how current resources are utilised?		
	Yes	☐	No	☐	Yes ☐ ☐		No
	Yes	☐	No	☐	Yes ☐ ☐		No
	Yes	☐	No	☐	Yes ☐ ☐		No
	Yes	☐	No	☐	Yes ☐ ☐		No
	Yes	☐	No	☐	Yes ☐ ☐		No

6. How will implementation of the guideline impact on patients with legally protected characteristics as defined by the Equality Act 2010? (Gender, Race, Sexual Orientation, Religion & Belief, Age, Disability, Gender Reassignment, Marriage/Civil Partnership, Pregnancy & Maternity and Socio-Economic Status)

7. Please detail any risks or issues that should be escalated to the Directorate / Acute Services / Board

8. In summary, please tick one of the options below

Guidance is fully implemented and no further actions required	☐
Guidance is partially implemented and work to complete this is already underway	☐
Guidance is partially implemented and outstanding actions are identified	☐
Guidance is partially implemented but outstanding actions are not identified	☐
Guidance is not implemented but only local actions required	☐
Guidance is not implemented but corporate level actions required	☐
Other (please specify below)	☐

9. Further comments (please use extra sheet if required)

7. NHS Highland

Current process:
- We place a notification of all new SIGN guidelines on the intranet
- If relevant to primary care, the link is issued to all GP practices
- We distribute the email from SIGN with the link to the service lead of the recommended distribution list for onward distribution and if there are hard copies available we order copies and distribute accordingly
- More recently we have been distributing to Care Homes and Community Teams as relevant
- Clinicians will usually be aware of new or updated guidelines coming out or relevance to their area and will have systems in place to review and incorporate into practice, but this activity is not captured formally in the organisation, hence the move to a new, more robust system.

Future process (awaiting approval):
- We plan to disseminate using the alert system in Datix which will allow us to maintain an audit trail to dissemination/receipt/response
- Assigning lead responsibility to named individual(s), for example clinical and service leads, to undertake a review of practice and provide an update on changes/challenges
- A list of new/updated guidelines and the review undertaken will also be sent to each quality and patient safety group for discussion, dissemination and action.

8. NHS Lanarkshire

Within NHS Lanarkshire we have a very structured process to follow regarding the notification, dissemination, implementation, evaluation and review of SIGN guidelines. The Healthcare Quality Assurance and Improvement Steering Group (previously Clinical Governance Group) are provided with regular updates from Clinical Quality regarding all SIGN guidelines.

A flowchart summarising the process is shown below.

DRAFT DOCUMENT FOR CONSIDERATION BY THE CLINICAL GOVERNANCE STEERING GROUP

The following flowchart illustrates the process for Notification, Dissemination, Evaluation, Implementation & Review of National Clinical Guidance (SIGN / NHS HIS) in NHS Lanarkshire

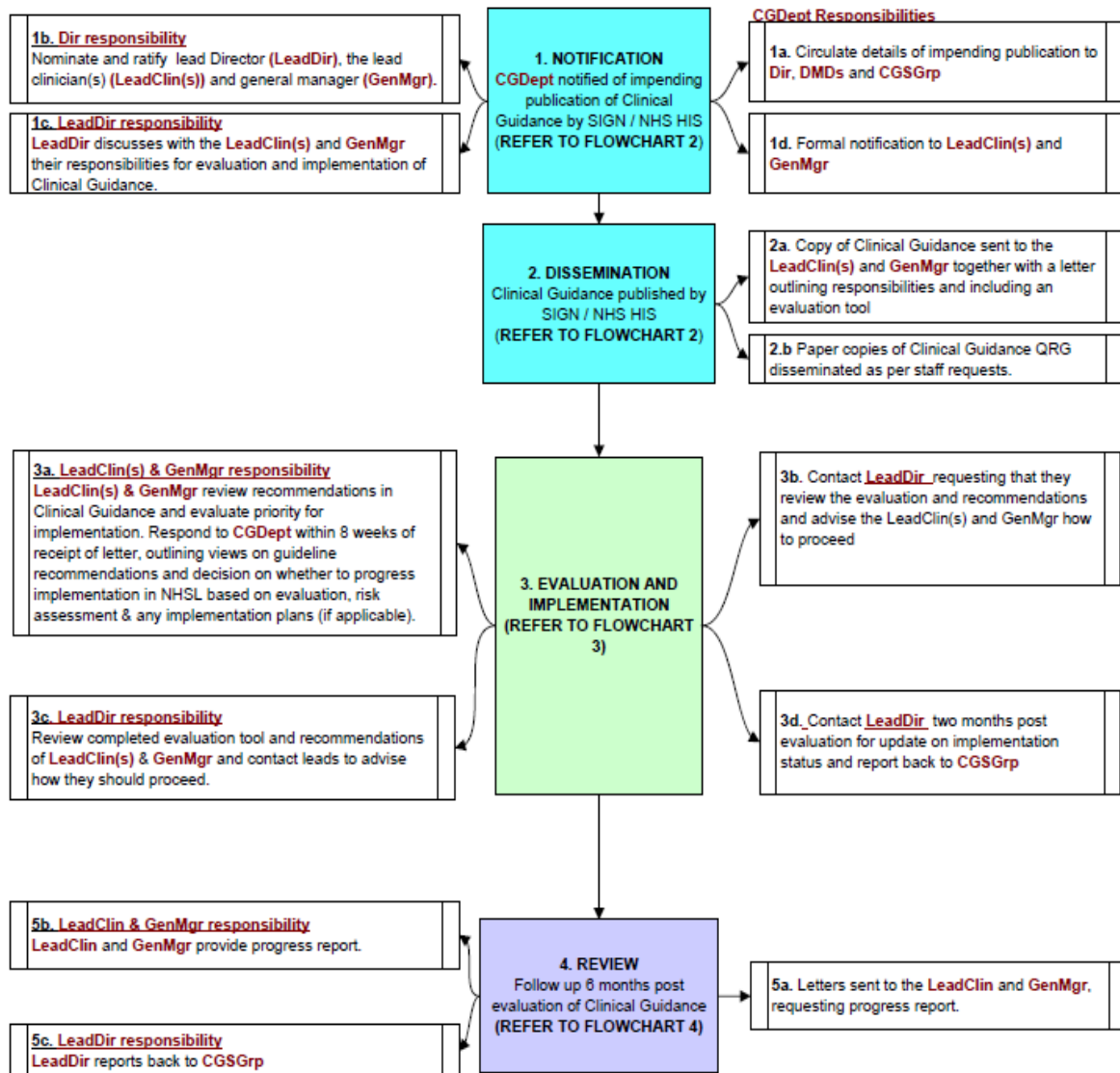**FLOWCHART 1 – SUMMARY OF NOTIFICATION, DISSEMINATION, EVALUATION, IMPLEMENTATION & REVIEW PROCESS**

KEY

The following are responsible for the notification, dissemination, evaluation, implementation and review of national clinical guidance:

Dir	Director(s)
LeadDir	The nominated lead Executive Director
LeadClin(s)	The nominated lead clinician. *If applicable, a second nominated lead clinician will be appointed to lead on aspects out-with the remit and clinical responsibility of the lead clinician*
GenMgr	The nominated lead general manager

CGDept	Clinical Governance Department (Acute & Primary Care)
CGSGrp	Clinical Governance Steering Group
DMT	Divisional Management Teams (Acute & Primary Care)
ALMT	Acute Clinical Division Management Teams and Primary Care Locality General Managers
DMD	Divisional Medical Director(s)

National Clinical Guidance Notification, Dissemination, Evaluation, Implementation & Review Process

The process for notification, dissemination, evaluation, implementation and review of National Clinical Guidance is standardised, and follows the path as detailed below. The Clinical Governance Steering Group has primary responsibility for ensuring that the process is followed. The nominated Lead Clinician and Lead General Manager (and any associated Multidisciplinary Implementation Group) will take guidance from the Lead Director on the implementation of National Clinical Guidance and development of any associated Action Plans. If necessary, a second nominated lead clinician will be appointed by the ExeDir to lead on aspects out with the remit and clinical responsibility of the lead clinician.

1b. Dir responsibility
Nominate and ratify lead Director (LeadDir), the lead clinician(s) (LeadClin(s)) and general manager (GenMgr).

1c. LeadDir responsibility
LeadDir discusses with the LeadClin(s) and GenMgr their responsibilities for evaluation and implementation of Clinical Guidance.

1. NOTIFICATION
CGDept notified of impending publication of Clinical Guidance by SIGN / NHS HIS
(REFER TO FLOWCHART 2)

CGDept Responsibilities

1a. Circulate details of impending publication to Dir, DMDs and CGSGrp

1d. Formal notification to LeadClin(s) and GenMgr

2. DISSEMINATION
Clinical Guidance published by SIGN / NHS HIS
(REFER TO FLOWCHART 2)

2a. Copy of Clinical Guidance sent to the LeadClin(s) and GenMgr together with a letter outlining responsibilities and including an evaluation tool

2.b Paper copies of Clinical Guidance QRG disseminated as per staff requests.

3a. LeadClin(s) & GenMgr responsibility
LeadClin(s) & GenMgr review recommendations in Clinical Guidance and evaluate priority for implementation. Respond to CGDept within 8 weeks of receipt of letter, outlining views on guideline recommendations and decision on whether to progress implementation in NHSL based on evaluation, risk assessment & any implementation plans (if applicable).

3c. LeadDir responsibility
Review completed evaluation tool and recommendations of LeadClin(s) & GenMgr and contact leads to advise how they should proceed.

**3. EVALUATION AND IMPLEMENTATION
(REFER TO FLOWCHART 3)**

3b. Contact LeadDir requesting that they review the evaluation and recommendations and advise the LeadClin(s) and GenMgr how to proceed

3d. Contact LeadDir two months post evaluation for update on implementation status and report back to CGSGrp

5b. LeadClin & GenMgr responsibility
LeadClin and GenMgr provide progress report.

5c. LeadDir responsibility
LeadDir reports back to CGSGrp

4. REVIEW
Follow up 6 months post evaluation of Clinical Guidance
(REFER TO FLOWCHART 4)

5a. Letters sent to the LeadClin and GenMgr, requesting progress report.

9. NHS Lothian

SIGN publishes guidelines to help NHS staff make decisions about care based on the best available evidence. Within NHS Lothian, a system has been developed to ensure that these guidelines are incorporated into everyday practice.

When a new guideline is published on the SIGN website, NHS Lothian disseminates this information by targeted email, with recipients asked to assess its relevance for further distribution in their area of responsibility. Notification of new guidelines is also included in the payslips of all NHS Lothian staff, together with a reminder of the SIGN website address, and a link to new SIGN guidelines is included in the weekly email distribution to GP practices. Copies of the accompanying patient information leaflet, along with the full and summary guidelines, are made available in NHS Lothian patient information centres.

Each new or updated guideline goes through an impact assessment process to see how current practice in NHS Lothian compares with the SIGN recommendations.

This work is led by an existing group, such as a Managed Clinical Network, or a specially convened Guideline Implementation Group, chaired by an appropriate Clinical Lead and facilitated by the Clinical Governance and Risk Management Support Team.

The purpose of the impact assessment is to identify any recommendations with which NHS Lothian is not compliant and where there is a concern about the impact on patient safety or care outcome. Compliance is measured by examining the existence of Lothian wide documentation, such as guidance and protocols, and an assessment of established practice. Where the impact assessment identifies that Lothian's systems reflect the SIGN recommendations, clinicians are encouraged to satisfy themselves that their practice is compliant, either from existing data or by carrying out an audit of key areas of practice.
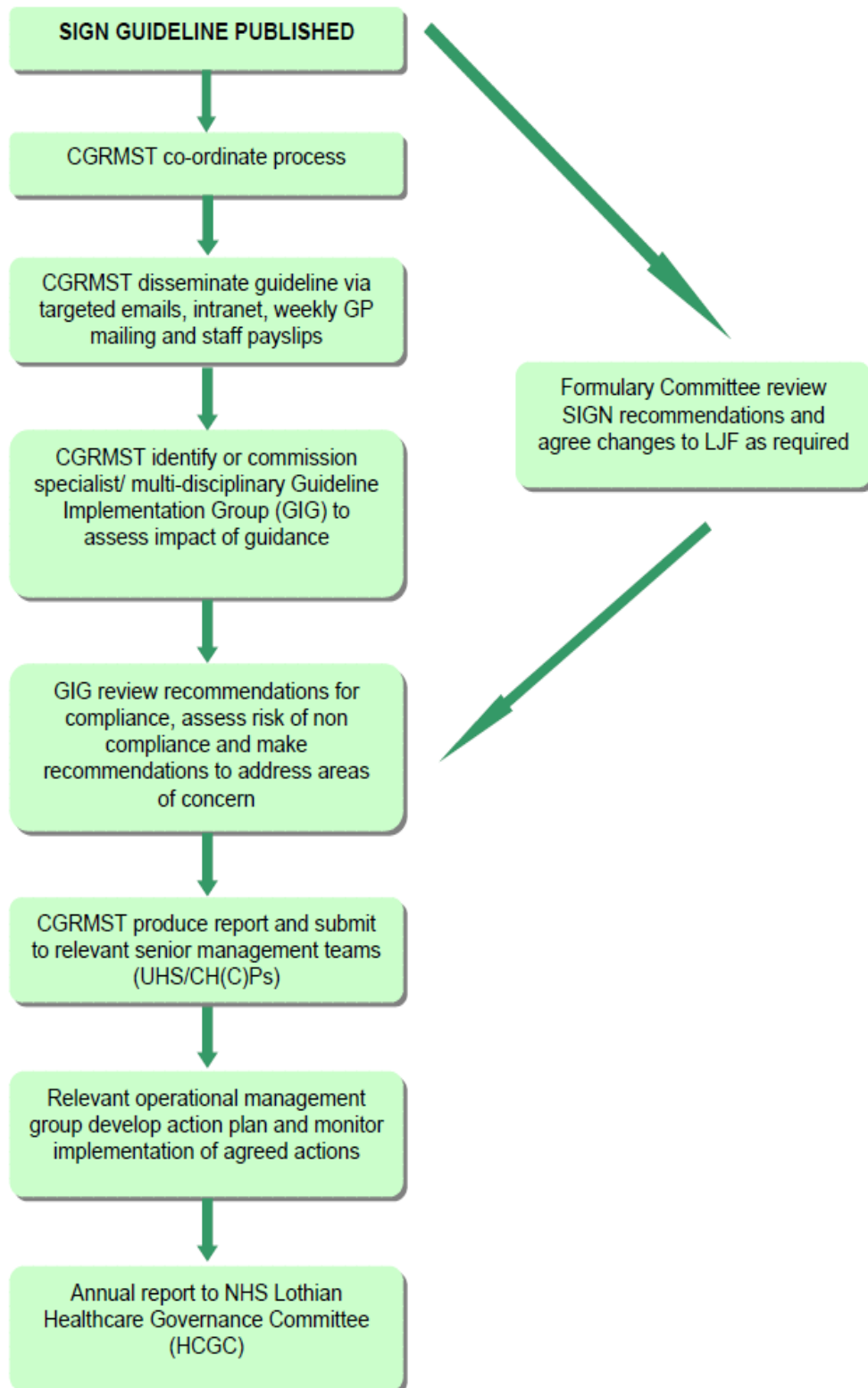
Guidance on diagnosis and management as well as the referral process is available on the NHS Lothian intranet site and is used to provide evidence of the advice available to GPs and other clinicians. If required, the information and electronic referral system is updated to reflect SIGN recommendations as part of the impact assessment process.

The Lothian Formulary Committee reviews the medication recommendations in each new SIGN guideline and any changes to the Lothian Joint Formulary are also included in the impact assessment report.

The final report is submitted to the relevant operational management group which considers the findings and, where necessary, develops a prioritised action plan. SIGN identifies key recommendations that should be prioritised for implementation and these are highlighted in the report. The management group remains accountable for the monitoring of these actions, and, where implementation of the recommendations is not achievable, items are placed on the appropriate risk register and escalated as required.

In conclusion, the SIGN guideline impact assessment process in NHS Lothian provides assurance that the recommendations in the guideline are incorporated into clinical systems and everyday practice. As a result of the SIGN recommendations being met, patients in Lothian will benefit from more consistent care which is based on the best available evidence. A flowchart demonstrating this process is shown below.

SUMMARY OF MANAGEMENT OF SIGN GUIDELINES IN NHS LOTHIAN

SIGN GUIDELINE PUBLISHED

CGRMST co-ordinate process

CGRMST disseminate guideline via targeted emails, intranet, weekly GP mailing and staff payslips

CGRMST identify or commission specialist/ multi-disciplinary Guideline Implementation Group (GIG) to assess impact of guidance

Formulary Committee review SIGN recommendations and agree changes to LJF as required

GIG review recommendations for compliance, assess risk of non compliance and make recommendations to address areas of concern

CGRMST produce report and submit to relevant senior management teams (UHS/CH(C)Ps)

Relevant operational management group develop action plan and monitor implementation of agreed actions

Annual report to NHS Lothian Healthcare Governance Committee (HCGC)

10. NHS Orkney

Currently the SIGN guideline is sent it out to a particular service lead depending on the subject matter.

We have been looking at all the SIGN guidelines and trying to seek assurance on where we are as a board. We have created a priority top 10 to concentrate on and are now in the process of asking clinicians and services what their priority is.

11. NHS Tayside

1. NHS Tayside has a system in place for distribution of new/updated SIGN guidelines to services throughout the organisation. Clinical groups are encouraged to discuss the new/updated guideline at their clinical governance groups and develop action plans where indicated. This process is currently under review.

2. Once I receive notification, an email is forwarded to our Directorate distribution, highlighting that the new/updated guideline can be accessed via the link provided. I also request that those on the distribution let me know if they would like a hard copy of the quick reference guide. Once I have collated responses I then submit the quantity required for our area. All correspondence/documentation referring to SIGN guidelines is filed electronically and also in hard copy in my office.
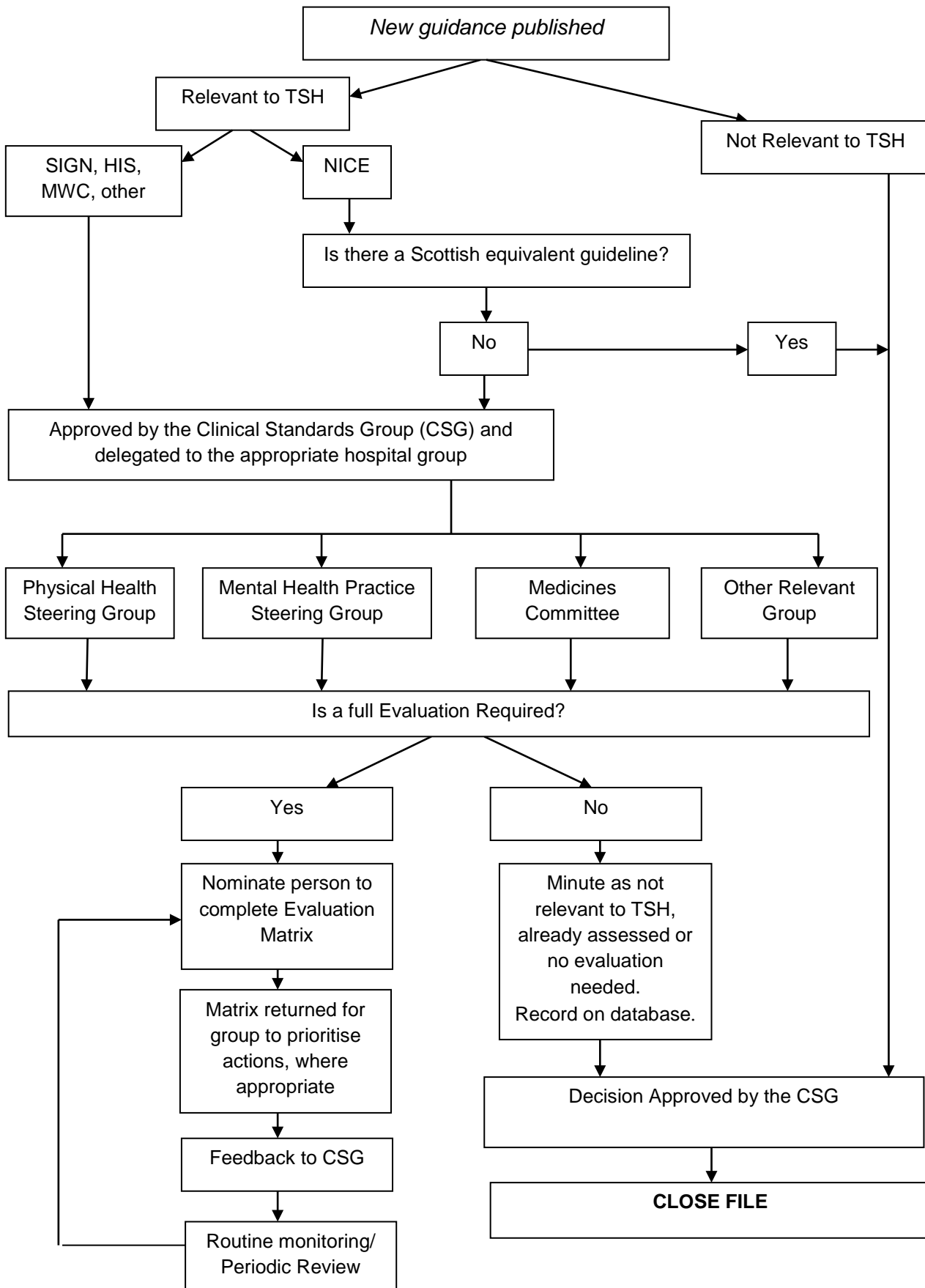
12. NHS Western Isles

When I receive a new guideline I forward to senior managers, acute and primary-care medical leads and the primary care manager who forward them to relevant personnel. Any guidelines are also included in a monthly bulletin which is sent to all mail users and then tabled at a number of governance groups. We have also set up an implementation tracker and a gap analysis is conducted which is then tabled at a governance group.

13. The State Hospitals Board for Scotland

All new guidelines are recorded with a central database. If a guideline is not relevant to The State Hospital, for example is for children or young adults, then we would record it as such. However, if a guideline is considered relevant, it would be allocated to the most appropriate Group or Committee who would decide whether a full evaluation of the guideline was necessary. If an evaluation was not required then the reason for this would be recorded within the database. If an evaluation was required then an Evaluation Matrix is drawn up from the guideline and a small group of professionals are identified to complete said document. Upon completion, this allows prioritisation of any actions required with all outcomes being recorded within the database and fed back to the Clinical Standards Group. Periodic monitoring would take place thereafter. A flowchart demonstrating the process is shown below.

Proposed process for new guidance

```
                        ┌─────────────────────────┐
                        │  New guidance published │
                        └─────────────────────────┘
```

New guidance published

Relevant to TSH

Not Relevant to TSH

SIGN, HIS, MWC, other

NICE

Is there a Scottish equivalent guideline?

No   **Yes**

Approved by the Clinical Standards Group (CSG) and delegated to the appropriate hospital group

Physical Health Steering Group

Mental Health Practice Steering Group

Medicines Committee

Other Relevant Group

Is a full Evaluation Required?

Yes   **No**

Nominate person to complete Evaluation Matrix

Minute as not relevant to TSH, already assessed or no evaluation needed. Record on database.

Matrix returned for group to prioritise actions, where appropriate

Feedback to CSG

Decision Approved by the CSG

Routine monitoring/ Periodic Review

CLOSE FILE

14. NHS Shetland

Currently in the process of changing the composition and remit of the Clinical Governance Coordinating Group, which previously co-ordinated the review of SIGN guidance.

The Clinical Governance Support Team will continue to monitor the publication of the guidance and distribute to relevant clinicians, however will be considering the best way of ensuring effective clinical review at the newly formed governance group.

15. NHS Forth Valley

No response.

Healthcare Improvement Scotland

www.healthcareimprovementscotland.org

Edinburgh Office: Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB
Telephone 0131 623 4300

Glasgow Office: Delta House | 50 West Nile Street | Glasgow | G1 2NP
Telephone 0141 225 6999

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group and the Scottish Intercollegiate Guidelines Network (SIGN) are part of our organisation.

You can read and download this document from our website. We are happy to consider requests for other languages or formats. Please contact our Equality and Diversity Officer on **0141 225 6999** or email **contactpublicinvolvement.his@nhs.net**