Healthcare Improvement Scotland | SIGN

APPROVED MINUTES

Scottish Intercollegiate Guidelines Network (SIGN) Council meeting
Monday 21 June 2021, 1.30pm – 3pm
Teams

Present	
Professor Angela Timoney (AT)	SIGN Chair
Professor Gregory Lip (GL)	Royal College of Physicians of Edinburgh– SIGN Vice-Chair
Mr Mohammed Asif (MA)	Royal College of Surgeons of Edinburgh
Dr Anthony Byrne (AB)	Royal College of Physicians of Edinburgh
Ms Arlene Coulson (AC)	Royal Pharmaceutical Society
Ms Maureen Huggins (MH)	Patient Representative
Dr Nauman Jadoon (NJ)	Early Career Professional
Dr Roberta James (RJ)	SIGN Programme Lead
Dr Scott Jamieson (SJ)	Royal College of General Practitioners
Mr Georgios Kontorinis (GK)	Royal College of Physicians and Surgeons of Glasgow
Dr Alan MacDonald (AMac)	Royal College of Physicians and Surgeons of Glasgow
Mr Kenneth McLean (KM)	Patient Representative
Ms Maureen McSherry (MMc)	Royal College of Midwives
Mr Steve Mulligan (SM)	British Association for Counselling and Psychotherapy
Ms Jacqueline Thompson (JT)	Royal College of Nursing
Mr James McTaggart (JM)	British Psychological Society (Scotland)
Emilia Crighton (EC)	Faculty of Public Health Medicine
Dr Safia Qureshi (SQ)	Director of Evidence, HIS
Dr Marie Mathers (MM)	Royal College of Pathologists
Mr Duncan Service (DS)	Evidence Manager, SIGN
Dr David Stephens (DSt)	Royal College of General Practitioners
Professor Lesley Colvin (LC)	Royal College of Anaesthetists – SIGN Vice-Chair
Mr Moray Nairn (MN)	Programme Manager, SIGN
In attendance	
Ms Molly Dobson (MD)	Project Officer, SIGN (Minutes)
Observers	
Ms Karen Graham (KG)	Programme Manager, SIGN
Apologies	
Ms Gaynor Rattray (GR)	Temp Executive Secretary to SIGN Council
Dr Diane Dixon (DD)	British Psychological Society
Ann Gow (AGo)	Director of NMAHP, HIS
Dr Sara Davies (SD)	Scottish Government
Dr Jane Morris (JM)	Royal College of Psychiatrists
Dr Chu Chin Lim (CCL)	Royal College of Obstetricians and Gynaecologists
Dr Hester Ward (HW)	Faculty of Public Health Medicine
Professor PhyoKyawMyint (PM)	Royal College of Physicians of London

Dr Alan Ogg (AO)	Faculty of Clinical Radiology
Dr Matthias Rohe (MR)	Early Career Professional
Jo Savege (JS)	Scottish Association of Social Workers
Jan Stanier (JSt)	Speech and Language Therapy
Miss Jasmine Wood (JW)	SIGN intern, Scottish Graduate School of Social

1.	**Welcome and apologies**	
	The Chair welcomed Council members. Apologies were not noted as MD did not have the complete list, but have been included above. AT went through the agenda, introducing each section and laying out expectations for the meeting.	**AT**
2.	**Register of Interests**	
	AT noted that the new DOI forms have been sent out by GR, and encouraged everyone to complete and return them to GR. There were no new declarations of interest.	**ALL/GR**
3.	**PRESENTATION:** *Moray Nairn, SIGN Programme Manager* 'Partnership working to enhance the quality of national covid-19 clinical guidance'	
	MN gave a presentation on the work which has been done by SIGN as part of the Scottish Government Clinical Guidance Cell over the course of the last year, working together to produce national COVID-19 clinical guidance. This was also presented as a conference poster at the NHS Event. The key points of the presentation were: • The Clinical Guidance Cell (CGC) was set up in February 2020 to produce guidance to support decision making about COVID-19 • The CGC is governed by the Chief Medical Officer, with support from a medical team within government. • The CGC is made up of 130 multi-disciplinary members • HIS became involved in the CGC to advise and give an overview from a guideline development perspective, and were able to help develop a rapid guideline methodology which the CGC now use for each piece of guidance. • This methodology was updated in April 2021, and improvements have been made. • Currently 139 projects in progress • All clinical guidance produced by the CGC is published on the SIGN website. • MN shared the methodology, showing each stage that SIGN is involved in.	**GR to send a copy of both presentation slides to Council members.**

	• Examples of outputs from the CGC include: rapid clinical guidelines, Scottish Government clinical advice documents and pragmatic guidelines. • Impact evaluation has been assessed by survey; all of the guidance has been used, and is found to be useful and valuable by the majority of people, but there could be greater awareness that the guidance exists. AT thanked MN for the presentation and noted that the presentation slides will be made available to the group. AT then asked the group if they had any questions for MN. SJ congratulated MN on the work done by the CGC, and asked whether there was a similar process to SIGN in terms of collecting DOIs and making these readily available. MN noted that the CGC is a Scottish Government organisation so we can't always influence the processes, however this is an area that was identified by SIGN as a weakness and there have since been improvements made to the transparency of the guidelines. AT asked about why there were no patient reps involved in the CGC initially. MN replied that the guidance in the early days was about acute management rather than a wider patient pathway. The advice now is more about remobilisation, and the updated methodology makes sure that patients views are taken into account for these guidelines. MN noted that there will be further analysis done on the impact survey to see what learnings can be taken for the future of the CGC.	
4.	**SIGN COUNCIL BUSINESS**	
	Feedback was given on the work done at the last SIGN development day. <u>Work stream 1: Widening the reach of SIGN guidelines</u> The questions considered in the workshop were: who do we want to reach? How can we maximise impact for the target audience? Are there any external groups we should be working with to do that? LC proposed putting together a team to work on this project. The team would consist of 6-8 people from SIGN council, 2 early-career practitioners (either those on SIGN council, or externally recruited), 2 people with lived experience and a programme manager. LC asked that anyone who would like to be involved get in touch with her or AT. There was a discussion about encouraging the assessment of outcomes of guidance by University departments as SIGN doesn't currently have the resource to do this assessment. KM noted that we would need to be clear about what we mean by "impact", and that it may be for those who propose guidelines to say what impact they are looking for as part of the guideline proposal. This approach was endorsed by several people. RJ noted that the current logic models used in SIGN methodology can be used as a basis for this work. It was also noted that impact assessment of a full guideline would be a very large piece of work, requiring a lot of	**LC**

	resource. It may be appropriate to agree with GDG what aspects of the guideline are most suitable for impact assessment.	**GL**
	<u>Work stream 2: Developing Early Years Practitioners' Group</u> The intention of this work stream is to develop and engage more with early career practitioners, which will give us insights to help with the guideline and help us develop the guideline development process and implementation aspects. This group is already in existence and GL with work with NJ and MR to expand the group including early careers practitioners from other disciplines.	**AT**
	<u>Work stream 3: Developing SIGN Council members input; Guideline sponsor recommendations</u> AT went through the SBAR for SIGN Council members as guideline sponsors *(sign 4.2)*. The purpose of this SBAR was to create a closer connection between SIGN Council members and guideline development groups (GDG). The proposal is that there should be a SIGN Council member on each GDG, to support the group, keep the council informed of progress, and raise issues to the Council if needed. It is critical that the role adds value to the group, so there has been some work done on what the roles and responsibilities would look like *(annex 1)*. Having a guideline sponsor could potentially strengthen recruitment, both from SIGN Council into development groups, and from development groups into SIGN Council. The Council were asked to approve the recommendations as set out in *sign 4.2*, and AT opened the floor up for questions and comments. Several Council members voiced strong support for this proposal. DS raised that it would be useful to know guideline development members up front, rather than once a guideline has been published, and that it would be very useful to have a clearer and more transparent method of advertising places on the GDGs, making sure that the group is compliant with diversity guidelines. JM raised a question of whether the wording in some of the responsibilities in annex 1 is a bit strong, and may scare council members away from being sponsors. "To manage external relationships…" and "Lead on measuring impact" to be softened. All Council members were in support, and the SBAR was approved with these changes.	**GL**
	<u>Work stream 4: Working with SIGN and Evidence Directorate to take forward SIGN methodology</u> One of the markers of SIGN is it's methodology for creating guidelines; SIGN is evidence, not eminence, based guidance. This work stream aims to take forward the methodology used by SIGN, and there is a proposal to move across to GRADE methodology, implementing EPPI reviewer to do so. GRADE is widely used, and it would hopefully not be a difficult transition to make, however there is a resource implication as it takes time to do a GRADE methodology, and SIGN guidelines already have a long timeline.	**RJ**
	<u>Current and future work programme</u>	

	Themes to prioritise in the current work programme; Mental Health, Diabetes, Cardiovascular, Obesity. There will be some work done to look at capacity and how SIGN can incorporate these themes into the work currently on our programme, particularly for topics that have been accepted but are not in progress yet. Once there is a plan in place, it will be shared by email with SIGN Council members. Additionally, SIGN are looking at how they can keep guidelines up to date in a better way, potentially by using the newly developed rapid methodology. Membership and discussion of vacant positions Current membership can be seen in *sign 4.3*. Current vacancies: • 1 member from Academy of Colleges. AT has been in touch and needs to follow up. • 1 member from the Royal College of Anaesthetists. Colin Rae has agreed to fill this place. • 1 member from the Royal College of Ophthalmologists. AT will be pursuing this. • 1 lay representative. AT opened a discussion about how we should address this vacancy. • 1 member from the Royal College of Surgeons of England. AT opened this up for discussion as well. There are also several deputy vacancies, however on the whole membership is looking healthy and engagement is good. No one had any issues to raise. AT will come back with a proposal about what do about some of our open positions, making sure we have good Primary Care representation.	**AT**
5.	**UPDATE FROM HIS EVIDENCE**	
	Key Updates: • Support to the National Testing Programme for COVID-19. RJ has been leading a small cross-directorate team who are supporting this programme. Scottish Government has welcomed this support, and we have been asked to continue providing support until the end of the financial year. The team has been increased to provide RJ with support in this work. SQ thanked RJ and everyone involved in the work. • Work Programme Committee. The Evidence Directorate is currently looking at all of the proposals for new work or evidence across the Directorate, to try and streamline the way they prioritise their work programmes and make sure they are aligned to clinical, National and HIS priorities. The first meeting of this committee happened in May, and 7 work topics were approved. One of these is a look at Diabetes and emerging technologies, working in collaboration with Scottish Health Technologies group. 5 potential SIGN guidelines were approved. These topics will now come to SIGN to fit into a work programme, and SQ is happy to discuss issues of resource.	**SQ**

	• <u>Collaboration with NICE</u>. Work has started on updating of the joint SIGN/NICE/RCGP Post covid-19 syndrome guideline. NICE have also asked us to collaborate on their acute COVD guideline. SIGN need to look at capacity, but this would be a positive move for SIGN with engagement with other guideline producing bodies. The NICE Chief Exec has also been in discussions with Robbie Pearson about how we can collaborate further in the future, particularly around future clinical guidelines and emerging technology appraisals. • <u>Realistic Medicine</u>. Pre-COVID, the team had been in touch with the Realistic Medicine team at Scottish Government, to try and bridge some of the perceived gaps between realistic medicine and what guidelines recommend. This has been paused, but is now being picked up again. There is clear alignment between evidence based guidelines and enabling effective therapeutic conversations. SIGN patient booklets also contribute to this.	
6.	**SIGN EXECUTIVE BUSINESS**	
	<u>Highlight report of current methodological issues</u> DS highlighted the work being done on incorporating qualitative research into SIGN guidelines. The recommendation in the report produced by DS *(sign 6.3)* is to continue prioritising quantitative evidence, and not have a fully qualitative guideline, though it can be useful to have both types of questions. The SIGN methodology is based on the traditional evidence based medicine hierarchy, and although qualitative evidence can be useful at offering an additional perspective, quantitative evidence will still allow us to make recommendations which will benefit a majority of people. It is recognised that expertise in assessing literature for qualitative evidence is not common within GDGs. It is also recognised that quantitative evidence allows for stronger recommendations which can then be implemented. All council members agreed with this recommendation. AT suggested it would be good to have this agreement in writing. <u>Highlight report on recent work and forthcoming projects in public partner involvement</u> KG provided an update. Including PO resource in the production of patient versions has piloted in the Bacterial UTI patient version guideline, and has been very successful. The recommendation is that this will be the approach going forward. An easy-read version of the Epilepsy in Children and Young People guideline has been produced in collaboration with Disability Equality Scotland, and is now available on the website. A long-COVID patient app is in production, with an interactive symptom diary which can be used by patients. User testing will involve patients The patient version of Epilepsy in Children and Young People has been published. Young people were involved in the guideline development group for the first time, so there is currently an	**DS** **ALL** **KG**

	evaluation going on to produce learnings from this. The findings from this evaluation will be shared with SIGN Council. JT asked that booklets continue to be produced alongside apps and other digital aids, and that they be available for translation. RJ noted that SIGN do have a translation service, and that anyone wishing to translate a booklet can get in touch with SIGN. There is also a request form on the SIGN website.	
7.	**MINUTES OF PREVIOUS MEETING**	
	No issue were raised, and minutes were accepted as accurate.	
10.	**NEXT STEPS**	
	There is a development meeting on the 11th Aug, where the workings of SIGN Council will be discussed. Everyone was asked to think about if and how they can offer sponsorship/membership on a GDG. There will be a call to members to ask for self nomination and this will also be discussed at the next session. AT will make changes to the SBAR as discussed above.	**ALL** **AT**
11.	**AOCB**	
	There was no AOCB raised.	
12.	**DATES OF FUTURE MEETINGS**	
	Next meeting will be a Development Meeting, held on 11th August.	