DRAFT MINUTES

Scottish Intercollegiate Guidelines Network (SIGN) Council meeting
Wednesday 3 June 2020, 11.00 am -12.00 pm
Zoom

Present	
Professor Angela Timoney (AT)	SIGN Chair
Dr Jenny Bennison (JB)	Royal College of General Practitioners – SIGN Vice-Chair
Mr Alistair Brown (AB)	Scottish Association of Social Workers (deputy)
Ms Iris Clarke (IC)	Allied Health Professionals
Professor Lesley Colvin (LC)	Royal College of Anaesthetists
Dr Emilia Crighton (EC)	Faculty of Public Health Medicine
Dr Sara Davies (SD)	Scottish Government
Dr Diane Dixon	British Psychological Society (deputy)
Dr George Fernie (GF)	Healthcare Improvement Scotland (deputy)
Ms Alison Gray (AG)	Allied Health Professionals
Mr David Hewitson (DH)	Scottish Association of Social Workers
Ms Maureen Huggins (MH)	Patient Representative
Dr Roberta James (RJ)	SIGN Programme Lead
Dr Scott Jamieson (SJ)	Royal College of General Practitioners (deputy)
Dr Ahmed Khan (AK)	Royal College of Psychiatrists (deputy)
Dr Chu Chin Lim (CCL)	Royal College of Obstetricians and Gynaecologists
Professor Gregory Lip (GL)	Royal College of Physicians of Edinburgh
Dr Donald Macgregor (DM)	Academy of Colleges
Dr Marie Mathers (MM)	Royal College of Pathologists
Dean Ian Mills	Faculty of General Dental Practice (UK) of the Royal College of Surgeons of England.
Professor Phyo Kyaw Myint (PM)	Royal College of Physicians of London
Professor Ronan O'Carroll (RO)	British Psychological Society
Dr Safia Qureshi (SQ)	Director of Evidence, HIS
Dr Matthias Rohe (MR)	Junior Representative
Mr Duncan Service (DS)	Evidence Manager, SIGN
Dr Lydia Simpson (LS)	Junior Representative
Matthew Smith-Lilley (MSL)	British Association for Counselling and Psychotherapy (BACP)
Dr David Stephens (DSt)	Royal College of General Practitioners
Ms Jacqueline Thompson (JT)	Royal College of Nursing (deputy)
Mr Andrew Thomson (ATh)	Scottish General Practitioners Committee of the BMA Representative
Mr Alan Timmins (ATi)	Royal Pharmaceutical Society (deputy)
Dr Simon Watson (SW)	Medical director, HIS
In attendance	
Ms Kirsty Allan (KA)	Executive Secretary to SIGN Council (Minutes)

Observers	
Ms Natalia Kapralova (NK)	PhD Student, University of Glasgow
Ms Gaynor Rattray (GR)	Guideline Coordinator, SIGN
Ms Catriona Vernal (CV)	Programme Manager, SIGN
Apologies	
Mr Mohammed Asif (MA)	Royal College of Surgeons of Edinburgh
Mr Andrew de Beaux (AdB)	Royal College of Surgeons of Edinburgh (deputy)
Dr Sushee Dunn (SD)	Royal College of Physicians of Edinburgh (deputy)
Dr Nauman Jadoon (NJ)	Junior Representative
Mr Michael Macmillan (MM)	Patient Representative
Mr Kenneth McLean (KM)	Patient Representative
Laura McIver (LM)	Healthcare Improvement Scotland
Mr Steve Mulligan (SM)	British Association for Counselling and Psychotherapy
Ms Caroline Rapu (CR)	Royal College of Nursing
Dr Colin Rae (CR)	Royal College of Anaesthetists
Dr Karen Ritchie (KR)	Healthcare Improvement Scotland
Dr Hester Ward (HW)	Faculty of Public Health Medicine
Ms Pauline Warsop (PW)	Patient Representative

1.	**Welcome and apologies**	
	The Chair welcomed Council members and observers to the meeting. Apologies noted as above.	
2.	**The evidence directorate during lockdown**	
	SQ gave a presentation to members on the work of the Evidence Directorate (ED) since lockdown began. The ED has contributed in a number of ways; the Once for Scotland work was highlighted as SIGN is contributing to this through liaising with the Clinical Cell of the Scottish Government in producing rapid guidelines during COVID-19. The work has caused SIGN to rethink ways of working in the production of guidelines. The SIGN team will consider what they can take from this experience going forward. SJ raised concerns with the rapid guidelines as some clinical networks have not been consulted on them and noted the lack of evidence for certain bits of the guidelines. JB questioned how this work is being shared. There is nothing that she is aware of which highlights that Healthcare Improvement Scotland is the place to find information on COVID evidence and guidance. SQ pointed out this is why SIGN has been asked to be involved in the Clinical Cell. The Scottish Academy is also represented on the	

	Clinical Cell and this link could be better used to distribute information. AT confirmed that where people go to for COVID-19 evidence and guidance will be addressed outside of this meeting.	**AT**
3.	**Current SIGN work**	
	RJ stated that the SIGN work programme had been originally paused in response to the COVID-19 pandemic. HIS had approached NICE with an offer of collaboration and SIGN was asked to take on the production of rapid guidelines on the topic maternity. The guideline did not go ahead as the Royal College of Obstetrics and Gynaecologists had produced a similar guideline. It was an opportunity to learn the process of producing rapid guidelines. The rapid evidence review of the assessment of COVID-19 in Primary Care was a collaboration with the University of Glasgow. RJ updated on the work SIGN has been doing with Ann Wales from the Scottish Government on the production of two different mobile apps. An app is to be developed from the Primary Care rapid evidence review and another one on delirium where the Chair from the guideline group is involved. DSt asked for clarification on what the Scottish Government Clinical Cell is and who is involved. The Clinical Cell is an advisory group to the Chief Medical Officer (CMO) in Scottish Government. The Clinical Cell is multidisciplinary with significant involvement of the Academy of Scottish Royal Colleges. SIGN Council members are asked to link in with the Academy around work coming from the Cell. It is to be transparent and process driven. A lead PM from SIGN, with support from the other PMs, RJ/SQ, is involved in enabling the Cell to strengthen its processes and in editorial review. The Cell has asked for SIGN support and involvement because of the expertise in producing evidence based clinical guidelines. The governance of the content of the guidelines sits with the Clinical Cell. As part of SIGN business as usual; • The updated asthma patient booklets were published. • The revisions to Osteoporosis were published. • The new SIGN website is in development with NSS developers. It is hoped it will go live soon and a link to the new site will be circulated to SIGN Council once it is. JB queried that the SIGN website simply links to NHS Inform, it is not obvious that there is any HIS or SIGN ownership in the work. JT stated within primary care and COVID-19 hubs there will be a number of advanced nurse/paramedics practitioners who will also be assessing patients as well as GPs. Moving forward with the Primary Care SIGN app could allow other clinicians be considered to be part of the expert group. RCN would be more than happy to connect SIGN with relevant people	**KA**

	SJ stated the pace of the work with the Clinical Cell was right at first but there are big decisions on care pathways and treatment taking place. There is a question about the review process within the Clinical Cell. SJ thinks there needs to be a review and evidence for the guidelines published. RJ advised that this is not the new normal for guideline development but we should take away the good points of rapid guideline work and use them going forward. The management of the guidelines which have been produced so far should be thought about. Do we take the guidelines down once they reach two months old? Or do we review them? Some of them may be useful to update going forward. The patient voice is also missing from them. SQ agreed with these points but reminded everyone there is opportunity in SIGN working with the Scottish Government. We are shaping and influencing the work in each guideline produced, and this will strengthen what is produced from the Clinical Cell. AT agreed that patient voices are not heard and there is an absence of some professions. AT acknowledged that the rapid guideline work reverted to old ways of working but SIGN can use their influence to shape and make decisions. The Clinical Cell is chaired by Professor Tom Evans. IM raised that there are challenges in dental care during COVID-19. SDCEP is based in Dundee and it is worth exploring working with them moving forward. A collaboration between dentistry and medicine should be considered as there is an overlap. DM noted there have been a lot of guidelines developed during the COVID-19 pandemic. They may not be valid moving forward. Evidence from outside of the UK is not being considered and should looked at. AT agreed that looking beyond the UK for guidance is good as we need robust evidence. DH noted that SIGN is unique as it operates at arm's length, there are links with the Colleges in Scotland and professional organisations. It is understandable why there is application of the SIGN badge at sign off by the Clinical Cell. But there is a concern for what has been lost along the way and the reputation of SIGN must not be damaged in the long run. The process works for the rapid guideline work but there is a need for SIGN to address what is and is not good practice. RJ agreed with DH and the letter from the CMO highlighted what the rapid process did and did not impact on for SIGN. SJ stated that we should be pointing out what research is being done, for example, false negatives from tests. He agreed the work will be a challenge but it is good that SIGN can help in the direction of it. MR brought up that things which normally take months are taking weeks during COVID-19. There is existing data which can be used.	

	It notes where people have been discharged from when they come to COVID-19 clinics. AT encouraged the members of SIGN Council to submit research plans where appropriate. RJ discussed the After Action Review for the Primary Care work with the University of Glasgow. The special skill set of GPs/researchers helped in the work. A key point that was more time is needed as the guideline is being drafted. The timescales for the initial draft to peer review to the creation of the next draft were not ideal. The key thing for RJ is that the guideline was created in a fortnight but those working on it spent more time on it outside of normal working hours. The way in which SJ, as a member of SIGN Council, was able to engage RCGP members as peer reviewers on this guideline worked well. SJ mentioned that the work with the University of Glasgow needed to ensure that what was applicable to GPs in the Borders also applied to GPs in Dundee and so on. RO stated that a newsletter detailing the updates from SIGN would be a useful way communicate with SIGN Council.	**KA/RJ**
4.	**Resuming the programme**	
	RJ took SIGN Council members through the SBAR produced detailing how the work of SIGN could be restarted during the COVID-19 pandemic. The main aim is to finish the guidelines which were close to publication before the programme was paused but being mindful of when and how they are published. Consideration will be taken so that the publication of the guidelines is not missed and we are not bombarding people with information. GL suggested a living guidelines approach similar to those produced for the COVID-19 pandemic. RJ confirmed the primary care rapid review was created this way. There is a commitment within the Clinical Cell that any guidance produced will be looked at this way. SJ highlighted that SIGN 117 Management of sore throat and indications for tonsillectomy is still used as a standard of care, including within dental work, but it has now been withdrawn as it is ten years old. The issue of SIGN 117 is to be taken outwith the SIGN Council meeting by SJ to the SIGN Executive. AT commented the COVID-19 work needs to be concentrated on for now and any business as usual work will be as per the paper discussed.	**SJ**
5.	**Your hot topics**	
	The SIGN Council members were asked to detail what their hot topics are in the current situation and how SIGN could help. AT noted that there are many areas which need further work, both in what is happening in the UK and internationally.	

	SQ commented that there have been changes to the ways the service is run, how it is provided and the impact of social distancing on this. It may not be a clinical topic and the immediate work is reflective of that. IC let Council members know that they have been successfully using MS Teams in NHS Highland. While Zoom has allowed people to attend SIGN Council more easily, MS teams could be used. AT agreed and highlighted that Zoom was chosen as at the time as you could only view four participants on MS teams. This has now changed. Virtual meetings for SIGN Council will be discussed further outside of this meeting. It was felt by members that the virtual meeting and the chat box allowed the meeting to be interactive and kept people involved. LS queried if SIGN Council has oversight of the work of the Clinical Cell. What is the role of members of SIGN Council? SQ clarified that SQ/RJ have an editorial role but there are reps of the Academy on the Clinical Cell, the main colleges are represented. The Academy/colleges link could be strengthened further and involve SIGN Council more. AT will discuss this with Miles Mack, the chair of the Academy. MH stated that from a patients and families perspective some issues where nationwide guidance might be useful are: • Visiting patients in hospital (is there a safe way to allow more visits to those that would benefit, for example, the more elderly or younger patients, those with dementia). • How is the return of patients to their home or to care homes best managed to ensure enough support (in the early stages it was very rapid to empty the hospitals, was/is there sufficient home support). Also is the regime for testing patients for COVID-19 before release standardised and appropriate across health boards. • Lifting of restrictions on those shielding - what is the best approach? JB, SJ, ATh all indicated that care homes are a hot topic for them. PM suggested that one thing SIGN could recommend would be review of evidence behind guidelines to highlight the lack of evidence and provide research direction. LC agreed but highlighted the major challenge to producing evidence-based guidance is a lack of high-quality evidence, how we approach that and how we work with colleagues outside of the UK to generate evidence. More research is needed on COVID-19 in the acute and long-term setting. AG stated moving forward all guidelines might need to include guidance around use of remote access within healthcare. Within each care pathway there is limited evidence to support indicators	**AT/RJ/KA** **AT/KA**

	for when remote access is contraindicated; there is a concern this becomes the 'norm' and clinical errors result. KM would like us to consider the following in guideline development: Consider guidelines which will address the needs of patients post COVID, for example, guidelines which support respiratory conditions, diabetes (which is noted and suggest we stick with the one we have for now). It is also suggested we consider guidelines to support mental health and nursing home/care home environments.	
6.	**Minutes of the meeting held 11 March 2020**	
	AT went through the minutes from the previous meeting held on 11 March 2020, and they were accepted as accurate apart from:- • Kenneth McLean's title to be changed from patient representative to lay representative. • Ian Mills job title to be amended to Dean of the Faculty of General Dental Practice (UK) of the Royal College of Surgeons of England. The minutes will be available on the SIGN website.	**KA**
7.	**Next steps**	
	• AT to take the discussion of SIGN Council's involvement in the work taking place with Scottish Government Clinical Cell to SIGN SMT on 10 June. It will also be on the agenda for the November SIGN Council meeting. • The paper produced by the trainee reps will be reviewed in July.	**AT** **AT/RJ**
8.	**Dates and format of future meetings**	
	9 September 2020 – Virtual meeting 4 November 2020 – Meeting Room 6.4 and 6.5, Delta House, Glasgow	