APPROVED MINUTES

Scottish Intercollegiate Guidelines Network (SIGN) Council meeting
Wednesday 9 September 2020, 11.00 am -12.30 pm
MS Teams

Present	
Professor Angela Timoney (AT)	SIGN Chair
Professor Lesley Colvin (LC)	Royal College of Anaesthetists – Vice-chair
Mr Mohammed Asif (MA)	Royal College of Surgeons of Edinburgh
Dr Jenny Bennison (JB)	Royal College of General Practitioners
Ms Arlene Coulson (AC)	Royal Pharmaceutical Society
Ms Alison Gray (AG)	Allied Health Professionals
Mr David Hewitson (DH)	Scottish Association of Social Workers
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 (deputy)
Dr Chu Chin Lim (CCL)	Royal College of Obstetricians and Gynaecologists
Mr Michael Macmillan (MM)	Patient Representative
Dean Ian Mills	Faculty of General Dental Practice (UK) of the Royal College of Surgeons of England.
Mr Kenneth McLean (KM)	Patient Representative
Mr Steve Mulligan (SM)	British Association for Counselling and Psychotherapy
Professor Phyo Kyaw Myint (PM)	Royal College of Physicians of London
Dr Alan Ogg (AO)	Faculty of Clinical Radiology
Dr Safia Qureshi (SQ)	Director of Evidence, HIS
Professor Stuart H Ralston (SR)	University of Edinburgh
Ms Caroline Rapu (CR)	Royal College of Nursing
Dr Matthias Rohe (MR)	Early Career Professional
Mr Duncan Service (DS)	Evidence Manager, SIGN
Dr Lydia Simpson (LS)	Early Career Professional
Dr David Stephens (DSt)	Royal College of General Practitioners
Mr Andrew Thomson (ATh)	Scottish General Practitioners Committee of the BMA Representative
Dr Hester Ward (HW)	Faculty of Public Health Medicine
Dr Simon Watson (SW)	Medical director, HIS
In attendance	
Ms Kirsty Allan (KA)	Executive Secretary to SIGN Council (Minutes)
Observers	
Ms Gaynor Rattray (GR)	Guideline Coordinator, SIGN
Apologies	
Dr Sara Davies (SD)	Scottish Government

Dr Diane Dixon (DD)	British Psychological Society (deputy)
Professor Gregory Lip (GL)	Royal College of Physicians of Edinburgh
Ann Gow (AGo)	Director of NMAHP, HIS
Dr Vivienne MacLaren (VM)	Faculty of Clinical Oncology
Dr Donald Macgregor (DM)	Academy of Colleges
Dr Rajan Madhok (RM)	Royal College of Physicians and Surgeons of Glasgow
Dr Marie Mathers (MM)	Royal College of Pathologists
Laura McIver (LM)	Healthcare Improvement Scotland
Dr Graham McKillop	Faculty of Clinical Radiology (deputy)
Ms Maureen McSherry (MMc)	Royal College of Midwives
Dr Jane Morris (JM)	Royal College of Psychiatrists
Professor Ronan O'Carroll (RO)	British Psychological Society
Dr Colin Rae (CR)	Royal College of Anaesthetists (deputy)
Dr Karen Ritchie (KR)	Healthcare Improvement Scotland
Jo Savege (JS)	Scottish Association of Social Workers
Matthew Smith-Lilley (MSL)	British Association for Counselling and Psychotherapy (BACP)
Ms Jacqueline Thompson (JT)	Royal College of Nursing (deputy)
Mr Alan Timmins (ATi)	Royal Pharmaceutical Society (deputy)
Ms Pauline Warsop (PW)	Patient Representative

1.	**Welcome and apologies**	
	The Chair welcomed Council members. Feedback was asked from members on the use of MS Teams and Zoom for SIGN council meetings. The Chair also welcomed Stuart Ralston, the Chair of the GDG for Osteoporosis to the group. Apologies were not gone through but noted above.	
2.	**Register of Interests**	
	This item was discussed under item 7.	
3.	**Vision for Healthcare Improvement Scotland Medical Directorate**	
	SW gave a verbal presentation to members on his vision for the Medical Directorate and how this ties in to the work of SIGN and SIGN Council. SW described that a significant component of the Medical Director's role is in relation to clinical and care governance, a role shared with the NMAHP Director, and that it is their responsibly to ensure high quality and effective Clinical Governance in all that HIS does. The medical director has a variety of other corporate objectives including strengthening relationships with key clinical stakeholder and influencing groups including universities, NHS medical and pharmacy leadership, Royal Colleges and other key professional groups.	

	MS concluded that the Evidence Directorate and this group have key role in the quality of care in Scotland, advising the country on best clinical practice guidelines is a heavy responsibility. MS quoted In James Surowiecki's book The 'Wisdom of crowds', to support his belief that a diverse range of experts and representative organisations make for better decisions in formulation of guidelines. He expressed that he is keen to understand how SIGN achieves the right balance of specialist expertise and the wisdom of a diverse 'crowd' in its work and sees this a key issue in clinical/care governance. MS is keen to support that as well as the wider aspects of SIGN's work.	
4.	**SIGN Guideline 142 on Management of osteoporosis and the prevention of fragility fractures**	
	Stuart Ralston (SR) gave a presentation to the group on his experience of being chair for the GDG and the GDG development process. There were several meetings of the group throughout 2018 and 2019 and the updated guideline was published in June 2020. The publication had been delayed slightly by COVID-19. SR thinks the SIGN guideline development process is good and the fact that SIGN is evidence based makes it a strong process. Through meetings with the PM and the group were taken through key updates to the guideline including why recommendations were made or not made. There were barriers during the process, as the guideline update was ahead of the assessment of drugs by SMC. AT asked the group if they had questions from SR. SJ raised the issue that GPs have with applying guideline recommendations. The preference is for recommendations that allow for informed decision making with patients. How recommendations are explained to patients should be considered in future. AT questioned how we link guideline s to clinical practice. AG liked the idea of a generic guideline that supports patients to understand and evaluate risk with a range of decision tools to access and use. RJ agreed and stated it is something that could be explored with our Patient Involvement Advisor. SQ made the group aware that we are working on better alignment across the teams within the Evidence Directorate. The SMC timetable is driven by submissions by pharma. CR asked what do we do to future proof guidelines s, including aligning recommendations on drugs and SMC. Is there diversity on who is involved in the GDG? SR confirmed the GDG for SIGN 142 was balanced and diverse. The group was aware of the constraints faced by SMC and that some licensed drugs have not yet gone through their process.	**RJ**

	IM pointed out there are also implications with drugs for patients receiving dental treatment. This should be borne in mind with recommendations. AT let the group know that she and RJ had a successfully meeting with SDCEP between this SIGN Council and the June meeting. She believes we can work well together.	
5.	**SIGN Council Business**	
	AT made the group aware of the appointment of the Vice-Chair for SIGN Council. There were candidates for the post and upon review it has been decided to appoint both to the position. The successful candidates are Professor Lesley Colvin, Royal College of Anaesthetists and Professor Gregory Lip from RCPE. They have complimentary skills which will strengthen SIGN Senior Management Team. AT and RJ will meet with LC and GL to discuss their skills and interests. JB is now demitting office as Vice-Chair and AT thanked her for her valued work with her and JK before her. RJ took Council members through the SBAR for SC members as sponsors of guidelines. The SIGN programme managers were asked what would be helpful to them and SMT had also commented the proposal. The benefits of a guideline sponsor include a stronger link between SC, the GDG and the SIGN team. The PMs will have a voice at SC with the SC guideline sponsor. The sponsor will champion the guideline at their Colleges and can help with implementation. RJ asked for approval from SC of two recommendations; • Every new guideline and those currently in development (where appropriate) should have a SIGN Council Sponsor • The role of the Sponsor should be as set out in Annex 1. A process for selecting Sponsors will be developed The role of the sponsor needs to be defined so there is no overlap with the PM role. AT stated the sponsor will also be an observer. They will have context of what happens within the development in the GDG. LS pointed out the disconnect between SC and GDG needs to be addressed as the two should complement each other. A clearer link would be a positive outcome. There is a concern around time commitment for this, especially in consultant roles. RJ detailed the SC sponsor would be at key stages of GD development with the option to commit more time if able. A verbal update could be brought to SC for discussion. DSt questioned how the SC rep would be recruited to the GDG. RJ clarified to SC that this process is still being worked on, and recruitment of GDG sponsors needs to be transparent. All Council members should have the opportunity to be a sponsor. The process will be worked on at SMT.	

	AT would like people to self-nominate for guideline sponsor and if there is more than one for the same guideline, there will be a process to decide the sponsor. JB questioned whether a sponsor could be a member of a GDG if they are not the chair. Should they not be a part of the decision making group? RJ confirmed that this is still to be decided but it should become clearer once the role of the sponsor is defined. It is hoped that they would be someone slightly removed from the group. AT thinks that the sponsor would look at the GDG process to see if it is working. MH questioned whether patient reps could be a sponsor of a GD. RJ stated it is hoped the sponsor would also be involved in the development of patient booklets. There has been no firm decision made about this yet but she thinks patient and lay reps should have the option. The role of the sponsor is not clinical, all SC members can be involved. LS asked if the sponsor would be named in the publication as recognition of the role. RJ liked this idea but how the sponsor is recognised needs to be thought through. She suggested the sponsor could help the PM in the transparency of the GDG and the recruitment process for it. DSt agreed the sponsor should be involved in recruitment to GDG but does not believe it is transparent how members are recruited to GDG. CR also welcomed the idea of the sponsor but how the role is recognised in the publication should be addressed. It needs to be clear what being a sponsor means and what the role is. This also needs to be a transparent process. SC members voted in to approve the two recommendations in the agreement that how the SC sponsor role works is brought to the November meeting. LS took the group through the ongoing work to strengthen engagement with Early Career Professionals. CR raised a concern that the work so far seems to be focused on doctors, and how we open it up to other processions should be addressed. LS stated that this is something they are trying to work out how to do. The role within SC was originally targeted at trainee doctors. There is a focus on doctors first then it will be expanded into other ECP roles. It has been recognised there is a need to do this. How recruitment to the role from other professions is in discussion as they all have different stages they move through in their career path. MR noted that NES is responsible for the training of multiple health care professions.	**SMT**

	SW made SC members aware that AGo, NMAHP should be joining SC and this can be discussed with her in advance of the next meeting. SJ questioned whether trainees will relate to the title of ECP but is in agreement that the name change makes it more accessible to other health care professions. SW is keen to explore this for pharmacists. AG thinks there will be similar issues for AHPs in the different stages of their career, but the template given by LS is good for others to replicate. AT agreed the name for the ECP has been an issue and this is being worked on. It was noted that SW and AGo will deputise for each other and should support the ECP work as well as AHPs. It was agreed AGo should be invited to the next ECP meeting. DSt made SC aware that rural GP fellows are a useful resource for SIGN as they work in mainland rural communities as well as the islands. MR agreed that remote and rural fellows are fully qualified. This is something which will be addressed in future for the ECP role in SC. The ECP role needs to first be sustainable and strengthened before healthcare leadership can be looked at. SW and LS agreed to have further discussion of what recently qualified means outwith SC. AT made the group aware of future arrangements of meetings of SIGN Council and the subgroups. Meetings were originally held three times per year in person. There will now be six 90 minute meetings of SIGN Council per year. They will remain virtual for the moment but once government guidance allows, face-to-face meetings will be arranged. There should be at least two face-to-face meetings per year as they are valuable. The group was informed that GPAG will be stood down and RM is in agreement of this. With the new way work comes into Evidence Directorate launching, GPAG is no longer needed. Strategy will continue and 3-year and 7-year scopes will be discussed at this or SMT. SMT will meet monthly while Strategy group will meet quarterly. This will allow for less duplication of work and maximise the process. Group members agreed that virtual meetings at an increased frequency will allow the group to do more. But once able, there should be face-to-face meetings too as these have their advantages.	**KA**
6.	**SIGN Executive Business**	
	RJ took council members through each paper. All new work which comes into the Evidence Directorate will be triaged and allocated to the appropriate team. It is hoped the new evidence directorate topic selection process will pick up issues around timing in the work programmes as well as maximise use of resource and technology. The group were updated on the continued work with the Scottish Government Clinical Cell.	

	The guidelines in development paper is a brief report of what has been started in the programme. We have published what was almost ready to be published before lockdown. The Primary Care assessment review has been updated and has the accompanying decision aid which is linked from the SIGN website. We are currently reaching out to GDG members to check availability to allow us to prioritise the restarting of the GD programme. DS went through the methodology paper with the group. Information on GRADE will be brought to the next meeting of SC. The G-I-N virtual conference programme will be sent out once it is agreed. DS will confirm if SC members can attend as well as what may need to sort out the practicalities around registration. RJ took members through the PPI update in the absence of KG. Key points were: 1. Engaging digitally with young people 2. G-I-N PUBLIC 3. New approaches for patient and public involvement within guideline development	**DS**
7.	**Minutes of the meeting held on 3 June 2020 and ROI**	
	AT went through the minutes from the previous meeting held on 3 June 2020, and they were accepted as accurate. The minutes will be available on the SIGN website. AT went through the action point register to review the progress of actioned agreed at the last meeting. The Register of Interests was circulated before the meeting and AT asked anyone who had any changes to be made, to note them to KA. AT explained the new declaration of interest form that is going to be adopted within the evidence directorate, but also noted that forms from 2020 will be transferable. A version of the new form will be circulated to members after the meeting. Those who have yet to make declarations should complete the form.	**KA** **KA**
8.	**Next steps**	
	• How the role of the guideline sponsor works is to be clarified and brought to the next meeting of SC • ECP to be put into the SC business update from the next meeting. Further work is to be done on the ECP • A report on the remobilisation of work is to be brought to the next meeting • Another GDG chair is to attend the next meeting of SC, if possible • Membership of SC is to be discussed at the next meeting	**SMT** **KA/ECP** **RJ** **AT/RJ** **AT/RJ**
9.	**Dates and format of future meetings**	
	4 November 2020 – to take place virtually 2021 dates to be confirmed	**AT/KA**
10.	**AOCB**	
	AT thanked JB again for her work as Vice-chair. AT also thanked LS as this was her final SC meeting as she is unable to make the	

	November meeting. AT acknowledged her valuable contribution to SIGN.	