Scottish Intercollegiate Guidelines Network (SIGN) Council meeting
Wednesday 13 December, Delta House, 2.00–3.30pm

APPROVED MINUTES

Present	
Professor Angela Timoney (AT)	SIGN Chair
Arlene Coulson (AC)	Royal Pharmaceutical Society
Maureen Huggins (MH)	Patient Representative
Dr Roberta James (RJ)	SIGN Programme Lead
Kenneth McLean (KM)	Patient Representative
Dr James Morton (JMo)	Royal College of General Practitioners
Dr Babar Akbar (BA)	Royal College of General Practitioners (obs)
Debbie Provan (DP)	AHP Federation
Ruth Stark (RS)	Scottish Association of Social Workers
Dr David Stephens (DSt)	Royal College of General Practitioners
Michelle Miller (MM)	Portfolio Lead, Improvement Support C
Calum McPherson (CMcP)	Scottish Clinical Lead Fellow, Medical Directorate
Louise Greig (LG)	Interim Lead Health Services Researcher
Dr Steve Mannion (SM)	Royal College of Physicians and Surgeons of Glasgow
Wendy Maltinsky (WM)	Chairperson of the Division of Health and Psychology Scotland
Anthony Byrne (AB)	Royal College of Physicians of Edinburgh
Ross Conway (RC)	Administrative Officer, SIGN
Anju Susan Babu (AB)	Administrative Officer, SIGN
Heather Gray (HG)	Lead Health Services Researcher, Research and information service
Aimie Littleallan (AL)	Project Officer, SIGN
Professor Lesley Colvin (LC)	Royal College of Anaesthetists – SIGN Vice-Chair
Professor Gregory Lip (GL)	Royal College of Physicians of Edinburgh– SIGN Vice-Chair
Dr Sara Davies (SD)	Scottish Government
Karen Graham (KG)	Patient Involvement Officer, SIGN
Yann Maidment (YM)	College of General Dentistry
Professor Phyo Kyaw Myint (PM)	Royal College of Physicians of London
Dr Colin Rae (CR)	Royal College of Anaesthetists
Nauman Jadoon (NJ)	Junior Representative
Matthew Smith-Lilley (MSL)	British Association for Counselling and Psychotherapy

Dr Sreebala Sripada (SS)	Royal College of Obstetrics and Gynaecology
Dr Jan Stanier (JSt)	AHP Federation
Jacqueline Thompson (JT)	Royal College of Nursing (job share)
Sheeba Zahir (SZ)	Royal Pharmaceutical Society Deputy

Apologies: Emilia Crighton, Antonia Torgersen, Katie Hislop, Mattias Rowe, Martin Robertson

1.	**WELCOME AND APOLOGIES**	
	AT welcomed everyone to the in-person meeting of SIGN Council and invited all to introduce themselves. Those attending remotely also introduced themselves. AT remarked that the new members could get a sense of the broad range of disciplines and professions around the table at the SIGN council.	
2.	**DECLARATION OF INTERESTS**	
	AT had a look through the declaration of interest form and observed that it is mostly up to date. She advised that all members have a look at their own names to ensure they are up to date. **Action: All members of Council to review the declaration of interest form and ensure they are up to date. Anyone interested in joining the council to submit their declaration of interest.**	**ALL**
3.	**SIGN COUNCIL BUSINESS**	
	<u>Discussion and agreement about CPD for guideline development group members</u> AT shared the paper on CPD with the group and stated that there has already been a discussion about this internally at SIGN for some time. She explained that it is onerous work on the part of those people who serve SIGN within the NHS in the guideline development groups. Many SIGN guidelines can take a year even with the new rapid methodology and others up to three years or more which includes several stages in guideline development. They wanted to find a way to recognize Continued Professional Development (CPD) and it is suggested this can be achieved by certification. A template has been prepared in terms of what is appropriate and what needs to be recognized. AT explained that she would like to have a discussion with the group on whether each stage in guideline development should be recognized or only the people who are on the guideline development	

	group are to be recognized and also decide the post documentation. AT then opened the floor for discussion. DSt agreed on behalf of the RCGPs and as the lead appraiser for Highland GPs that giving GPs credit would encourage them to join SIGN in the future and it would be great for their appraisals. AB agreed that it is very useful as non-clinical CPD recognition is prized. AT asked if they should consider recognition for various stages of guideline development or have one overall certificate. AT explained that this is because they need to minimize the workload implications within the SIGN team as well. They would need an agreement with the SIGN team on the hours it would take to do each stage. The people at the guideline development group would be able to log on and download the certificate. We would not be doing a second checking process if they were at the meeting or not as they have a responsibility to do that as a professionally registered member. KM agreed with AT. For simplicity it would be good for the certificate to say that the person participated in the guideline development. It rests with the members to explain what they did, what they got from it and how it improved their clinical performance or the knowledge and skills they bring to the area of healthcare they work in. HG asked if there were further breakdowns based on the five different communities with the set of key questions. She suggested it would be good to have them as learning objectives. AT confirmed that this was discussed earlier internally, and they decided it would be quite a lot of work and would be impractical. JMo added that one whole block as a reward was fine, although it would be important if people did do additional work over and above, they could ask for recognition on that. He pointed out that it would be important to be generous with hours as there is a lot of work that goes into this. AT agreed to take on board what JMo suggested. GL echoed what was said by mentioning that it was a big learning exercise as he recently was on one of the guideline groups. He added that there were lots of hours spent, lots of emails and versions of texts to review and edit and that calls for appropriate recognition to be provided. BA asked if they envisaged a system that would calculate the hours. AT replied that the SIGN team would set the standard hours as they have a sense of the time it would take to do each phase or activity of guideline development. And the group would have to agree on it. If anyone feels they did	

	more than the standard hours, they could discuss it with Angela. JSt shared that she had worked on a guideline development group which involved a phenomenal amount of work and at the end received a letter specifying which sections she contributed to. As AHPs it was easy not to get that recognition, but getting it was helpful for CPD. She stated that it is a positive thing to recognize CPD. At the end of these recommendations AT concluded as below: • One certificate is sufficient to cover the whole guideline. • There would be different hours depending on the type of guidelines being produced, and this would be reviewed in a year in terms of lessons learned and any changes or revisions needed. • In setting the number of hours of CPD the amount of time outside meetings would be fully recognised.	**AT and SIGN team**
4.	**PATIENT INVOLVEMENT**	
	<u>Patient and Public Involvement highlights</u> KG presented the paper on patient and public involvement highlights. Please refer the paper for details on activities undertaken for improving the processes for patient and public involvement at SIGN, the publishing of the dementia guideline and the feedback from the GIN conference. MSL commented on the GIN conference feedback. He said that they would heavily support expanding the involvement of experts by experience in shaping guidelines, particularly from a psychological therapies' perspective. He had worked extensively worked with NICE on the development of the Depression and adult guideline most recently. It took several years and one of the biggest critiques that came in not only from them as a professional membership organization but also from service users was the lack of acknowledging the value of patient choice and there not being one single best answer in relation to psychological therapies for the treatment of mental health conditions. MSL would support and help with anything that expands that choice and considers individual preference. KG thanked him for that support and handed over to the PPI partners. **<u>Update on current issues and developments</u>** KM gave a brief update on PPI. He and Martin attended SIGN at 30 and it was an opportunity to engage with many different professionals from various disciplines during the	

	day. They found the event to be very helpful. KM was a volunteer in the GIN conference and in two particular sessions - One was the fundamentals, which was consumer involvement in guideline development, which Karen and Jane Cowl from GIN public presented in and the other one was a plenary session on involving state holders, in which Roberta was co-chairing and they had a fantastic response to that particular plenary. KM encouraged all members of SIGN who could, to take part in such sessions. MH added that AC invited her to the NHS Tayside Partnership Forum where she talked about what it was like to be on a guideline development group, how she got on SIGN council and what it was like to be on the SIGN Council which people were very interested in. They were particularly interested in the buddying program and the suggestion of a glossary of terms for those who go on a guideline group. MH is a member of the National Dementia Carers Action Network, which is part of outside Scotland and the animation group is a subgroup of that. They create animations about issues facing people with dementia and their carers, and about brain health. They had a meeting and were discussing what future animations they could do. They envisaged picking out topics that perhaps people within the Scottish Dementia Working Group and the National Dementia Carers Action Network have experience of and making animation around that and not sort of quoting verbatim but acknowledging SIGN. MH asked if SIGN would approve of that and whether there were any comments around it before they started. AT asked for comments from the group. AB commented that the animations would be very helpful, and they should think about the audio version for accessibility for the visually impaired as a norm and not as an exception. Sometimes animations might be useful for guidelines for children. MM mentioned to MH that they have huge networks of practitioners and others that they are linking in with across Scotland from the dementia perspective and if MH wanted them to share the animations through their networks, they would be happy to do that. Within the dementia SIGN guideline there were topics like pre-death grief for example that came out strongly within the guideline. It was a new area and she felt if there was experience in the group of that they should be promoting it much more. MM was happy to support MH's proposal.	

	RJ also agreed that they could get the communications in regarding this, and the council would support the proposal. AT summarised the action points as below: • The council is very supportive of MH's proposal. • AB's suggestion to think of audio visual as well in terms of other guidelines to be considered. • In the future MH to get in touch with Roberta and the team in Communications KG spoke on behalf of Martin Robertson (Patient Representative) as he was not present at the meeting. Martin wanted to make Council aware that he is on the Core Indicators Task and Finish Group Scottish Government, and he had suggested dementia be added to that. He would have liked to see if SIGN could get people to take part in the Delphi study for that. KG said that this is something that will be coming to SIGN council and to anyone else who would be able to help with the process. AT confirmed she was more than happy to help and asked KG to send it to her so she could get it distributed out through the networks.	
5.	**UPDATE FROM EVIDENCE DIRECTORATE**	
	HG provided the evidence directorate update as Safia was unable to attend. **Right Decision Service (RDS)** - HIS has now taken on leadership for the RDS – a first-for-Scotland project delivering a suite of UK Conformity Assessed (UKCA) marked decision support tools. It had its official soft launch on 20 November 2023. Training is ongoing for Research and Information Service (RIS) staff, Information Scientists in particular. **Accessibility** – The directorate has developed 'principles of accessible content', and a checklist is being developed against which all the directorate's products will be reviewed. RIS is running accessibility training for its team in February 2024. **Sustainability** – This is being evaluated across the directorate's ways of working and as an embedded part of its methodologies. The directorate has developed a draft 'sustainability statement of intent' and is looking as to who to best coordinate its sustainability work. **Anti-racism and equality, diversity and inclusion (EDI)** – The directorate partnered with the Race and Ethnicity Network in HIS in November to run a session on anti-racism during critical appraisal run by Ramona Naicker.	

	Discussions are being held during methodology groups in HIS to consider how anti-racism and EDI can be better embedded in its methodologies. In addition, Trial Forge have developed and are piloting a randomised controlled trial EDI extraction table about participant characteristics from Trial Forge; this is being reviewed and considered by RIS teams. **Evidence directorate strategy** – The directorate's strategy has been updated for 2024-26 and will soon be launched following staff consultation.	
6.	**PRESENTATION**	
	Supporting implementation of dementia SIGN Guideline. Michelle Miller, Portfolio Lead: Community Care and Dementia, Healthcare Improvement Scotland Michelle Miller's presentation – Focus on Dementia has been included in the papers. Please refer. After the presentation the floor was opened for questions. BA commented that he was hugely impressed with the six high impact changes that MM had listed for patients with dementia in hospital. He asked if they have anything similar for people with dementia in care homes as that is something that as GPs they tend to struggle with, especially those that come into interim placements in care homes. MM explained that a dementia and delivery plan had been developed on the back of the dementia strategy that had been launched earlier this year. The Chief Executive of the Care Inspectorate asked if MM could send the quality improvement framework for reducing stress and distress to her to look at it from a care home perspective. They are very interested in seeing where the opportunities are to learn from each other. Within some of the earlier dementia improvement work that has informed some of their work around dementia in hospitals, one of their test sites were in a care home and they used an approach called experience-based code design. The teams themselves were observing what was happening on a day to day and basis and making improvements based on their observations. That had been some of the foundation of the toolkit work that they are developing. MM mentioned there was lots of transferability in what they were doing in hospitals and care homes and there was much to learn from the care homes as well in terms of meaningful activity.	

	DSt explained that as a GP what he found quite difficult about the guideline is that it didn't give him very key indicators of what he should do for an assessment and, more important, it didn't go into pharmaceutical management, which was not done because NICE has done that. He further added that there doesn't seem to be any guidance as to where a GP should look for pharmaceutical guidance both for treatment and for distressed patients. DSt asked if we were likely to be moving in that direction with Health Improvement Scotland. RJ answered that there has been a lot of discussions over months on what should be the remit of that guideline even before they started working on it. Also, where they could add value and not just duplicate what is in the NICE guideline. RJ thinks the references towards the NICE guideline are helpful and specific. Although it has not been particularly a direction of travel, they have been trying to make use of other really good quality recent guidelines rather than doing everything from scratch themselves. It could be something that they may do again in the future and have done in the past. AT and RJ were looking at the epilepsy in children guideline and very similarly there was a recent guideline that would refer to from that guideline in which they did the evidence reviews on areas where they thought they could add value and not just duplicate the NICE guideline. AT added that the key thing was to add value. It was a difficult guideline and in terms of determining the scope they got a lot of comments about bits that people wanted - learning disabilities, Down syndrome but they were out with the scope and in terms of the diagnostic test evidence was not brilliant. She will be keeping DSt's suggestion in mind. . MM updated that the delivery plan for the sementia strategy with a big focus on Brain Health Scotland was launching in February 2024 and she would keep the group informed of any updates from the Scottish Government. GL added to DSt's comments because he believes the SIGN dementia guideline also includes assessment of the qualitative literature as well. That is highly relevant in terms of delivering care to people with dementia. GL continued to speak of other plans – one of the remits as to the reach of the guidelines was to have a synopsis of the guideline in one of the journals and some of the specific chapters relevant to some specialty journals too because it was a well conducted systematic review of the appraisal of the evidence to publish some of those as standalone articles as well. It has done a whole lot of good work and needs to	

	be publicized into the scientific literature in that it would give more publicity and credence to the guideline per se. AT concluded that effectively they were talking about the implementation at the front line, but they have also been trying to get the guideline used as much as possible by getting them into the academic literature, getting them peer reviewed to make them open to others and available to be cited. The whole thing is part of what they are trying to do under widening the reach of SIGN guidelines. KM asked a question in terms of the delivery pattern and implementation - Does the guideline group have any comments on how they can work upstream such as early intervention, early diagnosis just as they do in other areas of healthcare. MM answered that this was the work Brain Health Scotland were taking forward currently and the very first Test of that Brain Health Clinic was in NHS Grampian through their public health team launched two weeks ago. In the dementia strategy it says there will be an evaluation of that work to support wider sharing. MM did some work from a quality improvement perspective about people with male cognitive impairment in one of the GP practices in Edinburgh. It includes how people who were having early signs of cognitive impairment could be supported and supported to get a diagnosis as well. MM told KM that there will be an evaluation of that work as well and he could keep an eye on it. KM concluded that this brain health work will be the most relevant work to look at currently and it will be an exciting emerging area. DP asked if those that were involved in the guideline development group would be considered as co-authors or acknowledged. GL confirmed that they would be considered as co-authors. In the synopsis, the guideline writing group will be listed in terms of the contributions. RS asked about the structural reforms taking place in the National Care Service and how it could affect the SIGN guideline being delivered and whether frontline staff who will facilitate these reforms have been considered in terms of delivery of this guideline. MM explained that they were working with people in health as well as social care and with the health and social care partnerships to support implementation. They have set up an advisory group for dementia and frailty chaired by one of the IJB Chief Officers in Scotland. The following week they will be having a session with the advisory group to discuss what some of the barriers and opportunities are and how things are going for them currently, not just in terms of the National Care Service but	**GL**

	around dementia and frailty as well. They expect this will give them some good insights and opportunities to influence because the group is highly influential with wide reaching networks, as does the SIGN Council as well. AT thanked them and assured RS and MM that their comments are noted and relevant.	
7.	**SIGN EXECUTIVE BUSINESS**	
	Update on the guideline development programme RJ presented the report on the guideline development programme. Will be included in the minutes. DSt asked if the sustainability of inhalers can be included in the scope of the asthma guideline as it is an important thing that GPs would like to know about in terms of evidence and sustainability and CFC's. RJ confirmed that it was updated about a year ago and it was triple badged as well. They will be looking at it again once the guideline is published. It will be updated if it needs to be, and it will be a standalone piece of work for sustainability. **Update on asthma collaboration with BTS/NICE** RJ explained what they were proposing to do with SIGN 158. They will be making guideline content available for when the Asthma guideline is published in October. They are still working through how it will be presented and building some sort of platform pathway type thing so that all their BTS content and NICE content can be found from the same place. Now they have this in one guideline as a PDF. Their proposals are from the scoping to revalidate acute asthma because they did not find much new evidence there. They will be refreshing the non-pharmacological management and occupational asthma. They are hoping to get that in time for October, but the next bit will be a new standalone guideline that would cover sections on difficult and severe asthma. They would have a new set of key questions and a new approach, and they will use all of the new information to update the patient booklet. AT concluded that effectively BTS and SIGN have agreed to this. AT and RJ wanted to be sure that SIGN Council are content with these proposals. Council agreed support **Update on progress with "35 in 5" and SIGN@30 action plan**	

	RJ presented the report on the guideline development programme. Will be included in the minutes.	
8.	**METHODOLOGY**	
	Update on progress and next steps for SIGN 50 SIGN 50 is the methodology manual last updated in 2019. RJ and the team have been trying to get it updated during the last year. RJ will be sending a rough draft out with the minutes of this meeting and hopefully in the new year if the group can send back any comments, queries, questions or ideas they can work through them and get it signed off at the next SIGN Council. RJ reiterated that any comments on it will be very gratefully received.	**RJ**
9.	**MINUTES** of the meeting held on 13 September	
	Check for accuracy and approve The minutes of the last meeting were reviewed and approved. **Review the progress of actions agreed at the last meeting** **Declarations of Interest** – They will be asking again in January 2024. **Sustainability presentation to be shared** – Done. Sustainability work is now going to move into the work happening in the Evidence Directorate. JMo and AT need to meet to discuss the next steps. **Landing Page** – in progress. **Workstreams – Methodology** - volunteers requested/invitations to be issued for first meeting – They are doing that separate work on SIGN 50. **Draft a proposal for managing vacancies, with particular attention to Primary Care** – in terms of vacancies, they have had very good responses from the Royal Colleges. AT going to try to meet with the President of the Academy sometime in the next couple of months, to check out if they are up to speed with what's important for them as well.	**All** **AT/RJ/JMo**

	In terms of the sustainability work as in the Scottish Parliament, with the RCGP and the Royal Pharmaceutical Society, RJ will be going there on behalf of SIGN.	
10.	**DATES AND FORMAT OF FUTURE MEETINGS**	
	What was originally done was SIGN Council met three times a year for half day long day meetings and during COVID, they were on teams and it was changed to six 90-minute meetings which alternated between a business meeting and a development meeting during the last year. Then they had four meetings, eleven in person, one hybrid, and two virtual. If the group would like to continue that for the next year then it can be set up again. The group agreed. AT thanked all for their contributions.	
11.	**AOCB**	
	SS asked if there were any guidance in the pipeline for obstetrics and gynaecology. AT and RJ confirmed that Perinatal disorders is just coming out and the other one that has been a long time in development, is diabetes and pregnancy which will be out in early 2024. Traditionally they have not had many obstetrics and gynaecology guidelines. RJ mentioned that topic referrals will be accepted. AB asked if SS knew anything about the stroke and pregnancy guideline, which somebody in Edinburgh was trying to coordinate. SS had not heard this was coming up and it could be a very small proportion of patients. If they had public referrals because of significant incidents, it may sit within the remit of stroke itself, she assumed. GL added it must be part of wider stroke guideline, because it was almost subset a bigger programme. AM mentioned they were contacted because one of their Neurologists were going to represent their area and it was like a neurology and obstetric joint project. AT asked if AB would like to put the council in touch with them. He agreed to connect them. AT concluded by wishing everyone a Merry Christmas and Happy New Year and looking forward to seeing everyone again in 2024.	**AB**