Scottish Intercollegiate Guidelines Network (SIGN) Council meeting

Wednesday 21 June, Delta House, 1.30–3.30pm

APPROVED MINUTES

Present	
Professor Angela Timoney (AT)	SIGN Chair
Dr Anthony Byrne (AB)	Royal College of Physicians of Edinburgh
Ms Arlene Coulson (AC)	Royal Pharmaceutical Society
Ms Halima Durrani (HD)	Patient Representative
Ms Maureen Huggins (MH)	Patient Representative
Dr Roberta James (RJ)	SIGN Programme Lead
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
Dr James Morton (JMo)	Royal College of General Practitioners
Dr Alan Ogg (AO)	Faculty of Clinical Radiology
Ms Debbie Provan (DP)	Allied Health Professional, Dietetics
Dr Ainharan Raveendran (ARa)	Royal College of Obstetrics and Gynaecology - deputy
Mr Martin Robertson (MRo)	Patient Representative
Mr Duncan Service (DS)	Evidence Manager, SIGN
Ms Ruth Stark	Scottish Association of Social Workers
Dr David Stephens (DSt)	Royal College of General Practitioners
Dr Antonia Torgersen	Royal College of Pathologists
In attendance	
Mrs Kirsty Littleallan (KL)	Executive Secretary to SIGN Council
Observers	
Ross Conway (RC)	Administrative Officer, SIGN
Heather Gray (HG)	Lead Health Services Researcher, Research and information service
Alex McEwan (AMc)	Scottish Government
Moray Nairn (MN)	Programme Manager, SIGN
Ailsa Stein (ASt)	Programme Manager, SIGN
Madeleine Tse-Laurence (MTL)	Programme Manager, SIGN
Apologies	
Professor Lesley Colvin (LC)	Royal College of Anaesthetists – SIGN Vice-Chair

Professor Gregory Lip (GL)	Royal College of Physicians of Edinburgh– SIGN Vice-Chair
Mr Mohammed Asif (MA)	Royal College of Surgeons of Edinburgh
Ms Donna Brough (DB)	Royal College of Midwives
Ms Katie Colville (KC)	Royal College of Midwives
Ms Heather Connolly (HC)	British Psychological Society
Dr Emilia Crighton (EC)	Faculty of Public Health Medicine
Dr Shridevi Gopi-Firth	Royal College of Psychiatrists
Katie Hislop (KH)	Scottish Government
Dr Sara Davies (SD)	Scottish Government
Mrs Ann Gow (AGo)	Director of Nursing, Midwifery and Allied Health Professionals (NMAHP), Healthcare Improvement Scotland
Mrs Karen Graham (KG)	Patient Involvement Officer, SIGN
Dr Nauman Jadoon (NJ)	Early Career Professional
Tosin Jegede (TJ)	Royal College of Nursing (job share)
Dr Ross Junkin	Royal College of Anaesthetists
Dr Vivienne MacLaren	Royal College of Radiologists - oncology
Mr Yann Maidment (YM)	College of General Dentistry
Mr Steve Mulligan (SMu)	British Association for Counselling and Psychotherapy
Professor Phyo Kyaw Myint (PM)	Royal College of Physicians of London
Ann Pullar (AP)	Scottish Government
Dr Christopher Pell (CP)	Royal College of Psychiatrists
Dr Safia Qureshi (SQ)	Director of Evidence, Healthcare Improvement Scotland
Dr Colin Rae (CR)	Royal College of Anaesthetists
Dr Matthias Rohe (MR)	Early Career Professional
Mr Matthew Smith-Lilley (MSL)	British Association for Counselling and Psychotherapy
Dr Sreebala Sripada	Royal College of Obstetrics and Gynaecology
Dr Jan Stanier (JSt)	Allied Health Professional, Speech and Language Therapy
Ms Jacqueline Thompson (JT)	Royal College of Nursing (job share)
Professor Steve Turner (ST)	Academy of Colleges
Dr Simon Watson (SW)	Medical Director, Healthcare Improvement Scotland
Ms Sheeba Zahir	Royal Pharmaceutical Society

1.	**WELCOME AND APOLOGIES**	
	AT welcomed everyone to the in-person meeting of SIGN Council, and asked all to introduce themselves. Those attending remotely were welcomed; Martin Robertson, Kenneth McLean and Kirsty Littleallan.	
2.	**DECLARATION OF INTERESTS**	
	Members of Council were thanked for completing their declarations of interests. **Action: members of Council with outstanding declarations of interests are to send their declarations to KL.**	**ALL/KL**
3.	**SIGN COUNCIL BUSINESS**	
	<u>Feedback on implementation of SIGN@30; update on SIGN@30 symposium</u> The SIGN@30 symposium is scheduled to take place on Tuesday 19 September and is free to attend. Members of Council are encouraged to attend as well as share the invite and programme with colleagues. The event will be a recognition of SIGN, its past achievements and where it's going. The event is in person; it will have three parallel workshops and a debate to conclude the day. A refresh of the SIGN branding has been agreed as part of SIGN@30. The refresh has been accepted by the Executive Team and the Quality Performance Committee. The brand statement is SIGN makes sense of evidence. The goal of 35 guidelines in 5 years is part of the SIGN@30 work. <u>Sustainability short life working group</u> The group consists of people outside of SIGN Council as well as SIGN Council members. The environment and sustainability are becoming increasingly important, with healthcare contributing to 5% of global emissions. At the first meeting the group agreed to the drafting of a sustainability framework, which would be the first to be brought into a guideline organisation. The framework is to help guide how to test and measure sustainability. It will establish principles to be guided by in putting together topic proposals and in guideline development. A meeting has taken place between JM and Koonal Shah, Associate Director – Science Policy and Research Programme, NICE to discuss their approach to sustainability. AT reiterated the importance of sustainability, the issue of climate change and that this must be taken into	

	account for guidelines in the future. There is a balance to be considered between active treatment and public health. The working group has people on it from other public bodies who have an interest in social prescribing. There is a need to work out what the role of guidelines are in this area. Patients don't always have the courage to challenge taking tablets/being prescribed tablets by a healthcare professional. There is an increasing need to look at how these difficulties could be overcome and get as many people behind doing so. As the guideline body for Scotland, SIGN should lead in the debate and provide support in the implementation of sustainability, providing the evidence base for clinicians and the people of Scotland to use. <u>Discussion about role and responsibility of SIGN Council members in recruitment to guideline development groups</u> AT outlined the expectations of SIGN Council members in guideline recruitment. The current nomination process through SIGN Council is not working, with requests from SIGN team members continuously not met. There is a risk of subject bias if the Programme Managers only receive nominations from a guideline group chair or other members of the group TB suggested the use of monthly newsletters or journals. It was countered that the audience for both is select and there is a risk of missing the submission deadline for both. It was agreed the timescales for guideline group recruitment likely won't work with this suggestion. The programme managers will need to look at the feasibility of how early Council can be contacted about guideline group recruitment or consultation. The current process for group recruitment has the chair confirmed, the date of the first group meeting agreed and then invitations to potential group members are nominated and invited. Earlier engagement with Council on all guideline group activity including recruitment consultation and peer review was agreed. The SIGN Executive doesn't have the capacity to follow a process which involves application and formal interview. SIGN is intercollegiate and those who represent Colleges or other organisations can reach out to those interested in guideline work on the SIGN team's behalf. This gives reassurance to the member that those suggested are suitable. The Programme Managers	

	make sure there is a good sills and geographic mix on guideline groups and offer peer review to those not selected. SIGN Council were given recommendations to increase engagement in group recruitment: 1. Explore ways to gain better engagement with recruitment through SIGN Council representatives. 2. Establish a landing page on the SIGN website when preparations for a new guideline start. The landing page would include the remit of the guideline, a list of specialties sought and how many representatives are likely to be needed for each. Criteria for the selection process, ie multidisciplinary, geographical and equalities diversity, should be included. Council members indicated they would like enough advance notice of recruitment. The landing page on the SIGN website was welcomed and Council members felt it would be useful as it would give more information about a group. It will give Council members something to refer to with prospective guideline group members during a recruitment process. Expressions of interest can be gathered by the SIGN Executive from the use of the recruitment landing page. JS and DP are working with the AHP federation (AFPFS) on better engagement with them and requests from SIGN. GH indicated this new process by SIGN is transparent and will be useful in signposting people to and aligns with the clinical care and governance process. Recruitment of those with lived experience is being considered and worked on by KG and RC. The suggestions on engagement for recruitment will be taken on board in this process. RJ made Council members aware that the new recruitment process using a landing page on the SIGN website would be trialled using the Chronic Pain guideline. The link to the notes of interest for Chronic Pain is to be posted on the SIGN Council MS Team. An update to Antibiotic prophylaxis in collaboration with the Scottish Antimicrobial Prescribing Group in HIS is upcoming for group set up and recruitment. The recruitment landing page needs to be explicit about what it is, what is being asked for and what is expected of volunteers and group members . **Action ALL SIGN Council to review the use of the recruitment landing page on the SIGN website over the next year.**	

	Action AT to meet with the Scottish academy about how best to do guideline group and peer review recruitment. <u>Feedback on progress with widening the reach; collaboration with NHS Research Scotland</u> The memorandum of understanding (MOU) for collaborations details the benefits to an organisation in entering a collaboration with SIGN, well as the benefits to SIGN in taking part in the collaboration. Each collaboration project will have its own MOU, as they will be tailored for each collaboration. The collaboration with NRS has been signed off and renamed a term of reference as per their request. **Action: the NRS TOR is to be shared with SIGN Council.**	**ALL** **AT** **KL**
4.	**PATIENT INVOLVEMENT**	
	<u>Patient and Public Involvement highlight report</u> Plain language version of dementia guideline has begun with people with dementia being invited to a meeting to discuss the first draft. The care of deteriorating patients guideline summary is to be produced rather than a full patient booklet. This approach is being taken after discussion with members of the guideline group. <u>Update on current issues and developments</u> The patient and public involvement (PPI) reps who were present at SIGN Council introduced themselves and gave individual updates on the PPI work the Public involvement Advisory Group (PIAG) has been doing. MH indicated they had been working on how to improve and fully integrate PPI involvement in SIGN Council. How best to involve those with lived experience, patients, carers and third sector bodies on guideline groups is being worked on. A guide for those volunteering to work with SIGN which will include the more practical parts of SIGN 100 is being created for a better understanding. This will include a glossary of the terms or acronyms people are more likely to hear at SIGN Council or at guideline groups. A role description for lived-experience reps is being worked on to make it clearer and outline what is expected of them in their role. Guidance for guideline group chairs on how to include a lay person in their group is to be used. Members of a guideline group will be discouraged from using acronyms at group meetings with lay rep members as this can make things difficult for them. A SIGN 100	

	module to cover the rest of the information in SIGN 100 is to be rolled out and can be worked through by people at their own pace. HD is contributing to the SIGN 100 update using their experience as a carer and is suggesting changes to make it easier to understand. MRo is involved in the plain language version of the dementia guideline. It isn't clear from the guideline what the PPI involvement was. KM is involved in GIN public and how members of the public are recruited to guideline work. A discussion has begun on sustainability in the work on GIN public. GH made Council members aware of the Community Engagement audit on the inclusion of PPI in a team's work. The work of SIGN PPI was rated highly. The HIS perspective is adopt and share the work being done.	
5.	**SIGN EXECUTIVE BUSINESS**	
	<u>Update on the current SIGN guideline programme and proposed work programme for 2023/24 to achieve our goal of 35 in 5</u> RJ made Council members aware of publication of guidelines since the March Council meeting. This includes the revalidation of SIGN 156: Children and young people exposed prenatally to alcohol, SIGN 155: Pharmacological management of migraine and the National clinical guideline for stroke for the UK and Ireland. The 2023-24 programme has been decided, the 2024-25 programme has almost been finalised and the 2026-27 programme has been tentatively planned. The priorities around what is planned may need to change depending on what other work comes to SIGN. The guideline programme will be made available on the SIGN website. AT confirmed that we would be explicit in what is coming, what input is needed and the landing page which was discussed earlier will be used for recruitment.	
6.	**PRESENTATION**	
	<u>Progress on abbreviated guideline development methodology.</u> Ailsa Stein (AS) gave a presentation on the adopt/adapte approach to guideline development that has been used in the update to perinatal mood disorders guideline. The Australian COPE guideline was used. • Internationally a move to sharing work rather than duplicating, so there are validated ways of sharing/adopting/adapting. Can be as resource intensive as starting from scratch so we are using the principles but trying various ways to produce guidance more efficiently.	

	• Benefits: faster, much fewer resources needed. People with lived experience are equal partners in the process. • Worked because mostly consensus recommendations and good practice points so easier to adapt wording, perhaps, than evidence-based recommendations. Less engagement from group, but still able to produce the guideline because we have ready made recommendations on which we can consult more widely. • Cons: very little discussion of background evidence. • Not tailor made for Scotland. There were some things that we couldn't include and may have approached differently if using our traditional approach (eg Stirling Anxiety Screening tool, context for use of tools. • MHRA safety advice on some therapies differs from Australian advice. MN gave a presentation his experience of using the new methodology for the creation of the guideline on type 1 diabetes. • working with subgroups to agree adaptations (investigating copyright implications of this step) • group writing "contextual narrative" to support each recommendation which will give information relevant to implementation and making it as aligned with the Scottish context as possible, while trying to address issues they have raised during consensus voting. • content will be packaged as Decision Support tool via RDS (June) • public consultation (August) The benefits of this approach include reduce the workload of the Evidence directorate Research and Information Service team and healthcare professionals. There is quicker delivery of the final product and its use is appropriate for less integrated topics. There are cons to the new approach as there isn't a comprehensive scope or inclusion of PPI. As there is no evidence review we cannot assure safety or quality of recommendations. There were concerns from Council members about safety and the fact that this cannot be compromised in any methodology used. Council members were assured that there would be a balance between quality and safety risks in any guideline produced using the new methodologies.	

	RJ highlighted that less and less is done by guideline group members because of their capacity. Clinical input is only asked for at certain points in the development of guidelines. More is done by the SIGN and other HIS teams to get the guideline work done. There are multiple ways clinical safety is assured in Evidence Directorate processes. Primary evidence isn't always used in products and appraisal methods used by RIS team for evidence gathered for use to ensure safety. The guideline group members have sight of the evidence used in the new methodologies but we must be open about the limitations of these new methodologies. **Action this item will come back to Council as new guideline methodologies develop.**	

7.	**METHODOLOGY**	
	Action this point to be brought back to September meeting.	**KL**
8.	**HIS EVIDENCE UPDATE**	
	The update from HIS Evidence wasn't given at the meeting.	
9.	**MINUTES**	
	March minutes approved as accurate and they will be loaded to the SIGN website.	**KL**
10.	**AGREE KEY POINTS OF MEETING**	
	1. PIAG work. SIGN Council recognise the good work of PIAG and they are to continue this. 2. Good insights into the new methodology. It has its pros and cons and SIGN Council will keep sight of it. 3. Sustainability and work of short life working group being chaired by JM.	
11.	**DATES AND FORMAT OF FUTURE MEETINGS**	
	Wednesday 13 September 2023 – virtual Tuesday 19 September - SIGN@30 RCPE conference Wednesday 13 December 2023 – hybrid, Gyle Square or Delta House	