



The Intensive Care Society

SSQ Committee Guideline Policy

2010



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ICS SSQ Committee: Guideline Policy

1. Introduction

1.1 Guidelines and statements that promote the delivery of the highest quality of critical care are key to the achievement of the objectives of ICS. The production of guidelines and statements of best practice are the responsibility of the ICS Standards & Safety and Quality of Care Committee (SSQ). This statement sets out the general principles that govern the production of ICS guidelines.

1.2 ICS guidance is produced by Guideline groups selected and approved by the ICS SSQ Committee with advice from the ICS membership and Council. The work of guideline groups is supported by ICS Head Office staff. The Society does not seek external funding for the production of its guidance.

2. Initiation of the guideline production process

2.1 Proposals for the production of a guideline are considered by the SSQ Committee, in consultation with the ICS council.

2.2 Updates/revisions to existing guidelines will be considered by the SSQ on a regular basis with the intention that existing guidelines are updated every 3-4 years (or sooner if the evidence base for the guideline is known to have changed). The chair of the guideline group (or another nominated individual) will be asked to review the guideline on a regular basis to advise the SSQ on the timing for an update to be undertaken.

3. Composition of the Guideline Group

3.1 The SSQ is responsible for issuing the invitation to the chair of the proposed guideline group. The invited individual must complete an ICS Declaration of Interest form and any potential conflicts of interest considered by the ICS Hon Secretary and the SSQ before further work is undertaken.

3.2 The Chair of the Guideline Group will submit an outline of the proposed scope, membership and timetable for the production of the guideline for approval by the SSQ. The outline should explicitly state the aim of the guideline or statement, as well as the intended users and the scope should make clear which areas are covered and not covered by the guidance. The guideline group should include a member of the SSQ and a lay/patient representative.

3.3 All guideline group members must complete the ICS Declaration of Interest form prior to the first meeting of the group.

3.4 Guideline Authorship: The Chair of the Guideline group will be asked to identify the members of the group who will constitute the "writing committee" for the Guideline, and who will be named as authors. This should be done as early as possible after the Guideline group starts work, and be made clear to all members of the group to avoid misunderstanding at a later date. While it is likely that for some Guidelines, the number of named authors may be small (ie two or three), for others, the list of authors named may run to 10 plus, reflecting those that should be recognised as authors of the work.

The authorship of an ICS guideline should be given in the following form:

A Smith, B Jones, C Black, D Grey, on behalf of the ICS Transfer Guideline Group

The full membership of the Guideline group should then be listed in a section at the start of the Guideline.

4. Guideline Preparation

4.1 ICS guidelines are based on the best available evidence. There is a range of guideline methodology and the guideline group should select the most appropriate methodology for the subject area concerned. In doing so guideline groups should note that the system used must adhere to the AGREE criteria (www.agreecollaboration.org) – see Appendix. Further guidance on guideline preparation is provided in the Appendix. In cases where there is insufficient evidence to underpin the production of the guideline, but where the subject merits guidance for good practice, the SSQ Committee may approve the production of a ICS Statement of Good Practice. The methodology followed in the production of the Statement should be made clear. The guideline/statement should include clear recommendations with an indication of the grade of the recommendation (appropriate to the methodology used in consideration of the evidence).

4.2 The budget for the production of the guideline should be agreed with ICS Head Office before work begins.

4.3 The Chair of the Guideline Group will write to all potential stakeholders in the final guideline to invite their organisation to either nominate a representative to sit on the group (or to nominate a contact to whom information on the draft guideline can be directed as work progresses). See Appendix 3 for list of potential stakeholder organisations and template letter.

4.4 The timetable for the production of the guideline should be set out at the start of the group's work. In general production of a full guideline should be completed within 2 years of approval of the outline by the SSQ, and updates to existing guidelines should be completed within 12 months. Progress reports on the work of the group should be provided for SSQ meetings (4 times a year).

5. Review and Completion of the Guideline

5.1 The final draft guideline should be submitted to the Chair of the SSQ for comment and discussion at a meeting of the SSQ. The chair of the guideline group will be invited to be present at that meeting. Peer review will be undertaken by the SSQ who may invite key expert reviewers to provide comments.

5.2 Following incorporation of comments from the SSQ, the final draft of the guideline should be placed on the ICS website for open consultation (and if the timing allows, an open meeting held at an ICS Summer/Winter meeting). The final draft document will also be sent to stakeholders (relevant organisations/Royal Colleges) inviting comments as well as endorsement/approval.

5.3 Format of guideline: The final draft of the guideline will include a summary of recommendations, the full text of the guideline, bibliography, membership of guideline group and declarations of interest where appropriate. The following additional material is also required: summary tables/quick reference guide; information for patients; audit questions. Areas for further research (presented in EPICOT format <http://www.bmj.com/cgi/reprint/333/7572/804.pdf>).

5.4 Copies of the guideline evidence tables, references and literature search records together with notes of the group meetings should be forwarded to ICS Head Office for archiving.

5.5 The Society may be approached by other groups with an invitation to endorse, or in some cases produce a joint guideline. In such circumstances the Society would expect to nominate at least one representative to be a member of the Guideline group, and the draft Guideline should be submitted for comment and consideration by the ICS SSQ Committee and Council before endorsement/approval is confirmed.

6. Publication and Dissemination

6.1 The guideline (or update to an existing guideline) will be published by the ICS. An electronic copy of the guideline will be available on the ICS website following publication. The members of the guideline group will be listed as authors of the guideline, under the auspices of the ICS SSQ Committee (see 3.4 above).

6.2 ICS Head Office, in consultation with the chair of the guideline group and the SSQ chair, will oversee the press and media coverage associated with the publication of the guideline.

6.3 ICS Head Office will arrange for a copy of the guideline to be sent to the RCP London Clinical Effectiveness forum with the AGREE rating.

6.4 ICS Head Office will arrange for relevant associated materials (educational documentation, audit tools and patient information) to appear on the ICS website.

Appendix 1: Appraisal of Guidelines for Research and Evaluation

www.agreecollaboration.org

The purpose of the Appraisal of Guidelines Research & Evaluation (AGREE) Instrument is to provide a framework for assessing the quality of clinical practice guidelines. The AGREE criteria for assessment of guidelines includes judgements about the methods used for developing the guidelines, the content of the final recommendations, and the factors linked to their uptake. The AGREE Instrument assesses both the quality of the reporting, and the quality of some aspects of recommendations. It provides an assessment of the predicted validity of a guideline, that is, the likelihood that it will achieve its intended outcome. It does not assess the impact of a guideline on patients' outcomes.

The 23 criteria are summarised below:

Scope and Purpose

1. The overall objective(s) of the guideline should be described in detail and the expected health benefits from the guideline should be specific to the clinical problem.
2. A detailed description of the clinical questions covered by the guideline should be provided.
3. There should be a clear description of the target population to be covered by the guideline.

Stakeholder involvement

4. The guideline development group should include individuals from all the relevant professional groups.
5. The patients' views and preference should be sought.
6. The target users of the guideline are clearly defined.
7. The guideline has been piloted among target users.

Rigour of development

8. Systematic methods were used to search for evidence
9. The criteria for selecting the evidence are clearly described.
10. The methods used for formulating the recommendations are clearly described.
11. The health benefits, Side effects and risks have been considered in formulating the recommendations.
12. There is an explicit link between the recommendations and supporting evidence.
13. The guideline has been externally reviewed by experts prior to its publication.
14. A procedure for updating the guideline is provided.

Clarity and Presentation

15. The recommendations are specific and unambiguous.
16. The different options for management of the condition are clearly presented.
17. Key recommendations are easily identifiable.
18. The guideline is supported with tools for application.

Applicability

19. The potential organisational barriers in applying the recommendations have been discussed.
20. The potential cost implications of applying the recommendations have been considered.
21. The guideline presents key review criteria for monitoring and/or audit purposes.
22. The guideline is editorially independent from the funding body.
23. Conflicts of interest of guideline development members have been recorded.

Appendix 2: Further information for guideline groups; preparation of the guideline

1. Convening the guideline group: The development group overseeing the formulation of the guideline must be explicitly multidisciplinary and include patient representation. The size of the group and the number of meetings will be determined by the scope of the guideline. Consideration must be given to involvement of stakeholder organisations (see Appendix 2).
2. The information retrieval strategy: A search strategy must be developed to search for evidence. This will include search terms and sources to be consulted such as Medline/US National Guideline Clearing House/Embase. Both ICNARC and The Centre for Reviews and Dissemination at York University may provide assistance with literature searches and guidance on formulating search strategies (see Appendix 3).
3. Quality checking the search results for inclusion/exclusion: A quality check for including/excluding evidence identified by search should be formulated. Examples of checklists are available on the SIGN website (www.sign.ac.uk).
4. Reviewing the evidence: A systematic method for grading evidence for inclusion/exclusion must be developed. The GRADE system should be used (see Appendix and www.gradeworking-group.org/society/index.htm)
5. Formulating and grading the recommendations: The methods used to formulate recommendations, with an explicit link between recommendation and evidence should be recorded.
6. Drafting the guideline: The AGREE instrument (Appraisal of Guidelines for Research and Evaluation) is a useful guide on constructing guidelines. The AGREE instrument can be downloaded from the following website: www.agreecollaboration.org
Guidelines will be appraised using the AGREE instrument, and it is helpful if they are drafted with the criteria in mind.
7. The draft guideline should include the following information:
 - Details of the search strategy used including search terms, sources consulted, dates of the literature covered.
 - Criteria for including or excluding evidence identified should be explicitly described.
 - A description of the methods used to formulate the recommendations and how final decisions were arrived at.
 - There should be explicit links between the recommendations and the evidence on which they are based (referenced as appropriate).
 - If evidence is not available, a description of how the consensus of expert opinion was reached.

Appendix 3: Specialist Colleges and Societies

Guideline Stakeholder list

Name of College / Society

ARNS

ARTP

College of Emergency Medicine

British Cardiovascular Society

British Geriatrics Society

British Paramedic Association

British Thoracic Society

Chartered Society of Physiotherapy

GPIAG

Intensive Care Society

Joint Royal Colleges Ambulance Liaison Committee

Resuscitation Council UK

Royal College of Physicians (London)

Royal College of Surgeons of England

Royal College of Physicians, Edinburgh

Royal College of Physicians and Surgeons, Glasgow

Royal College of Surgeons of Edinburgh

Royal College of General Practitioners

Royal College of Nursing

Royal College of Anaesthetists

Royal College of Midwives

Royal College of Obstetricians and Gynaecologists

Royal Pharmaceutical Society

Society for Acute Medicine

For information

Scottish Thoracic Society

Ulster Thoracic Society

Welsh Thoracic Society

SIGN

Other organisations may be added to this list as appropriate.

Appendix 4: Stakeholder organisations: template letter

Dear,

ICS xxx Guideline

We are writing to you as a potential stakeholder in the update of the ICS ??? guidelines. We would very much like the Royal College of?/British Society for ?? to be able to endorse these guidelines at the end of the process.

We feel that it is good clinical practice when formulating guidelines to inform all potential stakeholders that this process has been initiated to enable the relevant bodies/societies to have an opportunity to contribute. This then improves quality of the document as well as broadening its appeal.

If you would like to contribute, please nominate a representative from your organisation and forward his/her contact information so that we can send out further details. Your representative will have the opportunity to contribute to the relevant section/s and comment on the draft guidance before it is disseminated more widely.

We look forward to your response.

Yours sincerely

Chair of SSQ, Chair of Guideline Group

Appendix 5: ICS Clinical Practice Guideline notes

It is increasingly recognised that the production of guidelines should follow a rigorous and standardised process (1-3). However it should be acknowledged that many standards, for example those concerned with unit staffing for example, cannot follow a strict evidence based process of creation. Such guidance documents may be at least as useful as more formal guidelines to both health care providers and patients but it must be recognised that they are in essence a body of opinion rather than a scientific document.

The purpose of these short notes is to inform discussion within the ICS on the future process of guideline production. It will not describe the guideline process in detail but will refer to the very comprehensive published literature that is readily available.

Clinical guidelines are “systematically developed statements designed to help clinicians and patients make appropriate health care decisions for specific circumstances”. As such they should be simple, patient specific and user friendly(4). Successful guidelines incorporate a number of key components which include:

- Identification of the key decisions and their consequences
- Review of the relevant, valid evidence on the benefits, risks and costs of alternative decisions
- Presentation of the evidence needed to inform key decisions in a simple, accessible format.

Additionally the guidelines should have validity in the sense that "when followed they lead to the health gains and cost predicted for them" (1). It is accepted that validity rests on three important principles of guideline development namely:

The composition of the development panel

The group should be multi-disciplinary, have representation of patient preferences and be of sufficient size and expertise to encourage debate but not so large as to be unwieldy (probably 6 - 16 people). The group Chair is often a major factor in the success of the group. A clear timetable and work schedule is also important.

The identification and synthesis of evidence.

A comprehensive systematic review underpins all valid guidelines. Methodology for these reviews is well described. Purists would argue for a very broad and wide survey of the relevant literature. However alternate approaches have been proposed based on the assumption that important clinical information will always appear in editorials and review articles(5) Ultimately the rigor of the search strategy has to be balanced against the time/cost of the approach to evidence gathering.

The method of guideline construction

The grading of evidence and the strength of recommendation are key issues. Various grading systems have been published. Many recent guidelines are using the GRADE system to evaluate evidence www.gradeworkinggroup.org/society/index.htm (6). The GRADE approach is stated to have the following advantages:

- Clear separation between quality of evidence and strength of recommendation
- Explicit evaluation of the importance of outcomes of alternate management strategies
- Explicit, comprehensive criteria for downgrading or upgrading quality of evidence ratings
- Transparent process of moving from evidence to recommendations
- Explicit acknowledgment of values and preferences

- Clear, pragmatic interpretation of strong versus weak recommendations for clinicians, patients and policy makers

The review and debate of all the evidence available remains a vital function of the guidelines group despite the science of grading clinical information. Clinical experience and patient preferences remain important factors in the production of useful guidelines.

The process of guideline development

There is a comprehensive "how to do it" literature available on guideline development (3, 7-20). In the UK probably the most comprehensive approach is that taken by the Scottish Intercollegiate Guidelines Network (SIGN). The group receives central government funding and has produced many guidelines to a high, defined standard (www.sign.ac.uk/). Their process is described in the SIGN 50 document which could be used as a template for guideline developers (www.sign.ac.uk/guidelines/fulltext/50/index.html). The SIGN methodology complies with criteria used by AGREE (Appraisal of Guidelines for Research Evaluation in Europe) which identify good quality guidelines (www.agreecollaboration.org/).

SIGN describes a "50 simple steps" to guideline creation!

One key recommendation is the process of future guideline selections (as discussed on page 14 of the SIGN 50 manual). Not all topics are amenable to the process of guideline creation and both the breadth and depth of the proposed area are important.

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