



## **British Society of Gastroenterology Advice on the Production of Guidelines**

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## **Introduction**

The Clinical Services and Standards Committee (CSSC) of the British Society of Gastroenterology (BSG) commissions guidelines on the management of various gastrointestinal and liver disorders in order to promote and improve the standard of practice of clinical gastroenterology.

NICE has accredited the process used by the BSG to produce best practice clinical guidelines. Accreditation is valid for 5 years from July 2013 and is applicable to guidelines produced using the processes described in this BSG Advice Document. More information on accreditation can be viewed at [www.nice.org.uk/accreditation](http://www.nice.org.uk/accreditation). The Accreditation Mark is a registered trademark belonging to the Institute. The CSSC intends that future BSG guidelines will meet designated NICE standards. This document is intended as a guide to aid in the preparation of these guidelines and includes the criteria necessary for guidelines to carry the NICE Accreditation Mark.

The CSSC also commissions guidance documents and position statements which are similar to full guidelines in some respects but differ from them in others (for example they are not required to meet NICE criteria). The main part of this document relates to full guidelines only. Advice on guidance documents and position statements is given in Sections I and J.

### **A. Commissioning**

Most guidelines are commissioned by the CSSC via the specialist section committees. The BSG Council may sometimes suggest topics for guidelines.

Guidelines are usually commissioned because of a perceived need for greater clarity and consensus in the recommended management of a given condition. This need usually arises when there have been important recent advances in understanding and treatment, which should lead to improved patient outcomes, but have not been universally incorporated into clinical practice.

A guideline should make an important and ideally a special contribution. There may be circumstances, for example the recent appearance of guidelines on an identical topic from NICE or international specialist organisations that would make development of a BSG guideline on the same topic redundant.

### **B. The Guideline Development Group (GDG) and Initial Submission**

#### **1. GDG Constitution**

- Guidelines need to be the product of several individuals (typically five to ten) who are recognised authorities in the field. Self-elected single authors are not acceptable. The formulation of guidelines will be driven by a Guideline Development Group (GDG) which will include a writing committee (typically at least four authors) and others representing a range of relevant expertise, as well as patient representatives (ideally two individuals) and those whose everyday practice will be influenced by the guidelines (for example General Practitioners or other relevant specialties). The GDG should thus be multidisciplinary and should include a range of professionals who will be using the

guideline in their day-to-day clinical practice. All members of the GDG should be listed as co-authors including the patient representatives.

- A GDG Chairperson should be designated. The Chairperson should also be the lead author and along with at least some members of the GDG should be chosen by the relevant BSG section committee on the basis of having the relevant expertise: the GDG themselves may then choose other members of the GDG. An alternative approach would be an open call (via the BSG website) to interested applicants for submission of a CV. The final membership of the GDG must be approved by the CSSC Executive.

## 2. Patient Representation

- The GDG should **include patient representation in some meaningful form**, although there is some flexibility in regard to how this should be done. For some conditions there is an effective national patient organisation. It is recommended that these organisations be asked to nominate a patient representative on the GDG. For the many conditions where no such organisation may exist, other strategies to ensure patient and carer involvement would include:
  - Medical members of the GDG approaching individual patients under their care
  - An umbrella patient organisation such as the British Liver Trust or the Royal College of Physicians' Patient and Carer Network (PCN) approaching patients or carers with the condition
  - Advertising the position
- The aspiration should always be for patients to be members of the GDG. Even if this is not possible the GDG should always try to ensure that patients' and carers' views and preferences have been adequately considered and where appropriate incorporated into the guideline (see Section D2). Patient or carer members of GDGs will receive the same material support as do other members and will have technical language explained to them by other members of the GDG if necessary.

## 3. Conflict of Interests (see Appendix 1)

- All members of the GDG and any ad hoc groups or individuals having direct input into the guideline (including reviewers assigned by the BSG- see Section F2) must complete a Declaration of Conflict of Interests (COI) form (Appendix 1) before becoming involved in the process and also after the completed guideline is submitted.
- **It is crucial that the Chair must not have any COIs.**
- Where an individual is felt to have a possible COI with a particular section of the guideline the individual may continue to be involved in the overall process but either withdraw their involvement from that area or be involved in discussions but not in the recommendations or voting in that area. In some cases a COI may preclude an individual's membership of the GDG. Decisions in regard to these issues will be made by the Chair of the GDG in consultation with the head of the relevant BSG Section and with the CSSC Executive.
- All such decisions should be documented and available for external review.
- An 'interest' is defined as any arrangement in the past 12 months, which constitutes a current significant benefit to the individual, partner of that individual or their immediate family. It includes: financial and non-financial benefits. See appendix 1 for full definition of conflict of interests from NICE documents.

#### **4. The Submission Template (see Appendix 2)**

An initial proposal should be drafted by the GDG Chairperson on the Submission Template available on the BSG website and submitted to the Secretary of the CSSC for consideration in consultation with the relevant specialist section. The proposal should include:

- The overall objective of the guideline: this usually describes optimal management of specific gastrointestinal and liver conditions. The scope may include all or most aspects of the management of a specific condition e.g. IBD in adults, or it may focus on a specific management strategy e.g. liver transplantation or endoscopy, applied to one or more conditions.
- The target population of patients: this will usually be all patients with the condition in question or all patients undergoing the management strategy in question. Sometimes only specific age ranges, for example over 18 years, are included. Special patient groups, for example ethnic minorities, can be highlighted if appropriate.
- The target users: the guidelines are intended primarily to aid clinicians and so the target audience should include all healthcare professionals who contribute to clinical management of the condition. Some of these will be based in the primary care sector and therefore from the outset consideration should be given to which aspects of management can be primary care-based.
- The main clinical questions to be addressed.
- A stated intent to adhere to the AGREE II criteria (see BSG website).

#### **C. Non-Commissioned Guidelines**

- Individuals who have a particular interest in a topic may also submit a proposal for a guideline on the Submission Template (Appendix 2) to the appropriate BSG section and the CSSC Secretary. These are termed non-commissioned guidelines.
- Criteria for approval will include a decision from the relevant BSG section that the guideline would make an important contribution. As for commissioned guidelines (Section A) there may be circumstances which would make development of a BSG guideline redundant at that time.
- The GDG Chairperson as lead author will usually be one of the individuals who proposed the guideline. The Chairperson must be approved by the relevant BSG section that, with the CSSC, may make proposals for membership of the GDG. The GDG may then choose other members of the GDG but the final membership must be approved by the CSSC Executive.
- Points 2 to 4 in Section B also apply to non-commissioned guidelines.

#### **D. Development of Guidelines**

##### **1. AGREE II**

Guidelines should be developed in accordance with the principles laid down by the AGREE II instrument (on the BSG website). A more detailed account of the several stages of guideline development can be found on the NICE website.

##### **2. Stakeholder Views**

- Guideline development must take account of all relevant stakeholder views and preferences including professional groups, patients and carers. The GDG should conduct

a consultation exercise and prior to its first meeting should share the draft proposal with:

- Relevant professional organisations (for example, Royal College of Nursing, British Association for Study of the Liver, Association of Coloproctologists Great Britain & Ireland or Association of Upper Gastrointestinal Surgeons, Primary Care Society for Gastroenterology) who might influence or be influenced by the guideline.
  - The organisations and charities that represent and/or support patients and carers asking them which issues they think the guideline should address. This can be done directly or via the BSG. A form can be supplied by the BSG to facilitate structured feedback and will ask for the source(s) of any suggestions (e.g. telephone help line data, surveys).
- All replies must be seriously considered by the GDG and, when appropriate, incorporated into the initial guideline proposal, which should be developed into a final proposal on the Submission Template (Appendix 2). The Submission Template should then be re-submitted to the CSSC Secretary and should include:
    - The final GDG member list with signed COI forms.
    - The proposal (see Section B4) modified and developed in the light of consultations with stakeholders and members of the GDG. Final approval by the CSSC may be dependent on modifications to the proposal.

### **3. Clinical Questions**

- The GDG will develop the specific clinical questions to be addressed. These should not be limited in number and should include all questions relevant to optimal management of the condition in question. They should be set in the context of other recently published guidelines and where specific areas can be adequately covered by reference to these published guidelines, they may not need to be re-addressed in detail.
- The clinical questions are usually best grouped into clinical sections. A useful and suggested process is the PICO (Patients, Interventions, Controls and Outcomes) system, in which these four critical components are pre-defined as precisely as possible. The largest section will relate directly to management and may be divided into sub groups (for example, first line and second-line treatments, management of acute and chronic disease, management of specific complications, specific drug treatments). Additional sections on epidemiology, clinical manifestations, diagnosis, health economics and health service organisation are encouraged. Usually, a member of the GDG writing group, the section lead, is assigned responsibility for leading on all stages of the development of each section.

### **4. Evidence Search**

- For each clinical section, there should be a systematic, comprehensive, transparent and reproducible strategy to search for evidence on which management recommendations will be based. The overall search strategy should be decided by the GDG as a whole and described in adequate detail, if necessary in an appendix, including:
  - Electronic databases consulted (such as Ovid, Medline, Embase and US National Guideline Clearinghouse).
  - Time period covered and an indication of the reasons why, if this is limited (e.g. if an update on a previous guideline).
  - Search terms used: these should be key words derived from the clinical questions set by the GDG. Other sources of evidence may include hand-searching journals, viewing of references cited in relevant original papers, reviews and other

guidelines. Most GDG members will be expected to have expertise in at least some aspects of the condition and so, will already be familiar with some of the published literature. Publications dealing with patient experience of the disease and their treatment preferences should be actively searched for.

- Whether and under what circumstances conference abstracts can be used to help formulate recommendations.
- The GDG Chairperson is responsible for ensuring that all GDG members have adequate electronic access to relevant publications (via NHS Evidence, University sites, or other means).
- Libraries generated by keyword searches should be stored (e.g. in END Note) to allow excluded references to be traced. One way to store references is to save a search by creating an account on Pubmed and supplying a link for the search. Storage is essential because NICE considers a transparent pathway from evidence searching to inclusion/exclusion to be of paramount importance.
- A decision to include or exclude studies identified by the search must be made. Initially, this is done on the basis of relevance to the clinical questions as suggested by the title and in cases of doubt by the abstract. When selecting and evaluating evidence the four PICO components should be borne in mind (see Section D3). Further consideration regarding inclusion or exclusion is based on assessment of methodological quality (based on the full publication).
- It may be necessary to include studies of suboptimal quality if they constitute the best available evidence to inform some clinical questions. Their flaws need to be highlighted in the relevant guideline section (see 5 below).
- When published evidence on a specific point is unavailable or incomplete, statements based on clinical experience and patient views may be incorporated. Areas of uncertainty should be acknowledged.
- Shortly before the guideline is finalised the search should be repeated and any important studies published since the initial evidence search should be incorporated into the guideline.

## **5. Summary of Studies and Interpretation and Grading of Evidence**

- The evidence for each clinical question, from all relevant individual studies, should be systematically reviewed and summarised. It is useful to categorise references as systemic reviews, randomised controlled trials, cohort studies, case-control studies and other studies.
- Whilst the GDG has some flexibility here, NICE and the CSSC now recommend the GRADE system [http://www.gradeworkinggroup.org/publications/JCE\\_series.htm](http://www.gradeworkinggroup.org/publications/JCE_series.htm).
- The strength and limitations of the body of evidence should be clearly described. There should be discussion if needed of: risk of bias, consistency; applicability and relevance of study endpoints; the magnitude of the effect and any dose-response relationships.
- Construction of tables based on the PICO system is encouraged, incorporating the end points of several similar studies. If extensive, these tables may be incorporated into an appendix. The guideline should refer to any published work on relevant patient experiences.

## **6. Formulation of Recommendations**

- a) Recommendations should be specific to the topic and unambiguous. In general, they

should allow for the flexibility of clinical decisions in the particular circumstances of an individual patient. They may be applicable to the whole of the topic in question or sometimes only to specific clinical healthcare or social circumstances, which should be stated explicitly.

- b) Recommendations on specific clinical questions are drafted by the section leads. These should arise from and be explicitly linked to the corresponding evidence summary (Section D5). The GDG as a whole must then discuss all recommendations in detail including their potential health benefits, side effects and risks. The strategy used by the GDG to arrive at decisions in regard to formulating the recommendations should be described either in the text or in an appendix.
- c) Different grades of evidence may be available in response to different clinical questions. If the evidence is not conclusive, discussion with a view to reaching an informal consensus amongst the GDG should be tried. If this is not achievable, formal consensus techniques, such as Delphi may be useful. When disagreement persists, the GDG Chair should decide whether to seek resolution via (a) a formal voting system or (b) survey of relevant stakeholders. The GDG are encouraged to categorise their recommendations into “strong” or “weak” as per the GRADE system. Where the GDG’s decision on the strength of the recommendation is unanimous and the recommendation is strong, then the wording ‘we recommend’ should be used. Where the decision is majority and the recommendation weak, the wording ‘we suggest’ should be used.
- d) Strength of recommendation is different from and not automatically dictated by grade of evidence. Something which has only low quality or very low quality evidence base might be a “Strong” recommendation if it is clinically important and universally agreed by the GDG (for example timely referral for transplantation).
- e) More than one management option may be recommended if the evidence suggests that these are of similar efficacy. In this case clinicians and patients' views might influence which option is recommended and further consultation with patient groups may be appropriate. GDGs are asked to document (and to report to the CSSC Secretary) examples where patients’ views have directly influenced the final guideline. Alternatively, different options might be recommended as equally justifiable. If so, this must be clearly stated.
- f) The GDG should consider which aspects of management can appropriately be performed by a range of healthcare professionals (e.g. nurses, specialist workers) in different healthcare settings (e.g. primary care). If possible, the GDG's conclusions should be incorporated into the recommendations.

## **7. Implementation of Guidelines**

Where possible, tools to support implementation of the guideline should be included, if necessary in an appendix. Examples of these might include: screening, diagnostic and management algorithms, and checklists, care bundles and key performance indicators.

## **8. Cost and Service Implications**

The cost and service implications of implementing the guideline and the potential facilitators and organisational barriers to doing so should be considered. A full economic analysis is not expected but consideration should be given to the cost effectiveness of the recommendations, e.g. a particular intervention may require initial investment in staff or equipment but would result in healthcare benefits, thereby saving resources in the long term.

## 9. Assessment of Implementation

Guidelines should include a statement as to how the implementation of the guideline will be assessed. Specific criteria such as key performance indicators which can be audited or included in a quality improvement (QI) project should be specified and where possible, evidence-based and measurable standards of care should also be specified. In addition QI/ audit and monitoring tools such as questionnaires or a request for feedback via an online survey, or via the BSG website should be included.

## 10. Patient Summary

A patient summary should be included which is expressed in non-technical terms to assist patients in understanding best clinical practice.

## 11. Research Recommendations

A list of research recommendations should be included to resolve persisting uncertainties in regard to clinical questions.

## E. Format of Guidelines

- Guidelines to be published in 'Gut' will be up to 15,000 words in length and well referenced (usually 100-200 references in addition to the 15,000 word limit). Tables are encouraged (also in addition to the 15,000 words limit). The limit may exclude other additional data which may be submitted as a supplementary file, to be available online only.
- Guidelines should be written in a clear concise style with minimal repetition. They should be understandable by all healthcare professionals caring for the disease in question and also by informed patient representatives.
- The format of the guideline may be varied according to subject matter but should be based on the following outline structure:
  - Title.
  - Acknowledgments.
  - GDG: list of members, qualifications and currently held positions. The members assigned to lead on each clinical section should be highlighted.
  - Contents list: all main headings.
  - Abstract.
  - Executive Summary: to include a concise summary of the recommendations of the guideline, its purpose, the patient group, the target users and any special features
  - Patient summary- this should be included where relevant to the guideline. It should inform patients of best practice in non-technical language as far as is possible.
  - Date of previous guideline and time period covered by previous literature search (if an update).
  - Background: why the guideline is necessary, how it arose, particular issues surrounding the condition or its treatment.
  - Objective: the objective of the guideline should be summarised in one sentence.
  - Development process for the guideline: discussion of methodology with reference to search strategy and search terms used for evidence gathering, the criteria by which evidence was included/ excluded and the grading of evidence and recommendations. (See Section D).
  - Evidence summary: divided into sections, for example epidemiology, prevention,

clinical presentation, diagnosis, management (maybe several subsections here), and service organisation.

- **Recommendations should be stated in bold.** In the main text, they should also be divided into sections, with each recommendation close to and linked to the corresponding evidence summary. Management algorithms should be included when possible. In an additional duplicate one-page summary of the main points, the grade of evidence and strength of recommendation should be included (Section D6).
- Care bundles- these should be incorporated where applicable to the management of conditions to attempt to standardise best practice/ allow auditing/ QI projects.
- Key performance indicators- these should be incorporated where possible to allow for analysis/audit of standards and form the basis of QI projects.
- Cost-benefit analysis: if resources and expertise allows (this is not mandatory).
- Implications for the service organization; training and the desirability of implementation in specific settings.
- Research recommendations.
- Any declared conflicts of interests (see Appendix 1).
- References – numbered list, Vancouver style, comprehensive: 1-200.
- Planned review date.
- Appendices – should contain the final Submission Template (Appendix 2) and the grading system as well as tools for implementing the guideline, for example, algorithms, diagnostic tools, rating scales, screening tools etc.

#### **F. Review of Guidelines prior to Publication**

- The completed draft guideline should be submitted to the BSG office. The declaration of conflicts of interests should also be submitted at this point.
- The guideline is forwarded to the CSSC Secretary who will then approach two members of Council and two members of CSSC to act as full referees and to ensure the document is suitable for publication in 'Gut'. The turnaround time should be three weeks (maximum five). These four individuals will need to sign conflict of interest forms. The CSSC Secretary also checks that the language in the document is appropriate for the target audience.
- The guideline is also sent to all CSSC members for comments. It is placed under draft guidelines on the BSG website and members are invited, via BSG e-news or via mass e-mail, to send comments. It is sent to relevant patient organisations for comment if there is not already patient representation on the GDG (see Section B2 and D2).
- The CSSC Secretary summarises the feedback and sends this back to the GDG Chair and Lead Author. The anonymised feedback is also sent back to all those who have made comments or undertaken reviews.
- The Lead Author returns appropriately amended manuscript to guideline editor who checks that the suggested changes have been made. Amendments usually relate to clarity and emphasis rather than to content. When there is explicit disagreement in regard to content, the peer reviewers' views might not be taken on board if, in the opinion of the GDG, they are not supported by the evidence. In rare situations of unresolved disagreement, it would be possible to seek opinions from further peer reviewers.
- The manuscript is returned to lead author, either to submit to 'Gut' or to amend further.

- In conjunction with the 'Gut' Editor in Chief, a decision will be made as to which guidelines are potentially suitable for publication in 'Gut' and which are not. Those not suitable for 'Gut' may be suitable for Frontline Gastroenterology, a sub-specialty journal (for example, 'Endoscopy'), the BSG website or a paper document to be distributed by the Society. Updated revisions of previous BSG guidelines may be published in 'Gut' or as a BSG document independent of 'Gut', depending on the scale of the revision.
- Gut will arrange that the manuscript be reviewed by four to six external reviewers who are internationally renowned authorities in the field. Their suggestions will be fed back to the Chair of the GDG and usually if these suggestions are incorporated, the Guideline is acceptable for publication. However, publication in 'Gut' is dependent on broadly favourable reviews and the Editor in Chief of 'Gut' reserves the right to refuse publication.

### **G. Promoting the Guidelines**

- All guidelines are on the BSG website, which is accessible to the public. Guidelines may also be promoted by video blogs. Guidelines on major clinical topics are usually published in the BSG's co-owned Journal 'Gut'.
- New or updated guidelines on major clinical topics may be highlighted at national meetings of the BSG and associated organisations (BASL, Pancreatic Society, AUGIS, BAPEN etc). The GDG should liaise with the BSG who can utilise regional BSG leads to promote new guidelines in their areas.

### **H. Reviewing and Updating the Guidelines**

- The date of search, publication or last update and the proposed date for review must be clearly stated within the guideline.
- For existing guidelines the date of completion of the current guideline is clearly displayed on the BSG website; if not already explicitly stated the proposed date for updating the guideline, which will usually be every five years, will be determined by the GDG and stated on the website. Every two years the research objectives identified in the guidelines would be reviewed for evidence of additional studies, contributing to resolving the objective.
- A full review of a guideline after a fixed time period is not always appropriate as new evidence is published at different rates in different fields. At Section Committee meetings the Guidelines Section Lead is responsible for monitoring the progress and status of guidelines and undertakes discussions with the representatives from the GDG. The following factors will influence the decision whether and how to review a guideline on an unscheduled basis:
  - Emergence of new evidence that will change former recommendations.
  - Identification of any error in the guidelines after publication.
  - Emergence of any evidence of inequality in access to services between different social groups that can be addressed through guideline recommendations.
  - Emergence of any new technology or drugs or legislation that will change former recommendations.
- As a first step, the section commissions the GDG on this topic, who will carry out an

update search looking for new studies, evidence based guidelines, Health Technology Assessments and systematic reviews produced since publication of the last version of a guideline. These searches are based on the key questions and search strategies used in the original guideline but also include an element of horizon scanning to see if there are new treatments or technologies that should be considered as part of the update.

- Results are presented in the form of summaries of the findings of the studies that have been identified. The search results are incorporated into a report that summarises the new evidence and looks at how it will impact on the recommendations made in the existing guideline. This report will also note any new areas or key questions that have emerged since the previous publication and will be submitted to the CSSC Secretary/Guidelines Editor who will decide if the guideline as it stands will be revalidated or will undergo a complete or partial review or will be withdrawn and archived.
- For guidelines which were developed jointly with partner organisations (e.g. ESGE, HIS) a consultation with these organisations will take place and members from these organisation will be recruited to the working party to assess the need for review.
- The guidelines are available on the BSG website which is accessible to the public. They are listed by date of publication. A forum for feedback from BSG members via the members' area on the BSG website will be made available.
- Updates can be published in Gut as a letter but will be subject to the journal's peer review process. They will also be published on the BSG website as stated above. Prior to submission to Gut, updates will be submitted to the CSSC Secretary/Guidelines Editor who will arrange a peer review by the CSSC.

### **I. Guidance Documents**

The BSG (usually via the section committees but sometimes via the CSSC, Council or the Executive) also commissions guidance documents on specific topics. These are significant and influential documents and, whilst usually not as comprehensive as guidelines, they are expected to be developed with a similar degree of rigour. In particular they have the same requirements as guidelines in regard to declaration of COIs (see Section B3). However, guidance documents differ from guidelines in regard to the following points:

- They usually address a topic which is removed from the direct patient interface (examples include staffing of endoscopy units or endoscopy decontamination). For this reason, patient representation on the GDG is not mandatory, although it may sometimes be desirable.
- The composition of the GDG is more flexible than for guidelines; its membership is often self selected, although with the approval of the relevant section committee at least one of whose members should be on the GDG. Whilst the CSSC would wish to be informed regarding the membership it is unlikely to be prescriptive in this regard.
- Although they are expected to be evidence based where possible and developed in a rigorous manner, they are not currently subject to NICE quality standards. Often there is relatively little high-quality evidence to inform the questions addressed, and so recommendations are often based mainly on the informed opinions of GDG members.
- Guidance documents are submitted to the CSSC for approval just like guidelines. However, the review process is less rigorous, involving 2-3 reviewers from the CSSC.
- Following approval by the CSSC they are placed on the BSG website but are not usually

submitted to Gut for publication, although this (or submission to another journal) may be considered in some cases. Documents submitted to a journal for publication will have to undergo that journal's review process.

#### **J. Position Statements**

The BSG (usually via the section committees but sometimes via the CSSC, Council or the Executive) also commissions position statements on specific topics. These are significant and influential brief statements addressing novel, topical or controversial subjects where it is felt that the Society needs to clarify its position and give clear advice where possible to the membership.

Position statements are often limited to an expert opinion based on the latest best available evidence.

- Position statements are submitted to the CSSC for approval just like guidelines. The review process is less rigorous than guidelines, involving comments from members of the CSSC and Council.
- Following approval by the CSSC they are placed on the BSG website; cascaded to members through the BSG E newsletter; and may be submitted to Gut as a letter.
- Position statements are subject to a word count of less than 1000 words.

*This document is reviewed annually. The next review date is March 2019.*



BRITISH SOCIETY OF  
GASTROENTEROLOGY  
CLINICAL SERVICES

K.

## BRITISH SOCIETY OF GASTROENTEROLOGY

### APPENDIX 1 – Declaration of Conflict of Interests

(Refer to BSG guidelines advice document)

#### Title of guideline:

Do you, your partner (if applicable) or any member of your immediate family have any commercial interest (including personal shares, sponsorship or paid consultancy work) in any companies that are, or could be, involved in the above named guideline?

Company	Nature or purpose of support	Period of support	
		From	To

Does your department or unit receive financial support from any commercial organisations that are, or could be, involved in the above named guideline?

Company	Nature or purpose of support	Period of support	
		From	To

Are you a consultant to or a member of any national body, charity or pressure group whose work is related to the above named guideline?

Name of Group	Nature or purpose of support	Period of support	
		From	To

Do you receive editorial fees for commissioned articles for publication (in any format) or are you paid for editorial work for any publication related to the above named guideline?

If yes, please give details:

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Do you or your department hold a patent (existing or pending) related to the above named guideline? If yes, please give details:

--

#### **Please Note: 'nil' returns are required**

Name: \_\_\_\_\_ (Please print)

Role in guideline development: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### **Personal financial interest (from NICE documents)**

Any consultancy, directorship, position in or work (which is specific to the product or matter being discussed) in the commercial sector that attracts regular or occasional payments or benefits in kind such as hospitality.

- Clinicians receiving payment from the commercial sector for undertaking a procedure while giving advice on that procedure to NICE
- Any fee-paid work commissioned by the commercial sector for which the individual receives payment or financial benefit in kind
- Any shareholdings in the commercial sector held by the individual
- A financial interest in a company's product that is, or may become, a competitor to the product under consideration
- Expenses or hospitality provided by the commercial sector beyond that reasonably required for accommodation, meals and travel to attend meetings and conferences as set out in the NICE Hospitality Policy and Travel and Subsistence Policy
- Funds which include investments in the commercial sector that are held in a portfolio where the individual has the ability to instruct the fund manager as to the composition of the fund

#### **Non-personal financial interest**

- A grant from a company for the running of a unit or department where the individual is employed
- A grant or fellowship or other payment to sponsor a post or member of staff in the unit where the individual is employed
- The commissioning of research or other work by, or advice from, staff who work in a unit where the individual is employed
- Contracts with, or grants from, NICE

#### **Personal non-financial interest**

A clear opinion, reached as the conclusion of a research project, about the clinical and/or cost effectiveness of an intervention under review.

- A published statement in which the individual has expressed a clear opinion about the matter under consideration, which could reasonably be interpreted as prejudicial to an objective interpretation of the evidence.
- Authoring or co-authoring a document submitted as an evidence publication to a NICE advisory committee
- Holding office in a professional organisation (any organisation engaged in the medical, public health or social care sectors including the medical, nursing and midwifery Royal Colleges, NHS organisations, and universities), charity or advocacy group with a direct interest in the matter under consideration.
- Other reputational risks in relation to a matter under review



## BRITISH SOCIETY OF GASTROENTEROLOGY

### L. APPENDIX 2- Proposal for guideline- Submission Template

(Refer to BSG guidelines advice document)

**1. Lead author / applicant:**

Name	Qualifications	Position

**2. Contact details:**

Address	Telephone / Fax	Email

**3. Co-authors:**

Name	Qualifications	Position

**4. Title of guideline: (a provisional title may be provided at this stage)**

**5. Brief outline of the area the guideline will be covering:**

**6. Clearly state the overall objective of guideline:**

**7. Clearly state the clinical questions to be answered by the guideline and reason why the guideline is being produced: (e.g., health benefits arising from the guideline, absence of previous guidelines on this area or previous guidelines out of date)**

**8. Scope of guideline:**

Who are the target users?	Describe the patient group / target population covered by the guideline

**9. Guideline Development Group (GDG):**

Name of group member:	Representing (group / discipline):

**10. Time scale:**

<b>Start date:</b>	<b>(Anticipated) Finish date:</b>

- 11. Editorial independence:** Commercial sponsorship is discouraged and usually not acceptable. Any conflicts of interest for members of the GDG must be listed.

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- 12. Guideline methodology:**

<b>Details of systematic methods that will be used to search for evidence:</b>	
Databases to be searched	
Principal search terms	

<b>Describe the criteria that will be used for including/excluding evidence:</b> e.g. critical appraisal – methods used, who will appraise the evidence, grading scheme used

<b>Describe the methods that will be used to formulate recommendations:</b> Recommendations should arise from and be explicitly linked to the corresponding evidence summary. If recommendations are based on expert opinion describe any formal consensus technique and specify methods for resolving areas of disagreement e.g. the GDG will meet and vote on strength of recommendations using AGREE II Instrument.

<b>How will the cost implications and/or cost effectiveness of the advice be assessed?</b>

<b>Describe how patient /user views will be incorporated other than by inclusion on the GDG:</b>

- 13. Review of guideline:**

<b>What are the planned procedures for updating the guideline?</b> (The schedule for review is usually 5 years but may be sooner for rapidly developing topics, e.g., which Specialist Section /Committee will review the guideline and when.)