



**British Thoracic Society**

**Standards of Care Committee**

**Guideline Production Manual**

**1 July 2013**

# **British Thoracic Society Guideline Production Manual 2013**

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## **1. Introduction**

### **Background**

1.1 The British Thoracic Society has been at the forefront of the production of Guidelines for best clinical practice in respiratory medicine since the Society was established over 25 years ago. Over the past 5 years especially, the methodology for the production of evidence-based Guidelines has evolved considerably and the purpose of the current document is to set out in detail the policy for BTS Guidelines and the procedures by which they are produced and reviewed.

1.2 It is important to emphasise that BTS Guidelines are intended as an aid to clinical judgement. Guidelines cannot provide the answers to every clinical question and the ultimate decision about a particular clinical procedure or treatment will always depend on each individual patient's condition, circumstances and wishes, and the clinical judgement of the healthcare team.

1.3 This document has been developed to set out the policies, principles and processes that should be followed in the development of BTS Guidelines. While the document aims to be as instructive as possible it cannot cover, in detail, every possible issue that may arise during the course of BTS Guideline development. Issues that may arise during the work of a Guideline Group, that are not covered in this document, should be brought to the attention of the Chair of Standards of Care Committee for advice and guidance, via the BTS Deputy Chief Executive.

1.4 The development of the BTS Manual for Guideline Production has been informed by a number of sources of information including the SIGN 50 Guideline Developer's Handbook (1), the NICE Accreditation (2) process and as well as informal advice from a range of experts in the field of Guideline development and respiratory medicine. This advice and assistance is gratefully acknowledged.

### **Aims and objectives of the Society in relation to Guideline production**

1.5 The British Thoracic Society's main charitable objective is to improve the care of people with respiratory and associated disorders, and the production of Guidelines that promote optimum standards of care is key to the achievement of this objective.

1.6 The production of Guidelines is the responsibility of the BTS Standards of Care Committee (SOCC).

### **General principles for BTS Guidelines: AGREE Criteria**

1.7 BTS guidance is produced by Guideline Groups selected and approved by the BTS Standards of Care Committee with advice from the BTS network of Specialist Advisory Groups. The work of Guideline Groups is supported by BTS Head Office staff. The Society does not seek external funding for the production of its guidance.

1.8 BTS Guidelines are based on the best available evidence and should adhere to the AGREE criteria (<http://www.agreetrust.org/resource-centre/>) – see Appendix 1.

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### 2. Initiation of the Guideline production process

#### Role of the Standards of Care Committee

2.1 The Standards of Care Committee (SOCC) is one of the standing Committees of the Society and has the following remit:

- **Guideline development.** This involves the development of robust systems for the production of the Society's own Guidelines, from assessing the need for a Guideline to the submission for publication. The scope of this work will involve Guidelines on specific diseases, specific procedures and on processes of care, plus advice about key messages for dissemination, associated audit tool(s) and patient information.
- A **research responsibility** which will involve identifying gaps in knowledge exposed by the Guideline development process and advising on priority areas for research.

2.2 The Constitution of the Committee (at Appendix 2), sets out the membership, remit and mode of operation of the Committee.

2.3 The Chair of the Committee is a Trustee of the Society and sits on the BTS Executive Committee.

2.4 The BTS Deputy Chief Executive is the secretary to the Standards of Care Committee and the main point of contact for all Guideline Group members and Guideline-related matters at BTS Head Office.

#### Definition of a Guideline

2.5 The definition of a **Guideline** is as follows: "*Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.*" (3)

2.6 The Society requires that its Guidelines are based on the best possible evidence, but it recognises that in some areas, evidence may be sparse or of poor quality. It is important to ensure that robust methodology is used to develop guidance even in areas where the evidence base is weak. Guidance for good practice for these topics is often much needed, and can also serve to highlight areas where further research is required.

#### Process for identifying a topic for a Guideline

2.7 The SOCC is responsible for approving topics for new BTS Guidelines. Proposals for new Guidelines are submitted to the SOCC through the following channels:

- Through the Society's network of Specialist Advisory Groups (SAGs). The Specialist Advisory Groups provide an annual report to the BTS Executive Committee and as part of their report, the Groups are required to list any areas where it is felt that there is a need for guidance;

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- Through organisations associated with the Society such as the British Paediatric Respiratory Society (BPRS), and the Association for Chartered Physiotherapists in Respiratory Care (ACPRC), via their representatives on the SOCC, as well as other organisations such as the Primary Care Respiratory Society (PCRS-UK) and the Association for Respiratory Technology and Physiology (ARTP);
- Through the BTS Science and Research Committee, through the work of other BTS Committees or directly from the membership.

2.8 Proposals for new Guidelines are considered by the Standards of Care Committee at one of its regular meetings (and if the proposal has not emanated via the BTS SAG network, the Chair of the relevant SAG will be asked to comment on the proposal before it is considered by the SOCC).

2.9 Proposals for new Guidelines should address the points set out in Appendix 3 and each proposal must include details of the scope and justification for the proposed Guideline as well as an indication of the proposed membership of the Guideline group, including the name of Chair. The proposed Chair of the Guideline Group may be an existing member of the relevant SAG or be nominated by it. The Chair would be expected to have in-depth expertise of the subject to be covered by the Guideline, as well as a good understanding of the Guideline development process and the ability to manage the Guideline Group and ensure the timely delivery of the Guideline.

2.10 The SOCC will consider the following factors in the approval process for a new Guideline:

- Are there areas of clinical uncertainty as evidenced by wide variation in practice or outcomes?
- Is this a condition where effective treatment is proven and where mortality or morbidity can be reduced?
- Is this a clinical priority area for BTS where clinical guidance is lacking (and with a perceived need for guidance) and the area unlikely to be produced by other Guideline producers (such as NICE)?

2.11 If the Guideline proposal is approved in principle, the SOCC will invite the Chair of the Guideline group to submit a more detailed outline of the proposed scope, membership and timetable for the production of the Guideline for approval by the SOCC (this can be done by correspondence with the SOCC Chair).

2.12 The outline should explicitly include:

- the aim of the Guideline
- a description of the intended users of the Guideline
- a clear description of which areas are to be included and excluded from the guidance.
- a list of potential Guideline group members including a member of the SOCC and a lay/patient representative.

2.13 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 from the date that the Group is convened, and updates to existing Guidelines should be completed within 12-18 months. Progress reports on the work of the group should be provided for SOCC meetings (3 times a year).

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2.14 The budget for the production of the Guideline should be agreed with BTS Head Office before work begins. In general the following items are included within the budget for Guideline production (in line with BTS policies for reimbursement of expenses):

- Guideline group meeting costs (room hire, refreshments etc)
- Travel costs for group members to attend meetings
- Cost of literature searches undertaken by the Centre for Reviews and Dissemination in York
- Cost of obtaining copies of papers that cannot otherwise be acquired through group members' own library access (including reimbursement of librarian costs where agreed in advance with BTS Head Office)
- Cost of production of drawings/figures for inclusion in the final Guideline document.
- Training costs
- Dissemination/publicity costs (arrangements to be agreed with BTS Head Office)

### **3. Composition of Guideline Group**

#### **Process for selection of Guideline Group members**

3.1 When the SOCC has approved the proposed outline for the Guideline (see paras 2.10 – 2.12 above) the SOCC Chair issues a formal invitation to the Chair of the Guideline Group to take on this task, confirming that the BTS Guideline Policy for Guideline production must be followed. The Chair of the proposed group must complete a BTS Declaration of Interest form and any potential conflicts of interest considered by the BTS Honorary Secretary and the SOCC Chair before further work is undertaken (also para 3.4 below). In some cases, two co-Chairs may be appointed.

3.2 The SOCC Chair and the Guideline Group Chair will then issue formal invitations to members of the Guideline Group. The Guideline Group should be multidisciplinary and where appropriate include membership drawn from respiratory nursing, respiratory physiotherapy and lay/patient input (see para 3.7-3.9 below). The Group should also include relevant input from stakeholder organisations (see para 3.10-11 below). It is usual for a member of the SOCC to also be a member of the Guideline Group.

#### **Involvement of specialist trainees**

3.3 It is usual practice for each Guideline Group to have one or more Specialist Trainee members. This provides Specialist Trainees with an opportunity for valuable experience in Guideline preparation and bring the perspective of the Specialist Trainee to the Guideline. A call for volunteers from among BTS trainee members is normally issued soon after the Guideline Group is convened.

#### **Declarations of interest**

3.4 As noted above, the Chair of the proposed group must complete a BTS Declaration of Interest form and any potential conflicts of interest considered by the BTS Honorary Secretary and the Chair of the SOCC before work on the Guideline is undertaken. Each member of the Guideline Group must complete a BTS Declaration of Interest (DoI) form at or before the first meeting of the Guideline group. Full details of the BTS Declaration of Interest scheme can be found at <http://www.brit-thoracic.org.uk/about-bts/governance.aspx>

3.5 The Chair of the SOCC and the Chair of the Guideline Group have responsibility for scrutinising Declarations submitted by Guideline Group members. Guideline Group members will be

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invited to complete a DoI form as part of the annual BTS DoI scheme. Copies of DoI forms for group members will be kept on file at BTS Head Office for the duration of the work of the Guideline Group (and then for the subsequent period of time that the Guideline remains valid).

3.6 A statement should be included in each Guideline when published to confirm that the Guideline Group members adhered to the BTS policy for the Declaration of Interests, and where appropriate specific interests should be declared. An example of such a statement is given below:

“All members of the Guideline Group made declarations of interest in line with the BTS Policy and further details can be obtained on request from BTS.”

### **Lay/patient input**

3.7 In this context the phrase “lay/patient” is used as a generic term to describe patients, carers, lay representatives and those who represent and/or support patients in the voluntary sector. Lay/patient input in Guideline development is important to ensure that the Guideline reflects their needs and concerns, and to ensure that the Guideline addresses issues that may be overlooked by health professionals.

3.8 Each Guideline Group should include at least one a lay/patient representative. Lay/patient members of Guideline group can be sought from:

- The BTS Public Liaison Committee.
- The Patient Involvement Unit of the Royal College of Physicians (London).
- The British Lung Foundation, Asthma UK, Cystic Fibrosis Trust or other patient organisation.

3.9 Clear guidance should be given to each lay/patient member of the Guideline Group regarding their role and responsibilities as part of the work of the Guideline Group which will involve ensuring that patient views and experiences inform the work of the Guideline through:

- ensuring that key questions are informed by issues that matter to patients.
- identifying areas where patients’ preferences and choices may need to be acknowledged in the Guideline.
- helping to prepare any Patient Information literature which may be required, and identifying sources of further information.
- helping to ensure that the Guideline is sensitively and appropriately worded.

### **Stakeholder input**

3.10 The identification and involvement of stakeholders in the development of BTS Guidelines is crucial. One of the initial tasks for the Chair of the Guideline Group is to write to all potential stakeholders in the final Guideline to invite their organisation to either nominate a representative to participate in the preparation of the Guideline as a formal member of the Group, or to nominate a contact to whom information on the draft Guideline can be directed as work progresses. BTS Head Office holds a list of stakeholder organisations and contact with each stakeholder organisation is made through BTS. Correspondence with stakeholder organisations is usually undertaken by the BTS Deputy Chief Executive on behalf of the Guideline Group Chair.

3.11 The aim is to ensure that the Guideline Group membership comprises all relevant stakeholders. It is important that some organisations (for example, the Royal College of Physicians (London)) have a representative on each Guideline Group. In other cases, it may be sufficient for the

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organisation to have the opportunity to comment on the draft Guideline at an early stage (or to provide specialist input when required) rather than for the organisation to have a representative on the group itself.

3.12 Prior to its first meeting, the Guideline Group will have the opportunity to confirm the list of relevant stakeholder organisations that will be invited to endorse the Guideline at an early stage in the Guideline development process.

3.13 All stakeholders will be sent a copy of the draft Guideline at or before the public consultation stage. All stakeholder organisations will then be sent a copy of the final draft Guideline, prior to publication, with a request to confirm their endorsement of the document.

#### **Training for Guideline Group members**

3.14 It is important for all Guideline Group members to be appropriately trained in the methods to be used for the production of an evidence-based Guideline. Where possible the Chair of the Guideline Group should receive training in advance of the other members of the Group.

3.15 Training sessions are organised by BTS Head Office, and will usually take place as part of the first and second meeting of the Guideline Group. BTS plans to develop an online training module for Guideline Groups as part of the BTS Learning Hub and this will be made available to Guideline Group members in due course. Update with information on e-learning module.

#### **Confirmation of authorship/membership of writing group**

3.16 The Chair of the Guideline Group will confirm 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 a BTS Guideline should be given in the following form:

A Smith, B Jones, C Black, D Grey, ..... on behalf of the British Thoracic Society Pleural Disease 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**

### **Selecting the methodology**

4.1 BTS 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 should adhere to the AGREE criteria (<http://www.agreetrust.org/resource-centre/>) – see Appendix 1.

4.2 The methodology followed in the production of the Statement should be made clear. The Guideline should include clear recommendations with an indication of the grade of the

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recommendation (appropriate to the methodology used in consideration of the evidence). There should be an explicit link between the recommendations and supporting evidence.

**Defining the scope of the Guideline**

4.3 In line with the AGREE criteria, each Guideline should explicitly state the clinical questions to be addressed, and the patient population/target audience for the Guideline. Areas specifically excluded by the Guideline should also be itemised.

4.4 Consideration should be given to palliative care issues and where appropriate the document should include a section on end of life issues.

4.5 Studies often record side effects, harmful effects and risks of effects of interventions under scrutiny but these are rarely primary outcome measures. Where evidence permits, these will be balanced against beneficial effects with a view to informing recommendations.

**Defining key questions and developing search strategies**

4.6 BTS Guidelines should be based on a systematic review of the evidence. Systematic review is defined as “an efficient scientific technique to identify and summarise evidence on the effectiveness of interventions and to allow the generalisability and consistency of research findings to be assessed and data inconsistencies to be explored” (4).

4.7 The essential principles of systematic review should be adhered to as set out below:

- the literature is identified according to an explicit search strategy
- selected according to defined inclusion and exclusion criteria
- evaluated against consistent methodological standards.

4.8 Where high quality, directly relevant Guidelines exist within the scope of the new Guideline, reference can be made to the existing Guidelines rather than repeating work that has already been completed. However all such existing Guidelines must be evaluated using the AGREE instrument and be shown to have followed an acceptable methodology before they can be considered for use in this way.

4.9 Guideline groups are encouraged to break down the Guideline remit into a series of structured key questions using the PICOT format:

- **P**atients or population to which the question applies
- **I**ntervention (or diagnostic test, exposure, risk factor, etc.) being considered in relation to these patients
- **C**omparison(s) to be made between those receiving the intervention and another group who do not receive the intervention
- **O**utcome(s) to be used to establish the size of any effect caused by the intervention.
- **T**imeframe (optional)

4.10 The **Patients** or **population** to be covered by the literature searches is largely defined by the presence of the particular condition that the Guideline will cover. It should be made clear at this stage, however, which age groups are to be covered and which are excluded (for example, will the Guideline cover adults only (above 16 years of age) or children only (up to and including 16)).

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4.11 Consideration should also be given as to whether any particular ethnic or social groups have particular needs in relation to the topic under review. Exclusion of any group from the population covered by the Guideline should be identified when setting the key questions, and reasons given for their exclusion.

4.12 The **Interventions** (which in this context includes diagnostic tests, risk factors, risk exposure) must be specified clearly and precisely. The only exception is in drug therapy where drug classes should be used in preference to specific agents unless there is a clear reason for focusing on a named agent.

4.13 The decision on **Comparisons** is mostly between placebo / no treatment, or comparison with other therapies or the existing standard of care.

4.14 **Outcomes** should be identified in advance in relation to what will influence the views of Guideline group members as to how effective a particular intervention is. For some questions there will be a wide range of outcomes used in the literature, and if useful comparisons are to be made across studies it must be made clear which of these outcomes are important. Outcomes should be objective and directly related to patient outcomes (eg length of time to next cardiovascular incident or survival time, rather than just reductions in blood pressure). It is also important to include outcomes that are important to patients, rather than focusing entirely on clinical outcomes. Outcomes should include potential serious untoward effects of interventions.

4.15 The **Timeframe** covered by the question, where long term efficacy and safety data of interventions are important.

4.16 The questions identified in this way will then form the basis of the literature search. Guideline groups are encouraged to draw up as concise a list of key questions as possible. At an early stage in the process of formulating questions, contact should be made with the Centre for Reviews and Dissemination at York University. The information specialists in York are able to provide assistance with literature searches and guidance on formulating search strategies including advice on search terms and sources to be consulted such as Medline/US National Guideline Clearing House/Embase/Psychinfo (see Appendix 4).

4.17 The literature search must focus on the best available evidence to address each key question, and should ensure maximum coverage of studies that include:

- Systematic reviews.
- Randomised controlled trials.
- Observational studies
- Diagnostic studies

4.18 A useful summary of the systematic literature review procedure is given in the Figure in Appendix 4, taken from the SIGN 50 Handbook.

4.19 The details of the search strategies, dates of searches etc should be included in the final document (and can also be made available as an accompanying web appendix on publication).

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**Reviewing the evidence**

4.20 The literature search will produce a long list of potential sources of evidence. Each reference must then be assessed to ensure its relevance and validity. The Guideline Group members should review the evidence (bearing in mind the AGREE criteria).

4.21 It is suggested that this is best performed by dividing the literature into sections and allocating at least two Guideline group members to each section/set of literature to ensure that each paper is read by at least two people. Criteria should be formulated to ensure that this process is carried out uniformly across the Guideline group, and could include, for example:

1. Does this study address the clinical question?
2. Has the appropriate study type been used to produce the best evidence to answer the clinical question?

The chosen inclusion and exclusion criteria should be stated in the Guideline document.

4.22 Non-English abstracts should be considered, provided there is an English translation available. It would not be usual to provide translations of non-English papers unless a compelling case could be made. Guideline group should consult BTS Head Office if such an issue arises.

4.23 Abstracts should not be rejected on the basis of the Journal of publication, location of research or publication nor the date of publication.

4.24 For each section of the Guideline, two Group members should scrutinise the title and abstract of each article retrieved by the literature searches to decide whether the paper is relevant. Where there is a difference of opinion on a paper, the group members should endeavour to reach a consensus, and refer to other members of the group for a final decision. A note should be made of the decision for each reference (relevant/possibly relevant/not relevant). When a consensus has been reached on the list of relevant abstracts, full copies of papers of all relevant and possibly relevant articles should be obtained.

4.25 Guideline Group members are encouraged to make full use of their NHS/university library resources to obtain full copies of the papers remaining within copyright rules at all times. Where Guideline groups encounter difficulty in obtaining copies of papers, BTS Head Office can offer advice and assistance.

**Grading the evidence, formulating and grading recommendations**

4.26 When all relevant papers have been obtained (and any non-relevant papers excluded), Guideline group members are required to grade the evidence.

4.27 The quality of the evidence should be appraised using existing appraisal tools (eg SIGN checklists). Each study should be evaluated for internal validity, external validity and generalisability. BTS advises Guideline Groups to use the SIGN methodology (2). If a Guideline Group wishes to use an alternative system in the production of the Guideline concerned, the Guideline Group Chair should first seek advice from the SOCC Chair and BTS Head Office.

4.28 BTS is aware that GRADE methodology (5) is being used by some Guideline producers (for example NICE). SIGN is currently reviewing GRADE methodology with a view to incorporating elements into its own system. BTS plans to monitor the development of SIGN's methodology closely and may adopt any changes that may be approved by SIGN in the future.

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4.29 The current SIGN definitions for levels of evidence and grading of recommendations are included at Appendix 4.

4.30 For those studies that are deemed relevant to a particular key question, a checklist is prepared and the data relevant to the evidence review and guideline development is extracted into evidence tables (template evidence tables may be obtained from the SIGN website or BTS Head Office). This data commonly includes: the study author, year, design, quality, objective, population, setting, sample size, follow-up, and definitions and results of clinically relevant outcomes. Evidence tables are developed for each key question. Data are extracted by one or more authors, and disagreements are resolved by the remaining authors. Systematic reviews may also be included in a guideline if there are a large number of relevant reviews available in the literature. A level of evidence should be assigned to each paper (according to the table included in Appendix 4).

4.31 Guideline recommendations are graded to differentiate between those based on strong evidence and those based on weak evidence. This judgement is made on the basis of an (objective) assessment of the design and quality of each study and a considered judgement on the consistency, clinical relevance and external validity of the whole body of evidence.

4.32. Where there is a lack of evidence on a particular key question, the Guideline group should be clear about how a consensus has been reached in formulating a recommendation (for example using the Delphi process). Where areas of uncertainty within the evidence, this should be highlighted as appropriate within the Guideline document.

4.33 In grading the recommendations the guideline group should consider the following aspects for considered judgement:

- The volume of the body of evidence;
- The applicability of the obtained evidence to the defined target audience of the guideline.
- The generalisability of the evidence to the target population of the guideline.
- The level of consistency in the evidence obtained to support recommendations.
- The implications of recommendations on clinical practice in terms of resources and skilled expertise.

4.34 While BTS Guidelines explicitly exclude consideration of cost-benefit analysis, Guideline Groups may include a consideration of cost implications and cost-effectiveness issues where literature exists that is appropriate to the topic.

### **Drafting the Guideline**

**4.35 When producing a draft of the Guideline the following structure is suggested:**

- Title page listing authors
- Contents page
- Summary of recommendations (to be finalised on completion of the Guideline)
- Introduction (see above)
- The body of the Guideline, divided into sections as appropriate, with each recommendation clearly identified in bold type and numbered consecutively throughout the document
- Conclusion
- Appendices and list of web appendices
- Figures/Tables
- References (see at 4.38 below)

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4.36 The introduction should include:

- the aim of the Guideline
- a description of the intended users of the Guideline
- a description of the target patient population
- a clear description of which areas are included and excluded from the guidance.
- A description of the methodology used
- A description of the search methodology, the dates of the literature searches and how many papers were considered. The detailed search terms should be included in a Web Appendix
- A statement on when the Guideline should be reviewed/revised – this is normally within 3 years from the date of publication
- A description of the inclusion and exclusion criteria for evidence selection
- A statement on declarations of interest
- A full list of the Guideline Group members and the contributors to each section of the Guideline, noting where individual members have represented other organisations
- A list of stakeholders/endorsing organisations (to be finalised prior to publication)

4.37 The following sections are also associated with the Guideline, but are usually provided as web based appendices rather than part of the published document:

- Research recommendations
- Audit criteria
- Patient information where appropriate
- Educational material
- Quality standards (this document is subject to a separate production process following preparation of the Guideline - see Appendix 7).

4.38 Guideline groups should ensure that the level of evidence is clearly indicated against each evidence statement and that individual references that are included in the evidence summary appear in the accompanying evidence table (as well as in the bibliography). The grade of recommendation should be clearly indicated against the recommendation when it appears in the Guideline. Reference should be included in the Vancouver format (the style used by Thorax) where references are numbered sequentially in the text.

4.39 The following paragraph should be inserted at final draft stage:

*Healthcare providers need to use clinical judgement, knowledge and expertise when deciding whether it is appropriate to apply recommendations for the management of patients. The recommendations cited here are a guide and may not be appropriate for use in all situations. The guidance provided does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of each patient, in consultation with the patient and/or their guardian or carer.*

**Public consultation and peer review/approval by SOCC**

4.40 The final draft Guideline should be submitted to the Chair of the SOCC for comment and discussion at a meeting of the SOCC. The Chair of the Guideline Group will be invited to be present at that meeting. Peer review will be undertaken by SOCC members, who may also invite key expert reviewers to provide comments. The editors of Thorax will also be invited to propose expert reviewers comment on the draft Guideline.

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4.41 The final draft of the Guideline should usually be placed on the BTS website for open consultation, and if the timing allows, an open meeting held at a BTS Summer/Winter meeting. A consultation copy of the document should be sent to all stakeholders requesting their comments by the consultation deadline. The public consultation period can take place to coincide with the SOCC discussion of the document or immediately after the SOCC meeting.

4.42 Following the incorporation of comments from the SOCC meeting and the open consultation, the final draft document should be returned to the SOCC Chairman for approval. At this point the SOCC Chair may request a further review of the document before approval is given.

4.43 When the final draft has been approved, the document should be sent to stakeholders (relevant organisations/Royal Colleges) to request confirmation of endorsement, if applicable.

**Publication/Dissemination**

4.44 The principles and procedures for publication of the full Guideline/Executive Summary of the Guideline in *Thorax* are set out at Appendix 8. An online copy of the full Guideline (and associated web appendices) will be available on the BTS website following publication. Options for alternative publication arrangements should be discussed with the SOCC Chair and BTS Head Office.

4.45 BTS Head Office is responsible for liaising with the *Thorax* Production team regarding the likely timing of publication. BTS Head Office will submit the final manuscript to *Thorax* via Benchpress and will be the main point of contact with *Thorax* for production issues. The corresponding authors will be responsible for checking the proofs of the Guideline.

4.46 The sequence of events for the publication process is as follows:

- Final draft is considered by the SOCC (at this point a copy of the draft is sent to the *Thorax* editors for information with an estimate of when the final document is likely to be formally submitted to *Thorax*);
- When the final draft is approved by SOCC Chair, BTS Head Office takes responsibility for checking content (to confirm that all figures/tables and associated documents are available), and confirming the corresponding authors;
- BTS Head office submits required document to *Thorax* via BenchPress;
- *Thorax* will communicate with the designated corresponding authors for checking of proofs
- BTS Head Office will provide *Thorax* with instructions such as authorisation for production of colour figures etc;
- Final proofs signed off by corresponding author;
- BTS Head Office will produce the Full Guideline/Quick Reference Guide/Summary of Recommendations document (as required) for download from the BTS website to coincide with publication (published under BTS ISSN report series);
- *Thorax* confirms likely publication date;
- On publication, *Thorax* provides a pdf copy of the document which is placed on the BTS website with the associated full Guideline/Quick Reference Guide/additional documentation.

4.47 BTS Head Office, in consultation with the chair of the Guideline group and the SOCC chair, will oversee the press and media coverage associated with the publication of the Guideline.

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4.48 Copies of the Guideline evidence tables, references and literature search records together with notes of the Guideline group meetings should be held at BTS Head Office.

4.49 BTS Head Office will arrange for a copy of the Guideline to be sent to the RCP London Clinical Effectiveness Forum with the AGREE rating.

4.50 BTS Head Office will arrange for relevant associated materials (educational documentation, audit tools and patient information) to appear on the BTS website to coincide with the guideline publication.

## **5. Process for Review/Updating of Existing Guidelines**

5.1 Updates/revisions to existing Guidelines are considered by the SOCC (and SAG Chair) on a regular basis with the intention that existing Guidelines are reviewed within 5 years of the publication date to confirm whether a revision is required (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 a Guideline that is over 5 years old, to advise the SOCC on the need for an update. If no significant additional evidence is available, the SOCC may decide to confirm the validity of the existing Guideline for a further period, and review the Guideline again in 1-2 years' time.

5.2 In cases where it is known that new evidence is likely to become available within 5 years of publication of a Guideline, the Guideline Group may advise that a revision is required within the normal 5 year period.

5.3 The BTS website includes a list of published Guidelines with an indication of the status of the document as follows:

Valid	Guidelines that have been published within the past 5 years, or that have been reviewed and confirmed to still be current (with the date of review included).
Under review	Guidelines that have been published over 5 years ago and are being considered by the SOCC for possible revision
Update in progress	Guidelines that are in the process of being revised
Superseded	Guidelines that are deemed to be no longer valid as a more recent version has been published
Withdrawn	Guidelines that are deemed to no longer be valid but where a revision has not been published (with the date of withdrawal included) .

## **6. Production of Joint Guidelines**

6.1 The Society may be approached by other organisations or group with an invitation to produce a joint Guideline.

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6.2 The SOCC will consider proposals for the production of joint Guidelines, and will require that the methodology used in the Guideline production process meets the standards required for the production of BTS Guidelines. In such circumstances the Society would expect to nominate an appropriate proportion of members of the Guideline group (and this could include nomination of a co-chair), and the draft Guideline would be submitted for comment and approval by the BTS Standards of Care Committee in the normal way.

6.3 The British Thoracic Society has a formal agreement with SIGN to produce the British Guideline on the Management of Asthma and, in the case of this Guideline, the SIGN Guideline production procedure is used.

**7. BTS representation and endorsement of externally produced Guidelines**

7.1 The Society may be invited to nominate a BTS representative to act as a member of another organisation's guideline group. The Standards of Care Committee will approve an individual as a BTS representative on a Guideline group provided that:

- The Guideline topic and outline is deemed appropriate;
- The Guideline methodology and production process is in line with that used by the Society;
- That the nominated representative agrees to provide a brief written report to each meeting of the Standards of Care Committee.
- That the final draft guideline is presented to the SOCC (with the BTS representative in attendance) for approval.

7.2 In the case of requests for formal endorsement of another institution's Guideline, the Society would expect to nominate at least one representative member of the Guideline group, and the draft Guideline would be submitted for comment and approval by the BTS Standards of Care Committee in the normal way, before a decision on whether to endorse the Guideline is made (see 7.1 above).

**BTS 1 July 2013**



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**References**

1. SIGN 50: A Guideline Developer's Handbook  
<http://www.sign.ac.uk/Guidelines/fulltext/50/index.html>
2. NHS Evidence Accreditation  
<http://www.evidence.nhs.uk/Accreditation/Pages/Accreditation.aspx>
3. Field MJ, Lohr KN (Eds). Clinical Practice Guidelines: Directions for a New Program, Institute of Medicine, Washington, DC: National Academy Press, 1990.
4. Woolf S. Practice Guidelines, a new reality in medicine. II: Methods of developing Guidelines. Arch Intern Med 1992;152:946-52.
5. GRADE <http://www.gradeworkinggroup.org/>

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**Appendix 1**

**Appraisal of Guidelines for Research and Evaluation**

<http://www.agreetrust.org/resource-centre/>

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.

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Appendix 2

**BRITISH THORACIC SOCIETY  
STANDARDS OF CARE COMMITTEE**

**1. TERMS OF REFERENCE**

The BTS Standards of Care Committee has two major responsibilities:

- Primarily, **Guideline development**. This involves the development and maintenance of robust systems for the production of the Society's own Guidelines, from assessing the need for a Guideline to the submission for publication, in line with NHS Evidence Accreditation criteria. The scope of this work will involve Guidelines on specific diseases, specific procedures and on processes of care, plus advice about key messages for dissemination, associated audit tool(s) and patient information.
- Production of Quality Standards, based on BTS Guidelines, which aim to provide clinicians, commissioners, planners and patients with a guide to the standards of care that patients with a particular disease/condition should expect, together with measurable markers of good practice.
- The Committee also has a **research responsibility** which will involve identifying gaps in knowledge exposed by the Guideline development process and advising the **BTS Science and Research Committee** on priority areas for research.

**2. MEMBERSHIP**

2.1 Membership of the Committee comprises:-

- Chair
- Chair –elect (in the third year of the Chair's period of service, to allow handover)
- Council member(s), who may select to serve on the Committee while serving on Council. A maximum of 4 Council members to be on this Committee at any one time.
- Three consultant physicians who will be selected from those who come forward following the annual call for volunteers (in succession-one per year).
- Three Specialist Trainees who will be selected from those who come forward following the annual call for volunteers (in succession-one per year). One of these will serve additionally on the BTS Specialist Trainees Advisory Group (STAG) and will act as the link between the two.
- A representative from the BTS Nurse Advisory Group. This person will be nominated by the Group and will act as the link between the two.
- A member of the BTS Public Liaison Committee.
- Two representatives from the British Paediatric Respiratory Society (BPRS).
- A representative from the Association of Chartered Physiotherapists in Respiratory Care (ACPRC)
- Chairman of BTS Executive Committee, and Chief Executive, ex-officio (standing invitation to the former, although will not usually attend)

2.2 All members, however selected and in whatever capacity, will normally serve for a maximum of 3 years from the date of taking up membership. The term of service is usually effective from the date of Society's Annual General Meeting in December each year. The only exception is the Chair –

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elect. S/he will be appointed in the third year of the Chair's period of service, to allow handover, and will therefore expect to serve for no longer than 4 years, but exceptionally for 5 or 6 years. This will only occur if the Chair-elect is already serving on the Committee at the time of the election (see item 3.6, below).

### **2.3 Members can join Committees in one of 3 ways:-**

- By volunteering annually in response to a call for volunteers. This is circulated in the early summer each year to all BTS members. The call for volunteers will clearly state the vacancies that are available; the experience and special interests sought (if any) and the arrangements for selection. If there are more volunteers than places available, selection will be undertaken by a ballot involving all members of the current Committee based on the provision by volunteers of a short c.v and supporting statement.
- When elected to serve on Council, each Council member is asked to select a Standing Committee on which to serve. There is generally no barrier to a Council member joining their Committee of choice, although it may from time to time be necessary to negotiate filling a gap where one exists and the Society has need of additional Council input, and therefore first choice of Committee cannot always be guaranteed.
- By being the nominated representative of one of the bodies mentioned above in the membership list. In this event, the "three year rule" will still apply

### **2.4 All members of BTS Committees must be members of the Society unless they have been nominated by an external organisation.**

2.5 If a Committee wishes to involve a member with specific skills, and that person is not therefore likely to be a BTS member; or, if a Committee wishes to vary the membership as outlined above, this **MUST** be discussed first by the Chair with the Executive Committee (the Society's Trustees), and agreement of Trustees obtained.

2.6 Every effort is taken to agree dates of meetings one year in advance and notify these to all members as soon as they have been agreed. Dates agreed in advance will only be changed if there are exceptional circumstances, and then at least 8 weeks' notice will normally be given. If a member misses more than 2 meetings in succession, and there are no extenuating circumstances (in relation to sickness absence, for example), then the Society will ask that member to stand down.

2.7 All members are required to conduct themselves in accordance to the Society's policies and general procedures (e.g. for travel expenses), and in particular in relation to the policy about relationships with the bio-medical and tobacco industries, and the associated Declarations of Interest Scheme (DoI) (see section 6.3, following). Members are especially asked to note that efforts should be made to return a completed DoI form before the end of January each year, or prior to the first meeting of the Committee in every calendar year, whichever is earlier. If a form has not been completed after a reminder has been given at that meeting, the member concerned will be asked to withdraw until the information has been provided.

## **3. STANDING ORDERS**

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**3.1 Role of the Chair of the Committee**

The Chair of the Committee also serves as a Trustee of the Society during the time s/he is in post. S/he is therefore the main link between the development and execution of the Society's strategic objectives (as summarised in the Strategic Plan) and the detailed work of the Committee.

3.2 The Chair is responsible for the direction, conduct, moving forward and completion of Committee business, both during Committee meetings and between the meetings. In this task s/he is supported by the Society's staff (who provide a full secretariat service) and other members. A Deputy Chair post is not required.

3.3 The Chair will approve the Committee agenda and draft minutes, which are prepared by BTS staff. S/he will also prepare and/or commission papers from other and will chair the formal meetings of the Committee and any ad-hoc meetings and teleconferences.

3.4 While BTS staff can draft follow up correspondence and deal with queries arising from the work of the Committee on an operational level from day to day, it is anticipated that the Chair will provide advice on content and professional issues involved and, in particular, deal with peers and external organisations in relation to all areas where clinical leadership is required.

3.5 The Chair has an important role in ensuring that Declaration of Interest forms from all Committee members are scrutinised and any issue of concern discussed with the individual concerned and/or the Honorary Secretary. S/he must also ensure that at the beginning of each meeting members are asked to declare any additional recently-acquired interests, and is expected to exercise judgement in the conduct of Committee business in the event of any potential conflicts of interest.

3.6 Succession planning for the Chair of the Committee will take place as follows. In the summer of the year preceding the December when the Chair's 3 year term in office is due to end, the Society will advertise that a vacancy for the Chair of that Committee will be coming up. Members of the Committee plus any other member of the Society will be invited to apply by submitting a short c.v. and statement of interest. The Committee will then vote (secret ballot, based on information supplied) and the outcome of that vote made known to the Executive Committee at its December meeting. The Executive Committee is responsible for confirming the appointment of the new Chair of the Committee, taking into account the result of the ballot. Trustees reserve the right not to accept the outcome of a ballot, although the circumstances under which this right might be exercised would be exceptional. The Executive Committee's decision will be made known to the successful candidate so that the Chair-elect can spend the year before taking up post shadowing the incumbent and receiving information about being a Trustee of the Society.

3.7 Before a Chair is appointed, s/he will be asked to submit an updated Declaration of Interest form, if this is not already available. This will be submitted to the Chair of the Executive Committee (the Trustees) and Honorary Secretary for approval before the appointment is confirmed.

**3.8 Frequency and conduct of meetings of the Committee**

The Committee will normally meet 3 times a year, at the Society's headquarters building in London.

3.9 Trustees recognise that it may be necessary from time to time to plan an additional meeting in any year when anticipated business demands this. This would not normally be a problem, except that short notice may result in poor attendance, and it is now important to give at least 8 weeks' notice. For urgent/timing dependent issues that might arise which do not justify a full agenda, the

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Society's constitution allows business to be conducted by teleconference. This can be organised at no cost to Committee members or their employers. This paragraph does not contradict the restriction in paragraph 2.6, above)

3.10 Because some members have to travel some distance to attend meetings in London, and to maximise the amount of business that can be achieved and also opportunities for "off peak" travel (in at least the return portion) meetings are normally held between 10.30 and 3.00pm and lunch is provided.

3.11 It is not usually acceptable to conduct a Committee meeting at BTS headquarters with one or more members attending for all or part of the meeting via teleconference or web-cam, as this impedes progress of business. The Society recognises that in exceptional circumstances it may be necessary for a Committee member to participate for specific items of business, but this should be arranged on a case-by-case basis.

3.12 The Committee secretary (BTS staff member) will draft an agenda and discuss with the Chair no later than 3 weeks before the date of the meeting. The agenda and papers will be sent by post to all members no later than 7 days (and preferably) 10 days before the meeting takes place.. It is not good practice to table papers at meetings, especially those that contain detailed information and these will not normally be allowed, at the discretion of the Chair, and taking into account circumstances involved. Authors of papers are therefore asked to submit in time according to the date given by the secretariat, so that copying can take place.

3.13 The meeting agenda will usually include at least one draft guideline for consideration by the Committee. The draft guideline document is copied on dark blue paper to prevent unauthorised copying and circulation in advance of publication. Committee members are expected to read Committee papers in advance of the meeting, and in some cases the Chair will invite specific committee members to take responsibility for detailed comments on a particular draft guideline.

3.14 A draft minute, including named action points, will normally be produced within 7-10 days of the meeting to be agreed by the Chair and then sent to members as an aide-memoire for those who may have been asked to carry out actions, or for the information of those who were not able to attend.

### **3.15 Sub-Committees and ad-hoc groups**

Because the Society has a comprehensive network of Specialist Advisory Groups which act as expert advisors in specific disease/therapy areas, it is not generally permitted for Standing Committees to establish any sub-Committees and/or working parties and ad-hoc groupings. Any proposals that this ruling is relaxed must be discussed and agreed by the Executive Committee in advance.

## **4. CODE OF CONDUCT**

4.1 The Society values the contribution of those members who serve on its various Committees and Advisory Groups and Working Parties. Without this service, it would not be possible to carry out the great variety of work that is undertaken which contributes to the raising of standards of care of people with respiratory disease. BTS has a justifiably high reputation for the quality of its activities and the advice it gives to external bodies.

4.2 The Society is also proud to have been a pioneer in a number of areas, including its Declarations of Interest scheme, which has been replicated by a number of other Societies in recent

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years. The probity of our actions is underpinned by a number of policies and procedures which are kept under regular (annual) review. Members of the Standards of Care Committee are also expected to sign the confidentiality agreement at Annex 2 of the BTS Policy on Biomedical Industries & Commercial Sponsorship and associated Declarations of Interest Scheme.

4.3 Consequently, we ask all members of Committees, Advisory Groups and Working Parties to note and abide by the following policy and procedures documents:-

- BTS Policy on **Biomedical Industries & Commercial Sponsorship and associated Declarations of Interest Scheme**. This is reviewed annually by BTS Council and Trustees. (last approved November 2008)
- **Endorsement Policy** (reviewed in 2011 by Executive Committee and BTS Council)
- **Media policy** (ditto)
- **Travel and subsistence policy** (reviewed annually by Honorary Treasurer and Chief Executive)

These documents can all be found on the BTS website in the “governance” pages of the section entitled “About BTS”

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By: BTS Executive Committee

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## **Appendix 3**

### **Guideline proposals**

#### Issues to be addressed

1. A summary of the clinical problems and outcomes to be addressed.
2. Details of the group(s) or institution(s) supporting the proposal.
3. A brief background to the clinical topic which will be addressed by the proposed guideline.
4. Evidence of variation in practice in the management of the condition.
5. An indication of the benefits likely to arise from the development and successful implementation of the guideline.
6. A definition of the patient group to which the guideline will apply.
7. A definition of the aspects of management of the clinical condition which the proposed guideline will address.
8. An indication of the healthcare professionals potentially involved in developing the guideline.
9. An indication of the size and strength of the evidence base which is available to support recommendations on effective practice, citing key supporting papers.
10. Details of any existing guidelines or systematic reviews in the field.



## **Appendix 4**

### **Support for literature searches.**

Guideline groups are able to call upon the services of the Centre for Reviews and Dissemination (CRD) at the University of York for assistance with the development of search strategies, literature searches, the provision of lists of abstracts as well as acquisition of papers. The chair of the guideline group should consult the CRD as early as possible to ensure that maximum benefit is obtained from the services provided by the team in York. Further details of the services provided are available from Sally Welham.

### **Managing data**

The CRD will provide the results of literature searches as Endnote files (Endnote is a reference management software programme). The results of the searches (references and abstracts) can be exported into Word from Endnote for checking by guideline group members. It is suggested that one member of the guideline group is nominated to hold the central Endnote files for the searches. BTS will provide a copy of the Endnote software for one member of the group to allow them to manage the literature searches.

BTS can also arrange to make available the Word files containing the abstracts as downloads on a section of the BTS website. This allows all guideline group members to access what are often very large files that may be difficult to email.

BTS can also provide a copy of the database used by SIGN which has been developed to hold references, record results of checklists and produce evidence tables.

### **Obtaining copies of papers**

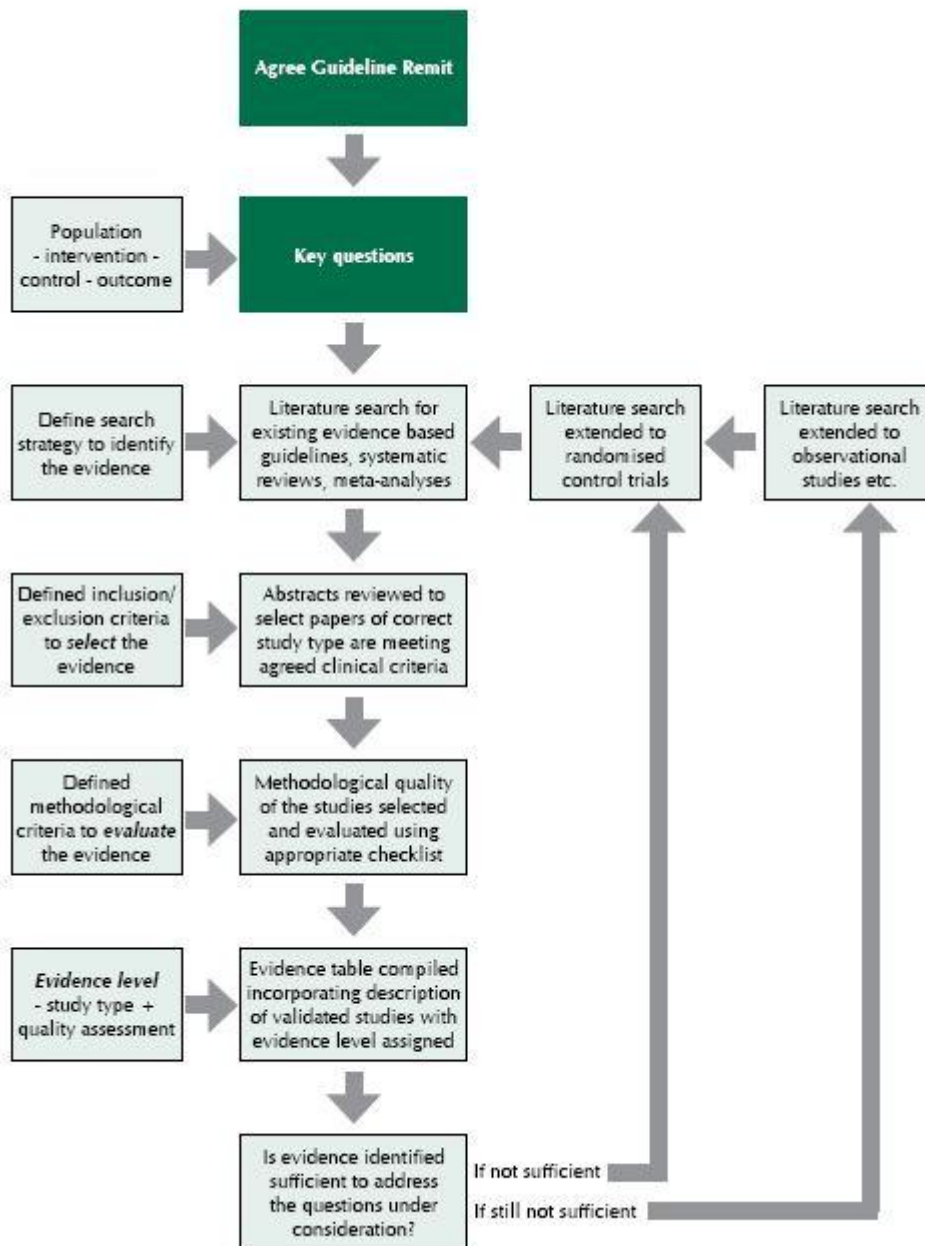
Guideline group members will sift through abstracts provided by the literature searches and will generate a list of references for which the full papers are required. Copies of papers may be obtained from:

- Journals/books held as personal copies by guideline group members
- Individual members' institutional library (or electronic library) subscriptions, eg via NHS or university Athens accounts.

The CRD can assist with ordering copies of journal articles that are otherwise difficult to locate.

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From SIGN 50



The systematic literature review procedure

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## SIGN Levels of Evidence

- 1++ High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
- 1+ Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias
- 1- Meta-analyses, systematic reviews, or RCTs with a high risk of bias
- 2++ High quality systematic reviews of case control or cohort studies  
High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
- 2+ Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
- 2- Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
- 3 Non-analytic studies, e.g. case reports, case series
- 4 Expert opinion

## SIGN Grades of recommendations

Grade	Type of evidence
A	At least one meta-analysis, systematic review, or RCT rated as 1++ and directly applicable to the target population <i>or</i>  A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+ directly applicable to the target population and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2++ directly applicable to the target population and demonstrating overall consistency of results <i>or</i>  Extrapolated evidence from studies rated as 1++ or 1+
C	A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results <i>or</i>  Extrapolated evidence from studies rated as 2++
D	Evidence level 3 or 4 <i>or</i>  Extrapolated evidence from studies rated as 2+
	Important practical points for which there is no, nor is there likely to be, any research evidence. The guideline committee wishes to emphasize these as Good Practice Points (GPP).

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## **Appendix 5**

This document was prepared by the BTS Audit Team to aid the formulation of BTS Audit tools.

### **Standard procedure for developing audit questions**

1. The purpose of this paper is to set out the procedure for the development of BTS audit tools.

### **Guidelines and Audit**

2. The BTS Standards of Care Committee Guideline Development Policy document includes the production of audit questions as one of the required elements of a new or revised BTS guideline.
3. Each Guideline Group should be provided with the following information and should consider possible audit questions when the guideline is finalised. Particular attention should be paid to the literature reviews and recommendations, and if required, a subgroup of the main guideline group should be identified to develop the audit. Alternatively, one member of the guideline group may be assigned responsibility for audit.
4. Proposals for new audits (those linked to Guideline publication, as well as those that may be required to address a particular need) will be considered and approved by the Professional and Organisational Standards Committee.

### **Development of Audit Tools**

5. In considering audit points, the following points should be borne in mind:
  - The strength of the evidence (the stronger the evidence the more dogmatic we can be about doing  $x,y,z$ );
  - Concerns about poor practice (greater concern might fuel the argument for collecting evidence to drive the case for improvement; conversely we might also want to collect data showing what is being done well);
  - The information to be collected to ascertain what is happening, for any item (bear in mind that if information is needed which requires judgements, rather than easily collected facts, the different judgements being made by different collectors of audit data might make the audit uninterpretable).
  - The amount of data that people will be asked to collect – this should be realistic and not too lengthy.
6. A set of draft audit questions (that is, the set of questions to which answers are required), should be prepared and referenced to the guideline for the evidence backing each question, where possible; eg what grades of staff undertake drain insertions & what prior training have they received? (The reference here would be to safety aspects of drain insertion). Further information regarding the details to be provided is given in below.
7. A draft set of audit points should then be sent to BTS Head Office to be reviewed and refined by discussions involving a subgroup from the guideline committee and the BTS audit team.

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8. When a final draft format has been agreed the questions will be set up on the audit system and piloted (to ensure that the data entry and reporting functions work correctly). If the pilot reveals any problems these should be rectified before the audit tool goes live. The guideline group/SAG should be sent the submitted data every year for review and comment.

9. Information required for each audit:

Title

Aim/objective (with reference to guideline/literature)

Case definition: what patients should be included/excluded

National audit period: to be agreed with audit team

Minimum number of cases to be recorded per institution

Set of audit questions with answer options

Description of reports with any specific requirements (eg calculation fields, formulae etc)

BTS Audit Team

October 2009

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**Appendix 6 – Supporting information**

Each Guideline should include the following information which may be most appropriately included as web-based appendices to the published document:

**Patient Information**

Guideline groups should provide examples of patient information leaflets as appropriate to the topic of the guideline, where these are not provided by other patient groups or lung charities. BTS Head Office will provide advice in relation to the development of patient information.

**Education materials**

The Guideline Group will be asked to develop educational materials to assist with the dissemination and implementation of the Guideline recommendations. Educational materials may be produced in one or more of the following formats:

As the topic of a session at the BTS Summer or Winter Meeting following (or just prior to) Guideline publication;

As the subject of a BTS Short Course

As the subject for the development of a module as part of the BTS Learning Hub

As a series of supplementary documents or powerpoint files made available to accompany the published guideline;

BTS Head Office will provide advice and assistance for the production of this supporting material.

**Research recommendations**

As part of the Guideline production process, Guideline Groups should provide a list of recommendations for further research. Research recommendations can be provided as an appendix to the main Guideline and will be passed to the BTS Science and Research Committee following publication of the Guideline.

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**Appendix 7**

**Quality Standards**

The Society aims to produce a Quality Standards document based on the recommendations of each BTS Guideline.

The procedure for the production of BTS Quality Standards can be obtained from BTS Head Office.

July 2012

Date of Production: March 2009

Approved by Standards of Care Committee: 1 July 2010, 23 June 2011, 26 June 2012, 25 June 2013

Due for next review: July 2014

**British Thoracic Society  
Guideline Production Manual 2013**

**Appendix 8**

**BTS Guidelines: Principles and procedures for publication in Thorax**

BTS Guidelines are produced under the auspices of the BTS Standards of Care Committee, in line with the policies and processes contained in the BTS Guideline Production Manual (2011).

BTS Guidelines are subject to a rigorous review and public consultation process as part of their development and are submitted to *Thorax* only after final approval by the BTS Standards of Care Committee. Following the agreement with the previous two sets of *Thorax* editors, BTS Guidelines are not subject to the Thorax peer review process and the content cannot be amended following submission (other than for journal style issues). The draft Guideline will be sent to Thorax editors as part of the formal consultation process and additional expert reviewers may be nominated by the editors at that point in the process (agreed June 2011).

Guidelines are submitted to *Thorax* through the journal's manuscript submission system and undergo the copy-editing and typesetting process. Where appropriate, appendices and other supporting information are provided as web-only documents. The full Guideline is published as a citable supplement to the main journal, published online via the *Thorax* website, and distributed as a paper copy to journal subscribers.

When published, a pdf of the Guideline supplement is provided to BTS by the *Thorax* production team and is made available to download from the BTS website. The Guideline is not made available via the BTS website until the Thorax supplement is published. Thorax editors will normally invite the Guideline authors to produce a one page summary of key points from the guideline to be published in the main Thorax journal.

BTS produces an Executive Summary or Quick Reference Guide which contains the key recommendations from the Guideline as well as important figures and tables. This is made available via the BTS website and may also be distributed as a paper copy to BTS members.

Please contact BTS Head Office for further information.

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