INTRODUCTION

The Clinical Effectiveness Group (CEG) of the British Association for Sexual Health (BASHH) develops national guidelines for the management of sexually transmitted infections (STIs) and related conditions. The purpose of these guidelines is to make clear and explicit recommendations for health care practitioners managing patients requiring diagnosis and management of these conditions. In 2011 BASHH achieved accreditation from the National Institute for Health and Care Excellence as a guideline producer. The BASHH guidelines are systematically developed and assessed in a robust and reproducible manner using the widely accepted “Appraisal of Guideline Research and Evaluation” (AGREE) instrument. The purpose of this document is to specify the methodology BASHH requires for guideline development and the process of guideline evaluation by the CEG. This is a development of the previously published CEG document which gave specifications for the BASHH guidelines.

METHOD OF GUIDELINE DEVELOPMENT

1. Guideline development is undertaken by a multi-disciplinary writing committee, with a lead author and a CEG editor appointed by the CEG to lead and co-ordinate the process and report on progress to the CEG regularly. Writing committee membership is decided by the lead author and CEG editor and will include relevant professional groups (for example genitourinary medicine physicians, nurses, health advisors, pharmacists, microbiologists and other professionals from allied specialities as appropriate) and when relevant this will involve working with the appropriate BASHH Special Interest Group (SIG) and the
BASHH National Audit Group. Writing committee and CEG members will sign the BASHH Conflict of interests (CoI) form (appendix 5).

2. Patients’ views and preferences should be sought and considered and the process documented. This may include patient representative involvement in the writing committee, information obtained from patient interviews or surveys during the writing and/or piloting process, reviewing published work on patient experiences or involving patient associations. The BASHH Public Panel also regularly review both draft guidelines and the accompanying patient information leaflets produced as guideline implementation tools.

3. Systematic, robust, reproducible and transparent strategies should be adopted to search for evidence with clear inclusion/exclusion strategies.

4. Recommendations should be formulated with consideration of their health benefits, side effects and risks, with evidence presented in the guideline that these issues have been addressed. Each recommendation should be linked to the supporting evidence with a list of relevant references. The GRADE system, adopted for use by BASHH as described in appendix 1, should be used to formulate and describe the strength of recommendation for intervention, treatment or tests. CEG and guideline development group members undergo training to use the GRADE system as described in appendix 1.

5. Consideration should be given to pragmatic and organisational issues relevant to the guideline. These may also be identified during the piloting of the guideline.

6. The authors should consider the cost implications of recommendations made as per the GRADE approach described in appendix 1.
7. Guidelines may recommend some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs should be marked with a footnote in the recommendations. The authors should also state that the prescriber should follow relevant professional guidance, taking full responsibility for the decision and that the patient (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.  

8. Where disagreement arises within the writing committee with regard to recommendations the writing committee should reach a consensus decision using the GRADE grid – see appendix 1. Members with a relevant declared CoI should be excluded from this process. If agreement cannot be reached the issue should be referred back to the CEG with supporting evidence and documents.

9. The particular needs of vulnerable groups such as MSM, young people and children, IVDU, BME, WSW and commercial sex workers and those with learning/physical disabilities should be considered and the writing committee may want to use an equality impact assessment tool (e.g. see: www.nice.org.uk/media/4DC/76/Item62_NEquIATTcTopicSelectionSMTA ppB221107.pdf ).

10. BASHH produce patient information leaflets (PILs) to support the implementation of their guidelines by clinicians and this should be undertaken by a member of the guideline writing committee in parallel to the main guideline’s development.
11. The CEG will review the draft guideline using the AGREE guideline appraisal tool, and following any final revisions the guideline will be externally peer reviewed by posting it on the BASHH website for a two month period and informing all BASHH members of the posting and inviting comments to be submitted to the CEG. At the same time the guideline will be sent to the BASHH public panel for their views and the BASHH national audit group for specific input into the recommended auditable outcome measures. Following this period the CEG Editor will collate the comments and send them to the chair of the writing committee for comment and action, as required.

12. The post-consultation draft of the guideline should be piloted for validation by a sample of target users. This will be co-ordinated by the CEG using health care professionals independent from the writing committee who adopt the guideline into their clinical practice in a virtual fashion for a period of time and then provide an evaluation using a standard feedback form; appendix 3.

13. The final guideline will be approved by the CEG and a review date agreed, upon which the CEG will decide the group to update the guideline and the above process will be re-visited. Should any interim evidence or comments be received which are thought to require a modification of the guideline by the CEG, the guideline may be amended prior to the agreed review date; this will be decided upon and action taken by the CEG.

14. The final guideline will be posted on the BASHH website with notification of BASHH members. Primary publication should be in a peer reviewed journal.

FORMAT, STRUCTURE AND CONTENT OF GUIDELINES

1. Format: A template guideline which specifies the format required by the CEG is given in appendix 2.
2. Specified content: This is to be inserted into guidelines at points in the guidelines referenced in appendix 2 and includes the following:

   a. The composition, discipline and relevant affiliation of members of the guideline development group, including CEG Editor/lead as final author on behalf of BASHH CEG.

   b. The objectives of the guideline including the potential health benefits for patients, the target patient population and also the target users of the guideline.

   c. Details of the search strategy including search terms, sources and dates of the literature reviewed, databases of systemic reviews, conference proceedings and other guidelines consulted.

   d. The methods used to formulate recommendations and the final decision making process, as described by the GRADE system (appendix 1).

   e. Details of any equality impact assessment should be stated.

   f. Description of the initial piloting of the guideline, feedback received from this pre-testing process and the incorporation of this feedback into the final draft (feedback forms specified in appendix 3).

   g. Auditable outcome measures. The BASHH National Audit Group should be invited to comment on these.

   h. Recommendations for further research should be considered and stated.

   i. The BASHH table of diagnostic tests should be updated as required.

   j. Statement of editorial independence – see appendix 4.

   k. Statement of conflict of interest. Members of BASHH guideline writing committees are required to complete the BASHH conflict of interest paperwork – see appendix 5.

   l. The composition, discipline and affiliation of members of the BASHH CEG at the time the guideline was written – see appendix 6.
3. Clarity of recommendations.
   a. The clinical questions covered by the guideline should be clearly described (with particular reference to key recommendations), for example specific treatment regimens and recommendations for follow-up.
   b. Where evidence and clinical practice allow, recommendations should be clear and definite. If the evidence is lacking or where there is uncertainty about the best management strategy the guideline should make this clear.
   c. Different strategies for prevention, screening, diagnosis, treatment and other aspects of patient management should be clearly stated with references to supporting evidence. These should be presented so that key recommendations addressing the most important clinical issues are easily identified by the guideline users. Authors may consider algorithms, flow charts, boxes or tables.

4. Supporting materials. These include tools for effective implementation of the guideline and may include the following
   a. Patient information leaflets – are developed by the CEG to accompany clinical guidelines. The standard format, processes for production, piloting and public panel input are described in appendix 7.
   b. A quick reference guide of key recommendations.
   c. Clinical care algorithms.

SUMMARY

In producing this latest framework for guideline development the CEG has updated its previous specification to clarify the steps involved, further embed patient and public involvement in the process and also change the method for formulating recommendations. The CEG now require that the GRADE system for formulating and stating the strength of recommendations is adopted and
this process for BASHH is described in appendix 1. This is in line with other NICE accredited guideline producers and so familiar with our target user group. The process summarising our guideline commissioning and producing processes are stated in appendices 8 and 9 to further clarify the writing process for guideline producers and appraisers. By adopting the online guideline appraisal tool developed by the AGREE organisation the CEG have a clear and consistent method for reviewing guidelines.

REFERENCES


5. AGREE. http://www.agreetrust.org/ Last accessed 3rd May 2013

APPENDIX 1:

GUIDANCE FOR GUIDELINE AUTHORS AND REVIEWERS FOR ADOPTING THE GRADE SYSTEM FOR ASSESSING EVIDENCE DURING GUIDELINE DEVELOPMENT

Introduction:

There has been a general move to using the GRADE system by many guideline producing bodies in recent years and the BMJ published a series of papers about the method in 2008:


The GRADE system applied in its purest form requires scientific analyses of evidence to produce “tables” from a series of “PICO” questions: Questions that identify the patient problem or population (P), intervention (I) (or
aetiology/diagnosis/frequency/prognosis), comparison (C) and outcome(s) (O). Practically this is very labour intensive and requires someone very experienced in this area, and many large guideline writing bodies employ a scientist to do this for them. However, some bodies adapt the GRADE system according to their own needs, assess the evidence in the way they have done in the past, and then make strengths of recommendations according the GRADE system, which when applied in this way is actually quite simple to do and understand. BASHH have adopted GRADE to use in this manner.

The principles of GRADE:

1. ASSESSMENT OF THE EVIDENCE

GRADE offers four levels of evidence quality: high, moderate, low, and very low, with randomised trials classed as high quality evidence and observational studies as low quality evidence. Quality may be downgraded as a result of limitations in study design or implementation, imprecision of estimates (wide confidence intervals), variability in results, indirectness of evidence, or publication bias. Quality may be upgraded because of a very large magnitude of effect, a dose-response gradient, and if all plausible biases would reduce an apparent treatment effect.

Summary of factors affecting quality of evidence:

- Study limitations
- Inconsistency of results
- Indirectness of evidence
- Imprecision
- Publication bias
- Factors that might increase quality of evidence
- Large magnitude of effect
- Plausible confounding, which would reduce a demonstrated effect
- Dose-response gradient

Based on the analysis of the evidence with these factors borne in mind the evidence should be graded as follows:
A: A body of evidence of high quality meta-analyses, systematic reviews of and RCTs directly applicable to the target population

B: As above but relating to high quality case control or cohort studies with low risk of bias or confounding and high probability that a relationship is causal

C: As B but trials may have some flaws

D: Non-analytic evidence eg. Case reports or series or expert opinion

However, when reviewing evidence graded A-D as above the grading can be altered follows:

- The strength of recommendation should be higher if the following apply:
  - A large effect of an intervention is demonstrated
  - Dose response/evidence of gradient
  - All plausible confounding would reduce a demonstrated effect or would suggest a spurious effect when results show no effect

- Lower if there is evidence of:
  - Serious/very serious study limitations
  - Inconsistency
  - Indirectness
  - Imprecision
  - Publication bias
  - Study limitations
  - Inconsistency of results
  - Indirectness of evidence
  - Imprecision
  - Publication bias

2. FORMULATING RECOMMENDATIONS
There are only two strengths of recommendation, which may be either for or against an intervention: 1 = strong or 2 = weak. Pragmatically this means the following:

**Strong recommendation for intervention**

For patients—Most people in this situation would want the recommended course of action and only a small proportion would not

For clinicians—Most people should receive the intervention

For quality monitors—Adherence to this recommendation could be used as a quality criterion or performance indicator. If clinicians choose not to follow such a recommendation, they should document their rationale

**Weak recommendation for intervention**

For patients—Most people in this situation would want the suggested course of action, but many would not

For clinicians—Examine the evidence or a summary of the evidence yourself and be prepared to discuss that evidence with patients, as well as their values and preferences

For quality monitors—Clinicians’ discussion or consideration of the pros and cons of the intervention, and their documentation of the discussion, could be used as a quality criterion.

**No specific recommendation**

The advantages and disadvantages are equivalent

The target population has not been identified

Insufficient evidence on which to formulate a recommendation

3. COMBINING 1&2: FOR EXAMPLE, AS DESCRIBED IN THE CURRENT BHIVA GUIDANCE MANUAL:
1A
Strong recommendation.
High-quality evidence.
Benefits clearly outweigh risk and burdens, or vice versa.
Consistent evidence from well performed randomised controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk.
Strong recommendations, can apply to most patients in most circumstances without reservation.
Clinicians should follow a strong recommendation unless there is a clear rationale for an alternative approach.

1B
Strong recommendation.
Moderate-quality evidence.
Benefits clearly outweigh risk and burdens, or vice versa.
Evidence from randomised controlled trials with important limitations (inconsistent results, methods flaws, indirect or imprecise), or very strong evidence of some other research design. Further research may impact our confidence in the estimate of benefit and risk.
Strong recommendation and applies to most patients.
Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.

1C
Strong recommendation.
Low-quality evidence.
Benefits appear to outweigh risk and burdens, or vice versa.
Evidence from observational studies, unsystematic clinical experience, or from randomised controlled trials with serious flaws. Any estimate of effect is uncertain.
Strong recommendation, and applies to most patients. Some of the evidence base supporting the recommendation is, however, of low quality.

1D
Strong recommendation.
Very low-quality evidence.
Benefits appear to outweigh risk and burdens, or vice versa.
Evidence limited to case studies. Strong recommendation based mainly on case studies and expert judgment.
4. CONSIDERATION OF USING PICO

This may be helpful if guideline writing committee wish to utilise this method, this is explained in the NICE guideline manual; chapter 4.6

Patients/population: which patients or population of patients are we interested in? How can they be best described? Are there subgroups that need to be considered?

Intervention: which intervention, treatment or approach should be used?

Comparison: what is/are the main alternative/s to compare with the intervention?

Outcome: what is really important for the patient? Which outcomes should be considered, such as intermediate or short-term measures; mortality; morbidity
and treatment complications; rates of relapse; late morbidity and readmission; return to work, physical and social functioning? Should other measures such as quality of life, general health status and costs be considered?

5. CONSIDERATION OF COSTS

These may or may not legitimately be included in the GRADE system, but it would be sensible in the current climate to always consider these, and if they are not considered this should be stated and why – for example, there is no significant difference in cost between the recommended treatments.

Generally speaking GRADE suggests a balance sheet should inform judgments about whether the net benefits are worth the incremental costs. Evidence profiles should always present resource use, not just monetary values.

6. USING THE GRADE GRID TO RESOLVE DIFFERENCES:

This supports the Delphi technique we already adopt, i.e. To develop a consensus within the group:
Summary

BASHH have now moved to the GRADE system for evaluating evidence and making recommendations by asking guideline authors and reviewers to apply the principles outlined in sections 1-3 above. Authors should consider structuring their analysis of evidence into PICO questions addressing Population / Intervention / Comparison / Outcome as stated in section 4. Costs should be included in the evaluation and formulation of recommendations as stated in section 5. When resolution of conflicting opinions is required the GRADE grid should be used. This appendix is a brief summary of the GRADE system how it is to be adopted by BASHH guideline authors.

7. GRADE TRAINING FOR BASHH GUIDELINE AUTHORS
Authors need to be familiar and confident in using the GRADE system, and training for this is available as follows:

1. The papers from the BMJ series in 2008, as listed in the introduction to this appendix. The articles can be accessed

<table>
<thead>
<tr>
<th>Grade score</th>
<th>1</th>
<th>2</th>
<th>0</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Desirable consequences of intervention clearly outweigh undesirable</td>
<td>Desirable probably outweigh undesirable</td>
<td>Trade offs equally balanced or uncertain</td>
<td>Undesirable probably outweighs desirable</td>
<td>Undesirable clearly outweighs desirable</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Strong: Definitely do it</td>
<td>Weak: Probably do it</td>
<td>No specific recommendation</td>
<td>Weak: Probably don’t do it</td>
<td>Strong: Definitely don’t do it</td>
</tr>
<tr>
<td>Panellists view</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
through the grade working group web site
at:  http://www.gradeworkinggroup.org/publications/index.htm

2. McMaster GRADE on line modules: these have been
recommended by the GRADE working group and take about 20
minutes each to complete. The web address
is: http://cebgrade.mcmaster.ca/

that is available through the GRADE working group website (link
above).
APPENDIX 2: TEMPLATE GUIDELINE & SPECIFIED CONTENT

TITLE

Clinical Effectiveness Group
British Association for Sexual Health and HIV

GENERIC CONTENT 2a: (see page X)

Where appropriate: *New in the 20xx guidelines:*

Introduction and Methodology
SPECIFIED CONTENT:
2b: Objectives
2c: Search strategy
2d: Methods
2e: Equality impact assessment
2f: Piloting & feedback

Aetiology

Clinical Features

Diagnosis

Management
  General advice
  Further Investigation
  Treatments:
Recommended & Alternative Regimens
Pregnancy & Breastfeeding
In HIV Positive Individuals
Reactions to Treatment
Follow-up
Contact tracing & treatment

SPECIFIED CONTENT
2f: Auditable outcomes
2g: Recommendations for further research
Piloting PIL devlpmnt etc as per text

Acknowledgements
Pilot sites, consultation responders making a significant contribution, etc

References Listed numerically in the Vancouver style alphabetically.

SPECIFIED CONTENT:
2g: Editorial independence – put here rather than separate appx
2h: Conflicts of interest – sample statement
2i: Membership of the Clinical Effectiveness Group
APPENDIX 3: PILOT FEEDBACK FORM

Guideline:

Dates for the period of guideline piloting:

Person undertaking the guideline piloting:
  Name:
  Affiliation:
  Date:

Good points about the guideline:

Points for improvement:

Any other general comments?
APPENDIX 4: STATEMENT OF EDITORIAL INDEPENDENCE

This guideline was commissioned, edited and endorsed by the BASHH CEG without external funding being sought or obtained.

All members of the guideline writing committee completed the BASHH conflicts of interest declaration detailed below at the time the guideline’s final draft was submitted to the CEG. The details of any actual or potential conflicts of interest will be documented by the CEG at this point in the guideline.
APPENDIX 5: BASHH CONFLICT OF INTERESTS DECLARATION:

Editorial independence of the BASHH CEG:

The BASHH Clinical Effectiveness Group (CEG) receives funding exclusively from BASHH for room hire and refreshments and for travel from either BASHH or from member’s employers. The professional activities of BASHH are funded by membership fees from the health care professionals subscribing to the organisation. The recommendations made in the clinical guidelines commissioned by the CEG are based on evidence from the medical literature synthesised according to the guideline production manual. The CEG functions independently of the BASHH board and so we believe that the no views or interests of the funding body influence the final guideline recommendations.

Ensuring editorial independence of the BASHH CEG members and guideline authors:

Whenever possible, members should not have CoI relevant to their role and members with CoI should represent not more than a minority of the group. The chair or co-chairs should not be a person(s) with a CoI.

For CEG members the guideline CoI form is completed at least every 3 years and for authors before they commence work on a guideline. If an individual’s circumstances regarding CoI change a new form should be submitted as soon as possible.

All CoI of each member should be reported and discussed openly by the prospective development group prior to the onset of the work. Each panel member should explain how their CoI could influence the guideline development process or specific recommendations. Chairs and vice chairs should not have any personal professional financial interests that are relevant to guideline production.
Potential for bias should be taken into account through a combination of factors, for example, systematic literature review, critical appraisal, peer review, editorial independence and a conflicts-of-interest policy. Details on the credibility and any potential bias of the guidance in general, and the conclusions and recommendations in particular should be stated in the guideline in question.

**As a current member of the CEG, or as an author involved in guideline production for the BASHH CEG I declare that:**

☐ Prior to accepting the invitation to participate in the BASHH CEG or a guideline development group I declared all interests and activities potentially resulting in conflicts of interest (CoI) with development group activity, by written disclosure to those convening the group. This disclosure reflects all current and planned commercial, non-commercial, intellectual, institutional, and patient/public activities pertinent to the potential scope of the guideline. If my circumstances with regard to this change during guideline production I will inform the BASHH CEG editor and lead guideline author.

☐ Any CoI s have been clearly declared and the impact they may have on the guidance process and development of recommendations has been stated and considered by the CEG.

☐ I have divested myself of financial investments I or my family members have in, and not participate in marketing activities or advisory boards of those whose interests could be affected by the guideline recommendations

Any relevant personal professional interests are declared here including personal professional financial interests:

Name:
Signature:
Guideline group:
APPENDIX 6: CEG COMPOSITION

From January 2015 the membership of the CEG is:
Dr Keith Radcliffe (Chair)
Dr Darren Cousins
Dr Mark FitzGerald
Professor Martin Fisher
Dr Deepa Grover
Dr Sarah Hardman
Dr Stephen Higgins
Dr Margaret Kingston
Dr Michael Rayment
Dr Ann Sullivan
APPENDIX 7: PATIENT INFORMATION LEAFLETS

1. PIL production process

PIL editor: Dr Stephen Higgins

Guideline writing group (GWG) produces first draft of PIL which should-
• be based on information in the guideline.
• Conform to the BASHH PIL template
PIL First draft reviewed by PIL editor (PILE).
When PILE is happy with draft he/she submits it to CEG and then the BASHH
Public Panel for review.
PILE modifies draft following CEG and Public Panel recommendations.
PIL is then sent to pilot GUM clinics. They will give the PIL (and patient
questionnaire) to patients for approximately a month, or until 10 feedback
forms have been received. The trial period can be extended when the PIL
relates to less common infections or clinical scenarios.
Pilot GUM clinics send patient feedback summary to PILE who acts on this as
required.
PIL reviewed by volunteer for Public Panel, currently Marian Nicholson (of
Herpes Viruses Association) for typographical errors, formatting, etc, and
returns to PILE.
PILE sends final draft of PIL to graphic designer after CEG review.
Graphic designer sends web-ready draft to PILE, who sends it on to BASHH
web master. PIL is posted on BASHH web site.
Note: In future BASHH intends to have all its PILs stamped with the
‘Information Standard.’ Conforming to the IS will alter this development
template from its current form.
2. PIL Template

XX - the basics

How common is XX?

How do you catch xx?

What would I notice if I had xx?

How do I get tested for xx?

How is xx treated?

Important information about your treatment

What about my partner?

When can I have sex again?

What happens if my xx is left untreated?

Can I catch xx again?

xx in pregnancy

More information: http://www.bashh.org/guidelines

xxx 201x: Leaflet produced by the Clinical Effectiveness Group of the British Association for Sexual Health and HIV

Acknowledgement: CEG and writing group lead

Copyright BASHH 2013
3. Pilot PIL feedback form there were 2 forms I think as need one for patients and staff to fill in each time and then a summary one –should include n=

PIL:

Dates for the period of PIL piloting:

Person undertaking the PIL piloting:

Name:

Affiliation:

Date:

Good points about the PIL:

Points for improvement:

Any other general comments?

PUBLIC PANEL REVIEW:
Date:

Good points about the PIL:

Points for improvement:

Any other general comments?
APPENDIX 8: PATHWAY FOR GUIDELINE COMMISSIONING

1. The CEG decides to review an existing guideline or commission a new one.

2. Lead CEG author is appointed and guideline writing committee chair identified together with possible group members by the CEG.

3. The CEG chair writes to the proposed guideline writing committee chair with the standard letter, pathway for authors, guidance on GRADE and framework for guideline development and invites them, with the lead CEG author, to form a multi-disciplinary writing group.

4. The guideline writing committee, together overseen by the CEG lead, produce a draft guideline.

5. The draft guideline is reviewed by the CEG members using the AGREE appraisal tool and feedback given to the writing committee chair. The second draft of the guideline is piloted by GU physicians and reviewed by the patient panel. Patient information is produced and also reviewed by the BASHH Public Panel. Any amendments are made by the writing committee.

6. The third and final draft of the guideline is placed on the BASHH website for two months and publicised to members via the monthly newsletter, with comments being received by the CEG lead author and referred as necessary for consideration to the writing committee.

7. The finalised guideline is adopted for use by BASHH, placed on the BASHH website and if appropriate submitted for publication.
APPENDIX 9: PATHWAY FOR GUIDELINE AUTHORS

1. The multi-disciplinary writing committee is formed by the chair and the CEG lead for the guideline. The people on the writing committee will depend on the guideline, but generally speaking consideration should be given to include the following:
   a. GUM physician
   b. GUM nurse
   c. Health advisor
   d. Pharmacist
   e. Virologist/microbiologist
   f. Patient representative (this may be after the writing and at the reviewing stage, or a patient may be involved from the outset, but patient involvement is an absolute requirement).
   g. Specialists from allied specialties, as appropriate, for example, gynaecology, urology, obstetrics, paediatrics).

2. Tasks for each member of the writing committee to be allocated by the chair of the writing committee with a time frame set for completion.

3. The writing committee should agree how the work will be carried out and whether they may choose to meet regularly, communicate by email or teleconference, or a combination of the two.

4. The BASHH framework for guideline development must be adhered to, with evidence reviewed, recommendations formulated and graded, and the layout of the guideline as specified in this document.

5. The first draft of the guideline to be reviewed and commented on by the writing committee and the CEG lead author, then when ready for dissemination by the CEG using the AGREE tool for guideline appraisal.

6. Comments from the CEG to be considered by the guideline writing committee, the guideline then piloted using the BASHH feedback form, by appropriate GUM clinics.

7. At this stage, an in parallel to stage 6, the BASHH Public Panel should review the guideline.
8. Feedback from the piloting and review from the public panel should be considered by the writing committee, the CEG and a final draft produced for consultation on the website for two months with feedback to the CEG lead author. Feedback from this process should be considered by the writing committee and the finalised guideline produced and approved by the CEG.

9. The finalised guideline is placed on the BASHH website, and consideration should be given to submission for publication in a specialty journal.
APPENDIX 10: Flow chart summarising the BASHH guideline development process

**Time frame**
CEG annually

Guideline topics for the year agreed by the CEG determined by existing guideline revision dates or new evidence or a need for new guidelines based on emerging evidence or practice.

**6 months**

Writing group formed & produces initial draft of guideline with input from CEG editor

**1 month**

Initial guideline draft reviewed by CEG using AGREE tool & feedback to writing group for review & produce next draft.

**2 months**

Draft for wider consultation produced & placed on BASHH website, sent to the public panel & the national audit group for their input

**2 months**

Writing group consider comments from the consultation and produce final draft for CEG review & piloting in their clinics

**1 month**

Final draft of guideline is produced following piloting & consultation & is approved by the CEG to be placed on the BASHH website as a ratified guideline and may be submitted for publication