Scoping project:

Evaluating clinical guideline coordination units globally

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Abbreviations and acronyms

AHRQ	Agency for Healthcare Research and Quality
BPAC^{NZ}	Best Practice Advocacy Centre New Zealand
CENETEC	Centro Nacional de Excelencia Tecnológica en Salud
CONITEC	National Committee for Health Technology Incorporation
CPG	Clinical Practice Guideline
EBHC	Saudi Center for Evidence Based Healthcare
EBM	Evidence Based Medicine
GESummit17	Global Evidence Summit 2017
G-I-N	Guidelines International Network
GRC	Guideline Review Committee
HAS	Haute Autorité de Santé
HSRU	Health Systems Research Unit
HTA	Health Technology Assessment
IETS	Instituto de Evaluación Tecnológica en Salud (IETS)
INAHTA	International Network of Agencies for Health Technology Assessment
KSA	Kingdom of Saudi Arabia
LMICs	Low and Middle Income Countries
NCEC	National Clinical Effectiveness Committee
NDoH	National Department of Health
NGPC	National Guideline and Pathway Committee
NICE	National Institute for Health and Care Excellence
NHMRC	National Health and Medical Research Council
NZGG	New Zealand Guidelines Group
MoH	Ministry of Health
SAGE	South African Guidelines Excellence
SAMRC	South African Medical Research Council
SIGN	Scottish Intercollegiate Guidelines Network

UK	United Kingdom
US	United States of America
WHO	World Health Organization

Summary

Background

The South African Guidelines Excellence (SAGE) project is a South African Medical Research Council (SAMRC) Flagship funded project. Members of the clinical guideline interest community and the SAGE Strategic Advisory Board expressed the need for a National Clinical Guideline Coordinating Unit, driven, funded and endorsed by the South African National Department of Health (NDoH). The structure and functions of such a unit are not clear. This study explored the potential scope for such a unit, as well as the operating principles, by reviewing a sample of clinical guideline coordination units globally.

Methodology

This study is a cross-sectional review of a sample of current guideline units globally. The process was a three phase approach to: 1) identify possible units; 2) verify the sample; and 3) to explore the structure and functions of the sample.

Phase 1 of the project included a broad search in Google and Pubmed, as well as consultations with the SAGE management and Advisory Board team members, to find relevant units in the field of clinical guideline development. Recommendations were made regarding the units to be included in the next phase of the project.

During phase 2 of the project, additional consultations were conducted (SAGE Methods Advisory Group and Advisory Board, Guidelines International Network (G-I-N), contacts of contacts, participants of the Global Evidence Summit 2017) for inclusion of additional units. Using information available online, either on the unit website or in documents, data was collected on the following for all selected units: Name unit; Website; Country; Purpose; Sub-objectives; Tasks / Scope; Place of the unit within the healthcare system; (Legislative) mandate; Date established and reason establishment; Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram); Human resources; Funding (amount, sources, duration); Guideline development processes; Outputs e.g. guidelines produced; Implementation, monitoring and evaluation; 3 key challenges and facilitators in establishing the unit; 3 key challenges and facilitators regarding the ongoing functioning of the unit; Collaborators; and Contact information.

During phase 3 of the project, secretariats / contact persons of the included units were approached with the request to check the correctness of the information collected from online sources (if any) and to add missing information.

Results

We included 21 units, nine are part of government (mainly MoH) and 10 are units within a larger organisation. Human resources and funding differ substantially among the units. Most (15) organizations are financed exclusively by the government (mostly the MoH).

Agency for Healthcare Research and Quality (AHRQ) / National Guideline Clearinghouse (United States)	**National Guideline and Pathway Committee (Qatar)**	**Australian CPGs / National Health and Medical Research Council (Australia)**	**Instituto de Evaluación Tecnológica en Salud (IETS) (Colombia)**
CONITEC – National Committee for Health Technology Incorporation (Brazil)	**National Institute for Health and Care Excellence (NICE) (UK)**	**Best Practice Advocacy Centre (New Zealand)**	**Medical Information Network Distribution Service (Minds) project, Japan Council for Quality Health Care (Japan)**
Guideline Review Committee and GRC	**Saudi Center for Evidence Based**	**Clinical Evidence Unit (Chile)**	**National Center for Health Technology**

Secretariat (WHO)	**Healthcare (EBHC) (Kingdom of Saudi Arabia)**		**Excellence (CENETEC) (Mexico)**
Haute Autorité de Santé (HAS) (France)	**Scottish Intercollegiate Guidelines Network (SIGN) (Scotland)**	**Clinical Excellence Unit (Iran)**	**New Zealand Guidelines Group (New Zealand)**
National Clinical Effectiveness Committee (Ireland)	**AUB Grade Center (Lebanon)**	**Duodecim Finnish Medical Society and Medical Publications Ltd (Finland)**	

When looking at the purpose / main objective of the units, these are development of CPGs using accepted methodologies (e.g. systematic reviews, AGREE, GRADE, consensus) (7 units); provide access to CPGs (clearinghouse – database of CPGs on a website) (4 units); approve/endorsement for implementation (3 units); adopt, contextualise (by addressing implementation issues of existing recommendations), adapt (by changing the existing recommendations) CPGs (3 units); methodological support (2 units); HTA (2 units). Besides these objectives, other tasks mentioned were: Commission CPGs; Critical appraisal; Approve / endorse for implementation; Standards / guideline development; Capacity building; Implementation; M&E (implementation, impact); Coordination/governance; Prioritisation; Communication strategy; and invite multidisciplinary partners.

The number of CPGs available online differs: from 218 to 1 726 for clearinghouses, to 4 to 429 for units websites. Most units consider the implementation the responsibility of the developers / organisations they develop the guidelines for, although some (6) do provide support / facilitation with the process.

Key challenges in establishing and ongoing functioning of the units are funding, human resources, getting buy-in, technical and methodological issues.

Units collaborate with a range of partners: medical professional organisations; guideline developer organisations - (inter)national; International organisations (e.g. WHO, Cochrane, G-I-N, HTA networks); Academic institutions, GRADE working groups; Government (mainly MoH); healthcare providers, insurers.

Way forward

Despite the differences in the settings clinical guideline coordination units operated in, in South Africa we can learn from the other units, especially regarding the objectives / tasks they perform, and the challenges they face. Key stakeholders in South Africa should now look carefully at what tasks could potentially be conducted by such a unit and link these to the needs of the country, and based on that decide on the operating principles of the unit. If needed, some organisations from this study could be reviewed further.

Background to SAGE project

The South African Guidelines Excellence (SAGE) project is a South African Medical Research Council (SAMRC) Flagship funded project. The project is developing an innovative partnership that aims to enhance the quality of primary health care by engaging in a stakeholder driven process to improve the standards of local guideline development, adaptation, contextualisation and ultimately implementation. SAGE is a collaborative research project including Cochrane South Africa and the Health Systems Research Unit (HSRU), SAMRC; Centre for Evidence-Based Health Care and Division of Physiotherapy, Stellenbosch University; and International Centre for Allied Health Evidence, University of South Australia.

SAGE is managing five project stages: stakeholder mapping strategies and identification of implementation enablers and constraints, local guideline quality evaluation, systematic review of 'gold standard' implementation, and capacity building for guideline developers.

Background/rationale scoping project: Evaluating clinical guideline coordination units globally

SAGE stakeholders including those consulted at the Summit in February 2016 and the Strategic Advisory Board expressed a need for a National Clinical Guideline Coordinating Unit, driven, funded and endorsed by the National Department of Health (NDoH), but possibly functioning independently. This unit could undertake the following:

- Lead prioritisation for the NDoH;
- Develop clear standards and provide good governance;
- Develop a clear communication strategy;
- Invite multi-disciplinary/sectoral panels to participate in guideline work (government, academia including professional societies and colleges, medical schemes and health care providers in the public and private sector);
- Provide online platforms to facilitate e-access, provide process for feedback and avoid duplication; and,
- Act as a referencing and credentialing group.

A request was put forward for guidance from the SAGE research team regarding the potential scope for a South African National Clinical Guidelines Coordination Unit.

Globally, there are many models of units that provide this coordinated service. A review of such models may be helpful to identify possible success factors for these units and to identify the best, most cost-effective approach for South Africa.

Scoping project objectives

To conduct a defined research project exploring e.g. the purpose, scope and operating principles (including funding models, staffing) of a sample of clinical guidelines coordination units in different countries or settings globally.

Areas to explore include, but are not limited to: different countries and settings e.g. United States, World Health Organisation (WHO), United Kingdom and possibly 2-3 options in low- and middle-income countries (LMICs); clarify glossary e.g. what is a clearing house vs Health Technology Assessment (HTA) unit or other approaches.

Methodology

A protocol was developed describing the proposed approach for the evaluation and this was reviewed and approved by the SAGE management team. It was decided that the scoping project will be conducted in three phases with respect to identifying and collecting information on units. The current report covers all phases of the project.

Phase 1

A broad search in Google and Pubmed was conducted in May 2017 to find relevant units in the field of clinical guideline development.

The following key words were used: clinical guideline AND coordination OR clearinghouse OR organisation/organisation OR centre/center OR network OR program/programme OR committee OR department/ministry of health (MoH) OR institute OR consortium OR agency OR Health Technology Assessment/HTA.

High level information was collected on the units found: Name unit; Website; Country; Purpose.

The SAGE management team was consulted to identify any additional potential units. Furthermore, recommendations were made which units should be included in the next phase of the project.

The focus was on (inter)national units that advise government, not e.g. international units, or clinical guideline groups within organisations of health professionals. Furthermore, the focus was on clinical guidelines units, not on units conducting HTA only (although the latter could be part of the first).

It must be noted that units in LMICs might have been missed if they don't have a website and/or are not part of an international network that provides information on the unit. Furthermore, the search was conducted in English, so websites that are not found via the English keywords above might have been missed.

Phase 2

The SAGE methods advisory group and advisory board were contacted by email (August 2017) to request suggestions for countries, especially LMICs, which might have relevant units (including the names and contact details for these units), in addition to those included in the phase 1 report. They were also asked to comment on the selected units for phase 2 of the report. Finally their input was requested on the list of items on which information should be collected for each unit.

Also via Guidelines International Network (G-I-N), contacts of contacts, and through approaching participants of the Global Evidence Summit 2017 (GESummit17), which was held from 13-16 September 2017 in Cape Town, additional units were found (see the Acknowledgements section for all those involved).

Using information available online, either on the unit website or in documents (e.g. handbooks, annual reports, scientific articles, brochures, presentations), data was collected on the following for all selected units:

- Name unit
- Website
- Country
- Purpose
- Sub-objectives
- Tasks / Scope
- Place of the unit within the healthcare system
- (Legislative) mandate

- Date established; reason establishment
- Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)
- Human resources
- Funding (amount, sources, duration)
- Guideline development processes
- Outputs e.g. guidelines produced
- Implementation, monitoring and evaluation
- 3 key challenges and facilitators in establishing the unit
- 3 key challenges and facilitators regarding the ongoing functioning of the unit
- Collaborators
- Contact information

Phase 3

Secretariats / contact persons of the included units were approached (August 2017) by email with the request to check the correctness of the information collected from online sources (if any) and to add missing information. For some units meetings to accomplish the same were held during the GESummit17 and for others Skype calls were conducted.

Results – unit identification and data collection

Phase 1

24 Relevant units were found in the broad search and no additional units were proposed by the SAGE management team:

1. Agency for Healthcare Research and Quality (AHRQ) / National Guideline Clearinghouse	13. Institute for Quality and Efficiency in Health Care or Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (IQWiG)
2. Australian Clinical Practice Guidelines / National Health and Medical Research Council	14. Institut national d'excellence en santé et en services sociaux (INESSS)
3. Andalusian Agency for Health Technology Assessment (AETSA)	15. Instituto de Evaluación Tecnológica en Salud (IETS)
4. Catalan Agency for Health Information, Assessment and Quality (CAHIAQ) or Agència de Qualitat i Avaluació Sanitàries de Catalunya (AQuAS)	16. National Care Management Program [Programm für Nationale VersorgungsLeitlinien]
5. Centre of Standardization of the Republican Centre for Health Development (RCHD-CS)	17. National Center for Health Technology Excellence or Centro Nacional de Excelencia Tecnológica en Salud (CENETEC)
6. CONITEC – National Committee for Health Technology Incorporation	18. National Clinical Effectiveness Committee
7. CPG Infobase: Clinical Practice Guidelines	19. National Guideline and Pathway Committee
8. Guidelines International Network	20. National Guideline Centre (NGC)
9. Guideline Review Committee and GRC Secretariat (WHO)	21. National Institute for Health and Care Excellence (NICE)

10. Haute Autorité de Santé (HAS)	22. Norwegian Institute of Public Health (NIPH)
11. Health Sciences Institute in Aragon (IACS)	23. Saudi Center for Evidence Based Healthcare (EBHC)
12. Health Technology Assessment Section, Ministry of Health Malaysia	24. Scottish Intercollegiate Guidelines Network (SIGN)

A description of the high level information collected on these units found is given in the tables in Appendix 1 (Name unit - in alphabetical order; Website; Country; Purpose). This also includes some short notes related to the information found.

No information was found from low-income countries. Information from five upper middle-income countries was found (Brazil, Colombia, Kazakhstan, Malaysia, and Mexico), however, only limited information was found on the International Network of Agencies for Health Technology Assessment (INAHTA) website, and the units websites (if available) were not in English. It was considered, however, to be interesting for South Africa to know more about the unit in Brazil, since this country is part of BRICS.

Language was also an issue for units from high-income countries, as some websites are only in the local language.

The selection of units to review in more detail focusses more on units that are linked to the government (MoH) and the national health care system.

Based on the high level information, the recommendation was to include the following units in phase 2 of the project to collect further in-depth information available online (in alphabetical order):

1. Agency for Healthcare Research and Quality (AHRQ) / National Guideline Clearinghouse (United States)
2. CONITEC – National Committee for Health Technology Incorporation (Brazil)
3. Guideline Review Committee and GRC Secretariat (WHO)
4. Haute Autorité de Santé (HAS) (France)
5. National Clinical Effectiveness Committee (Ireland)
6. National Guideline and Pathway Committee (Qatar)
7. National Institute for Health and Care Excellence (NICE) (UK)
8. Saudi Center for Evidence Based Healthcare (EBHC) (Kingdom of Saudi Arabia)
9. Scottish Intercollegiate Guidelines Network (SIGN) (Scotland)

Note that technically speaking the WHO is not a country, however, the structure of the GRC and GRC secretariat was considered to be of interest to South Africa, and hence we decided to look at the organisation WHO as a country.

The report on phase 1 of the study was reviewed and approved by the SAGE management team.

Phase 2

The SAGE advisory board recommended including the following countries: Australia, Colombia, Cuba, Ghana, Japan, Mauritius, Mexico, New Zealand, Thailand, Turkey and Zambia. Australia, Colombia and Mexico were included in the phase 1 report and now added to the selection for phase 2 as well. Information was found on units in Japan and New Zealand (one past and one current unit) and this was added to the phase 2 results. For the other countries no information was found online and no contact details could be retrieved, except for Zambia for which it was indicated that there is no such unit.

The SAGE methods advisory group recommend contact persons in the following countries to check on the existence of a relevant unit: Chile, Colombia, Nigeria, Thailand and countries in the Eastern Mediterranean Region (Lebanon, Egypt). As indicated above, Columbia was added to phase 2 already and for the other countries the contact persons were approached by email. It was indicated (and confirmed during the GESummit17) that Nigeria does not have a guideline unit, and also Thailand and Egypt do not have one. Information on the Clinical Evidence Unit in the MoH in Chile, which is hosted within the Department of Health Technology Assessment and Evidence Based Healthcare, and the AUB Grade Center in Lebanon was included.

Via G-I-N, contacts from contacts and participants of the GESummit2017, the following countries were suggested: China, Finland, India, and Iran. There is no such unit in India or China (although the latter has an EBM/GRADE support centre). Information from Finland and Iran was included.

So based on additional input the following 10 units (alphabetical order) were added to phase 2, giving a total of 19 units included in this phase:

10. AUB Grade Center (Lebanon)
11. Australian CPGs / National Health and Medical Research Council (Australia)
12. Best Practice Advocacy Centre (New Zealand)
13. Clinical Evidence Unit (Chile)
14. Clinical Excellence Unit (Iran)
15. Duodecim (Finland)
16. Instituto de Evaluación Tecnológica en Salud (IETS) (Colombia)
17. Medical Information Network Distribution Service (Minds) project, Japan Council for Quality Health Care (Japan)
18. National Center for Health Technology Excellence (CENETEC) (Mexico)
19. New Zealand Guidelines Group (New Zealand)

Even the extended search did not retrieve any information on low-income countries, only four upper middle-income countries were included in addition: Colombia, Iran, Lebanon and Mexico. The results section looking at similarities and dissimilarities between the different units does not take income into account as all four units turned out to have different main objectives.

Also some additional items (reason establishment; funding duration; 3 key challenges and facilitators in establishing the unit; 3 key challenges and facilitators regarding the ongoing functioning of the unit; collaborators) were added based on feedback from the SAGE methods advisory group to the original list used to collect information on all the units.

All information collected was documented in the form of descriptions of each of the units in Appendix 2. [Note that this also includes additional information retrieved in Phase 3 of the project.]

Phase 3

Of the 19 units included all, except for Best Practice Advocacy Centre (New Zealand), Saudi Center for Evidence Based Healthcare, and National Guideline and Pathway Committee (Qatar) (even after regular follow-ups), provided feedback to the information collected by email, Skype or face-to-face meeting.

Results – similarities and differences units

The information from the 19 individual units provided in Appendix 2 is summarized below in text and tables to look at similarities and differences between the units. Note that 2 of the units explored actually consist of 2 separate entities and hence a total of 21 units are included in the tables.

Date and reason establishment

As can be seen in Figure 1 and Table 1, five of the units have been established in the last five years; another 11 in the period 1998-2012; and the remaining five in 1997 or earlier (the EBM guidelines pilot in Finland started in 1989).

The reasons for establishment vary slightly, but all relate in the end to improving the quality of healthcare based on evidence: standardising CPGs; providing methodological support for CPGs; capacity building in CPGs; making CPGs available (timely).

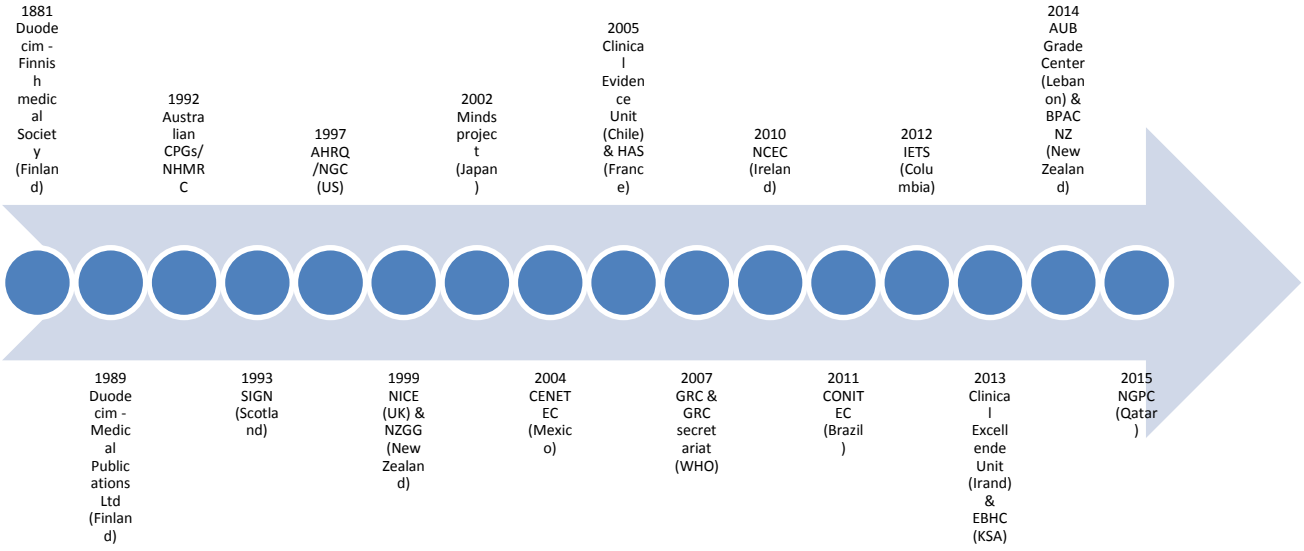

Figure 1. Date establishment of clinical guideline coordination units.

Table 1. Date and reason establishment clinical guideline coordination units

Units	Date establishment/active	Reason establishment
AHRQ/NGC (US)	1997	Difficult to find CPGs; No standard reporting format.
AUB Grade Center (Lebanon)	2014	Methodological support and capacity building needed.
Australian CPGs/NHMRC	1992	-
BPAC^{nz} (New	2014	Less expensive and resource intensive way to get

Units	Date establishment/active	Reason establishment
Zealand)*		CPGs.
Clinical Evidence Unit (Chile)	2005	National protocols needed to address priority health problems.
Clinical Excellence Unit (Iran)	2013	Inform reimbursement of interventions.
CONITEC (Brazil)	2011	-
Duodecim – Finnish Medical Society (Finland)	1881 (guideline development unknown)	-
Duodecim – Medical Publications Ltd (Finland)	1989	-
GRC (WHO)	2007	Ensure high quality guidelines developed using a transparent and explicit progress, based on evidence.
GRC secretariat (WHO)	2007	Ensure high quality guidelines developed using a transparent and explicit progress, based on evidence.
HAS (France)	2005	Single body with expertise for patient-centred continuous quality improvement.
IETS (Columbia)	2012	-
Minds project (Japan)	2002	-
CENETEC (Mexico)	2004	Need for reliable and timely information on health technologies by decision and policy makers.
NCEC (Ireland)	2010	-
NGPC (Qatar)*	2015	Gap between current practice in the country and international best practice.
NICE (UK)	1999	Create common standards of evidence based care in the country.
NZGG (New Zealand)	1999-2012 (end date)	Establishing evidence based healthcare.
EBHC (KSA)*	2013?	-
SIGN (Scotland)	1993	-

* Information not verified by unit.

Purpose and sub-objectives, tasks / scope

Table 2 combines the purpose, sub-objectives and tasks or scope of the units. This is not only based on the information reported in these sections of the data collection form, but also on other information provided in the form. This information is also available in the separate Excel overview document linked to this report.

Table 2. Purpose, sub-objectives, tasks / scope clinical guideline coordination units																
Units	**Develop CPGs**	**Adopt, Contextua-lise, Adapt CPGs**	**Commissio n CPGs**	**Provide online access**	**Critical appraisal**	**Approve / endorse for implement ation**	**HTA**	**Methodo-logical support**	**Standards / guideline develop-ment**	**Capacity building**	**Implemen-tation**	**M&E (implemen tation, impact)**	**Coordina-tion/gover -nance**	**Prioriti-sation**	**Communi-cation strategy**	**Invite multi-disciplin-ary partners**
AHRQ/NGC (US)				x	x											
AUB Grade Center (Lebanon)	x	x						x		x						
Australian CPGs/NHMRC	x			x	x			x	x				x			
BPAC^{nz} (New Zealand)*		x		x												
CENETEC (Mexico)	x			x			x					x				
Clinical Evidence Unit (Chile)	x			x				x		x						
Clinical Excellence Unit (Iran)		x		x												
CONITEC (Brazil)	x	x		x			x				x	x				
Duodecim - Finnish Medical Society (Finland)	x			x												
Duodecim - Medical Publications Ltd (Finland)	x			x							x					
EBHC (KSA)*		x		x						x	x		x		x	x
GRC (WHO)				x	x	x			x	x						
GRC secretariat (WHO)				x	x			x		x			x			
HAS (France)	x			x			x				x				x	x
IETS (Columbia)	x	x		x			x	x			x		x			
Minds project (Japan)				x	x			x			x	x				
NCEC (Ireland)			x	x	x	x		x	x			x	x	x		
NGPC (Qatar)*				x	x	x				x	x	x		x	x	
NICE (UK)	x	x	x	x	x		x		x		x	x			x	x
NZGG (New Zealand)	x			x				x			x					
SIGN (Scotland)	1			1							1			1	1	1
*Information not verified by unit.																

When looking at the purpose / main objective of the units (highlighted yellow), these are development of CPGs using accepted methodologies (e.g. systematic reviews, AGREE, GRADE, consensus) (7 units); provide access to CPGs (clearinghouse – database of CPGs on a website) (4 units); approve/endorsement for implementation (3 units); adopt, contextualise (by addressing implementation issues of existing recommendations), adapt (by changing the existing recommendations) CPGs (3 units); methodological support (2 units); HTA (2 units).

When taking also sub-objectives, tasks / scope into account, the following was found (Figure 2):

- Besides the 4 units that have a clearinghouse function; all except 1 of the other units, also provide access to CPGs.
- Although 7 units have development of CPGs as their main task, 5 additional units have it as one of their tasks.
- 10 Units consider implementation as one of their tasks.
- The 8 units that provide critical appraisal, either do this because they have a clearinghouse function (3 units); because they approve / endorse guidelines for implementation (3 units); because they commission CPGs (1 unit); because methodological support is given (1 unit).
- 8 Units provide methodological support.
- 3 Units have adopting, contextualising and adapting CPGs as their main task, but another 4 do this as well.
- 6 Units conduct capacity building; the same number conducts M&E.
- 5 Units indicated to have a coordinating/governance role, but these all have a different main task.
- For 2 units HTA is the main task, but a further 3 are involved in this. Note that the units with a clear focus on health technologies often started off as a HTA unit – focussing on assessing (including cost-effectiveness) and recommending incorporation of health technologies in the health care system - and development of guidelines was at a later stage included as part of their objectives.
- Of the 5 units that have a communication strategy, 4 units indicate to invite multidisciplinary partners.
- 4 Units have standards/ guideline development as a task.
- 2 Units indicated to commission CPGs.

No clear set of sub-objectives specifically related to the main objective of the unit could be defined. Some patterns should be distinguished:

- Of the 7 units with development of CPGs as the main task, 5 are involved in implementation.
- Of the 4 clearinghouses, 3 have a process of critical appraisal as they need to check external (or internal in case of the WHO) guidelines against specific criteria before approval.
- Of the 3 units that approve / endorse CPGs all have a critical appraisal process, 2 develop standards / guidelines for development, 2 do capacity building, 2 M&E, and 2 prioritisation.
- Of the 2 units that provide methodological support, both do capacity building.

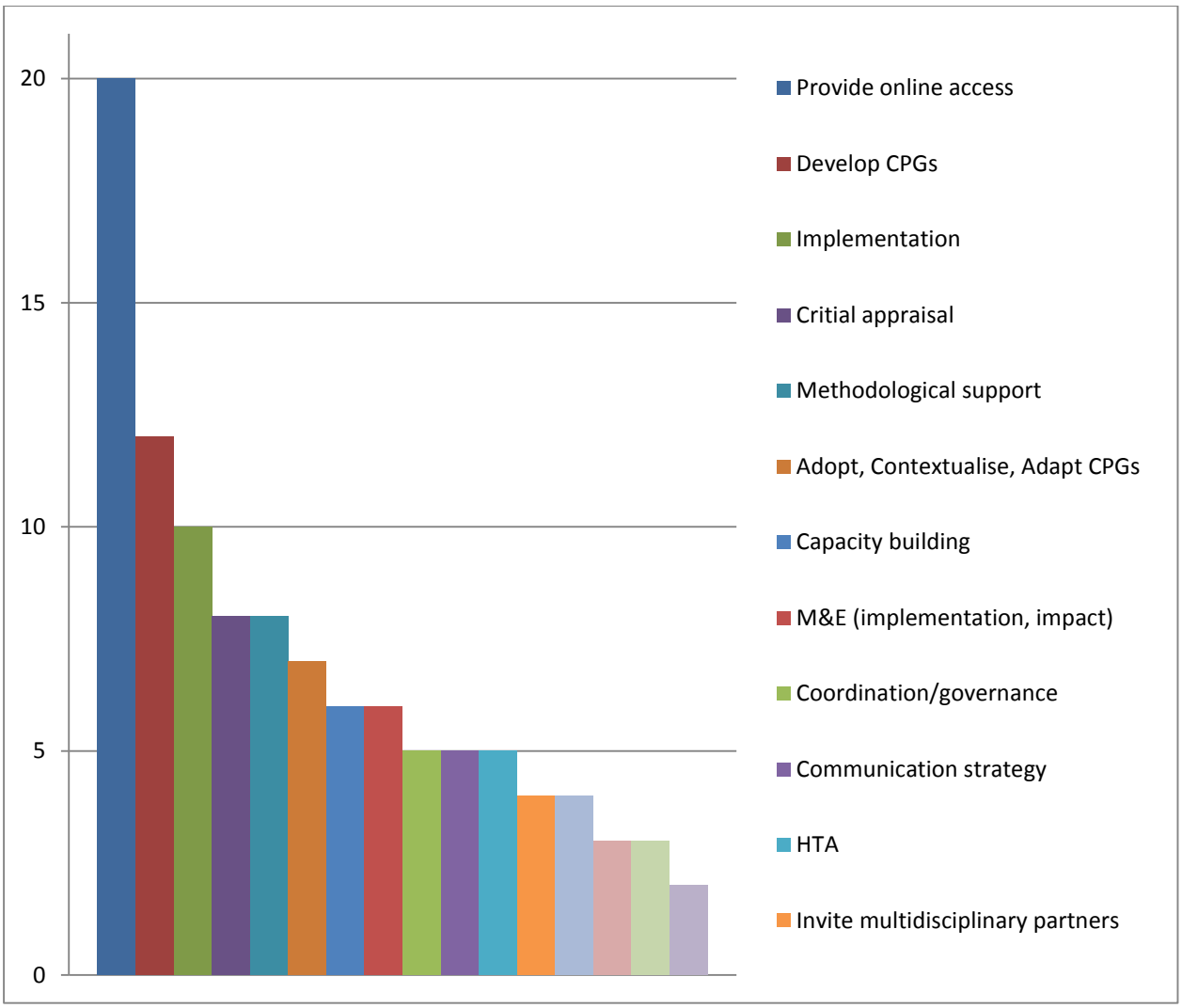

Figure 2. Objectives / tasks clinical guideline coordination units.

Looking at the place of the unit in the healthcare system (which is further discussed below) no clear pattern was found linking this to the main objectives, however, the following was observed:

- Of the four clearinghouses, two are within government and two within not-for-profit organisations.
- Both units focussing on HTA are within government.
- The three independent public bodies (HAS, NICE, SIGN) all focus on developing CPGS.

The unit structure (which is also discussed below: unit within a larger organisation, committee, project, standalone organisation) was not clearly linked to the main objective of the unit. The Excel tool linked to this report includes the place of the unit in the healthcare system and the unit structure as well.

Place of the unit in the healthcare system and unit structure

Of the 21 units, nine are part of government (mainly MoH) while three are independent, but public bodies, and two are a UN agency (Table 3). The rest are not-for-profit organisations (5; of which one public-private partnership), or linked to a university (1) or professional society (1).

Looking at the units, 10 are units within a larger organisation, 4 have the form of a committee and 2 of a project, and 5 are standalone units.

Only about half of the units gave information on that actual structure within the guideline unit (and not the organisation as a whole), and between those differences exist (Table 3). In general there seems to be a distinction between those that govern the guideline process (e.g. strategic direction and policies of the unit, prioritising the work, quality control, final approval of recommendations); those that provide technical expertise to the program (methodology and process of CPGs development, coordination of the work); and those that actually do the guideline development. In addition there is admin and IT support, marketing / dissemination / implementation.

Table 3. Place clinical guideline coordination units in the healthcare system and unit structure

Units	Place of the unit within the healthcare system	Unit structure
AHRQ/NGC (US)	Government (AHRQ is part of the U.S. DoH & Human Services)	Unit within larger organisation. Program official (1). Editorial Board (healthcare professionals with CPG expertise) that guides future work, governs content by working with content teams. Expert Panel (healthcare professionals with wider expertise) that guides broad project areas.
AUB Grade Center (Lebanon)	University (AUB)	One of 4 related units within AUB.
Australian CPGs/NHMRC	Government (NHMRC is part of Australian Government)	Part of one of 4 committees within NHMRC.
BPAC^{nz} (New Zealand)*	Independent, not-for-profit organisation	Standalone unit.
Clinical Evidence Unit (Chile)	Government (MoH)	One of 3 units.
Clinical Excellence Unit (Iran)	Government (MoH)	Unit within MoH.
CONITEC (Brazil)	Government (Department of Management and Incorporation of Health Technologies)	Committee with a Plenary assembly and an executive secretariat (multidisciplinary team - technical and administrative) that coordinates the activities, issues technical reports. Plenary assembly (members of MoH and related institutions) is responsible for making the actual CPG recommendations.
Duodecim – Finnish Medical Society (Finland)	Professional society	Standalone unit. Members.
Duodecim – Medical Publications Ltd (Finland)	Not-for profit organisation	Standalone unit. Editors, marketing, IT, technical editors.
GRC (WHO)	UN agency (WHO)	Committee (guidance processes, quality assurance). Each guideline: Guideline Steering Group (scope and guidance CPG) and guideline developers.

Units	Place of the unit within the healthcare system	Unit structure
GRC secretariat (WHO)	UN agency (WHO)	Unit within WHO- Secretariat (technical support, admin).
HAS (France)	Independent public body	One of the specialist committees within HAS: ~20 members, chaired by a board member (responsible for the policy, strategy), assisted by an operational manager.
IETS (Columbia)	Not-for-profit, public private agency	One of 3 sub-divisions.
Minds project (Japan)	Not-for-profit organisation (Japan Council for Quality Health Care)	Project within Department of EBM and guidelines: director, 7 committees that deal with different aspects of CPGs.
CENETEC (Mexico)	Government (MoH)	One of 4 main programs.
NCEC (Ireland)	Government (MoH)	Committee with 1 of 3 subgroups.
NGPC (Qatar)*	Government (Ministry of Public Health)	Project: Committee (nominates guideline development groups (GDG) members, reviews and approves topics and CPGs); GDGs (contextualisation process); Stakeholder Representative Group (work closely with GDG - review recommendations, determine dissemination).
NICE (UK)	Non Departmental (independent) Public Body	One of 6 teams.
NZGG (New Zealand)	Independent, not-for-profit organisation	Standalone unit. Advisory board (governance); research, implementation, business development and corporate service teams; each guideline had a team with 1-2 researchers and volunteers.
EBHC (KSA)*	Government (MoH)	Unit within MoH. Head; admin; secretariat; 4 divisions: planning (managed by steering committee), technical (managed by technical committee), logistics, dissemination (managed by dissemination committee)
SIGN (Scotland)	Independent public body	Standalone unit. Council (policy making body; methodology, editorial policy); Executive (implementation of decisions, delivering guideline programme); multidisciplinary guideline development groups (supported by Executive).

* Information not verified by unit.

Human resources

Table 4 displays the core staff of the unit in principle. However, the number of employees indicated by the different units differs largely (1-613), probably because some units did not specify only the number of staff involved in CPGs, but the complete organisational staff. When ignoring the outliers, CPG units probably will have between 1 and 40 staff members. Furthermore, some units really do have more staff, as they carry out more activities with their own staff, while others mainly have a coordinating role and rely on part-time staff or external people for actual guideline development or decision making (MoH, health institutions, universities, hospitals, patient organisations, and individual experts). External people are often paid by their own employers (so in principle volunteers).

Funding

Only a minority of units indicated the amount of funding, but again this shows a large range (0.07-99 million USD) for the same reasons as indicated at the human resources (Table 4). Most units (15) are financed exclusively by the government (mostly the MoH), and some (4) have most of their funding provided by the government, but may receive some funding from projects / private sector. Only two units seem to rely on private funding or project contracts and workshops exclusively.

Table 4. Human resources and funding clinical guideline coordination units

Units	Human Resources	Funding (annual amount, source)
AHRQ/NGC (US)	1	USD 1.5 million, Government
AUB Grade Center (Lebanon)	3	Project contracts, Workshops
Australian CPGs/NHMRC	7	Government
BPAC^{nz} (New Zealand)*	15	Government (indirectly)
Clinical Evidence Unit	7	Government
Clinical Excellence Unit (Iran)	7-10	Government
CONITEC (Brazil)	30	Government
Duodecim – Finnish Medical Society (Finland)	-	Government
Duodecim – Medical Publications Ltd (Finland)	>8	Private
GRC (WHO)	30	Government Member States & partners, Project contracts
GRC secretariat (WHO)	3	Government Member States & partners, Project contracts
HAS (France)	20	USD 1 million, Government
IETS (Columbia)	40	USD 3 million, Government and private
Minds project (Japan)	7	Government
CENETEC (Mexico)	69	USD 2 million, Government
NCEC (Ireland)	~6	Government
NGPC (Qatar)*	-	Government
NICE (UK)	613	DoH USD 82 million DoH, other - government and private (USD 17 million)
NZGG (New Zealand)	30	Government, USD 0.35 million (+ 0.7 million/guideline)
EBHC (KSA)*	9	Government
SIGN (Scotland)	12	Government

*Information not verified by unit.

Outputs

The number of CPGs available online differs largely: from 218 to 1 726 for clearinghouses, to 4 to 429 for units websites. One unit publishes the guidelines in academic journals (Table 5).

With respect to the legislative mandate of the guidelines, most units (18) indicate no legal status or they have an advisory / recommending / credibility status. In Ireland CPGs that are endorsed by MoH become national guidelines (although the legal status is not clear). In Iran, insurance companies and government require health professionals to adhere to the CPGs for reimbursement purposes. Only in Qatar the guidelines seem to be mandatory to be followed by health care professionals and deviations from the guidelines should be justified in writing.

Implementation, monitoring and evaluation

Most units consider the implementation the responsibility of the developers / organisations they develop the guidelines for, although some (6) do provide support / facilitation with the process, especially focussing on distribution of the guidelines, making available guideline products that increase usage, communicating the existence of guidelines, and developing frameworks / tools for implementation (Table 5). Only two units have a sub-unit focussing on implementation, and an additional two indicated to be involved in implementation projects, and one provides training (on-site and online) to users of guidelines. Monitoring of adherence to/usage of CPGs is mentioned by two units, while also two mentioned the evaluation of implementation of CPGs (improvements in healthcare quality indicators).

Table 5. Guideline development processes, outputs, implementation and M&E clinical guideline coordination units

Units	Outputs	Implementation, M&E
AHRQ/NGC (US)	Online clearinghouse with 1 726 summaries	No
AUB Grade Center (Lebanon)	5 published guidelines in academic journals	No
Australian CPGs/NHMRC	Online clearinghouse with 343 guidelines	No
BPAC^{nz} (New Zealand)*	2015-2017 4 contextualisations	-
Clinical Evidence Unit	86 guidelines, mostly online	-
Clinical Excellence Unit (Iran)	~200 guidelines	-
CONITEC (Brazil)	~135 guidelines online	Developing tools
Duodecim – Finnish Medical Society (Finland)	~100 guidelines online	No
Duodecim – Medical Publications Ltd (Finland)	~1000 guidelines online (subscription)	Implementation tools (training, patient versions)
GRC (WHO)	~170 guidelines online	No
GRC secretariat (WHO)	~170 guidelines online	No
HAS (France)	~100 guidelines online	Communication interventions

Units	Outputs	Implementation, M&E
IETS (Columbia)	Participated in >70 GPCs; some available online	Implementation and Dissemination Branch: Conduct and support (including tools) of implementation activities
Minds project (Japan)	Online clearinghouse with 191 Japanese and 27 English CPGs (218)	Implementation (not further defined); Evaluation improvements healthcare quality (indicators)
CENETEC (Mexico)	429 CPGs (current) online	Evaluation process of implementation CPGs, checklist for monitoring adherence
NCEC (Ireland)	15 guidelines on DoH website	Facilitating role
NGPC (Qatar)*	11 guidelines on Ministry of Public Health website	Communication interventions; post implementation framework development; monitor usage
NICE (UK)	276 guidelines online	Implementation strategy group: Products: quality standards; interactive tool
NZGG (New Zealand)	~19 guidelines (1 still current) online	Projects
EBHC (KSA)*	22 guidelines online	Engaging stakeholders
SIGN (Scotland)	~140 guidelines online	Distribution, support implementation

*Information not verified by unit.

Challenges and facilitators

An attempt was made to collect data on key challenges and facilitators both in establishing the unit and regarding the ongoing functioning of the unit. In total six units reported challenges at the start and four facilitators at that stage, and nine reported challenges for continuation of the work and eight facilitators. However, many more challenges were reported compared to facilitators, so for the latter the issues are combined for both phases.

The key challenges in establishing the unit / clearing house can be summarized as follows:

- Getting buy-in with respect to the importance of the unit / clearing house from:
  - Guideline developers (including issue of copyright)
  - Healthcare professionals (importance of CPGs/EBM for clinical practice)
  - Insurance companies
  - Government/policy makers (importance CPGs/EMB for decision making)
- Getting financial support
- Identifying/lack of qualified guideline developers
- Decision makers unclear about distinction HTA unit and Evidence Based Healthcare

The key challenges in the ongoing functioning of the unit / clearing house can be summarized as follows:

- Funding:
    - Contract work, no sustainable funding.
    - Too limited.
    - Difficult to get money for updating of guidelines.
    - Difficult to get the private sector involved.
- Human resources:
    - Insufficient.
    - Identifying qualified guideline developers.
- Getting buy-in from:
    - Academics (to provide the evidence needed).
    - Professional bodies (to endorse the guidelines).
    - Government / guideline users (want easy/short guidelines versus complex/long guidelines that are developed; planning needs to be related to political agenda).
    - Patients/Caregivers (as partners in the development process).
- Technical:
    - Keep up with website security / regulations.
    - Improved user functionality.
- Methodological:
    - Lack of national framework for development and updating CPGs.
    - Monitoring of implementation of CPGs.
    - Keeping the standards high.
    - Not enough time for stakeholder engagement.

The key facilitators in establishing / the ongoing functioning of the unit / clearing house can be summarized as follows:

- Legislation:
    - Healthcare system based on CPGs.
    - Insurance system based on CPGs.
- Human resources:
    - Influential director.
    - Experienced / influential / trusted guideline developers.
    - Experienced technical contractor.
    - Good staff retention (increase experience).
- Having buy-in from:
    - Government (want to fund cost-effective health care system)
    - Guideline developers (see unit / clearing house as a way to disseminate work).
    - Users (based on dissemination of good quality work).
- Methodological:
    - Wide focus of CPGs.
    - Clear annual work program.
    - Rigorous/transparent methods.
    - Exchange knowledge/practices with other (international) organisations.
- Implementation:

- Comprehensive collection (guidelines plus supporting material)
- Easy to search
- Accessible for patients
- Clinical decision support

Collaborators

An overview of the different type of collaborators that clinical guideline units have is given in the figure below.

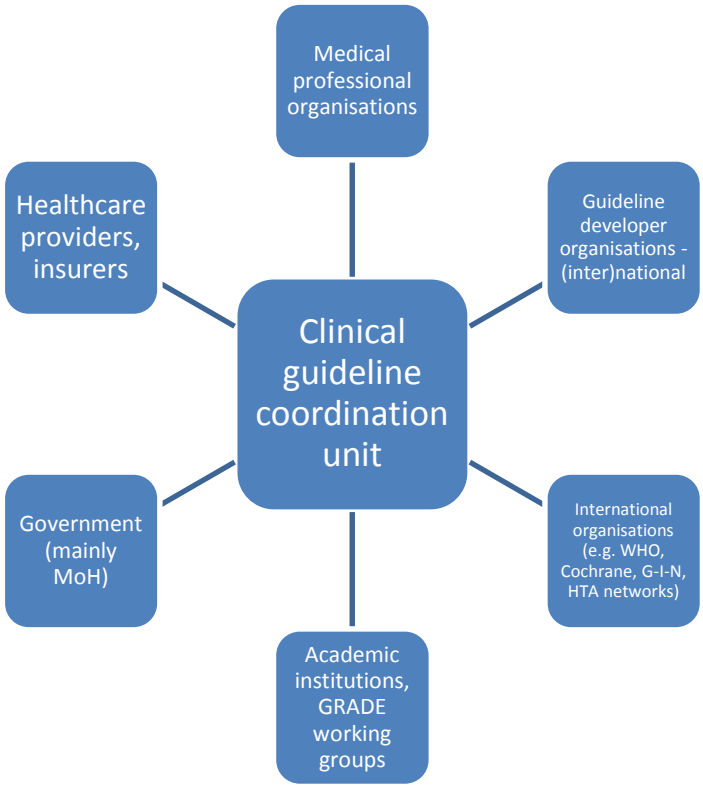

Figure 2. Collaborators of clinical guideline coordination units.

Way forward

Despite the differences in the settings clinical guideline coordination units operated in, in South Africa we can learn from the other units, especially regarding the objectives / tasks they perform, and the challenges they face. Key stakeholders in South Africa should now look carefully at what tasks could potentially be conducted by such a unit and link these to the needs of the country, and based on that decide on the operating principles of the unit. If needed, some organisations from this study could be reviewed further.

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Michel Laurence (HAS)

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Clarice Alegre Petramale (Brazil)

Daniela Pachito (Brazil)

Davina Ghersi (NHMRC)

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Appendix 1. Unit descriptions – Phase 1

Agency for Healthcare Research and Quality (AHRQ) / National Guideline Clearinghouse	
Website	https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/index.html and https://www.guideline.gov/
Country	US
Purpose	The National Guideline Clearinghouse™ (NGC), an AHRQ initiative, is a publicly available database of evidence-based clinical practice guidelines and related documents. NGC supports AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable by providing objective, detailed information on CPGs, and to further their dissemination, implementation, and use in order to inform health care decisions. Created in 1984, the U.S. Preventive Services Task Force (USPSTF or Task Force) is an independent group of national experts in prevention and evidence-based medicine that works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counselling services, or preventive medications.

Australian Clinical Practice Guidelines/ National Health and Medical Research Council	
Website	https://www.clinicalguidelines.gov.au/about
Country	Australia
Purpose	The CPGs Portal provides access to CPGs produced for Australian practice that have been assessed against selection criteria modified from the United States' National Guidelines Clearinghouse, and adapted to the Australian context. Over 2400 documents have been assessed for inclusion on this portal. Selection of guidelines is an ongoing process as we seek to identify and assess new CPGs which relate to Australian practice questions.
Note	Portal (database) that selects relevant (US) guidelines to make these available.

Andalusian Agency for Health Technology Assessment (AETSA)	
Website	http://www.inahta.org/members/aetsa/
Country	Spain
Purpose	AETSA also coordinates groups for developing evidence-based clinical guidelines.
Note	Own website (http://www.aetsa.org/) in Spanish; limited info on INAHTA website.

Catalan Agency for Health Information, Assessment and Quality (CAHIAQ) or Agència de Qualitat i Avaluació Sanitàries de Catalunya (AQuAS)	
Website	http://www.inahta.org/members/aquas/
Country	Spain
Purpose	AQuAS has also an active participation in making and coordinating groups for developing evidence-based CPGs.
Note	Own website (http://aquas.gencat.cat/en/inici)/ mainly in Spanish; limited info on INAHTA website.

Centre of Standardization of the Republican Centre for Health Development (RCHD-CS)	
Website	http://www.inahta.org/members/rchd-cs/
Country	Kazakhstan
Purpose	Centre of Standardization of the Republican Centre for Health Development was established in 2010 to improve and coordinate the activities of healthcare organisations of the Republic of Kazakhstan. Our centre standardizes healthcare delivery through development and implementation of CPGs/protocols and assesses health technologies.
Note	Own website (http://www.rcrz.kz/index.php/en/)/ mainly in local language; limited info on INAHTA website.

CONITEC – National Committee for Technology Incorporation	
Website	http://www.inahta.org/members/conitec/
Country	Brazil
Purpose	The Committee is responsible for advising the Brazilian Ministry of Health in the incorporation or disinvestment of health technologies into the Brazilian Public Health System (SUS) and development of clinical guidelines.
Note	Own website (http://conitec.gov.br/) in Portuguese; limited info on INAHTA website. However, of interest as Brazil is part of BRICS. Advises Ministry of Health (MoH).

CPG Infobase: Clinical Practice Guidelines	
Website	https://www.cma.ca/En/Pages/clinical-practice-guidelines.aspx
Country	Canada
Purpose	The CPG Infobase is a database of evidence-based Canadian CPGs (CPGs). Maintained by Joule™, a CMA company, it includes approximately 1,200 CPGs developed or endorsed by authoritative medical or health organisations in Canada.
Note	Infobase (database) of guidelines to make these available.

Guidelines International Network	
Website	http://www.g-i-n.net/home
Country	Scotland
Purpose	G-I-N mission is to lead, strengthen and support collaboration and work within the guideline development, adaptation and implementation community. Three principal aims: • Providing a network and partnerships for guideline organisations, implementers, end-users, researchers, students and other stakeholders • Assisting members in reducing duplication of effort and improving the efficiency and effectiveness of evidence-based guideline development, adaptation, dissemination and implementation •Promoting best practice through the development of opportunities for learning and building capacity, and the establishment of high quality standards of guideline development, adaptation, dissemination and implementation.
Note	International network organisation; possible source for information on relevant organisations.

Guideline Review Committee (GRC) and GRC Secretariat (WHO)	
Website	http://www.who.int/publications/guidelines/guidelines_review_committee/en/
Country	Switzerland
Purpose	The GRC meets on a monthly basis to review initial proposals for guideline development and final versions of guidelines prior to their publication. The review of initial proposal includes an assessment of whether the guideline development process will be able to meet the WHO requirements that are described in the WHO handbook for guideline development. The review of final submissions is conducted to ensure the process and form of the recommendations has followed the WHO requirements guidelines. The GRC also offers suggestions and advice on how to improve the quality of the guidelines.
Note	Operates on international level. Limited info on website.

Haute Autorité de Santé (HAS)	
Website	http://www.inahta.org/members/has/
Country	France
Purpose	With a general mission to contribute to the regulation of the health system by improving health quality and efficiency, HAS has seen the scope of its missions expanded since 2005, through numerous legislative changes. They can be grouped into two main activities: Evaluation and Recommendation; Accreditation and certification. The HAS also develops and makes available to the health actors tools, guides and methods to improve their care or the implementation of their projects. The HAS evaluates medically and economically the products, acts, benefits and technologies of health, with a view to their reimbursement. It defines recommendations for good clinical practice, public health recommendations, medico-economic studies, management guides for professionals and patients. It also gives opinions in the framework of its mission to assist public decision-making.
Note	More information available on http://www.has-sante.fr/portail/jcms/fc_1249693/fr/piliers .

Health Sciences Institute in Aragon (IACS)	
Website	http://www.inahta.org/members/iacs/
Country	Spain
Purpose	IACS holds the secretary of the national clearing house of CPGs (GuiaSalud - http://portal.guiasalud.es/web/guest/home), coordinating the development, dissemination and adoption of evidence based products for the Spanish national health system.
Note	Own website (http://www.iacs.es/) in Spanish; limited info on INAHTA website.

Health Technology Assessment Section, Ministry of Health Malaysia	
Website	http://www.inahta.org/members/mahtas/
Country	Malaysia
Purpose	Advocating evidence-informed health decision making by: • Producing transparent, relevant, accessible health technology assessment, CPGs and other synthesized research evidence • Fostering collaboration with local and international stakeholders • Strengthening health technology assessment capacity in Malaysia • Empowering consumer
Note	Does not have an own website.

Institute for Quality and Efficiency in Health Care or Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (IQWiG)

Website	http://www.inahta.org/members/iqwig/
Country	Germany
Purpose	The Institute's primary goal is to contribute to improvements in health care in Germany. IQWiG undertakes and publishes assessments addressing the effectiveness, quality, and efficiency of health services, and is particularly active in the following areas: evaluation of the benefits and harms of drug and non-drug interventions, evaluation of evidence-based guidelines for diseases of the greatest epidemiological importance, and provision to the public of easily understandable general information on the quality and efficiency of health care.
Note	Mainly provides evidence-based reports and general population information (not guidelines). More info: https://www.iqwig.de/en/home.2724.html

Institut national d'excellence en santé et en services sociaux (INESSS)	
Website	http://www.inahta.org/members/inesss/
Country	Canada
Purpose	INESSS is an independent organisation that reports to Québec's Minister of Health and Social services. It also develops CPGs in order to ensure optimal use of health and social service resources.
Note	Own website (http://www.inesss.qc.ca/en.html)/ mainly in French; limited info on INAHTA website.

Instituto de Evaluación Tecnológica en Salud (IETS)	
Website	http://www.inahta.org/members/iets/
Country	Colombia
Purpose	IETS produces health technology assessments, evidence-based clinical guidelines and protocols of drugs, medical devices, procedures and treatments to support policy makers and healthcare professionals decide what technologies are effective, offer the best quality and value for money and therefore should be financed with public funds.
Note	Own website (http://www.iets.org.co/) in Spanish; limited info on INAHTA website.

National Care Management Program [Programm für Nationale VersorgungsLeitlinien]	
Website	http://www.leitlinien.de/nvl
Country	Germany
Purpose	The NVL program aims to develop and implement interdisciplinary guidelines on selected high prevalence disorders, taking into account the methods of evidence-based medicine. In particular, national care guidelines are the basis for the design of concepts for structured and integrated care.
Note	Own website (http://www.iets.org.co/) in German.

National Center for Health Technology Excellence or Centro Nacional de Excelencia Tecnológica en Salud (CENETEC)	
Website	http://www.inahta.org/members/cenetec/
Country	Mexico
Purpose	CENETEC has been appointed by the MoH to coordinate a program of adaptation of CPGs, for the Mexican Public Health Sector.
Note	Own website (http://www.cenetec.salud.gob.mx/contenidos/english/english.html)/ mainly in Spanish; limited info on INAHTA website.

National Clinical Effectiveness Committee	
Website	http://health.gov.ie/national-patient-safety-office/ncec/governance-ncec/
Country	Ireland
Purpose	The NCEC role is to recommend guidelines and audit to the Minister for Health to become National Clinical Guidelines and National Clinical Audit for implementation in Irish healthcare. Currently, it does this by: • Prioritising clinical guidelines that are important to national policy and the Irish health system. • Assessing clinical guidelines against criteria to judge that they have been developed in the best possible way. This assures that National Clinical Guidelines are based on best available evidence, have involved key people, including patients, in their development and have examined the cost involved in implementation. Clinical guidelines that successfully go through these steps are recommended to the Minister for Health through the Chief Medical Officer for endorsement and publication as National Clinical Guidelines.
Note	Advises MoH.

National Guideline and Pathway Committee	
Website	https://www.moph.gov.qa/national-clinical-guidelines
Country	Qatar
Purpose	The National Clinical Guideline (NCG) team develops and introduces clinical guidelines to help standardize; whenever possible, the management and treatment of patients across the Qatari healthcare system, whilst simultaneously optimising both outcome and resource utilisation. By early 2017, 60 guideline development workshops were completed and guidelines and pathways will continue to be uploaded on the MoPH website as they become approved. The NCG team continues to monitor usage and maintain the published guidelines. With the support from quality departments across Qatar's healthcare provider organisations the NCG team is working on enabling, adaptable and sustainable systems that aim to help improve access, adoption and compliance to the guidelines.
Note	Part of MoH. Limited info on website.

National Guideline Centre (NGC)	
Website	http://www.ngc.ac.uk/
Country	UK
Purpose	The National Guideline Centre (NGC) is a multi-disciplinary health services research team funded by the National Institute for Health and Care Excellence (NICE). We produce evidence based CPGs on behalf of NICE. Our guidelines aim to improve the quality of patient care within the NHS in England and Wales.
Note	Linked to NICE.

National Institute for Health and Care Excellence (NICE)	
Website	https://www.nice.org.uk/
Country	UK
Purpose	NICE provides national guidance and advice to improve health and social care. NICE's role is to improve outcomes for people using the NHS and other public health and social care services. We do this by: • Producing evidence-based guidance and advice for health, public health and social care practitioners. • Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services. • Providing a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.
Note	Link to NHS.

Norwegian Institute of Public Health (NIPH)	
Website	http://www.inahta.org/members/niph/
Country	Norway
Purpose	Current activities of the new domain within NIPH: HTA, systematic reviews and dissemination, teaching and support for EBM and evidence-based policy, clinical guidelines, research and method development, method support to Cochrane Collaboration, EPOC (Effective Practice and Organisation of Care Group) satellite, and secretariat for the Campbell Collaboration.
Note	Clinical guidelines don't feature on own website (https://www.fhi.no/en/)

Saudi Center for Evidence Based Healthcare (EBHC)	
Website	http://www.moh.gov.sa/endepts/Proofs/Pages/Definition.aspx
Country	Kingdom of Saudi Arabia
Purpose	The EBHC is also tasked with addressing clinical quality by providing national leadership and facilitating collaboration in the adaptation/development, implementation, and evaluation of nationally agreed evidence based CPGs.

Scottish Intercollegiate Guidelines Network (SIGN)	
Website	http://www.sign.ac.uk/about/index.html
Country	Scotland
Purpose	SIGN was established in 1993 to sponsor and support the development of evidence-based national clinical guidelines for NHS Scotland and to facilitate their implementation into local practice for the benefit of patients. SIGN aims to ensure appropriate involvement of healthcare professionals, patients and carers in the guideline development process and to employ internationally agreed standards of guideline development methodology. SIGN is part of the Evidence and Improvement Directorate of Healthcare Improvement Scotland.
Note	Link to NHS.

Appendix 2. Unit descriptions – Phase 2

Agency for Healthcare Research and Quality (AHRQ) / National Guideline Clearinghouse	
Website	https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/index.html; https://www.guideline.gov/;
Country	US
Purpose	The National Guideline Clearinghouse™ (NGC), an Agency for Healthcare Research and Quality (AHRQ) initiative, is a publicly available database of evidence-based CPGs and related documents. NGC supports AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable by providing objective, detailed information on CPGs, and to further their dissemination, implementation, and use in order to inform health care decisions. [AHRQ's technical contractor for NGC is ECRI Institute; they *have served* as the sole prime contractor to develop, maintain, and enhance the NGC.]
Sub-objectives	-
Tasks / Scope	Curate evidence-based CPGs developed by other entities that meet NGC's criteria for inclusion, obtain copyright permissions (as needed) to abstract information from the guideline and related documents (if any) into a structured record (database) and make these records available online. Update records as guidelines are updated. Withdraw records from public view when the guideline no longer meets criteria for inclusion or when the guideline developer requests it be removed. NGC's role in the evidence-based ecosystem is to *disseminate* evidence-based CPGs that meet specific criteria.
Place of the unit within the healthcare system	AHRQ = U.S. Department of Health and Human Services [ECRI = NGO]
(Legislative) mandate	No
Date established; reason establishment	AHRQ: Awarded the contract to develop NGC in 1997; the Website went live in January 1999. [ECRI: NGC contractor since 1997] AHRQ identified two major needs that prompted the establishment of NGC: 1. It was not easy to find guidelines – at the time, many were published in peer-reviewed journals or as grey literature and were not accessible to the masses (because individuals/organisations did not have subscription to the journals and the Web was just beginning). Related to this, guideline developers would sell their guidelines and not everyone could afford access to them all. So, the need to offer a one-stop 'shop' to facilitate finding guidelines of interest was one reason. 2. Guidelines come in all shapes and sizes and didn't follow reporting standards (Conference on Guideline Standardization (COGS) statement was the first), making it difficult to compare across guidelines of a similar topic. So, the need to offer a structured view of the guidelines to facilitate comparison was another reason.
Organisational	The NGC Editorial Board is composed of health care professionals with

structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	collective expertise in evidence-based CPGs and quality measures. The Board serves as a resource for feedback and guidance on developments in health care that inform future work. The Board also provides valuable perspectives in the form of Expert Commentaries on topics germane to the guideline and quality measures fields and works collaboratively with the Agency for Healthcare Research and Quality (AHRQ) to govern content, specifically working with the NGC content teams in key aspects of content development and production. The NGC Expert Panel is composed of health care professionals with collective expertise in all aspects of evidence-based health, CPGs, quality measurement and reporting, health care policy and administration, and health informatics. The Expert Panel provides feedback and guidance to NGC on broad project areas.
Human resources	AHRQ: 1 program official [ECRI: clinical, editorial, technical staff at multiple levels]
Funding (amount, sources, duration)	Avg $1.5 million per year from AHRQ (funded by the U.S. Department of Health and Human Services) for 20 years.
Guideline development processes	NGC does not develop guidelines.
Outputs e.g. guidelines produced	Guidelines that meet NGC inclusion criteria and for which copyright permissions have been obtained are available on https://www.guideline.gov/ ~1 726 guidelines
Implementation, monitoring and evaluation	N/A
3 key challenges and facilitators in establishing the unit	Challenges: - Obtaining buy-in from the medical and health plan (payer) community to join AHRQ in the establishment of NGC as a public-private partnership. - Cooperation early-on from the guideline developer community to submit their (perhaps proprietary) guidelines and related technical documents to AHRQ and its contractor for abstraction into a record that would be published to the public. - Negotiating the limits of the copyright permissions granted to AHRQ from guideline developers for this work. Facilitators: - AHRQ's Director at the time was a charismatic and influential leader. - The evidence-based guideline experts that first engaged with AHRQ in (1) establishing criteria for inclusion added credibility and (2) being champions for the resource added a boundary-spanning effect to spread the news and encourage participation of guideline developers. - AHRQ's selection of a highly-skilled technical contractor with roots in informatics and evidence-based practice also added credibility and the combined AHRQ-contractor reputation yielded the foundation of strong relationship management with the guideline development community.

3 key challenges and facilitators regarding the ongoing functioning of the unit	Challenges: - Keeping up with the pace of technological change, in terms of information security and related government regulations/requirements and user experiences/expectations with website functionality (the advancing human-computer interface changes) - Keeping up with current versions of taxonomies used to index NGC content - Gaining buy-in from the users of NGC content, which include major medical publishers*, to support an alternative business model where the private sector partners with AHRQ to sustain NGC. (Kind of going back to how we began – NGC started as a public-private partnership between AHRQ and the American Medical Association and the Association of Health Insurance Plans (then known as American Association of Health Plans) then it shifted to an AHRQ- only supported resource.) *Major medical publishers further distribute NGC content to its paying subscribers (usually as a part of a package of evidence-based info). Facilitators: - A vital guideline development community who seeks NGC out as a primary tool to help them disseminate their content to the masses. - A solid, reputable, high-performing technical contractor. - A group of multi-disciplinary experts (in the Editorial Board) who continue to help NGC thrive and serve as a leader in the evidence-based practice ecosystem.
Collaborators	In the first 5 years of NGC (1997-2002), AHRQ entered into agreements with the American Medical Association and the American Association of Health Plans (now known as America's Health Insurance Plans), making NGC a public-private partnership. After that time, given NGC's early success, the two private organisations moved on to other priority matters and AHRQ became the sole sponsor of NGC. As part of the work, NGC has established and maintains relationships close to 200 guideline developer organisations. Although there is no formal agreement per se, we see those guideline developer organisations as our partners because without their participation in NGC, we would only have a shell or a system to support abstracting and posting guideline content. Nurturing our relationships with guideline developer organisations has been part of our operational approach and we have many touch points with them: When we find a guideline or they submit it to us. When we seek and obtain copyright permissions from them. When we send our abstracts of their guidelines for their verification and we receive their feedback. And, annually, we seek their verification of all their guidelines we have on our site to learn if anything is incorrect, meaning should be removed, updated or added. We also seek to confirm contact information that we have on file for them, and we send them web analytics reports of our summaries of their guidelines. In addition, we communicate with them early on and regularly when we will be changing important aspects of our site (for example, changing inclusion criteria). And, of course, AHRQ has partnered with ECRI Institute for 20 years as the technical contractor for NGC. Every contract is a partnership and we've worked closely since the beginning.

Contact information	Mary P. Nix, Deputy Director, Division of Practice Improvement, Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality - Mary.Nix@ahrq.hhs.gov
Note	AHRQ has budget constraints and the future of NGC is uncertain. AHRQ is exploring alternative business models (private-public partnership).

AUB Grade Center	
Website	http://aub.gradeworkinggroup.org
Country	Lebanon
Purpose	The AUB GRADE Centre's mission is to (1) provide support to Lebanese and regional organisations aiming to apply the GRADE methodology to produce systematic reviews and guidelines for enhancing evidence based health care; (2) build capacity in GRADE methodology through mentorship, education, training, advocacy and collaborations.
Sub-objectives	
Tasks / Scope	
Place of the unit within the healthcare system	The AUB GRADE Center is housed by the Clinical Research Institute, Faculty of Medicine, American University of Beirut.
(Legislative) mandate	None.
Date established; reason establishment	2014 Reason: as per purpose above.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	No subunits. Belongs to a wider network related to evidence synthesis and translation at the American University of Beirut that includes: Clinical Epidemiology Unit SPARK center K2P center AUB GRADE center
Human resources	Director (permanent position). Coordinator (permanent position). Research Fellow. Trainees.
Funding (amount, sources, duration)	Through contracts for supporting guideline development efforts and conducting training workshops.
Guideline development processes	Follows GRADE methodology, Guidelines 2.0 checklist, adolopment for adaptation, living guidelines.
Outputs e.g.	Capacity building and advocacy work in Lebanon

guidelines produced	The World Health Organisation Guidance on Clinical Management of Crimean-Congo Haemorrhagic Fever (not published yet) The American Society of Haematology (ASH) guidelines on management of venous thromboembolism in patients with cancer (not published yet) RARE- Best practices conference: use of GRADE in sickle cell disease (not published yet) Adaptation of the American College of Rheumatology (ACR) guidelines for Rheumatoid Arthritis for the Eastern Mediterranean region https://www.ncbi.nlm.nih.gov/pubmed/28934978 Adaptation of guidelines for the Saudi Ministry of Health https://www.ncbi.nlm.nih.gov/pubmed/28042639 https://www.ncbi.nlm.nih.gov/pubmed/27761572 https://www.ncbi.nlm.nih.gov/pubmed/26336014 https://www.ncbi.nlm.nih.gov/pubmed/26219456
Implementation, monitoring and evaluation	None.
3 key challenges and facilitators in establishing the unit	Challenges: Identifying individuals qualified in guideline development. Getting institutional support. Lack of interest in guidelines at the national level.
3 key challenges and facilitators regarding the ongoing functioning of the unit	Challenges: - Identifying individuals qualified in guideline development. - Lack of interest in guidelines at the national level.
Collaborators	AUB GRADE collaborates with national, regional and international bodies such as the World Health Organisation (WHO), the WHO Eastern Mediterranean Regional Office (EMRO), ministries of health and academic institutions in the region, and medical professional societies in Europe and North America.
Contact information	Elie Akl, Director - ea32@aub.edu.lb
Note	

Australian Clinical Practice Guidelines / National Health and Medical Research Council	
Website	https://www.clinicalguidelines.gov.au/about and https://www.nhmrc.gov.au/
Country	Australia
Purpose	The scope and reach of NHMRC's activities are broad, with the agency spanning a wide range of health topics in the various aspects of its work – from funding research to guideline development and advice.

Sub-objectives	The Clinical Practice Guidelines Portal provides access to CPGs produced for Australian practice. The Clinical Practice Guidelines in Development Register is a place for Australian guideline developers to share information about guidelines they are working on and to keep up to date with guidelines others are developing.
Tasks / Scope	1. Approve high quality clinical guidelines prepared by third parties 2. Develop guidelines that address clinical, public and environmental health topics 3. Report on the quality of Australian CPGs 4. Progress a new guideline development standard and methodology
Place of the unit within the healthcare system	Initiative of the National Health and Medical Research Council, Australian Government. Independent statutory agency within the Health and Ageing portfolio.
(Legislative) mandate	-
Date established; reason establishment.	National Health and Medical Research Council Act 1992.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	Principal committees: - Australian Health Ethics Committee (AHEC) - Research Committee (RC) - Health Translation Advisory Committee (HTAC): Promoting dissemination and implementation of research findings and NHMRC-issued guidelines - Health Innovation Advisory Committee (HIAC)
Human resources	219 staff (30 June 2016); 7 for CPG work.
Funding (amount, sources, duration)	Government.
Guideline development processes	Development of CPGs under contract. Approval of third party guidelines developed to NHMRC standards. Development and promotion of guideline development standards. Development and promotion of guideline development methods. Management of a national guideline developer network.
Outputs e.g. guidelines produced	During the year 2015/16 the NHMRC Council approved five guidelines. In total 343 guidelines.
Implementation, monitoring and evaluation	Reports on the status of guidelines in Australia. Implementation of guidelines is a developer responsibility.
3 key challenges and facilitators in establishing the unit	Not relevant.
3 key challenges	Challenges:

and facilitators regarding the ongoing functioning of the unit	Funding for revision of guidelines. Lack of an agreed national framework for guideline development and updating.
Collaborators	Guidelines are developed by governments, professional colleges, specialty societies and non-government agencies.
Contact information	Geraint Duggan, Director Clinical Guidelines - clinicalguidelines@nhmrc.gov.au
Note	NHMRC develops public health and environmental health guidelines.

Best Practice Advocacy Centre	
Website	http://www.bpac.org.nz/guidelines/
Country	New Zealand
Purpose	bpac^{nz} advocates for best practice in healthcare and investigations across a wide range of health service delivery areas in New Zealand.
Sub-objectives	-
Tasks / Scope	Guideline division: Contextualisation of clinical guidelines for the New Zealand health sector.
Place of the unit within the healthcare system	An independent, not-for-profit organisation.
(Legislative) mandate	-
Date established; reason establishment	Until 2012, The New Zealand Guideline Group produced clinical guidelines for New Zealand; however their funding was withdrawn in 2012. As a result, New Zealand's Best Practice Advocacy Centre (bpac^{nz}) sought a less expensive and resource intensive way of promoting high quality, evidence-based healthcare and held discussions with NICE about using our guidelines. In 2014 NICE signed a licence agreement for the contextualisation of NICE guidelines for the New Zealand population with bpac^{nz}. Note that the larger organisation was established in 2003.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	bpac^{nz} Guidelines is part of bpac^{nz} Better medicine.
Human resources	15 (total organisation)
Funding (amount, sources, duration)	PHARMAC (government funded) funded BPAC to using NICE guidelines.
Guideline	Bpac^{nz} makes changes of a contextual nature to clinical guidelines, overseen

development processes	by NICE and guided by a Guideline Review and Contextualisation Group (GRCG), before these guidelines are published. The process bpac[nz] undertakes is based on the ADAPTE approach. While a standard NICE guideline for use in England takes 2 years to develop, plus an additional 9 months to scope the work before-hand, the contextualisation process is far shorter, taking 6-9 months in total. The process involves: - A review of the scope - Committee consideration of the original recommendations and contextual changes proposed - Consideration of the changes by NICE to ensure changes are contextual - Stakeholder consultation in New Zealand - Final changes proposed to NICE for sign-off - Publication of final guideline (co-badged) Having a robust quality assurance process is a cornerstone of NICE's reputation, therefore holding a stakeholder consultation and having steps in the process where NICE quality assures the work and signs it off are mandatory. Many elements of the process, however, can be changed to suit an individual country's needs.
Outputs e.g. guidelines produced	Since obtaining the licence, bpac[nz] has completed 4 contextualisations: - Respiratory tract infections (published May 2015) - Urinary incontinence (published May 2016) - Antimicrobial resistance (publishing autumn 2017) - Sepsis (publishing autumn 2017)
Implementation, monitoring and evaluation	-
3 key challenges and facilitators in establishing the unit	-
3 key challenges and facilitators regarding the ongoing functioning of the unit	-
Collaborators	NICE
Contact information	contact@bpac.org.nz Moira Godbert-Laird - Moira.Godbert-Laird@nice.org.uk [contextualization service]
Note	Information not verified by unit. Very limited information available online.

Clinical Evidence Unit	
Website	http://diprece.minsal.cl/programas-de-salud/guias-clinicas/
Country	Chile
Purpose	Generation of national CPGs
Sub-objectives	
Tasks / Scope	- Generation of national CPGs - Generation of Clinical Attention Documents and Protocols - Development of short reports about evidence of interventions for authority - Methodological support for other departments in MoH in generation of evidence based documents - Technical transference of abilities in EBM to professionals in other departments.
Place of the unit within the healthcare system	- MoH - Undersecretary of Public Health - Division of Health Planning - HTA / EMB Department - Clinical Evidence Unit
(Legislative) mandate	Law Nº 19.966, established the necessity of national protocols for attention of prioritized health problems.
Date established; reason establishment	2005 – 2010 Secretaría AUGE. 2010 – 2016 Departamento Secretaría Técnica GES y de Coordinación Evidencial y Metdológica. 2016 – 2017 Departamento de Salud Basada en Evidencia y Garantías Sanitarias. 2017 – date Departamento de Evaluación de Tecnologías Sanitarias y Salud Basada en Evidencia.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	Departamento de Evaluación de Tecnologías Sanitarias y Salud Basada en Evidencia. (HTA / EMB Dept): - Clinical Evidence Unit - Economic Evaluations Unit - Evidence Informed Policies Unit
Human resources	4 full time professionals 2 part time professionals 1 administrative staff (shared with other units inside same department)
Funding (amount, sources, duration)	Historical funding from government budget; about USD $ 70.000 / year.
Guideline development processes	From 2005 – 2013, usually based on expert consensus and opinion. 2014 – 2015 Progressive implementation of GRADE. 2015 – date Only GRADE system for appraisal of evidence and recommendations making.
Outputs e.g.	86 CPGs associated with AUGE system (system of explicit coverage associated

guidelines produced	with access, opportunity, quality and financial protection guarantees) . Others Guidelines.
Implementation, monitoring and evaluation	No implementation and monitoring program; these are functions of another undersecretary in the MoH. Just recently been provided with feedback about use of CPG in the health system.
3 key challenges and facilitators in establishing the unit	Challenges: - Confusion of decision makers between Health Technology Assessment and Evidence Based Healthcare ("are the same processes, so it's the same"; "all things related to evidence"). - Lack of professionals with academic training or experience in EMB.
3 key challenges and facilitators regarding the ongoing functioning of the unit	Challenges: - Lack of continuous financial support from the authority. - Overwhelming use of professional resources in activities not related to generation of Clinical Guidelines (boutique projects like: High cost medicines fund, abort law project, other political requirements). - Needing to adjust planning in GPC processes to political context (like AIDS problem this year).
Collaborators	GRADE Working Group
Contact information	Pamela Burdiles, Unit Coordinator: pburdiles@minsal.cl Dino Sepúlveda, Head of Department: dino.sepulveda@minsal.cl
Note	-

Clinical Excellence Unit	
Website	-
Country	Iran
Purpose	Development of guidelines, publication of guidelines (in local journals), making guidelines available via the website and a database that includes the local guidelines, and actively disseminate the guidelines.
Sub-objectives	-
Tasks / Scope	-
Place of the unit within the healthcare system	The Clinical Excellence Unit is part of the Iran Ministry of Health.
(Legislative) mandate	Currently, there is no obligation for health practitioners to adhere to the guidelines. However, recently health insurance companies & also Ministry of Health require from health practitioners (both in public and private practice) to adhere to the guidelines in order for them to be reimbursed.
Date established; reason	Established in 2010, but only more active from 2013, due to push from insurers to have guidelines that inform reimbursement of interventions. Furthermore,

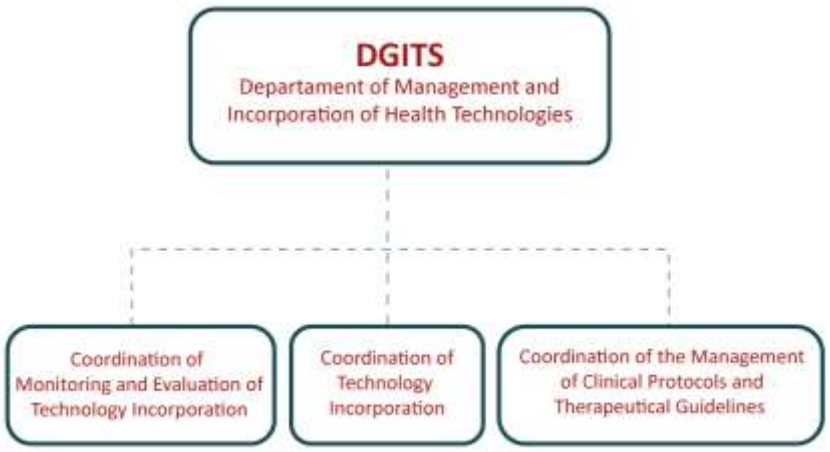
establishment	guidelines are used to check if practitioners have treated a patient correctly in case of medical claims.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	-
Human resources	7-10 full time staff; large number of part-time staff (University Medical faculty members)
Funding (amount, sources, duration)	MoH
Guideline development processes	Local guidelines were developed initially, but currently International Guidelines like US & UK (NICE) guidelines are adapted/adopted.
Outputs e.g. guidelines produced	About 200 guidelines have been developed.
Implementation, monitoring and evaluation	-
3 key challenges and facilitators in establishing the unit	-
3 key challenges and facilitators regarding the ongoing functioning of the unit	-
Collaborators	NICE, professional organisations
Contact information	Payam Kabiri – kabiri@research.ac.ir [meeting at GESummit17]
Note	-

CONITEC – National Committee for Health Technology Incorporation	
Website	http://conitec.gov.br/en/; http://www.inahta.org/members/conitec/; http://press.ispor.org/LatinAmerica/2016/03/a-perspective-on-health-technology-assessment-activities-in-brazil/
Country	Brazil
Purpose	CONITEC is responsible for helping the MoH in the incorporation, disinvestment or alteration of new health technologies provided by the Brazilian Public Health System (SUS), including medicines, products and procedures, such as vaccines, products for in vitro diagnosis, equipment, technical procedures, systems of

	organisation, information, education and support, assistance programs and protocols, which provide health care and services for the population.
Sub-objectives	It is worthwhile to mention the role of CONITEC in the elaboration and adjustment of clinical protocols and therapeutic *guidelines* (PCDT) and being able to request their elaboration or revision, according to SUS interests, having in mind that a clinical protocol and therapeutic guideline establishes criteria for the diagnosis of diseases or their deterioration; the recommended therapy, medicines and other appropriate products, as applicable; the recommended dosage and administration regimens; the mechanisms for clinical control; and the follow-up and verification of therapeutic results to be observed by SUS managers.
Tasks / Scope	- Development and update clinical guidelines. - Incorporation or disinvestment of health technologies into SUS.
Place of the unit within the healthcare system	CONITEC is still a Committee, following priorities identified by the government, and 7 out of 13 members are MoH representatives. CONITEC is not yet an independent agency. The Department of Management and Incorporation of Health Technologies (DGITS), is responsible for managing and coordinating CONITEC's activities.
(Legislative) mandate	Advisory role.
Date established; reason establishment	CONITEC: December 2011 DGITS: August 2013
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	CONITEC's operating structure is composed of two bodies: Plenary and Executive Secretariat. The Plenary is the body responsible for making recommendations on the incorporation, disinvestment or alteration of technologies for SUS. The Plenary is also responsible for the elaboration or adjustment in clinical protocols and therapeutic *guidelines*, as well as updates of the National List of Essential Medicines (RENAME). It consists of thirteen members, one representative from each secretariat of the MoH – the Plenary's president is designated by the Secretariat of Science, Technology and Strategic Inputs (SCTIE) – and one representative from each of the following institutions: Brazilian Health Surveillance Agency (ANVISA), National Regulatory Agency for Private Health Insurance and Plans (ANS), National Health Council (CNS), National Council of State Health Secretaries (CONASS), National Council of Municipal Health Secretaries (CONASEMS) and Federal Council of Medicine (CFM).

The Executive Secretariat (multidisciplinary team that combines technical and administrative support) ruled by the Department of Management and Incorporation of Health Technologies (DGITS), is responsible for managing and coordinating CONITEC's activities, as well as for issuing technical reports on the technologies being assessed, considering scientific evidence, economic evaluation and the budget impact related to the technology incorporation to SUS.

DGITS was created in August 2013 and its responsibilities include to follow up, subsidize and support CONITEC's activities and requests, as well as to contribute to the access and rational use of safe and efficient technologies.



All the reports are submitted to Public Consultations in order to ensure transparency and public participation. The contributions and suggestions of the public consultation are analysed and entered into CONITEC's final report, which is later forwarded to the Secretary of Science, Technology and Strategic Inputs of

	the Brazilian MoH for a final decision. The Secretary can also request a public hearing prior to its decision.
Human resources	Plenary assembly: 13 members. Executive secretary: 30 professionals. In addition to internal staff, CONITEC has a network of partner institutions in universities and teaching hospitals that are hired to develop studies assessing health technologies.
Funding (amount, sources, duration)	MoH
Guideline development processes	CONITEC develops clinical guidelines according to MoH priorities for the public health care in Brazil. The Committee has a Clinical Guideline Subcommittee which has the support of several specialists, health institutions and universities, and is able to critically asses the quality and results of available scientific studies on each topic. The Subcommittee submits the initial proposal of each Clinical Guideline for evaluation of the CONITEC plenary. After the document evaluation, CONITEC makes it available for Public Consultation on its electronic portal for the population to participate in the process. The CONITEC plenary analyses all contributions received in the Public Consultation and approves the final version of the document, which is subsequently published in the Official Union Report. These guidelines are updated every 2 years or whenever there is inclusion, alteration or exclusion of a technology that generates the need to revise recommendations in health care.
Outputs e.g. guidelines produced	The website (http://conitec.gov.br/) provides all the final reports, clinical guidelines, and information on evaluated demands or ongoing analysis. http://conitec.gov.br/index.php/protocolos-e-diretrizes ~135 guidelines
Implementation, monitoring and evaluation	CONITEC is developing tools that enable implementation and monitoring.
3 key challenges and facilitators in establishing the unit	Challenge: Slow structuring of the DGITS after the creation of the Committee. Facilitator: Enactment of law 12.401/2011 and Decree 7.646/2011 that created CONITEC and established HTA process rules in Brazil.
3 key challenges and facilitators regarding the ongoing functioning of the unit	Challenges: - Monitor the technologies incorporated in the SUS, as well as the implementation of the Clinical Guidelines; - Involve more and more patients and caregivers in the HTA process. Facilitator: - Exchange of knowledge and practices with HTA agencies and health institutions during technical visits and international events.
Collaborators	G-I-N, HTSi, INAHTA, REBRATS, RedETSA

Contact information	Jorgiany Souza Emerick Ebeidalla - jorgiany.ebeidalla@saude.gov.br
Note	-

Duodecim	
Website	http://www.duodecim.fi/english/
Country	Finland
Purpose	Provide reliable and easy-to-use medical information for health care professionals as well as for the general public.
Sub-objectives	-
Tasks / Scope	Development of the following products: 1. Evidence-Based Medicine Guidelines: concise point-of-care tools for primary and ambulatory care. They are produced by Duodecim Medical Publications Ltd., which is a non-profit company 100% owned by the Finnish Medical Society Duodecim. EBM Guidelines are available via subscriptions. All primary care practices and all hospitals in Finland have a license, so practically every health care professional in Finland can access EBM Guidelines. It is also available in 9 other languages. 2. The Evidence-Based Medicine Electronic Decision Support (Evidence into practice) 3. Current Care Guidelines are comprehensive national guidelines. They are produced by the Finnish Medical Society Duodecim and specialist societies. 1 and 2 are from Duodecim Medical Publications Ltd. 3 from the Finnish Medical Society Duodecim.
Place of the unit within the healthcare system	Part of the Finnish Medical Society.
(Legislative) mandate	-
Date established; reason establishment	Finnish Medical Society Duodecim in 1881. Duodecim Medical Publications Ltd since 1989. Pilot EBM guidelines 1989.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	Duodecim comprises The Finnish Medical Society Duodecim and Duodecim Medical Publications Ltd. The Finnish Medical Society Duodecim is Finland's largest scientific association. It exists to develop the professional skills and clinical practice of doctors through continuing education, publications and research grants. Established in 1881, Duodecim's membership today comprises more than 20,000 doctors and medical students. Duodecim Medical Publications Ltd publishes information content for medical and healthcare professionals in the form of traditional printed products but also as electronic databases, solutions integrated into healthcare systems and an online learning environment. The publicly accessible Terveyskirjasto.fi service as well as applications to support self-care are aimed for general public interested in medicine.

Human resources	EBM guidelines: 8 salaried physician editors ~500 Finnish physician authors experts Marketing, IT and technical editors.
Funding (amount, sources, duration)	The Current Care Guidelines are produced with public funding. Duodecim Medical Publications Ltd = non-profit company.
Guideline development processes	The Current Care Guidelines are maintained and developed by The Finnish Medical Society Duodecim in association with various medical specialist societies. The Current Care Guidelines editorial team is responsible for the production of the Guidelines. Updates every 3 years (scheduled) and (interim) continuous updates. Duodecim's methodology handbook: https://www.dropbox.com/s/6n1sssoxz5fa7uy/Duodecim%27s%20Methodology%20Handbook%202016.pdf?dl=0
Outputs e.g. guidelines produced	Current Care guidelines: about 100 EBM Guidelines: about 1000
Implementation, monitoring and evaluation	- On-site training on the use of electronic guidelines and health portal - eLearing courses - Powerpoint presentations - Patient versions of guidelines
3 key challenges and facilitators in establishing the unit	-
3 key challenges and facilitators regarding the ongoing functioning of the unit	Facilitators: - Guidelines developed by a trusted professionals organisation - Comprehensive collection of concise guidelines together with other resources - Quickly searchable with one search term - Images, videos, calculators; supporting material - Drug information available on the same platform - International collaboration to keep contents up-to-date - Guidelines also available for patients - Patient-specific guidance via clinical decision support
Collaborators	Healthcare organisations and entities in Finland, Cochrane, GRADE Working Groups, G-I-N, Wiley-Blackwell, EBSCO Health
Contact information	Ilkka Kunnamo, Editor-in-Chief, EBM Guidelines - ilkka.kunnamo@duodecim.fi
Note	-

Guideline Review Committee (GRC) and GRC Secretariat (WHO)	
Website	http://www.who.int/publications/guidelines/guidelines_review_committee/en/

	[In the process of being updated.]
Country	Switzerland
Purpose	GRC: To ensure that WHO guidelines are of high quality, that they are developed using a transparent and explicit process, and that, to the extent possible, recommendations are based on evidence.
Sub-objectives	GRC: - Define appropriate and standardized processes for guideline development at WHO; - Ensure that all guidelines published by WHO are of high quality and comply with explicit standards; - Develop and implement a plan to ensure that GRC members have the necessary knowledge of the approved methods for guideline development and to identify opportunities to build capacity in guideline development among WHO staff; and - Develop collaborations with other organisations and international networks that have methodological expertise and skills in guideline development, adaptation and implementation.
Tasks / Scope	The GRC *Secretariat* has several important roles: - Coordinates and provides technical support on guideline development to WHO technical units at headquarters and in the regional offices; - Sets benchmarks; - Evaluates guideline development processes, documents and standards to achieve quality assurance and improvement for WHO guidelines; - Organizes training on guideline development methods and procedures for WHO staff; - Provides administrative and technical support for the work of the GRC; - Collaborates with other organisations and international networks that provide methodological expertise in guideline development, adaptation and implementation; and - Maintains a database of GRC submissions. - Note that the secretariat does not do the approval of the guidelines. [That is done by the GRC.]
Place of the unit within the healthcare system	Part of WHO.
(Legislative) mandate	Recommendations.
Date established; reason establishment	2007; To ensure that WHO guidelines are of high quality, that they are developed using a transparent and explicit process, and that, to the extent possible, recommendations are based on evidence. There was criticism that the guidelines were largely based on expert opinion. Note that the secretariat started off with a focus on editing of guidelines, but the current focus is on providing technical expertise.
Unit structure (sub-units, centres,	The Secretariat of the GRC is in the Health Systems and Innovation Cluster, Department of Information Evidence and Research (IER). So the guideline quality oversight is in a centralized, technical unit (while the guidelines are

directorates, working groups, committees etc.) (organogram)	developed decentralized).
Human resources	The GRC Secretariat consists of 3 staff members: 2 technical staff and 1 admin staff. The GRC is composed of approximately 30 individuals, including representatives from all WHO regions as well as external members (e.g. academics). Each guideline has a WHO Guideline Steering Group (5-15 people): This includes staff from the WHO unit that initiated the development of the guideline (including a responsible technical officer – content expert) and WHO technical experts from other units. [So only internal staff.] The GSC drafts the scope of the guideline and supports the process. Each guideline is actually developed by external people.
Funding (amount, sources, duration)	The secretariat is funded by core WHO funding (government member states and partners contribute). WHO units pay a fee to have documents reviewed by the GRC. Some external funding for projects e.g. Gates Foundation, Wellcome Trust, Department for International Development UK, Government of Japan. Challenging to get funding for projects. GRC, WHO GSG, guideline developers are all paid by their respective employers.
Guideline development processes	Note that the GRC does not provide guidance on the technical content of the guidelines, but rather on how to develop guidelines that will meet WHO standards; questions scope, evidence for recommendations etc. The GRC meets on a monthly basis (10 a year) to review initial proposals for guideline development and final versions of guidelines prior to their publication. The review of initial proposal includes an assessment of whether the guideline development process will be able to meet the WHO requirements that are described in the WHO handbook for guideline development. If it is approved, the guideline can be developed, if not, the proposal needs to be adapted and reviewed again. The review of final submissions is conducted to ensure the process and form of the recommendations has followed the WHO requirements guidelines. Besides approving or not approving guidelines, there can be a "conditional approval". In that case the revised guideline only goes back to the secretariat for approval and not to the GRC. This to make the process more time efficient.
Outputs e.g. guidelines produced	An overview of all guidelines developed can be found on: http://www.who.int/publications/guidelines/en/ ~170 guidelines
Implementation, monitoring and evaluation	The GRC (Secretariat) is not involved in implementation and M&E of the guideline, that is the responsibility of the WHO unit that initiated the development of the guideline. It is perceived by the GRC secretariat that this should be done more often. There has recently been an evaluation of WHO information products (including guidelines) and one of the comments was that products are in general too long. So it is important not to keep sight of the end user. Currently there is a lot of focus on providing detail on the methodology.
3 key challenges and facilitators in establishing the	Challenge: Initially the GRC process was perceived as a bureaucracy that one "needed to get through".

unit	
3 key challenges and facilitators regarding the ongoing functioning of the unit	Challenges: - Adequate human and financial resources. - GRADE system. - Development of global guidelines that need to be suitable in local contexts. - Evidence to decision framework. Focus on evidence and harm, but there could be other drivers of recommendations (e.g. equity) that deserve more attention. - Presentation of the guideline document (language too difficult, focus too much on methodology). - Identification of methodologists from LMIC; capacity building. Facilitators: - GRC secretariat perceived as a valuable source of technical support. - Criticizers in the past are now the best advocates.
Collaborators	The Cochrane Collaboration is an official relation since 2011. Working on a collaboration with the Global Evidence Synthesis Initiative (American University of Beirut). In addition there are informal relations with e.g. NICE, U.S. Preventive Services Task Force.
Contact information	Susan Norris, main technical staff - norriss@who.int
Note	Operates on international level.

Haute Autorité de Santé (HAS)	
Website	http://www.inahta.org/members/has/; https://www.has-sante.fr/portail/jcms/r_1455081/en/home-page?portal=r_1455081
Country	France
Purpose	Contributing to the regulation of the healthcare system by improving health quality and efficiency.
Sub-objectives	HAS' mission is defined by French legislation and can be grouped into two main activities: Assessments and Recommendations - Evaluation of healthcare products, procedures, services and technologies from a medical and economic standpoint for reimbursement decision-making purposes. - Development of recommendations for good clinical practice, public health recommendations, health economic studies, and treatment *guidelines* intended for professionals and patients. - Issuance of advisory opinions within HAS' scope of action to effectively inform public authority decision-making. Accreditation and Certification - Accreditation of healthcare organisations and non-mandatory certification of practitioners in select medical specialities. - Improvement in the quality of medical information found online and in the

	press, including certification of medical sales and prescription software. - Provision of consumer information on the quality of care received in healthcare organisations via a dedicated website: www.scopesante.fr. HAS also develops tools, *guidelines* and methods for the healthcare community at large with the aim of improving the provision of care and/or helping with the implementation of external, non-HAS projects.
Tasks / Scope	Guideline development and implementation.
Place of the unit within the healthcare system	Consultative body providing independent scientific advice to the French public authorities.
(Legislative) mandate	HAS may perform assessments on its own initiative or at the request of government (e.g. the MoH), national health insurance, learned societies, users' associations, etc.
Date established; reason establishment	January 1st, 2005; HAS was formed by the merger of ANAES (French National Agency for Accreditation and Evaluation in Health), the Transparency Committee, and the Committee for the assessment of devices and health technologies (CEPP) – two committees previously run by AFSSAPS (Agency for the Safety of Healthcare Products) – and FOPIM (Fund for the Promotion of Medical and Health Economics Information). The objective was to bring together into a single body all the expertise needed for patient-centred continuous quality improvement.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	HAS is governed by a board of seven members; the Board Chair is appointed by the Head of State. The HAS Board is responsible for providing strategic direction, programming and implementation of its legislative-assigned scope of action and function. As the decision-making body of HAS, it is responsible for maintaining high standards and impartiality of its activities and results. The Board deliberates on opinions, recommendations and decisions regarding certification, and on the accreditation procedure for healthcare organisations, as well as on the annual budget and accounts, internal regulations (Board, committees, departments), accounting and financial regulations, and loans and investment of reserves. There are specialist committees, each chaired by a Board member. Each Board member is responsible for the policy, strategy and executive powers of their committee, and sets up working groups. Each Chair is supported by an operational manager who reports to the Director of HAS. With the support of their respective scientific and technical division, the specialist committees are responsible for examining the dossiers that fall within their area of expertise. [Note that the number of specialist committees is currently changing due to the fact that a new President of HAS will be elected.] Guidelines Committee Composition: The Committee is comprised of about 20 members appointed for a three-year term by the HAS Board: 1 chairman appointed among the members of the HAS Board; a number individuals appointed on their expertise. The chair of the Committee may invite any competent person whose contribution is considered useful, including external collaborators. 3 operating departments, a general secretariat and several divisions.

Human resources	- 7-membered Board - 400 employees - 20 members in Guidelines Committee - 2800 active external experts, patient associations and healthcare professionals, including 550 surveyors
Funding (amount, sources, duration)	In 2015, its operating budget was EUR 52.0 million (EUR 50.6 million in 2014 and EUR 54.7 million in 2013). [1 million USD HTA budget] Financially autonomous.
Guideline development processes	1. Following a preliminary scoping phase, a systematic review of the literature is conducted, after which the working group project manager drafts a scientific argument and proposed guidelines. After discussion at meetings based on existing data and practices, the working group drafts the initial version of the guidelines to submit to peer review. The peer review gives a formalised opinion on the content and form of the initial version of the guidelines through notations and comments. The working group finalises the guidelines after analysing and discussing the responses of the peer review. 2. Formal consensus rating 3. Accelerated method
Outputs e.g. guidelines produced	Overview of all guidelines developed: https://www.has-sante.fr/portail/jcms/c_6056/fr/recherche-avancee?portlet=c_39085&search_antidot=&lang=en&typesf=guidelines/generated.RecommandationsProfessionnelles (~100 guidelines)
Implementation, monitoring and evaluation	Dissemination strategies involve communicating with the media, editing and publishing reports, professional and public conferences, and exchange of information at local, regional, national and international levels. Information posted on the website (abstracts, reports, etc.) is continuously updated. Assessment reports and documents supporting decisions are posted on the HAS website.
3 key challenges and facilitators in establishing the unit	Facilitators: - The definition of an annual work program. - A rigorous and transparent methodology. - A strict respect for the obligations to declare interests and prevent conflicts of interest.
3 key challenges and facilitators regarding the ongoing functioning of the unit	Facilitators: - Public hearings when scientific data are rare and uncertain, difficult to interpret, with a societal debate component. - Recommendations focusing on areas for improvement. - A multidisciplinary approach always involving representatives of patient associations.
Collaborators	Seed (Shaping European Early Dialogues for health technologies); EUnetHTA (European Network for HTA Joint Action2), PaSQ (European Union Network for Patient Safety and Quality of Care)
Contact information	Bruno Lucet - b.lucet@has-sante.fr Michel Laurence - m.laurence@has-sante.fr

Note	-

Instituto de Evaluación Tecnológica en Salud (IETS)	
Website	http://www.inahta.org/members/iets/, http://www.iets.org.co [Spanish]
Country	Colombia
Purpose	IETS produces health technology assessments, evidence-based clinical guidelines and protocols of drugs, medical devices, procedures and treatments to support policy makers and healthcare professionals decide what technologies are effective, offer the best quality and value for money and therefore should be financed with public funds. IETS supports healthcare providers, insurance entities and local government on implementing CPGs and HTA.
Sub-objectives	-
Tasks / Scope	Design, development, oversight and critical appraisal of clinical guidelines, economic evaluations and budget impact analyses commissioned by a wide range of bodies within the Colombian government.
Place of the unit within the healthcare system	Its members include the Colombian MoH and Social Protection, the National Institute of Food and Drug Monitoring (INVIMA), the Colombian National Institute of Health (INS), the Colombian Administrative Department of Science, Technology and Innovation (Colciencias), the Colombian Medical School Association (Ascofame) and the Colombian Association of Scientific Societies.
(Legislative) mandate	Law 1438 of 2011. In Colombia it is mandatory that hospitals implement CPGs.
Date established; reason establishment.	September 2012.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	Sub-divisions: - HTA evaluations - Implementation and dissemination - CPGs
Human resources	Permanent staff: 40 Consultants: 25
Funding (amount, sources, duration)	Not-for-profit, public-private agency. Current HTA budget (USD): 3 million annually
Guideline development processes	Develop CPGs from systematic review. Adopt existing CPGs from based on Agree evaluation form and expert consensus. Adapt CPGs (update with context specific evidence) if the experts identify that the recommendations need changes.
Outputs e.g.	- Already IETS has participated in more than 70 CPGs.

guidelines produced	- 14 CPGs developed. - 10 CPGs adopted. - 4 CPG updated. - 48 CPGs supervised by IETS. - 40 tools for implementing CPGs (16 public/online; 24 not public yet). - IETS has produced 5 methodological guidelines to develop and evaluate CPGs in public health, adopt CPGs, implementation of CPGs, measuring and include or exclude technologies from benefit plans in Colombia.
Implementation, monitoring and evaluation	Through the Implementation and Dissemination Branch the implementation of evidence from clinical guidelines is planned and conducted, together with all actors in the health sector. IETS offers courses, advisors, and support to hospitals and other providers in health care about implementing CPGs.
3 key challenges and facilitators in establishing the unit	Challenges: - Teaching healthcare professionals the importance of evidence based medicine (EBM). - Strengthen the decision making process to include evidence based policies and implementing processes. - Financial support from the MoH. Facilitators: - High technical skills of the team members. - Changes in healthcare system; the healthcare model is now based on CPGs. - Medical autonomy and self-regulation.
3 key challenges and facilitators regarding the ongoing functioning of the unit	Challenges: - To have alliances in the country with the academic sector to avoid conflict of interest and increase the effectiveness of the research process. - Budget; IETS works on contracts for the MoH and other public institutions. - Medical self-regulation. Facilitators: - To show Colombia what the importance of this unit is within the Colombian Health System; some actors believed that IETS wasn´t necessary, but our work has changed this perception. - In Colombia it is mandatory that hospitals implement CPGs. - The health system in Colombia is based in risk management, CPGs are necessary for this.
Collaborators	Cochrane Colombia, Member of G-I-N, INAHTA, REDETSA
Contact information	Jaime Hernán Rodríguez Moreno, Deputy Director of Health Technology Assessment - Jaime.rodriguez@iets.org.co
Note	-

Medical Information Network Distribution Service (Minds) project, Japan Council for Quality Health Care	
Website	http://minds.jcqhc.or.jp/

	http://minds.jcqhc.or.jp/english/english.php
Country	Japan
Purpose	The aim of Minds project is to help medical practitioners to fully utilize the information related to the evidence-based medicine (EBM) in their practice.
Sub-objectives	Minds project also provides patients and the public with information to help understand the basics of diseases and to share with their practitioners the up-to-date evidence, on which modern medical practices are based.
Tasks / Scope	- Minds project supports CPG developers by providing CPG development methods suitable for the healthcare system in Japan, - Minds project disseminates CPGs which show high quality methodology on the MINDS website, - Minds project implements CPGs into clinical practice, - Minds project assesses improvements in healthcare quality by quality indicators.
Place of the unit within the healthcare system	Minds project is carried out by the Japan Council for Quality Health Care (JQ). JQ, Public Interest Incorporated Foundation, is a third party non-profit organisation, established in 1995 to conduct hospital accreditation in Japan. Now it broadens its activities including evidence-based medicine and CPGs.
(Legislative) mandate	None
Date established; reason establishment	2002
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	The operating body of Minds project is the Department of EBM and guidelines, JQ. This department has a director, who is an Executive Board Member of JQ, and there are 7 committees: Advisory Committee, Guideline Selection Committee, Guideline Development Support Committee, Guideline Implementation Committee, Patient and Public Expert Committee, Guideline Evaluation Expert Committee, Guideline Development Expert Committee.
Human resources	7 staff members, 3 contractors, 4 visiting researchers.
Funding (amount, sources, duration)	Minds project has been financially supported by the MoH, Labor and Welfare of Japan since its inception in 2002 through a Grants-in-Aid for Scientific Research from 2002 to 2010. Since 2011 it is financially supported by MoH, Labor and Welfare of Japan as a consignment project (different type of subsidy).
Guideline development processes	Minds project functions as a guideline clearinghouse; CPGs developed in Japan are formally evaluated by the Guideline Evaluation Expert Committee and only those guidelines which meet with the quality standard (using AGREE II) and are authorized to be available to public by the Guideline Selection Committee are disseminated through the Minds website (Minds Guideline Library).
Outputs e.g. guidelines produced	Online English guideline repository (http://minds.jcqhc.or.jp/english/english.php): 27 guidelines (as of September 7, 2017) and Japanese guideline repository (http://minds.jcqhc.or.jp/): 191

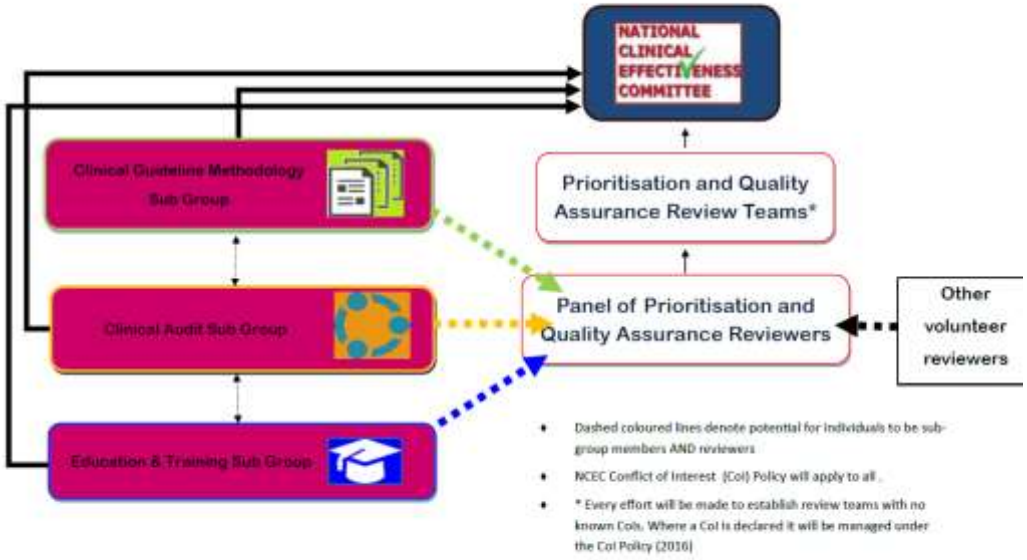
	guidelines (as of September 7, 2017).
Implementation, monitoring and evaluation	- Minds project implements CPGs into clinical practice, - Minds project assesses improvements in healthcare quality by quality indicators.
3 key challenges and facilitators in establishing the unit	-
3 key challenges and facilitators regarding the ongoing functioning of the unit	-
Collaborators	MoH, Labour and Welfare, Japan Medical association, G-I-N, Cochrane (others are under consideration)
Contact information	Hiroyuki Sugawara - minds.help@jcqhc.or.jp
Note	-

National Center for Health Technology Excellence or Centro Nacional de Excelencia Tecnológica en Salud (CENETEC)	
Website	http://cenetec-difusion.com/gpc-sns/
Country	Mexico
Purpose	The National Center for Health Technology Excellence (CENETEC) is a MoH agency, which main purpose is to produce objective, reliable and timely information related to Health Technologies.
Sub-objectives	- To collect, verify, update and exchange information on health technologies, in particular medical devices as an aid to their prioritization of need and allocation of resources; - To formulate appropriate national strategies and plans for the establishment of systems for the assessment, planning, procurement and management of health technologies, in particular medical devices, in collaboration with personnel involved in health-technology assessment and biomedical engineering; - To draw up national or regional guidelines for good manufacturing and regulatory practices, to establish surveillance systems and other measures to ensure the quality, safety and efficacy of medical devices and where appropriate in international harmonization; - To establish, where necessary, regional and national institutions of health technology, and to collaborate and build partnership with health-care providers, industry, patients´ associations and professional, scientific and technical organisations;

	- To collect information that interrelates medical devices, which deal with priority public health conditions at different levels of care and in various settings and environments, with the required infrastructure, procedures and reference tools;
Tasks / Scope	CENETEC has been appointed by the MoH to coordinate a program of adaptation of CPGs, for the Mexican Public Health Sector.
Place of the unit within the healthcare system	Body within the Mexican MoH.
(Legislative) mandate	Federal Government (Reglamento Interno of the MoH).
Date established; reason establishment	2004; in response to the need for reliable and timely information on health technologies by decision and policy makers.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	4 main programs: - CPGs - Health Technology Assessment - Biomedical Engineering - eHealth
Human resources	69
Funding (amount, resources, duration)	MoH. 2 million USD
Guideline development processes	Methodological manuals http://cenetec-difusion.com/gpc-sns/?page_id=1944
Outputs e.g. guidelines produced	- Master Catalogue http://cenetec-difusion.com/gpc-sns/?cat=52 429 current CPGs - Guideline repository http://cenetec-difusion.com/gpc-sns/?cat=56 372 outdated CPGs - ~800 CPGs in total
Implementation, monitoring and evaluation	We have an evaluation process of implementation CPGs (http://cenetec-difusion.com/gpc-sns/?page_id=148) and every institution has a checklist for monitoring the adherence to guideline recommendations.
3 key challenges and facilitators in establishing the unit	Challenges: Lack of physical equipment and material, lack of trained personal to disseminate CPGs.
3 key challenges and facilitators regarding the ongoing	Challenges: Change the habits of how health care workers are practicing, excess of work compared to available time, disagreement with the concept of the CPGs, personnel reluctant to use the CPGs. Facilitators: Availability of CPGs in electronic media, trained personnel in the

functioning of the unit	dissemination of CPGs, incentives for the use of CPGs.
Collaborators	PAHO/WHO, RedETSA, Medical Society of Mexico
Contact information	Ojino Sosa MD, Chief of CPGs - ojino.sosa@salud.gob.mx
Note	Own website mainly in Spanish.

National Clinical Effectiveness Committee	
Website	http://health.gov.ie/national-patient-safety-office/ncec/governance-ncec/
Country	Ireland
Purpose	The NCEC role is to recommend guidelines to the Minister for Health to become National Clinical Guidelines for implementation in Irish healthcare.
Sub-objectives	1. Provide strategic leadership for the national clinical effectiveness agenda. 2. Contribute to national patient safety and quality improvement agendas. 3. Publish standards for clinical practice guidance. 4. Publish guidance for National Clinical Guidelines and National Clinical Audit. 5. Prioritise and quality assure National Clinical Guidelines and National Clinical Audit. 6. Commission National Clinical Guidelines and National Clinical Audit. 7. Align National Clinical Guidelines and National Clinical Audit with implementation levers. 8. Report periodically on the implementation and impact of National Clinical Guidelines and the performance of National Clinical Audit. 9. Establish sub-committees for NCEC work streams. 10. Publish an Annual Report.
Tasks / Scope	- Prioritising clinical guidelines and audit that are important to national policy and the Irish health system. - Assessing clinical guidelines and audit against criteria to judge that they have been developed in the best possible way. This assures that National Clinical Guidelines and standards for National Clinical Audit are based on best available evidence, have involved key people, including patients, in their development and have examined the cost involved in implementation.
Place of the unit within the healthcare system	The NCEC comprises experts appointed to the role by the Minister for Health from key stakeholders in Irish healthcare.
(Legislative) mandate	Clinical guidelines that successfully go through the process are recommended to the Minister for Health through the Chief Medical Officer for endorsement and publication as National Clinical Guidelines. Once a National Clinical Guideline is endorsed it will supersede any other guidelines on that topic.
Date established; reason establishment	September 2010.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	Committee; not a unit; met 5 times in 2016. Meeting schedule is a minimum of 4 meetings per annum with provision for one additional based on agenda requirements. Each meeting is preceded by a Lunch and Learn session for members. There are 3 subgroups for the NCEC – clinical audit, clinical guideline methodology and education and training.



	Clinical Guideline Methodology Subgroup: The subgroup first met on 28th April 2016. The CGMS supports the NCEC to meet its terms of reference on National Clinical Guidelines by: 1. Guiding the development of NCEC processes for prioritisation and quality assurance of National Clinical Guidelines, including providing guidance on processes for the development and updating of documents, manuals and tools. 2. Considering changes and making recommendations to NCEC National Clinical Guidelines processes so as to maintain relevance, quality assurance and efficiency. 3. Horizon scanning developments in the methodology of guideline development.
Human resources	May 2015: 20 Members, <u>not</u> staff. The NCEC is supported by the Clinical Effectiveness Unit (CEU), National Patient Safety Office (NPSO), Department of Health. Full staff complement for the CEU is: - Head of Clinical Effectiveness (currently vacant) - 4 Clinical Effectiveness Officers (first position filled in November 2014) - Administrative support The CEU functions as a stream within the National Patient Safety Office and so contributes to the overall work of the NPSO. For example, with the annual NPSO Conference.
Funding (amount, sources, duration)	Budget: The work of the NCEC is supported through the Department of Health and funding is requested through usual organisational procedures. Monies approved and used are detailed in the NCEC Annual Reports. Guideline Development Groups: Are supported through their organisations. NCEC Panel of Appraisers: volunteers from across the health care system
Guideline development processes	Clinical guidelines submitted to the NCEC should have been recently developed or reviewed. It is the responsibility of guideline development groups (GDGs) to utilise a robust clinical guideline development process. This requires GDGs to have

	appropriate clinical and methodological expertise along with multidisciplinary and patient representation. Clinical guidelines prioritised by the NCEC will proceed to appraisal. NCEC and the Health Information and Quality Authority (HIQA) have developed National Quality Assurance Criteria based on AGREE II. These criteria are used by NCEC in quality assuring and recommending clinical guidelines. GDGs should ensure that the clinical guidelines they submit to the NCEC address the quality assurance criteria listed. **Figure 1 Framework for Endorsement of National Clinical Guidelines**  *National Quality Assurance Criteria for Clinical Guidelines Version 2 (HIQA and NCEC 2015)
Outputs e.g. guidelines produced	The Department of Health publishes endorsed NCEC National Clinical Guidelines on the website: 15 guidelines currently published. A further 9 have been prioritised, 1 has completed QA and is awaiting publication, 2 are undergoing update and 5 have been identified by Notices of Intent. See list of published guidelines on http://health.gov.ie/national-patient-safety-office/ncec/national-clinical-guidelines/. A list of guidelines in development is also available to download from this page. In November 2016, the *Standards for Clinical Practice Guidance* were published.
Implementation, monitoring and evaluation	In line with its terms of reference the NCEC will facilitate with other stakeholders the dissemination of endorsed National Clinical Guidelines to front-line staff and to the public in an appropriate format. The endorsed National Clinical Guideline will supersede all previous guidelines and the relevant stakeholders should ensure that the endorsed National Clinical Guideline is implemented. National Clinical Guidelines endorsed by the Minister for Health are mandated for implementation in the Irish health system and their implementation is monitored through; the HSE[1] Performance Assurance Reports, compliance with the National Standards for Safer Better Healthcare[2] and increased alignment with the clinical indemnity scheme[3]. A number of Quality and Patient Safety Performance Indicators that can measure implementation and the impact of National Clinical Guidelines already exist and are specified in the HSE Service Plan 2017.
3 key challenges and facilitators in establishing the unit	-
3 key challenges and facilitators	-

[1] HSE is the Health Service Executive. This organisation is responsible for the provision of public health services in Ireland. Further information on the scope of the services is available at http://www.hse.ie/eng/

[2] Available at https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare

[3] Further information is available at http://stateclaims.ie/about-our-work/clinical-indemnity-scheme/

regarding the ongoing functioning of the unit	
Collaborators	Relationships with international guideline agencies such as NICE, SIGN, and GIN were explored. In addition, links were made with the BPAC[NZ].
Contact information	Rosarie Lynch - ncec@health.gov.ie Sara Condell
Note	

National Guideline and Pathway Committee	
Website	https://www.moph.gov.qa/national-clinical-guidelines
Country	Qatar
Purpose	Development and introduction of clinical guidelines to help standardize, whenever possible, the management and treatment of patients across the Qatari healthcare system, whilst simultaneously optimising both outcome and resource utilisation.
Sub-objectives	-
Tasks / Scope	Guideline development, awareness raising, implementation, monitoring and evaluation.
Place of the unit within the healthcare system	*Project/team* within the Ministry of Public Health (MoPH), Healthcare Quality and Patient Safety Department. Works with representatives from different healthcare organisations. The NGPC team works in close collaboration with e.g. the cancer and diabetes programme that also develop guidelines.
(Legislative) mandate	In principle the guidelines are mandatory for all providers to follow, but if the provider finds it necessary to deviate from the guideline this can be done, but should be justified and documented.
Date established; reason establishment	The project started in April 2015; The gaps between current practice in Qatar and the international best practice approach.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	MoPH - Nominates members of the National Guideline and Pathway Committee (NGPC); - Works with NGPC to support all their activities; - Works to ensure that activity goals are clearly defined, budget and resources correctly allocated, monitors and documents activities, liaise with all relevant parties etc. National Guideline and Pathway Committee (NGPC) - Ensures Guideline Development Group (GDG) members are carefully selected based on the guideline topic and expertize; - Ensures no conflict of interest among Guideline Development Group (GDG) members; - Reviews and approves proposed prioritization of topics;

	- Nominates appropriate GDG members; - Reviews and approves National Guidelines and Pathways. <u>Guideline Development Groups (GDG)</u> - Meet to review baseline Map of Medicine Referral Guides and MCG Guidelines; - Review feedback and approval of the modified Guidelines and Pathway; - Modify guidance to the Qatari context. <u>Stakeholder Representative Group (SRG)</u> - Stakeholder representatives from the different healthcare organisations, within Qatar, who have the potential to be Engagement Champions; - SRGs continue to be instrumental for the success of the NGPC development as they work closely with the team on decisions related to communication goals, tools, methods and messages focused on educating and updating end-users and the public; - • Review and approve preliminary messages and help the NGPC team in determining their mode of dissemination, streamlining the process by coordinating / linking the NGPC team with leaders across the various facilities.
Human resources	-
Funding (amount, sources, duration)	MoPH
Guideline development processes	1. Baseline guideline development: To ensure use of reliable evidence and to substantially reduce time and effort involved in assessing primary and secondary literature directly from evidence databases, high impact guidance from Hearst Health was deployed. These baseline guidelines are based on Map of Medicine Referral Guides and MCG content that was localized to the Qatar National context; 2. Baseline guideline disseminated to GDG members prior to the NGPC workshop; 3. Full day (accredited) workshops to review baseline organized by the MoPH for GDG members. MoPH staff facilitate the workshops but do not influence guideline content. GDGs were encouraged to share relevant guidelines already utilized at their work place or from the international literature as the workshops are seen as an opportunity for subject matter experts to examine and discuss all the relevant information so that the final content may incorporate the necessary information need for a high quality localized guideline. [Note: also SIGN, NICE, locally produced guidelines to be used as source of evidence]; 4. Post workshop: a) Baseline guidelines modified based on workshop feedback b) GDG review and finalize draft National Guideline in preparation for NGPC approval c) NGPC reviews and approves draft National Guideline d) Guideline published to an open-access portal accessible via an MoPH website link. Content will be regularly revised and brought up to date.
Outputs e.g.	By early 2017, 60 guideline development workshops were completed and

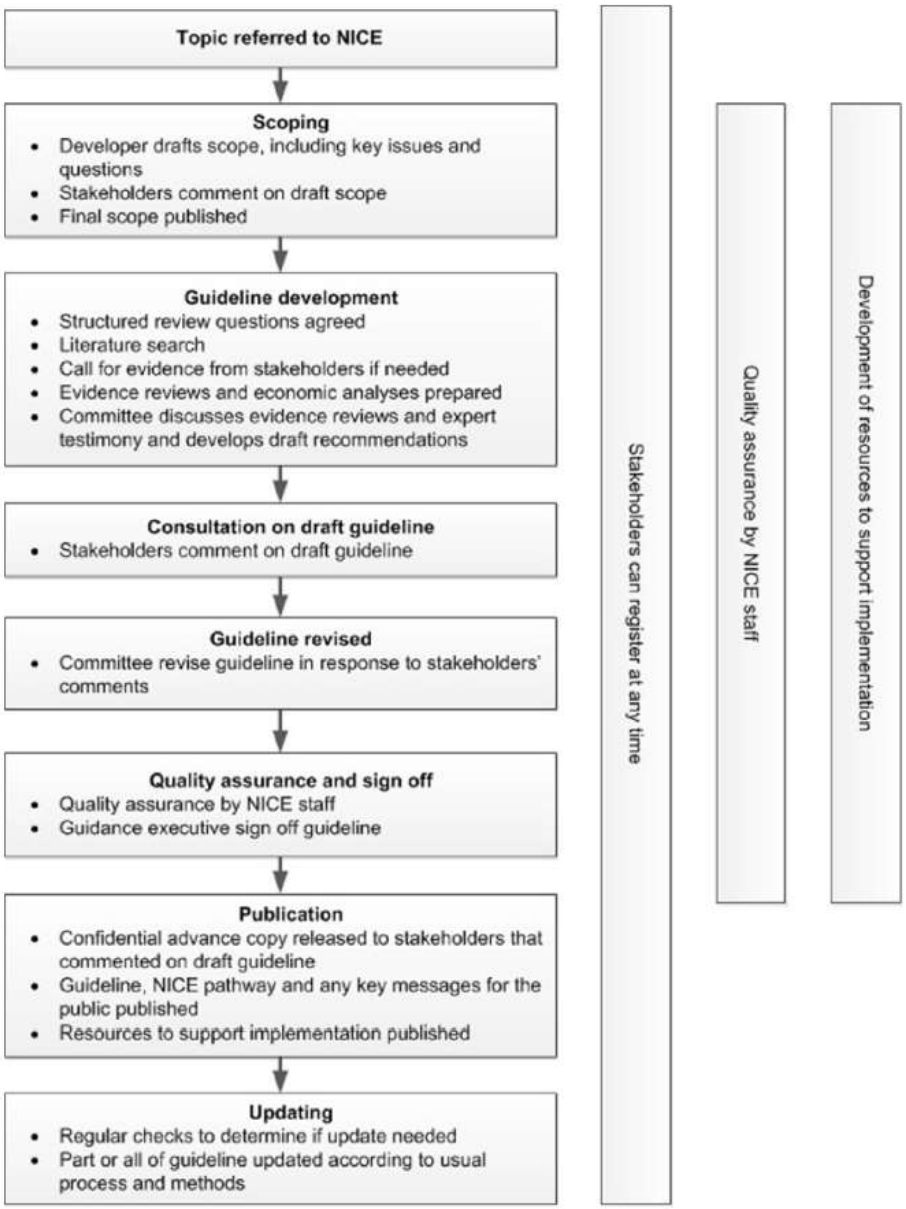
guidelines produced	guidelines and pathways will continue to be uploaded on the MoPH website as they become approved. Currently, eleven national clinical guidelines have been developed out of 30 guidelines embodied in the project. The guidelines which have already been developed include common cold, tonsillitis, community acquired pneumonia, asthma in children, asthma in adults, hypothyroidism, hyperthyroidism, hypertension, diarrhoea in children, lower UTI in females and obesity.
Implementation, monitoring and evaluation	The NGPC team has also conducted numerous 'Awareness presentations' at provider sites. These visits are targeting the leaderships of the health institutions and health practitioners with an insight into the process of National Clinical Guideline and Pathway development. It is also explained to those in attendance, how the introduction of the National Clinical Guidelines is expected to lead to more standardized, evidence-based care, with optimised patient outcomes. Post implementation framework development: Two frameworks (Clinical governance and Outcomes Improvement) are currently available in draft form, both are expected to enhance NGPC development governance and system performance monitoring of NGPC uptake and adoption. The NGPC team continues to monitor usage (data collection, clinical quality audits). With the support from quality departments across Qatar's healthcare provider organisations the NGPC team is working on enabling, adaptable and sustainable systems that aim to help improve access, adoption and compliance to the guidelines.
3 key challenges and facilitators in establishing the unit	-
3 key challenges and facilitators regarding the ongoing functioning of the unit	-
Collaborators	World Health Organisation
Contact information	Contact form on the MoPH website.
Note	Information not verified by unit. Project, time-frame unclear.

National Institute for Health and Care Excellence (NICE)	
Website	https://www.nice.org.uk/

Country	UK
Purpose	NICE provides national guidance and advice to improve health and social care. NICE's role is to improve outcomes for people using the NHS and other public health and social care services.
Sub-objectives	-
Tasks / Scope	- Producing evidence-based guidance and advice for health, public health and social care practitioners. [NICE guidelines, technology appraisal guidelines, interventional procedures guidance.] - Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services. - Providing a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.
Place of the unit within the healthcare system	As a Non Departmental Public Body (NDPB), NICE is accountable to their sponsor department, the Department of Health, but operationally they are independent of government.
(Legislative) mandate	The way NICE was established in legislation means that the guidance is officially England-only. Different types of NICE guidance have a different status within the NHS, public health and social care. Technology appraisals and highly specialised technologies guidance: NHS in England and Wales is legally obliged to fund and resource medicines and treatments recommended through NICE's technology appraisal programme. None of the other guidance and products are subject to the same legal obligations. Nevertheless, health and social care professionals are actively encouraged to follow the recommendations to help them deliver the highest quality care. Of course, NICE's recommendations are not intended to replace the professional expertise and clinical judgement of health professionals, as they discuss treatment options with their patients.
Date established; reason establishment	1999; It used to be that where you lived influenced hugely what health care you would get. So the main driver for the establishment of NICE was to create common standards of evidence based care. The first team that was established (health technology assessment) set the stage for the processes used in the other teams as well.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	The NICE Board sets our strategic priorities and policies, but the day to day decision-making is the responsibility of the Senior Management Team (SMT) (7 members). Then there are 12 independent advisory committees. 6 teams: 1. Centre for Guidelines (CfG): Develops guidance on the promotion of good health; the prevention of ill health; the appropriate treatment and care for people with specific diseases and conditions social care and service delivery. Responsible for: Clinical guidelines; Public health guidelines; Social care guidelines. 2. Centre for Health Technology Evaluation (CHTE): Develops guidance on the use of new and existing treatments within the NHS, such as medicines, medical technologies and surgical procedures. 3. Health and Social Care Directorate: Produces a range of products to improve quality within the NHS. 4. Evidence Resources Directorate: Maintains and builds NICE's digital services. Provides access to quality information to support guidance development and

	other NICE programmes, identifying, selecting and appraising new evidence. 5. Communications directorate: Raises awareness of NICE's work. Responsible for: the publication and dissemination of NICE guidance. 6. Business, planning and resources directorate
Human resources	The average number of whole-time equivalent persons employed (excluding non-executive directors) was 613 in 2015/16.
Funding (amount, sources, duration)	NICE is an NDPB with the majority of funding (83%) coming through grant-in-aid from the Department of Health. The remaining funding comes from other NDPBs (NHS England and Health Education England) and income-generating activities (NICE International and the Scientific Advice Programme). NICE's total funding from the Department of Health for 2015/16 was £63.1 million. NICE also received £12.7 million operating income from other sources.
Guideline development processes	NICE uses 2 different models: 1. Internally developed guidelines (by teams within NICE) 2. Guidelines for which the development is commissioned out to 1 of the 3 collaborators: National Guideline Alliance (NGA); National Guideline Centre (NGC); Social Care Institute for Excellence (SCIE)). All Public health guidelines are developed in-house; all Social care guidelines are outsourced; Clinical guidelines are a mixture. NICE also provides cost-effectiveness analyses / economic analyses in the guidelines, but even for internally developed guidelines this is outsourced for some guidelines (York Health Economics Consortium (YHEC)). Currently guidelines are considered for an updated every 2 years, unless strong signal evidence (e.g. RCT) comes in that warrants an earlier update. NICE also has a contextualisation service for the population of other countries: to re-consider and re-write published NICE guideline recommendations based on the differences in circumstance and population in the other country. It is also permitted for countries to translate and adapt the NICE guidance themselves.

Figure 1.1 Stages of guideline development



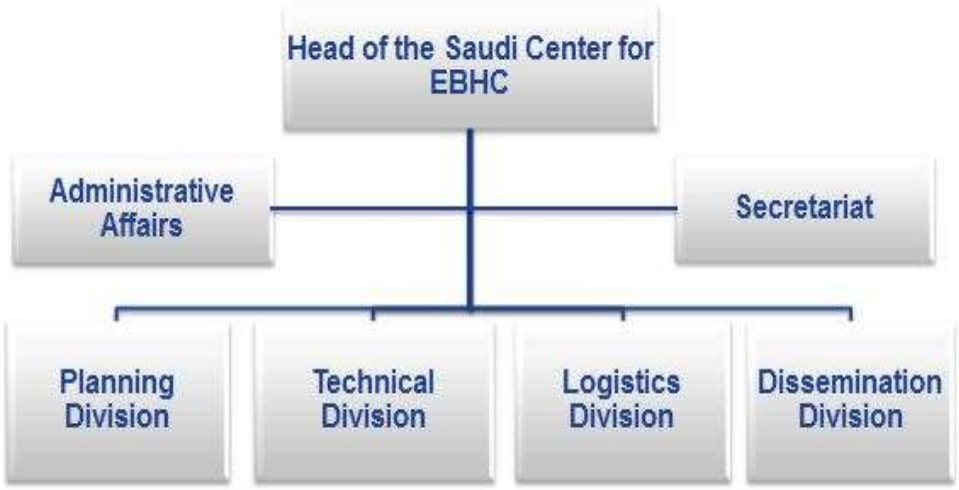
Outputs e.g. guidelines produced	In 2015/16 26 new clinical guidelines published. 276 guidelines online.
Implementation, monitoring and evaluation	Our aim is to drive and enable the effective use of NICE guidance and standards to support local initiatives, improve outcomes and reduce variation. The implementation strategy group (ISG) is drawn from leading academics in this field. They provide information and advice on the latest implementation science and the implications for our approach. A relatively new product are the quality standards for those providing and commissioning health, public health and social care services. For these auditable statements are created for guideline recommendations. These cover the key areas in the guideline that will drive the quality of care. NICE Pathways is an interactive tool for health and social care professionals providing fast access to NICE guidance and associated products: - NICE Pathways offer an easy-to-use, intuitive way of accessing a range of clinical, public health and social care information from NICE. They include up to date NICE guidance, quality standards and related information.

	- NICE Pathways are a key resource for users of NICE guidance as they allow users to navigate the breadth and depth of NICE recommendations on any subject through interactive topic-based diagrams. - NICE Pathways visually represent all of NICE's recommendations on a topic, linking to other relevant topics to create a network of information. Because they bring together guidance and supporting information on the topic from all of our work programmes, users do not need to understand how NICE classifies different types of guidance to be able to see everything NICE has said about a particular topic. - NICE Pathways are for people who use NICE guidance. This includes health and social care professionals, public health experts, those who commission or provide health and social care services, employers and members of the public. - NICE Pathways are a useful tool for professionals at any career stage, from learning and training to continuing professional development and keeping up to date.
3 key challenges and facilitators in establishing the unit	-
3 key challenges and facilitators regarding the ongoing functioning of the unit	Challenges: - You are as good as your best guideline. Important to keep adhering to the core principles: Evidence based; Expert input; Patient and public involvement; Independent advisory committees; Genuine consultation; Regular review; Open and transparent. - Stakeholder involvement in public health guidance is a new field; challenge to talk their language. - It is important for the implementation of a guideline who is commenting on it e.g. an accepted professional body. - Technology should be improved so that when recommendations on cross-cutting issues are updated, these are updated in all related guidelines. Currently it is difficult to keep track of what is recommended where. Facilitators: - Since the health care system is government funded, NICE's work keeps its value. - Good staff retention.
Collaborators	Professional networks of staff. National Guideline Alliance (NGA); National Guideline Centre (NGC); Social Care Institute for Excellence (SCIE). Accreditation team: accredits guidelines of other organisations: Royal Pharmaceutical Society, The Midlands Therapeutics Review and Advisory Committee, British Transplantation Society etc. Criterion is that the content is developed appropriately, although the content might differ from NICE's guidelines.
Contact information	Katy Summerscales - nice@nice.org.uk Kay Nolan – Kay.Nolan@nice.org.uk [meeting at GESummit17] Moira Godbert-Laird - Moira.Godbert-Laird@nice.org.uk for contextualisation service
Note	-

New Zealand Guidelines Group	
Website	http://www.health.govt.nz/about-ministry/ministry-health-websites/new-zealand-guidelines-group
Country	New Zealand
Purpose	To promote the use of evidence in the delivery of health and disability services.
Sub-objectives	-
Tasks / Scope	NZGG developed evidence-based guidelines and summaries for consumers and practitioners; and it supported the implementation of guidelines through implementation projects and implementation planning.
Place of the unit within the healthcare system	The New Zealand Guidelines Group (NZGG) was an independent, not-for-profit organisation.
(Legislative) mandate	None.
Date established; reason establishment	Set up in 1999 out of an interest in establishing evidence based healthcare for the most important health issues in the country. The NZGG went into voluntary liquidation in mid-2012. Currently guidelines are developed by universities under contract of the MoH.
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	The organisation was governed by an Advisory Board that drew on leadership from New Zealand in nursing, Mäori Health, Pacific Health, consumer perspectives, medicine, disability support, public health medicine and general practice. Operationally, it was made up of research, implementation, business development and corporate service teams. There were different guideline teams. If a guideline development process was initiated, 1-2 researchers were allocated, and a call for volunteers (which included a range of people) went out.
Human resources	The groups started off with 2 staff members and about 100 volunteers. Later on there were about 30 staff members (2008/9) and about 500 volunteers.
Funding (amount, sources, duration)	Contracts with NZGG's funders, primarily the MoH. And the accident compensation corporation (government insurer). There was about half a million NZ dollars needed for the basic funding (to keep the organisation going) and then per guideline another 1 million (based on proposals submitted to the MoH).
Guideline development processes	Systematic reviews of the evidence, supported by expert assessment through the guideline development teams.
Outputs e.g. guidelines produced	1 guideline still current? ~19 guidelines developed?

Implementation, monitoring and evaluation	Implementation projects.
3 key challenges and facilitators in establishing the unit	-
3 key challenges and facilitators regarding the ongoing functioning of the unit	Challenges (reason for failing): - No ongoing contracts / no sustainable funding - Mismatch between guideline developers that wanted extensive and expensive guidelines versus the MoH that wanted something short and simple within a short period of time. - Time for guideline development was too short to get stakeholders engaged and hence their buy in; guideline would not always be accepted. Facilitators (things that worked): - Staff got experienced over time: different types of guidelines, different topics (individual professional organisations that develop guidelines re-invent the wheel every time); experience with the process e.g. of writing recommendations, speeded up the process - Wide focus of guidelines (individual professional organisations often focus on 1 topic, e.g. stroke OR diabetes, while a guideline unit could incorporate both together)
Collaborators	NZGG had links to international organisations, such as the Cochrane Collaboration and the G-I-N.
Contact information	Catherine Marshall - bluekakariki@gmail.com [meeting at GESummit17]
Note	-

Saudi Center for Evidence Based Healthcare (EBHC)	
Website	http://www.moh.gov.sa/endepts/Proofs/Pages/Definition.aspx
Country	Kingdom of Saudi Arabia
Purpose	To ensure safe and comprehensive healthcare services and to provide guidance to specialists and healthcare professionals, allowing them to provide the best health care in the Kingdom.
Sub-objectives	The EBHC is also tasked with addressing clinical quality by providing national leadership and facilitating collaboration in the adaptation/ development, implementation, and evaluation of nationally agreed evidence based CPGs.
Tasks / Scope	- Delivery of (CPGs): adapting the best available international CPGs for prevention, diagnosis and treatment. - Transfer and retention of methodological expertise at EBHC. - Promote the awareness and practice of evidence-based medicine across the Kingdom, through training, awareness campaigns, thereby laying down a robust, nationally agreed accreditation, drawing upon CPGs. - Capacity building through recruitment of qualified personnel and through

	strategic partnerships. - Creating an environment of collaboration and consensus to give national credibility to CPGs. - Establishing the rules and regulations that are necessary to implement such guidelines in healthcare institutions.
Place of the unit within the healthcare system	Part of the MoH.
(Legislative) mandate	National credibility.
Date established; reason establishment	2013?
Unit structure (sub-units, centres, directorates, working groups, committees etc.) (organogram)	 Secretariat: - Preparing letters and other official documents. - Communicating with external parties. - Providing administrative/logistical support to senior staff. - Filing and retrieving documents, records and reports. - Scheduling appointments, and assisting with planning and preparation of meetings. - Responding to public inquiries. Administrative Affairs Division: - Typing and formatting all letters. - Sending and checking the delivery of letters. - Delivering maintenance, inventory, and supplies. - Reviewing inbound/outbound documents, and receiving and forwarding phone calls. - Checking messages. - Receiving and directing visitors to the center.

	- Providing administrative support for adaptation of CPGs and Saudi Commission for Health Specialties (SCHS) programs. Planning Division: The division is managed by a steering committee. It reviews the operational plan for selecting the action course of the CPGs adaptation, sets implementation mechanism and deadlines, finds out difficulties and obstacles, prepares necessary training programs and determines training committees. Technical Division: It is managed by the technical committee (Project manager, Methodology Specialist, Statistics specialist, Medical information specialist) to implement the methodology of CPG adaptation, which is a scientific process that starts with conducting scientific research and ends up by writing the clinical recommendations. Logistics Division: It is tasked with preparing logistics for internal and external events (meetings, workshops, trainings etc.) including bookings, preparations, and other relevant logistics. The division is also responsible for maintaining inventory of equipment and supplies, as well as facilities and offices. Dissemination and Follow-up Division: Under the supervision of the Dissemination Committee, the CPGs and related news will be disseminated through the relevant channels, as well as following them up until received by competent authorities (implementation and monitoring are not yet assigned to EBHC). The CPGs will be in the form of: - Printed scientific materials: handbooks, brochures, pocket books, pamphlets etc. - EBHC website on the MOH electronic gate. - Software and Apps for smartphones. - Printed and online newspaper and newsletter.
Human resources	9 key team members: Director, Strategic Advisor, Scientific Advisor, Project Manager, Project Coordinator, Logistics, Executive Assistant, Administrative Assistant (2)
Funding (amount, sources, duration)	MoH
Guideline development processes	Approach guideline project: prioritizing topics, identifying existing evidence syntheses (including HTA), identifying evidence specific to the local setting, and using the evidence to decision framework for formulation of recommendations (adapt CPGs).
Outputs e.g. guidelines produced	22 guidelines developed up to date
Implementation, monitoring and	Engaging stakeholders in supporting CPG dissemination and implementation for the benefit of patients and clinical staff alike.

evaluation	
3 key challenges and facilitators in establishing the unit	-
3 key challenges and facilitators regarding the ongoing functioning of the unit	-
Collaborators	Oxford University Center for CEBM
Contact information	ebhc@moh.gov.sa
Note	Information not verified by unit. AUB GRADE Center was sub-contracted to assist EBHC to adapt guidelines, so unclear what the status of the EBHC is. McMaster (Canada) worked with EBHC in the past, however, there have been numerous changes in the Ministry of Health and the current status of the EBHC is unclear.

Scottish Intercollegiate Guidelines Network (SIGN)	
Website	http://www.sign.ac.uk/
Country	Scotland
Purpose	To improve the quality of health care for patients in Scotland by reducing variation in practice and outcome, through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence.
Sub-objectives	-
Tasks / Scope	Develop evidence-based guidelines, produce patient booklets that are a lay translation of the clinical guidelines.
Place of the unit within the healthcare system	SIGN is part of the Evidence Directorate of Healthcare Improvement Scotland, however, it is editorially independent from Healthcare Improvement Scotland and the Scottish Government which ultimately funds Healthcare Improvement Scotland.
(Legislative) mandate	None
Date established; reason establishment	1993
Unit structure (sub-units, centres,	SIGN Council is the policy-making body for SIGN with overall responsibility for methodology and editorial policy. Members of SIGN Council are nominated by particular Royal Colleges or other professional organisations or committees,

directorates, working groups, committees etc.) (organogram)	but also represent their specialty or discipline in a wider sense and consult with other specialist societies in their field. Public partners are identified from an open call for interested individuals. Members of SIGN Council determine the overall direction of SIGN's development and play a key role in shaping the SIGN guideline programme. Some are also actively involved in aspects of the guideline development process and all provide input into the selection of topics for guideline development and the composition of guideline development groups. The work of SIGN is supported by an Executive. The SIGN Executive is made up of a Programme Team working closely with the Healthcare Improvement Scotland Knowledge and Information Team. Together they we are responsible for the implementation of decisions taken by SIGN Council and its subgroups, and for delivering the guideline programme to time and on budget. The guidelines are developed by multidisciplinary guideline development groups (clinicians, other health and social care professionals, patient organisations and individuals) with representation from across Scotland, with support from the SIGN Executive. The guideline development groups are selected in consultation with the member organisations of SIGN Council.
Human resources	12 staff members
Funding (amount, sources, duration)	Core funding from Healthcare Improvement Scotland supports the SIGN Executive, and expenses and costs associated with guideline development projects. Members of SIGN guideline development groups do not receive any payment for their participation, although independent practitioners are entitled to claim locum payments and travel expenses. Patient representatives can also claim expenses to enable them to attend guideline development group meetings. The expenses of other members of SIGN guideline development groups are met by their employing NHS boards, under an agreement with the Scottish Government Health Directorate.
Guideline development processes	Each guideline is based on a systematic review and critical appraisal of the current scientific literature. This means that the evidence base for the guideline is identified, selected, and evaluated according to a defined methodology. In this way, potential sources of bias in the guideline are minimised and the likely validity of the recommendations is maximised. The guideline recommendations are explicitly linked to the supporting evidence. This provides groups of practitioners working in NHS Scotland with information to help select and prioritise recommendations for local implementation, depending on local needs, priorities, and resources.
Outputs e.g. guidelines produced	An overview of current guidelines can be found here: http://www.sign.ac.uk/our-guidelines.html ~140 guidelines
Implementation, monitoring and evaluation	The guidelines are distributed within the NHS in Scotland via a network of Guideline Distribution Co-ordinators in each NHS board. Implementation is the responsibility of each individual NHS board and local ownership of the implementation process is crucial to success in changing

	practice. However, we can help support implementation by getting involved in: - raising awareness of our latest recommendations - networking with national projects and clinical networks responsible for improving clinical practice to support the implementation of key recommendations - developing implementation support tools and resources alongside specific guidelines (such as costing tools, care pathways, algorithms, audit tools and data sets).
3 key challenges and facilitators in establishing the unit	-
3 key challenges and facilitators regarding the ongoing functioning of the unit	-
Collaborators	Association of Comprehensive Cancer Centres (Netherlands); Belgian Health Care knowledge Centre; British Thoracic Society; Cochrane Collaboration ; European Centre for Disease Prevention and Control; German Guideline Program in Oncology; G-I-N; GIN Public; The GRADE Working Group; NICE
Contact information	sign@sign.ac.uk
Note	-