Balancing quality and resources in clinical guideline development – why we do what we do

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Introduction

The Danish National Cancer Plan IV was introduced in 2016. The plan resulted in a reinforced focus on developing and updating clinical practice guidelines for cancer.

The Danish Health Authority delegated the responsibility of harmonising and improving the quality of clinical cancer guidelines to the Danish Multidisciplinary Cancer Groups (DMCG.dk) and the Danish Center for Clinical Practice Guidelines – Cancer (DCCPG-C).

DMCG.dk is the organisation of 24 disease specific groups, each one managing a national clinical cancer registry and developing national clinical guidelines.

The task is challenging; how do we address the extensive variability in the existing guideline development practice as well as the considerable time constraints clinicians face, while at the same time maintaining commitment and ownership in the DMCGs and producing high quality guidelines?

Objective

The objective is to achieve an optimal balance between high quality guidelines and resource consumption in guideline development driven by clinicians.

Results & Discussion

Due to varying clinical logics and different needs in terms of applicability, a flexible model was needed. In this context GRADE was not considered useful and instead a heuristic approach was chosen.

Based on the AGREE II tool and inspired by the Oxford Levels of Evidence, one common guideline template was developed and introduced in both Danish and English to the 24 cancer groups.

The template is adjusted continuously in collaboration with the DMCGs and customised to each DMCG.

Eight supplementary guides reflecting the different stages of the development phase were prepared to support methodological rigor.

Best practice

The model is based on pronounced clinical commitment. With clinicians as developers we ensure that only clinically relevant questions are answered and that consensus or good practice recommendations are defined by professionals who understand the context. This is not only important for the development but also crucial for the implementation of the guidelines.

A clinician's primary task is to take care of the patients. Shortage in clinical staff and an increased number of patients means every hand is needed. Subsequently, most of the guideline work is conducted outside normal working hours. With this model, however, clinicians get reimbursed for working in their spare time.

To limit clinical resource consumption, DCCPG-C handles references, layout and manages version control. DCCPG-C also provides methodological support such as literature review, critical appraisal of evidence and preparation of syntheses.

Conversion from one model to another takes time and vigilance. Step-wise development plans are prepared for the 24 cancer groups individually and put into practice supported by DCCPG-C.

Balancing quality and resources in clinical guideline development takes compromises. This is *why we do what we do* and we are very interested in learning how *you* do?

Great ideas and advice?

Our model has yet to be consolidated. Suggestions concerning the refinement of our workflow and products are very welcome.

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