Adopt, adapt or start from scratch

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NHMRC Standards
The following Standards apply to the Adopt, adapt or start from scratch module:

2. To be transparent guidelines will make publicly available:
   2.1. The details of all processes and procedures used to develop the guideline
   2.2. The source evidence
   2.3. The declarations of interest of members of the guideline development group and information on how any conflicts of interest were managed
   2.4. All sources of funding for the guideline.

6. To be evidence informed guidelines will:
   6.1. Be informed by well conducted systematic reviews
   6.2. Consider the body of evidence for each outcome (including the quality of that evidence) and other factors that influence the process of making recommendations including benefits and harms, values and preferences, resource use and acceptability.
   6.3. Be subjected to appropriate peer review.

7. To make actionable recommendations guidelines will:
   7.1 Discuss the options for action
   7.2 Clearly articulate what the recommended course of action is, and when it should be taken
   7.3 Clearly articulate what the intervention is so it can be implemented
   7.4 Clearly link each recommendation to the evidence that supports it
   7.5 Grade the strength of each recommendation
Overview
There are many thousands of guidelines available on a wide range of topics, but there are a number of important factors to consider before deciding to adopt or adapt one of those instead of developing something new.

For many developers the opportunity to adapt an existing guideline is an attractive option as it has the apparent potential to reduce guideline development costs and avoid duplication of evidence reviews and advice. However, there is no evidence to date to suggest that adapting a guideline saves time or money compared to developing one from scratch (Burgers, Anzueto et al. 2012; Darzi, Abou-Jaoude et al. 2017). This is consistent with the experiences of Australian guideline developers who have found that adapting a guideline is often not a straightforward exercise and does not save time.

The reality is that while many guidelines are in circulation, only a few meet the quality and suitability standards important for adaptation; just because a guideline is available (locally or internationally) does not mean it should be used, let alone adapted for use elsewhere. For example, during the period 2005 to 2013, there were 102 guidelines developed on cardiovascular health in Australia and only 15 included documentation showing them to be evidence based (NHMRC 2014).

In most instances it is rare to find an entire guideline that fully matches the intended scope or questions. However, recommendations from a variety of guidelines can be considered, even when the scope of those guidelines may be quite different. For example the NHMRC Australian guidelines for the prevention and control of infection in healthcare adopted recommendations contained in the US Centers for Disease Control and Prevention Guidelines for Preventing Health-Care-Associated Pneumonia, 2003 (for droplet precautions) and the UK’s epic2: National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England (Pratt, Pellowe et al. 2007) (safe handling of sharps) even though the focus of these guidelines was different.

Adoption or adaptation of a guideline, its recommendations or other components could be considered if a relevant international guideline is identified but there is no Australian equivalent, or if an Australian guideline needs to be made more applicable to a new setting. If an existing guideline is identified but it is considered out of date, consider updating it (or updating selected recommendations) if the scope and evidence review questions are still relevant.

Table 1. Guideline components to consider adopting or adapting

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline questions</td>
<td>The questions on which the guideline and reviews of evidence are based.</td>
</tr>
<tr>
<td>Evidence tables</td>
<td>Tables that summarise the characteristics of the studies included.</td>
</tr>
<tr>
<td>Summary of findings table</td>
<td>A table containing the main findings of an evidence review based on a specific question and selection of outcomes.</td>
</tr>
<tr>
<td>GRADE evidence-to-decision tables (EtD table)</td>
<td>Frameworks that structure the formulation of recommendations, including detailed information on decisions made with regard to questions, criteria, evidence, judgements and conclusions.</td>
</tr>
<tr>
<td>Evidence statements</td>
<td>Statements that summarise the body of evidence with regard to specific questions.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>The guideline’s recommendations for policy or practice.</td>
</tr>
<tr>
<td>Supporting content</td>
<td>Content in the guideline that supports the recommendations, such as tables, figures, practice points or other text.</td>
</tr>
</tbody>
</table>
If a relevant guideline is identified, it is necessary to ensure that the decisions made during its development were well-documented so the motivations for developing the guideline and the judgements underpinning the recommendations can be understood. If the guideline is then found to be trustworthy, developers can choose to adopt the recommendations without modifications or else contextualise them to better suit a different setting. Guidelines with a broad scope tend to include a mixture of recommendations that have been adopted (with or without contextualisation), adapted or developed from scratch.

Developers starting from scratch should also be aware that the end users of their guideline may include other developers. If a guideline is to remain useful and current it should include documentation of its development process (including evidence sources and details of the context for which the guideline was intended) to facilitate future adoption or adaptation by other developers.

Adopting or adapting a guideline can be important in order to minimise duplication, but in some cases the development process will become more complex than if starting from scratch so it is important that methodological advice is sought early in the scoping phase to assist developers in making this decision.

What to do

1. Find out what guidance is available

Once the scope has been defined, developers should locate relevant guidelines on similar topics. Online guideline libraries or portals are useful for identifying relevant guidelines that are in development or use:

- Australian Clinical Practice Guidelines portal and register (Australia)
- Agency for Health and Research Quality (US)
- Guidelines International Network (G-I-N) library (International)
- NICE (UK)
- World Health Organisation (International)
- Centers for Disease Control and Prevention (US)
- Scottish Intercollegiate Guidelines Network (UK)

Guidelines can also be found by searching on literature databases such as Pubmed (e.g. using the medical subject heading (MeSH) term ‘practice guideline.pt’), government websites, and the websites of relevant professional organisations and condition groups.

If relevant guidelines are found, it may be worth contacting their developers for advice on guideline scope and the selection of topics. Sometimes it is necessary to assess guidelines at the level of questions, recommendations or evidence tables to determine how relevant the content is to the topic.

It is also possible to develop guidelines using a partial adaptation or hybrid approach, whereby some recommendations are adapted from other guidelines and some are developed from scratch based on new reviews of available evidence. If more than one high quality guideline is available it may be appropriate to draw from a selection.

Engaging stakeholders can also help inform this process by identifying:

- related advice that people are currently using
• whether a guideline has ever been developed on this topic (and if so, if it was successfully implemented and well received), and
• any policy or practice issues which need to be clarified or resolved (e.g. if there is variation in practice, if best practice is unknown, or there are other complexities related to the topic).

2. Check if a guideline is suitable to adopt or adapt
The fact that a guideline is available does not necessarily mean it is suitable to adopt or adapt. While the AGREE II instrument is useful for evaluating the overall quality of a guideline (Brouwers, Kho et al. 2010), this tool comments more on the process of guideline development than the quality of the evidence and evidence synthesis.

Other factors to consider when evaluating suitability to adopt or adapt include understanding how the evidence was interpreted, whether there were conflicts of interest, what values and preferences were considered, and in which context the recommendations were intended to be applied. These factors have been demonstrated to affect the grading of recommendations (Agoritsas, Neumann et al. 2017) and should be transparent in a trustworthy guideline. Similarly, judging a guideline by the reputation of the developers or the applicability of its recommendations alone should not justify its use for another guideline.

It is crucial that the evidence review process is available to access in full, including well-documented evidence tables supporting each recommendation, so that the original judgements of the evidence underpinning recommendations can be assessed. Consider when the review was undertaken, if new evidence is available, and whether the evidence is likely to change (e.g. the relationship between foods high in saturated fat to the risk of cardiovascular disease). Even if the evidence appears out of date (e.g. more than five years old), it may still be appropriate to adopt the recommendation as written based on the relative stability of the evidence.

Consider if it would be possible to implement the recommendations in the new context, including whether they would be feasible to administer, whether expected users would accept them, and whether there would be resource constraints. If there are likely to be new or different barriers to implementation it may be more appropriate to adapt the recommendations rather than adopt them verbatim, which is a decision that might be best made after consulting stakeholders.

Another important consideration is the method used by the original developers to formulate recommendations, since it can be challenging to convert recommendations from one grading system to another.

Table 2 provides an overview of the factors to consider when assessing a guideline’s suitability to adopt or adapt, and suggestions for how to check this information.
<table>
<thead>
<tr>
<th>Issue</th>
<th>Questions</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevance</td>
<td>• Is the clinical or public health context similar to Australia?</td>
<td>• Match the topic and scope using relevant keywords on the topic</td>
</tr>
<tr>
<td></td>
<td>• Are the population, intended users and settings comparable?</td>
<td>• Check the subtopics or questions</td>
</tr>
<tr>
<td></td>
<td>• Are the recommended interventions available in Australia?</td>
<td>• Break down questions into PICO or equivalent components for keywords</td>
</tr>
<tr>
<td></td>
<td>• Are the guideline questions relevant in the new context?</td>
<td>• Check how values and preferences were incorporated into the guideline</td>
</tr>
<tr>
<td></td>
<td>• Do the values and preferences considered in the guideline reflect the</td>
<td>(i.e a literature search, consultation, representation on the development</td>
</tr>
<tr>
<td></td>
<td>new context?</td>
<td>group)</td>
</tr>
<tr>
<td></td>
<td>• Relevant outcomes used?</td>
<td>• Check if relevant outcome sets exist (e.g. CORE)</td>
</tr>
<tr>
<td>Currency</td>
<td>• When was the evidence review conducted?</td>
<td>• Check the details in the search strategy including the date cut-offs</td>
</tr>
<tr>
<td></td>
<td>• Is the evidence out of date?</td>
<td>for inclusion of evidence</td>
</tr>
<tr>
<td></td>
<td>• Is evidence likely to change?</td>
<td>• Check whether the guideline made reference to emerging evidence at the</td>
</tr>
<tr>
<td></td>
<td>• Has new evidence superseded the information contained in the</td>
<td>time of publication</td>
</tr>
<tr>
<td></td>
<td>recommendations?</td>
<td>• Assess overall quality using AGREE II</td>
</tr>
<tr>
<td></td>
<td>• Does new evidence contradict the recommendations?</td>
<td>• Check what grading system was used</td>
</tr>
<tr>
<td></td>
<td>• Match the topic and scope using relevant keywords on the topic</td>
<td>• Check that the evidence tables are available and complete</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td>• Is there a detailed description of the development process?</td>
<td>• Use the Implementability Actions Checklist to assess implementability</td>
</tr>
<tr>
<td></td>
<td>• Were conflicts of interest declared and managed?</td>
<td>• Check dissemination plan and materials</td>
</tr>
<tr>
<td></td>
<td>• Was a grading system used for the recommendations?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Are the evidence tables clearly laid out and accurate?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Was the evidence review systematic and well-documented?</td>
<td></td>
</tr>
<tr>
<td>Access to evidence</td>
<td>• Are the tables detailing the source</td>
<td>• Check that the evidence tables are available and complete</td>
</tr>
<tr>
<td></td>
<td>evidence (e.g. GRADE Evidence to Decision tables) available?</td>
<td>• Contact the developers</td>
</tr>
<tr>
<td></td>
<td>• Can permission be sought to use these tables?</td>
<td></td>
</tr>
<tr>
<td>Implementability</td>
<td>• What information is provided in the guideline to assist implementation?</td>
<td>• Use the Implementability Actions Checklist to assess implementability</td>
</tr>
<tr>
<td></td>
<td>• What steps were taken to improve the guideline’s implementability?</td>
<td>• Check dissemination plan and materials</td>
</tr>
<tr>
<td>Acceptability</td>
<td>• Are the recommendations acceptable?</td>
<td>• Consult with stakeholders</td>
</tr>
<tr>
<td></td>
<td>• How do the recommendations relate to current practice? Are there</td>
<td>• Check if relevant audits have been conducted</td>
</tr>
<tr>
<td></td>
<td>barriers?</td>
<td></td>
</tr>
</tbody>
</table>
3. Decide which guideline components to adopt or adapt

While scoping a guideline, specific questions or gaps may be identified that are already addressed elsewhere or in guidance that is soon to be released (see the Australian Clinical Practice Guidelines Register for guidelines in development). If there is already a guideline in development that addresses some of these topics, consider contacting the developers to discuss the scope of the topic and if aspects of the evidence review can be shared. This will help avoid duplication and ensure efforts and resources are directed to addressing existing gaps in the evidence base.

If the new guideline has a discrete scope, it may be easier to adopt an existing guideline in full, as was the case for the 2012 Australian guideline on the Management of borderline personality disorder, which was adapted from the 2009 UK guidelines (with the addition of new questions).

For guidelines with a broad scope, it may be more practical to review the topics contained within the guidelines and to draw on relevant guidance from a range of resources. For example, while revising the Australian Clinical practice guidelines for antenatal care, developers drew on vaccination recommendations for pregnant women from existing immunisation guidelines, foetal care recommendations from existing professional college guidelines (RCOG 2013; Gardener, Daly et al. 2016), and weight gain recommendations from existing obesity guidelines. It is common however for there to be new topics or questions to address, which may need new evidence reviews and new recommendations (if possible) to combine with the components adapted from existing guidelines.

Even if only part of a guideline or recommendation is relevant for the intended setting, some guideline components may still be useful (see Table 1 in the ‘Overview’). For example, evidence tables or evidence statements might assist in developing a more suitable recommendation, particularly if the reference guideline is well-documented and the decision-making transparent.

In the above example of Australia’s Clinical practice guidelines for antenatal care, a recommendation on folate supplementation was sourced from a UK NICE guideline but it was not perfectly suited to Australian practice. Since the evidence underlying the recommendation was identical to that which was required to formulate one in an Australian setting, it was adapted (and rephrased to the active voice).

NICE recommendation:

*Pregnant women (and those intending to become pregnant) should be informed that dietary supplementation with folic acid, before conception and up to 12 weeks of gestation, reduces the risk of having a baby with neural tube defects (anencephaly, spina bifida). The recommended dose is 400 micrograms per day.*

ANC recommendation:

*Inform women that dietary supplementation with folic acid, from 12 weeks before conception and throughout the first 12 weeks of pregnancy, reduces the risk of having a baby with a neural tube defect (for example, anencephaly or spina bifida) and recommend a dose of 500 micrograms a day.*
4. **Adopt a guideline or its recommendations**

If the decision is made to adopt an entire guideline (including all recommendations and supporting information), steps should be taken to contextualise it for implementation. Developers should document and make available their rationale for deciding to adopt the guideline, and provide accompanying information necessary for implementation. For example, developers may choose to adopt a guideline but reformat it to encourage better uptake in the new setting.

If the guideline development group has reviewed the recommendations contained in a guideline and decides that only some should be adopted, the rationale for this decision should be recorded alongside each recommendation, including when the decision was made and when the recommendation should next be reviewed. In addition, mark the most recent date that evidence was searched against each recommendation. Ensure sources are cited appropriately to indicate whose judgement was responsible for the recommendation. For example, the [NHMRC Clinical Practice Guidelines for the Management of Overweight and Obesity](https://www.nhmrc.gov.au/guidelines) included recommendations adopted from a SIGN guideline, which were clearly distinguished from the other recommendations (NHMRC 2013).

It is possible to make minor editorial changes to adopted recommendations to ensure they are consistent with the rest of the guideline (e.g. changing the wording from the passive to the active voice). Care should be taken however to avoid changing the meaning of the recommendation or the strength of the language used, as the wording used in a recommendation is likely to have been carefully and deliberately chosen. Consider asking the original guideline developers to review any changes made to the recommendations to confirm that their original meaning and intent has been retained.

One issue faced by developers is the challenge of adopting recommendations from a guideline that has used a different grading system, which has become familiar to NHMRC given its recent move to the GRADE process. There is no ‘one size fits all’ approach to manage such a transition and developers should consider and document their methods based on their specific circumstances (e.g. which components of the reference guideline are available to them). In general, recommendations previously graded ‘A’ under the NHMRC process (or equivalent system for high quality evidence) can be trusted to guide policy and practice and translate well to ‘strong’ evidence-based recommendations in the GRADE system. For recommendations graded lower than this, it is best to evaluate the evidence base and work through the new grading process accordingly.

5. **Adapt a guideline or its recommendations**

There are a number of validated frameworks available to formally adapt a guideline, many of which describe how to assess and make decisions about recommendations by integrating the GRADE evidence-to-decision (EtD) model (Darzi, Abou-Jaoude et al. 2017). An adapted guideline development process may sometimes be more complex than starting from scratch, so it is important to involve methodological and expert advice to assist the guideline development group in this process.

The most widely used model and one of the first to be developed is the [ADAPTE framework](https://www.cpguide.eurogress.com/en-GB/ADAPTE), which can help to guide the process of systematically selecting, appraising and customising a guideline for a specific setting (ADAPTE Collaboration 2009; Darzi, Abou-Jaoude et al. 2017).

Another model is the [GRADE-ADOLOPMENT framework](https://www.gradeworkinggroup.org/), which combines advice on adoption, adaptation, and the creation of recommendations from scratch (Schunemann, Wiercioch et al. 2017). Importantly, testing of the GRADE-ADOLOPMENT framework on 226 recommendations across
22 guidelines showed that its efficiency depends on the availability of a GRADE EtD table for each recommendation (Neumann, Brignardello-Petersen et al. 2016), as this component would otherwise need to be created (GRADE 2013; Schunemann, Wiercioch et al. 2017). With an EtD table, developers can decide if new judgements of the evidence differ from the original assessments to the extent that they change the direction and strength of a recommendation, and adapt it accordingly (Schunemann, Wiercioch et al. 2017).

Regardless of the method used, it is important to cite the developers of the source guideline to acknowledge the work used to create the adapted recommendation (e.g. the original evidence review) and describe the changes made. For example, in the case described in step 3 regarding the adaptation of a recommendation on folate supplementation, the changes were marked in the evidence table as follows:

"1 level I study supported the NICE recommendation on folic acid supplementation. Dosage changed in line with Australian advice." (DoHA 2012).

Importantly, deciding what to adapt and which framework to use still requires methodological expertise to apply the framework properly and to recognise issues as they arise so that steps can be taken to fix them. Failed attempts at adaptation are typically the result of a lack of detail provided in the source guideline, and a thorough prior assessment of a guideline’s suitability for adaptation can mitigate this risk.

In some cases it may be appropriate to modify an existing adaptation framework to suit specific purposes. It is worth remembering that guideline development should remain pragmatic, and provided all decisions are transparent and well-documented it should be possible to create a trustworthy guideline with limited resources (Browman, Somerfield et al. 2015).
NHMRC requirements
An adapted clinical practice guideline is eligible for NHMRC approval if the source information, evidence and decision making process is transparent and well-documented, and other criteria are met as per the procedures and requirements.

Useful resources
The ADAPTE framework
AGREE II assessment tool
GRADE working group
GRADE Evidence to decision framework from the GRADE Handbook
GRADE-ADOLOPMENT framework
GRADE’s Database of Evidence profiles and Evidence to Decision frameworks
Australian Clinical Practice Guidelines portal (Australia)
Agency for Health and Research Quality (US)
Guidelines International Network (G-I-N) library (International)
NICE (UK)
World Health Organisation (International)
Pubmed

References


RCOG (2013). Small-for-Gestational-Age Fetus, Investigation and Management (Green-top Guideline No. 31), Royal College of Obstetricians and Gynaecologists.