NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

Methods for Living Guidelines for Management and Care of People in Primary, Hospital and Critical Care with Suspected or Confirmed COVID-19 Infection: Technical Report

21 October 2020

1. Introduction

The Australian Living Evidence Consortium and Cochrane Australia have established the National COVID-19 Clinical Evidence Taskforce ('the Taskforce'). As part of this effort, we are partnering with peak professional bodies and other key stakeholder groups to rapidly develop living, evidence-informed guidelines for primary, hospital and critical care of people with suspected or confirmed COVID19 infection. This document describes the methods used to develop and maintain the guidelines.

The treatment of novel coronavirus disease 2019 (COVID-19) is a rapidly expanding area of research, with an unprecedented global effort underway to combat this disease. As a result, recommendations based on current evidence are likely to become quickly outdated as new primary studies are published. The living evidence approach facilitates rapid prioritisation and updating of recommendations. By continually incorporating all new emerging evidence, these methods ensure that the currency of these clinical recommendations is maintained.

1.1. Purpose

The Australian guidelines for the clinical care of people with COVID-19 ('the guidelines') are living guidelines that will be continually updated between April and September 2020. Using the best available evidence, the guidelines provide a series of best-practice recommendations to assist clinical decision-making in the management and care of individuals with suspected or confirmed COVID-19 infection.

1.2. Scope

The guidelines aim to provide specific, patient-focused recommendations on management and care of people with suspected or confirmed COVID-19 infection. They do not include interventions used in the prevention of COVID-19 infection or transmission (whether in the community or in healthcare settings), nor screening and diagnosis of COVID-19 infection.

The initial scope of the guidelines was agreed in discussion with representatives from organisational members of the Taskforce, and endorsed by the Executive of the Taskforce. The scope is designed to avoid duplication of work with other guideline development organisations and focus on high-priority areas of clinical need.

To provide specific, patient-focused recommendations on management and care of people with suspected or confirmed COVID-19 infection, only where care for this patient group differs from usual care provided to patients with similar clinical conditions (for example, other viral pneumonia or acute respiratory distress syndrome due to other causes).

Revisions to the scope of this guideline will be made as necessary, in discussion with the members of the Taskforce and the guideline panels, and endorsed by the Executive of the Taskforce.

1.3. Target Audience

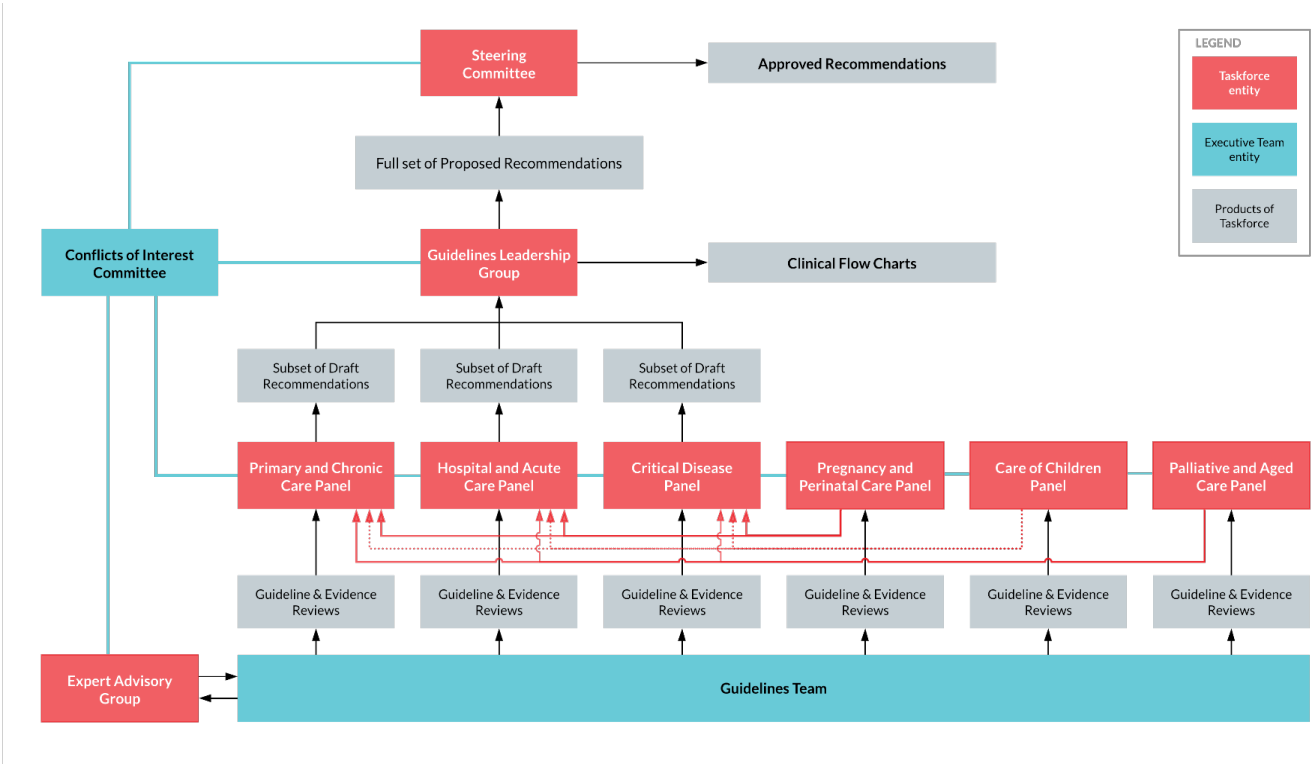
The guideline recommendations are intended to be used by individuals responsible for the management and care of people with COVID-19 infection. These include health professionals, individuals providing support and education to people with COVID-19 and people with diagnosed or suspected COVID-19.

Individuals such as policy makers, practice managers, researchers and students may use or adopt these recommendations for purposes other than the treatment of COVID-19. However, additional considerations not addressed within this guideline may be required when using these recommendations for any purpose other than for the treatment or support of individuals with COVID-19.

2. Methodology

This Technical Report outlines the guideline development process and methodology. The guidelines are being developed according to the procedures and requirements for meeting the 2016 NHMRC standard for clinical practice guidelines, including the use of the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) Working Group approach to appraising the certainty (quality) of evidence.(1, 2) The guidelines are being developed by the National COVID-19 Clinical Evidence Taskforce[1]. The work of developing the guidelines is led by a Guidelines Leadership Group (GLG) that guides and reviews the work undertaken by several Guidelines Panels and is advised by a Consumer Panel. Guideline Panels are convened to review evidence and make recommendations as appropriate to specific areas of clinical practice. An Evidence Review Team is undertaking the work of identifying, appraising and synthesising evidence to inform development of guideline recommendations (see Figure 1). Membership of each of these groups is available at https://covid19evidence.net.au/about-the-taskforce/

Figure 1. Organisational relationships within the Taskforce



[1] https://covid19evidence.net.au/

2.1. Identification of clinical questions

The guidelines seek to provide recommendations addressing key clinical questions in management and care of people with COVID-19. Clinical questions are selected and prioritised for living evidence review where they meet the three key criteria for living evidence described below. For these questions, the available evidence will be continually monitored, and the associated recommendation updated as appropriate.

The key criteria for assessing a question's suitability for living evidence synthesis are:

- the question is a high priority to clinicians and patients;
- there is currently not enough relevant, reliable evidence to support a strong recommendation (that is, there remains a high degree of uncertainty about the most appropriate clinical practice); and
- there is a reasonable likelihood of new evidence being available in the near future.

Question development is conducted in two phases. At guideline inception (March 2020), an initial consultation was conducted to identify questions of importance to stakeholders. This included:

- an online form requesting nomination of questions distributed to the membership of organisational partners of the Taskforce (20–22 March 2020) and direct discussions with clinical leaders in the organisational partners of the Taskforce;
- a review of existing guidelines (available on known guideline developer websites, through grey literature searches and submissions from Taskforce members as at 25 March 2020) to identify candidate questions identified by other guideline developing organisations and their stakeholders; and
- discussions with panel members and key stakeholders (led by Julian Elliott during March 2020).

Questions arising from these three methods were compared to the agreed scope and prioritised by the Executive of the Taskforce.

Further priority questions are sought on an ongoing basis from the guideline and consumer panels, the organisational members of the Taskforce, and through online forms publicly available on the Taskforce website and the web version of the guidelines. Each week, new clinical questions are prioritised by the members of the Guideline Panels on the basis of four criteria:

1. Likely impact on patient outcomes
2. Proportion of clinical population impacted
3. Extent of variation in current practice
4. Likelihood of new evidence emerging

High-priority questions are then selected by the Guideline Leadership Group for evidence review and recommendation development.

Each question is formulated using the PICO framework:

- Population: the patient population to whom the recommendation will apply.
- Intervention: the intervention under investigation.
- Comparator: the alternative to the intervention under investigation (i.e. the control, often another intervention, no intervention or usual care).
- Outcomes: the patient-relevant outcomes of interest (where possible these are aligned with the COVID-19 Core Outcomes Set[2]). Secondary outcomes may also include those relevant to staff, such as the infection risk associated with some interventions.

[2] https://www.covid-19-cos.org/

- Study designs: the study designs considered appropriate and sufficiently robust to address the question.

The benefits of a given intervention may differ across different populations. As a result, each PICO question is sufficiently specific that it is clear to a reader to which individual patients it would apply.

The list of clinical questions addressed by the guidelines will evolve and expand over time, with new questions added as they are prioritised. An up-to-date list of the current questions addressed by the guidelines is available at the guideline website (https://covid19evidence.net.au/). Appendix 1 provides the list of clinical questions included at time of submission of this Technical Report.

2.2. Search methods

An information specialist is engaged to oversee the process for evidence surveillance and to advise and support the evidence review teams with searches of databases and other sources.

The guideline's initial recommendations were informed by existing national and international guidelines of the treatment of adults with COVID-19. These guidelines were sourced by members of the Taskforce and continue to be monitored for updates.

Ongoing evidence surveillance combines daily horizon scans of several COVID-19 sources plus targeted searches for specific sets of PICO questions as they are prioritised by the guideline panels. Many organisations and groups are maintaining repositories of COVID-19 research, and some have a narrow focus (e.g. presenting the results of primary studies) while others aim to be comprehensive and capture all COVID-19 related research. The purpose of the horizon scan is to be aware of new evidence syntheses (systematic reviews, rapid reviews, living reviews) and primary studies that fall within the scope of the guideline (see Table 1).

Table 1. COVID-19 sources scanned daily

Type	**Sources**
All COVID-19 research	**CDC COVID-19 Research Articles Database**[3] Comprises systematic searches of over 20 sources, including various bibliographic databases, trial registers, manuscript preprint servers (e.g. medRxiv) and handsearching of selected grey literature sources. Updated Monday through Friday.
COVID-19 systematic reviews and other syntheses	Sources of completed systematic reviews: - Epistemonikos - COVID-19 Evidence Reviews maintained by the VA Evidence Synthesis Program Organisations producing evidence summaries: - Cochrane - Oxford CEBM COVID-19 Evidence Service - Epistemonikos Living Evidence Repository for COVID-19 - McMaster University COVID-19 Rapid Evidence Reviews - NICE COVID-19 rapid guidelines and evidence summaries - ECRI (Emergency Care Research Institute)

[3] Search methodology as described by CDC.

COVID-19 primary studies	**Living mapping and living systematic review of Covid-19 studies (covid-nma.org)** Identifies randomised trials, non-randomised studies and case series from daily screening of searches of PubMed, Chinarxiv and MedRxiv. Provides study characteristics, risk of bias assessments and forest plots.

For the respiratory support section of the guideline we additionally run a daily auto-alert in PubMed and a twice-weekly search of Embase. This enables us to make sure that evidence relevant to PICOs that may incorporate non-COVID-19 research is also identified. Since the recommendations in the guideline on antivirals and other disease-modifying treatments are based on evidence from RCTs, we rely on the daily horizon scans to identify new reports.

As additional questions are prioritised and approved by the guideline panels, we check that our existing search surveillance methods cover the PICO components of the new questions and update or expand the search accordingly.

Records from searches of PubMed and Embase are imported into EndNote and duplicates removed. Following transfer to Covidence, two team members independently screen titles and abstracts. The Evidence Review Team collectively decides which studies are relevant to the guideline PICOs.

2.3. Assessment of evidence and formulation of recommendations

When seeking evidence to inform recommendation development, the Evidence Review Team first identifies whether there are relevant systematic reviews addressing the clinical questions of interest and appraise the risk of bias of these reviews. Where relevant, good-quality reviews are available, their results are used as the basis of evidence profiles to inform recommendation development. In instances where a good-quality systematic review exists and further relevant research studies have been published after the review search date, the additional primary studies are incorporated and the meta-analysis is updated accordingly.

Where there is no existing systematic review to address a specific clinical question, the Evidence Review Team conducts and maintains living evidence reviews.

Use of GRADE and MAGICapp

This guideline uses GRADE methodology, which is supported by the online guideline development and publication platform 'MAGICapp' (Making GRADE the Irresistible Choice).(2, 3)

The Taskforce chose to use GRADE as it is recommended as best practice by NHMRC and is being used by a number of international organisations, including the World Health Organization and Cochrane, enabling international collaboration. (1, 4)

GRADE is a transparent framework for developing and presenting summaries of evidence and provides a systematic approach for making clinical practice recommendations

The reasons for using MAGICapp include to:

- enable collaboration between multiple authors across geographic locations,
- ensure a standard approach in reviewing evidence and formulating recommendations consistent with GRADE methodology,
- allow for interactive web publication format and easy access to the guidelines, and
- facilitate rapid updating of recommendations.

MAGICapp has been designed to develop and publish clinical guidelines using GRADE methodology and has built-in, standardised steps for evaluating evidence and developing recommendations consistent with the GRADE Approach. For more details of GRADE methodology, please refer to Appendix 2.

Study screening and selection

Studies retrieved by the search process (section 2.2) are uploaded into one or more reviews within Covidence for screening and selection by members of the Evidence Review Team.

Articles are only eligible for inclusion if they reported results of primary research or systematic reviews relevant to the PICO question and were undertaken in patients with a diagnosis or clinical suspicion of COVID-19.

Specific inclusion and exclusion criteria are developed as appropriate to the PICO question of interest. In some exceptional instances, the guideline panels consider indirect evidence from patients with SARS/MERS/pandemic influenza or similar conditions to be important to the formulation of COVID-19 clinical care recommendations. For the corresponding PICO questions, the study eligibility criteria are adjusted accordingly.

Titles and abstracts are screened by at least two members of the Evidence Review Team in Covidence. Disagreements are resolved through discussion between the two reviewers. If disagreements cannot be resolved, an independent third reviewer adjudicates. Full text articles are screened using the same process, with expert clinical input as required.

Data extraction and risk of bias assessment

The Evidence Review Team extract data from the literature using standardised data collection forms, including description of the population, setting and intervention(s) of each study, the study methods, the outcomes measured, measurement instruments or definitions used, and results data. A summary table of study characteristics is used to group studies for analysis, in accordance with pre-specified questions (and subgroups, where relevant). When needed, an outcome matrix is used to map the outcomes, measures and effect estimates reported by each study, and to select the eligible data for analysis. Where clinical questions arise about the definition or relative importance of outcome measures, decisions are made by consulting the core outcomes set, in discussion with the relevant Guideline Panel.

For data extraction from primary research studies, data extraction templates are generated within Covidence and data is extracted independently by two reviewers. Any disagreements are resolved through discussion between the two reviewers. If a disagreement cannot be resolved, an independent third reviewer adjudicates. The extraction is study specific; in instances where multiple articles present data from the same study, all relevant data are extracted with due consideration of avoiding duplication. Extracted data are cross-referenced with the relevant outcome matrix to ensure that all outcomes of importance are analysed.

For systematic reviews, the risk of bias or quality assessment of included studies presented in the review is used where available. For individual primary studies, each study is assessed for risk of bias. Randomised trials are assessed using the Cochrane Risk of Bias 2.0 assessment tool.(5) Non-randomised studies are assessed using the ROBINS-I Risk of Bias assessment tool.(6)

Evidence synthesis

Once data collection is complete, available studies are mapped against our clinical questions and outcomes of interest and an appropriate method of synthesis is selected.

Where an existing systematic review is available and up-to-date, further synthesis is not required. We monitor such reviews on an ongoing basis, as systematic reviews for treatments related to COVID-19 are often living reviews, or otherwise periodically updated.

Where an existing systematic review is available but not up-to-date, a limited update may be conducted by integrating the findings of more recent primary studies into the review's synthesis, using the existing eligibility criteria and synthesis methods.

Where comparable studies are available to answer a clinical question and present comparable data on an outcome of interest, a systematic review protocol is rapidly developed based on the clinical question of interest. Synthesis methods are selected as appropriate to the available evidence, in accordance with Cochrane norms and standards.(5)

In some cases, it will not be possible to conduct meta-analysis—for example, if there is high statistical heterogeneity that cannot be explained, or if the available studies do not provide data in a format amenable to meta-analysis. In these cases, depending on the data available, we will tabulate the data in groups consistent with the planned analysis, presenting the results of each study narratively.

For numerical results of individual studies or pooled analyses, all effect estimates are presented with 95% confidence intervals (where possible). For pooled analysis, heterogeneity is assessed using the I^2 statistic. For results without meta-analysis, heterogeneity is assessed based on the size and direction of effect of the included studies.

Development of the recommendations

The Evidence Review Team drafts the initial recommendations which are then discussed, revised and agreed by the relevant guideline panels, approved by the Guideline Leadership Group and endorsed by the Steering Committee.

GRADE methodology considers several factors when developing recommendations:

- benefit and harms
- certainty of evidence
- preferences and values of patients and other key stakeholders
- resources and cost-effectiveness considerations
- feasibility
- acceptability
- equity

The benefits, harms and certainty of available evidence are summarised from the evidence profile. Panels also consider resources and cost-effectiveness considerations, feasibility, acceptability and equity in formulating their decisions. Consumer representatives on the Guideline Leadership Group, and the Consumer Panel they chair, are tasked with reflecting on these elements. In particular, the consumer representatives will consider whether strong or varying patient preferences and values are likely to impact on the nature or implementability of the recommendations.

Based on the aforementioned factors, GRADE rates recommendations as either strong or conditional. The principle for the strength of recommendations is:

- the strength is strong when most or all individuals will be best served by the recommended course of action

- the strength is conditional when not all individuals will be best served by the recommended course of action and there is a need to consider the individual patient's circumstances, preferences, and values.

In addition, practical advice for implementing recommendations is given in relevant recommendations, such as contraindications, dosages, and patient selection criteria.

For some topics, a systematic review of the available evidence is conducted or is available in the literature, but there is either a lack of evidence or insufficient certainty of evidence on which to base a recommendation. In cases where the guideline panel determined that recommendations are important, statements and advice about topics are developed based on consensus and expert opinion (guided by any underlying or indirect evidence). These statements are labelled as Consensus Statements.

The following criteria are used in determining the strength of recommendations:

- **Strong for**: moderate to high certainty evidence suggests that benefits in critical outcomes clearly outweigh the reported harms; a strong recommendation can be made in the absence of high-certainty evidence if patients are expected to highly desire such practice and there are no potential harms in providing it.
- **Strong against**: moderate to high certainty evidence suggests harms outweigh benefits; high certainty evidence suggests lack of benefits.
- **Conditional for**: moderate to high certainty evidence suggests equivalent benefits and harms, patients would mostly want to receive the practice, and there is no significant resources implication in doing so; low certainty evidence suggests benefits outweigh harms and there are no significant implications in patients' preferences or resources implications.
- **Conditional against**: moderate to high certainty evidence suggests equivalent benefits and harms, but there is expected large variation in patients' preference to receive this practice or important resource implications; low certainty evidence suggests harms outweigh benefits and there are no significant implications in patients' preferences or resource implications.
- **Consensus statement**: evidence is absent or of insufficient certainty; unclear balance between benefits and harms, and there is expected large variation in patients' preferences. No formal method of reaching consensus was used but this was addressed in internal reviews.

In order to make changes from previous guidelines clearly visible, each recommendation is labelled with either an 'Updated' or 'New' tag. Updated recommendations are existing recommendations where the strength or the direction of the recommendation has changed, and details regarding the history of a recommendation are recorded in the recommendation version history. New recommendations were not present in previous guidelines. All evidence tables pertaining to the recommendation are available within MAGICapp.

2.4. Guideline Panels

Seven multidisciplinary guideline panels are convened to consider the research evidence, review consensus recommendations developed by other guideline groups and contribute their clinical expertise. These panels are comprised of clinicians with clinical expertise relevant to the specific aspect(s) of care covered by the Guideline Panel.

The Guideline Panels include:

- Disease Modifying Treatments and Chemoprophylaxis
- Critical Care Panel
- Hospital and Acute Care
- Primary and Chronic Care
- Paediatric and Adolescent Care
- Pregnant and Perinatal Care
- Care of Older People and Palliative Care

The responsibilities of each Guideline Panel are to:

- Develop PICO (Population, Intervention, Comparator, Outcomes) criteria for prioritised clinical questions
- Review Evidence Profile tables and Summary of Findings tables for living recommendations, as they are prepared or updated by the Guidelines Team.
- Draft new or revised recommendations, with evidence-based recommendations developed according to GRADE methods, and consensus-based recommendations developed according to NHMRC methods in the absence of sufficient evidence.
- Review curated lists of guidance sourced from clinical guidelines, position statements or protocols external to the Taskforce, and discuss the adoption or adaptation of this guidance for inclusion in the Clinical Flow Charts and whether or not the aspects of care meet the criteria for living recommendations.
- Identify aspects of care not addressed by existing Taskforce recommendations or the Clinical Flow Charts and advise other Panels and/or the GLG of these.

Selection and Nomination of Guideline Panel Members

Potential members and chairs of guideline panels are sought through consultation with members of the Taskforce and through a call for expressions of interest to the members and networks of these organisations.

Guideline Panel members are appointed by the Executive Team, on the basis of their clinical subject matter expertise and their understanding of the principles of evidence-based medicine (previous experience in GRADE is not mandatory as training will be given by the Guidelines Team). Consideration is given to ensuring a diverse membership for each Panel, including on the basis of clinical expertise, gender, and geographic location within Australia.

2.5. National Guidelines Leadership Group

The National Guidelines Leadership Group (GLG) is comprised of the Clinical Chairs from each of the Expert Guideline Panels, two Consumer representatives, and a senior clinical representative nominated by each of the Taskforce member organisations. The GLG is Co-Chaired by the Executive Director of the Taskforce, and one elected GLG member. The Taskforce Senior Clinical Advisor functions as the Deputy Chair. The GLG also includes members of the Taskforce Executive Team and senior members of the Evidence Team.

The responsibilities of the GLG are to:

- Review all new or revised recommendations drafted by the Expert Guideline Panels, checking for consistency in guidance within and between Panels.
- Agree on the new or revised recommendations to be submitted to the SC for approval.
- Approve Clinical Flow Charts for publication on the Taskforce website (subject to SC approval of any new or revised recommendations)
- Prioritise new topics for evidence review, based on feedback received from the clinical community, Expert Guideline Panels, National Steering Committee, Jurisdictional Liaison Group, and/or surveillance undertaken by the Guidelines Evidence Team or Taskforce members.
- Oversee the appropriate constitution of Expert Guideline Panels and approve the establishment of new panels as required.
- Provide advice to the Steering Committee on any emerging clinical, research or strategic issues that may impact the work of the taskforce.

Selection and Nomination of Guideline Panel Members

Members for the GLG are sought via three different mechanisms reflecting the three sub-groups on GLG:

1. Clinical Co-Chairs are identified from each of the Guideline Panels. This facilitates cross-panel coordination.
2. Senior clinical representative nominated by each of the Taskforce member organisations.
3. Consumer Panel members – the consumer panel is represented by the two consumer panel co-chairs.

Members of the Steering Committee, GLG and Expert Guideline Panels are permitted to nominate a proxy. All proxies must complete a Declaration of Interest prior to attending the relevant meeting. Proxies attending without prior-approval by the Taskforce Executive do so as an observer and are not permitted to participate in recommendation development.

2.6. National Steering Committee

The Taskforce is overseen by a Steering Committee (SC) which is comprised of a representative from each of the member organisations the Chair of the National Guidelines Leadership Group, and a representative of Cochrane Australia (Taskforce Secretariat). The SC is chaired by a representative of the Australian Living Evidence Consortium.

The Steering Committee is governed by a consensus based decision-making process. As members of the Steering Committee, all member organisations are considered to be formally endorsing the guideline (please refer to Appendix 3 for list of member organisations).

Guideline Recommendations Approval Process

The approvals process including the process for where consensus is not achieved is described below.

- Draft Recommendations are tabled for discussion at the Steering Committee meeting
- Committee members have until 2pm the day following the Steering Committee meeting to consider the proposed recommendations within their organisation and raise any objections.
- Silence (i.e. no response from the Steering Committee Member and/or nominated proxy) signals approval and consent to publish
- Guideline Recommendations are published after 2pm the day following the Steering Committee meeting if NO objections are received.
- Non-attendance at the Steering Committee meeting by either the Member or nominated proxy still permits the organisation to raise objections or points of clarification prior to the approval deadline.

Process where Consensus is not achieved by the Steering Committee Meeting

In situations where the Steering Committee is unable to reach consensus, the following may occur:

- Where considered necessary by the Steering Committee Chair, an Emergency Steering Committee meeting may be called; or
- Where considered necessary by the Steering Committee Chair, the proposed recommendation may be re-reviewed by the Guidelines Leadership Group.

Selection of Steering Committee Members

Members are nominated to the Steering Committee by their respective organisations. New members organisations are invited to nominate a member for the Steering Committee and a senior clinical representative for the GLG. Each organisation undertakes their nomination process independently of the Taskforce.

2.7. Consumer Involvement

Consumers are involved in development of the Guidelines, through:

- Guideline Leadership Group, and
- a Consumer Panel.

Consumer Members of the Guideline Leadership Group

There are two consumers on the Guideline Leadership Group, overseeing all of the guideline development conducted by the National COVID19 Clinical Evidence Taskforce.

These consumer representatives:

- contribute to online, weekly one-hour meetings of the Guidelines Leadership Group
- provide strategic consumer input into the guideline development program, including selection of clinical questions to be addressed, decisions on high priority topics, and strategic conversations about the focus of guideline development activity and other aligned topics
- co-chair the Consumer Panel, convened by the Consumers Health Forum of Australia, and act as a bridge between the broader Consumer Panel and the Guidelines Leadership Group.

The Consumer Panel

A Consumer Panel, co-convened by the Consumers Health Forum of Australia (CHF) and the Taskforce, advises the Guidelines Leadership Group. It is co-chaired by the Guidelines Leadership Group consumer representatives, CHF and the Taskforce. At the time of publication of this report, the Consumers Health Forum of Australia has completed the process of recruiting consumers on behalf of the Taskforce.

The Panel consists of ten to twelve experienced consumer representatives who advise the Guidelines Leadership Group on national guideline development for treatment of COVID-19. The Panel will have fortnightly online meetings and provide strategic consumer advice to the guideline development program, including contributing ideas for clinical questions to be addressed, views on high priority topics, input on relative importance of different outcomes and feedback on guideline recommendations as they are developed.

Consumer Panel members are appointed to Panel via an Expression of Interest Process run in collaboration with our partner, CHF (please refer to Appendix 4).

2.8. Conflicts of interest

The Conflicts of Interest Committee (COIC) is comprised of four members with experience in the assessment and management of conflicts of interest. All members of the COIC are appointed by the Executive Team, however their deliberations and advice are independent of the Taskforce.

Committee Members:

- Lisa Bero – Chair
- Quinn Grundy
- Joel Lexchin
- Barbara Mintzes

The responsibilities of the COIC are to:

- Advise on the format and content of the Declarations of Conflicts of Interest to be completed by individuals appointed to the SC, GLG, or Panels.
- Advise on the development of the Taskforce's Conflict of Interest Policy.
- Assess the Declarations of Conflicts of Interest made by individuals appointed to the SC, GLG, or Panels.

All individuals who participate in the decision-making related to the development of the guidelines are required to complete a Declaration of Interests and to remove themselves from any discussions relating to potential conflicts. Members attending a meeting without prior submission of a declaration of interest can attend as an observer only.

The COI Policy, Declaration of Interest Form and Conflict of Interest summaries for all individuals engaged in guideline development can be found in Appendix 5-7.

2.9. Considering the needs of specific populations

The Taskforce is mindful of the potential for Aboriginal and Torres Strait Islander (ATSI) peoples or other population groups (including culturally and linguistically diverse communities and other groups for whom specific sociocultural factors influence health) to have a specific, differential course of illness, treatment requirements and responses to treatments. Our guideline development methods have been designed in awareness of this.

Guideline panels have been convened to intentionally include a diversity of representation, including Aboriginal and Torres Strait Islander peoples and remote and regional groups. The National Aboriginal Community Controlled Health Organisation (NACCHO) is represented at the Steering Committee and Guidelines Leadership Group. Any issues of particular relevance to Aboriginal and Torres Strait Islander Peoples will also be considered by the Consumer Panel.

Searches have been designed and are being conducted to include all population groups (that is, no limiters are being made on searches in terms of the patient or population of studies, other than that they must have a diagnosis or suspicion of COVID-19). Where evidence emerges that suggests that different approaches are appropriate for Aboriginal and Torres Strait Islander peoples or other population groups, specific recommendations will be made for these population groups. To date searches have not identified any issues of particular relevance to Aboriginal and Torres Strait Islander peoples.

2.10. Future updates of the guidelines

Each week we review new evidence for the current living guideline recommendations and where needed, recommendations are revised and re-published. We also continually add new recommendations to address high-priority clinical questions as they arise. We aim to publish an updated version of the guidelines each week until the end of September 2020.

Guideline panels will consider, refine and agree further new recommendations and revised existing recommendations at panel meetings conducted each week.

Revised and new recommendations made each week by the guideline panels are endorsed by the Guidelines Leadership Group before publication in MAGICapp.

Each week, current, revised and new endorsed recommendations are published in MAGICapp, and the website clearly identifies those recommendations that are new or have been revised since last publication. The new or revised recommendations are distributed to each of the communications contacts of the members of the Taskforce for dissemination. Recommendations are also disseminated through relevant traditional and social media channels.

3. Dissemination and Implementation Plan

3.1. Dissemination and implementation

Each week the guidelines are republished and made publicly available within MAGICapp.

The Taskforce is working with a communications firm to execute a comprehensive communications plan to ensure the effective dissemination of the guidelines to key stakeholders in health policy and practice.

Each week, after the updated guidelines are released, the Taskforce prepares and distributes a 'Taskforce Communique' to all organisational members, partners and funders of the Taskforce (publicly available online at https://covid19evidence.net.au/). The Communique provides an overview of the work of the Taskforce for that week and an update on the current state of the guidelines. It also includes content for Taskforce members to adapt for their newsletters, publications and direct communications with their members.

The Taskforce also prepares a weekly update for media following publication of the updated guidelines that includes traditional press release content, along with social media copy (#COVID19ClinicalEvidence), multimedia assets developed around the key messages from the guideline, and supporting tools and messages. The Taskforce plans to develop a full implementation plan.

3.2. Jurisdictional Liaison Group (JLG)

How the JLG was established

In mid-April, shortly after Commonwealth funding for the Taskforce was first announced, members of the Executive began reaching out to key jurisdictional agencies and Departments of Health contacts with whom the Australian Living Evidence Consortium had already established a relationship regarding the development of Living Guidelines in chronic disease areas (e.g. Australian Commission on Safety and Quality in Healthcare Care, Safer Care Victoria, NSW Agency for Clinical Innovation, SA Commission on Excellence and Innovation in Health). Meetings were scheduled throughout April and May to meet and provide a briefing on the Taskforce initiative, understand the local COVID-19 response structures, outline the role of the JLG and identify the best 'point people' to join the Jurisdictional Liaison Group.

The Taskforce's *Principles of Partnership and Collaboration* Version 1.0 was ratified 12 May 2020 to provide a framework for working with the commonwealth, states, territories via the JLG (please refer to excerpt in Appendix 8).

Follow-up correspondence was sent in the first week of June to confirm the involvement of key contacts identified, either through our existing relationships or through meetings and referrals, and seek representation from jurisdictions with whom we had not yet had an opportunity to meet.

Membership of the JLG is not fixed and has evolved over time as jurisdictions' dedicated COVID-19 structures and personnel have evolved (in some cases several times) in response to the local level of COVID-19 infection and response.

Current members of the JLG

There are currently 65 members of the JLG acting as key contacts for their respective jurisdictions and agencies (please refer to Appendix 9 for a full list of current contacts).

How we communicate with the JLG

Communication with members is via two primary mechanisms: regular weekly updates on new or updated recommendations, and new questions/topics under review via the Taskforce communique issued each Thursday; and individual, targeted communication and consultation (largely via email) regarding key recommendations or emerging evidence identified to be of high policy relevance, or of particular relevance to a jurisdiction or agency based on existing guidance.

The use of Remdesivir as a disease-modifying treatment provides a good example (please refer to Appendix 9). Other key recommendations have included hydroxychloroquine, dexamethasone, and several recommendations related to pregnancy and birth.

JLG members are also encouraged to alert the Taskforce of priority questions identified by their respective clinical networks. Examples of questions in-scope for this guideline have included VTE prophylaxis, clarification of the evidence for experimental disease-modifying treatments, use of different forms of oxygen therapy, and markers of disease progression.

3.3. Key recommendations

The Taskforce uses several measures to identify the high-priority clinical questions for which living recommendations are developed and kept up-to-date (see section 2.1). In light of this approach, all of the Taskforce recommendations (Annex 2) can be considered as key recommendations.

3.4. Evaluation plan

The process of developing the guidelines and impact of the guidelines on policy and practice will be evaluated.

3.4.1 Process evaluation

The process evaluation aims to continually improve process and outputs of the Taskforce and guidelines project, and inform future living guideline projects, by capturing the experience of participants each month during the living guidelines project. A secondary aim is to provide contextual and explanatory data to inform the impact evaluation.

The process evaluation includes:

- Six, prospective 4-weekly timepoints (beginning first week of May)
- Three, fortnightly retrospective timepoints (March 23, April 6 and 20; activity tracking only)
- Three focused data collection methods each month
    - Online survey of all participants
    - Semi-structured interviews with key contributors
    - Stocktake of activity and progress
- Mixed quantitative and qualitative analysis

Ethics approval has been granted by Monash University.

Results will be provided each month to the Taskforce Executive and Steering Committee, with a final report provided to the Australian Living Evidence Consortium Executive. The results of the process evaluation will be used as the basis of a peer-reviewed journal publication.

3.4.2 Impact Evaluation

The impact evaluation aims to evaluate the impact of the guidelines on management and care of people with COVID-19 by identifying the extent to which end users: were aware of the guidelines; accepted, adopted or endorsed the guidelines; and used the guidelines to inform decision-making in health care practice and policy.

The impact evaluation will include:

- mixed qualitative and quantitative methods to assess three levels of impact: awareness; acceptance/adoption and action.
- awareness measures such as:
    - website traffic
    - traditional and social media mentions
    - number of organisational and individual members engaged in work of Taskforce
- acceptance/adoption measures such as:
    - endorsement/adoption of recommendations by clinical bodies, jurisdictional groups and others
    - approval of guidelines by NHMRC
    - use/explicit consideration of recommendations or guidelines in development and/or revision of jurisdictional or health service protocols
- action measures such as:
    - changes in clinical practice
        - exemplar case to capture practice changes resulting from guidelines
        - changes in prescribing data related to recommendations
        - changes in registry data related to recommendations
    - changes in policy
        - drug indications, availability, use, etc
        - revisions to Position Statements, etc
        - example case studies examining value of Taskforce to policy-making process

Results will be reported to the Taskforce Executive and Steering Committee and the Australian Living Evidence Consortium Executive and used as the basis of a peer-reviewed journal publication

4. References

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4. World Health Organization. WHO Handbook for Guideline Development (second edition). Geneva: World Health Organization; 2014.
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7. Schünemann H, Brożek J, Guyatt G, Oxman A. Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach.; 2013.

Appendices

Appendix 1. List of clinical questions

The clinical questions for each recommendation are available within MAGICapp. Listed below are those clinical questions that either have a recommendation published, or a recommendation that is under development, as of 6 May 2020.

Topic	Question
Disease severity definitions	What are definitions of the different levels of COVID-19 disease severity?
Markers	In patients with mild/moderate/severe/critical COVID-19 disease (confirmed or suspected) what markers of disease progression (clinical, haematological, coagulation, infection/inflammatory, biochemical, radiological, scoring system or prognostic model) compared to any ther marker or no marker, are associated with disease progression?
Disease- modifying treatments	Should you use Hydroxychloroquine sulfate or Chloroquine in addition to standard care, or standard care alone, in patients with COVID-19?
Disease- modifying treatments	Should you use a combination of lopinavir/ritanovir in addition to standard care, or standard care alone, in patients with COVID-19?
Disease- modifying treatments	Should you use Remdesivir (GS-5734) in addition to standard care, or standard care alone, in patients with COVID-19?
Disease- modifying treatments	Should you use other treatments in addition to standard care, or standard care alone, in patients with COVID-19?
Disease- modifying treatments	Should you use a combination of lopinavir/ritanovir in addition to standard care, or standard care alone, in patients with COVID-19?
Corticosteroids	In people with mild/moderate/severe/critical COVID19 illness, does treatment with corticosteroids as compared to no corticosteroid treatment, lead to improved clinical outcomes?
Corticosteroids	In people with mild/moderate/severe/critical COVID19 illness, does treatment with corticosteroids as compared to no corticosteroid treatment, lead to improved clinical outcomes?
Corticosteroids	In patients with asthma and/or COPD and suspected or confirmed COVID-19, does early additional oral steroids compared to standard care improve outcomes?
Corticosteroids	In patients with asthma and/or COPD and suspected or confirmed COVID-19, should patients continue to use corticosteroids?
Corticosteroids	In patients with asthma and/or COPD and suspected or confirmed COVID-19 should patients use a nebuliser?
Anticoagulants	In patients with mild confirmed COVID-19 (with one or more risk factors) and moderate confirmed COVID-19 (with no risk factors), does the use of DVT prophylaxis, compared to standard care, lead to improved clinical outcomes?
Anticoagulants	In severe/critically ill COVID-19 patients, do higher prophylactic doses of LMW heparin, as compared to usual

	prophylactic doses of LMW heparin, lead to improved clinical outcomes?
Anticoagulants	In critically ill COVID-19 patients, do higher prophylactic doses of LMW heparin, as compared to usual therapeutic doses of LMW heparin, lead to improved clinical outcomes?
Anticoagulants	In people with moderate/severe/critical COVID-19 illness, does therapeutic anticoagulation, as compared to standard DVT prophylaxis, lead to improved clinical outcomes?
Anticoagulants	In patients with hypoxia and raised D-dimer, does investigation for pulmonary emboli as compared to no investigation for pulmonary emboli, reduce mortality?
Anticoagulants	In COVID-19 patients with rising D-dimer in whom thrombosis has not been proven with imaging, does starting full anticoagulation immediately, as compared to waiting for results of imaging where imaging may be delayed before starting anticoagulation, lead to improved clinical outcomes? If yes, at what threshold of D-dimer?
Respiratory support: HFNO	High-flow nasal oxygen therapy for COVID-19 patients with acute hypoxaemic respiratory failure
Respiratory support: NIV	Non-invasive ventilation for COVID-19 patients with acute hypoxaemic respiratory failure
Respiratory support: HFNO Droplets	Droplet and aerosol dispersal patterns of supplementary oxygen interventions.
Respiratory support: Recruitment manoeuvres	Recruitment manoeuvres for COVID-19 patients receiving mechanical ventilation
Respiratory support: Prone positioning	Prone positioning for COVID-19 patients receiving respiratory support for acute hypoxaemic respiratory failure
Respiratory support: ECMO	Extracorporeal membrane oxygenation for COVID-19 patients with refractory hypoxaemia
Respiratory support: Mechanical ventilation	Early vs late use of mechanical ventilation in COVID-19 patients with acute hypoxaemic respiratory failure
Respiratory support: Prone positioning	Prone positioning vs no prone positioning for COVID-19 patients receiving respiratory support for acute hypoxaemic respiratory failure
Respiratory support: PEEP	Higher PEEP vs lower PEEP for COVID-19 patients receiving mechanical ventilation
Respiratory support: Videolaryngoscopy	Videolaryngoscopy vs direct laryngoscopy in COVID-19 patients with acute hypoxaemic respiratory failure
Respiratory support: Rehabilitation/Mobilisation	Early vs standard rehabilitation and/or mobilisation in COVID-19 patients post extubation
Respiratory support: Neuromuscular blockers	In intubated patients with COVID19 in intensive care, does continuing neuromuscular blockers after use for intubation, compared with not continuing neuromuscular blockers, improve clinical outcomes?

Respiratory support: Nitric oxide	In patients with COVID19 in intensive care, does provision of nitric oxide, compared to no provision of nitric oxide, improve clinical outcomes?
Respiratory support: Nitric oxide	In patients with COVID19 in intensive care, with severe ARDS and hypoxemia despite optimizing ventilation and other rescue strategies, does provision of nitric oxide, compared to no provision of nitric oxide, improve clinical outcomes?

Appendix 2. GRADE Methodology

The guidelines are developed following the GRADE methodology (Grading of Recommendations, Assessment, Development and Evaluation). GRADE provides a transparent and structured approach for specifying health care questions, choosing outcomes of interest and rating their importance, evaluating the available evidence, and bringing together the evidence with values and preferences of patients as well as society to arrive at recommendations. This description of the GRADE methodology reflects guidance from the GRADE handbook (7), supplemented with additional information on how this is implemented in the MAGICapp platform.

Based on the stages of guideline development outlined in the GRADE handbook, the process of developing recommendations involves:

1. framing the health care question
2. selecting and rating the importance of outcomes
3. summarising the evidence
4. assessing the certainty of evidence
5. converting evidence to recommendations.

Framing the question

The GRADE methodology uses the PICO framework for framing health care questions. The emphasis is on carefully specifying four components of the clinical question being addressed. The GRADE handbook defines these four components as:

- Patient: the patients or population to whom the recommendations are meant to apply.
- Intervention: the therapeutic, diagnostic, or other intervention under investigation (e.g. the experimental intervention, or in observational studies the exposure factor).
- Comparison: the alternative intervention; intervention in the control group.
- Outcome: the outcome(s) of interest.

If there are subgroups within the population with different levels of baseline risk, separate questions may be required to develop appropriate recommendations, as the benefits of treatment may differ even if the effect of the intervention is similar across the subgroups.

Selecting and rating the importance of outcomes

GRADE emphasises that outcomes that are important or critical to the relevant patient population should be considered in developing recommendations. The choice of outcomes is therefore guided by their relative importance to patients and whether they are critical, important or not important for deciding on a recommendation, rather than what data are available in the existing evidence. Important or critical outcomes for which there is no evidence available are still reported.

In order to identify the critical and important outcomes for these guidelines, we will incorporate the results from theCOVID-19 Core Outcome Set Project[4] rapidly initiated by Cochrane. The project is bringing patients, the public and health professionals together to identify, prioritise and agree on the most important outcomes for research in COVID-19 The findings of this international survey will be used to select outcomes for the recommendations in the guideline. Evidence profiles completed before the publication of the core outcome set will be reassessed and updated if needed. When evidence about the most important outcomes is lacking or unavailable, surrogate or substitute outcomes may be used, but as these outcomes only provide indirect evidence about outcomes that

[4] https://www.cochrane.org/news/covid-19-core-outcome-set-project-invitation-complete-survey-10-april-2020

are most important to patients, this may result in the evidence being judged as lower certainty.

Judgements about the balance between desirable and undesirable health outcomes are based on a summary of findings table or evidence profile derived from a high-quality systematic review of the effects of the intervention of interest. Where available, evidence about the value that the population places on key outcomes can also guide the panel's deliberations on these judgements.

Summarising the evidence

A summary of evidence includes an estimate of the treatment effect for each outcome, a rating of the certainty of evidence for that outcome, and a narrative summary of the evidence and its findings. Evidence profiles that present findings for each outcome in an accessible format are provided in MAGICapp. They include:

- a list of outcomes evaluated for the PICO question and the timeframe over which these outcomes were assessed;
- a rating of outcome importance;
- number of studies and participants contributing to the evidence for each outcome;
- the relative effect of the intervention, e.g. odds ratio, relative risk, or hazard ratio for dichotomous outcomes, mean difference or standardised mean difference for continuous outcomes;
- for dichotomous outcomes, the assumed baseline risk (per 1000 people), e.g. prevalence in target population or control group risk. For this guideline the assumed baseline risk was generally the control group risk, based on the observed numbers of events in the control group;
- the corresponding risk (per 1000 people) in the intervention group;
- the absolute effect, e.g. for dichotomous outcomes, the absolute difference in the number of events per 1000 people based on the assumed control risk and the relative effect estimate and its confidence interval;
- judgements about factors affecting the certainty of evidence (as per the GRADE Approach);
- overall certainty rating of the effect estimates, based on the GRADE guidelines and the judgements about individual quality of evidence factors; and
- a plain text summary of the evidence, based on the size of the effect and the certainty of evidence. To maintain consistency and avoid over-interpretation, standard phrases will be used for the summaries (Table 1).

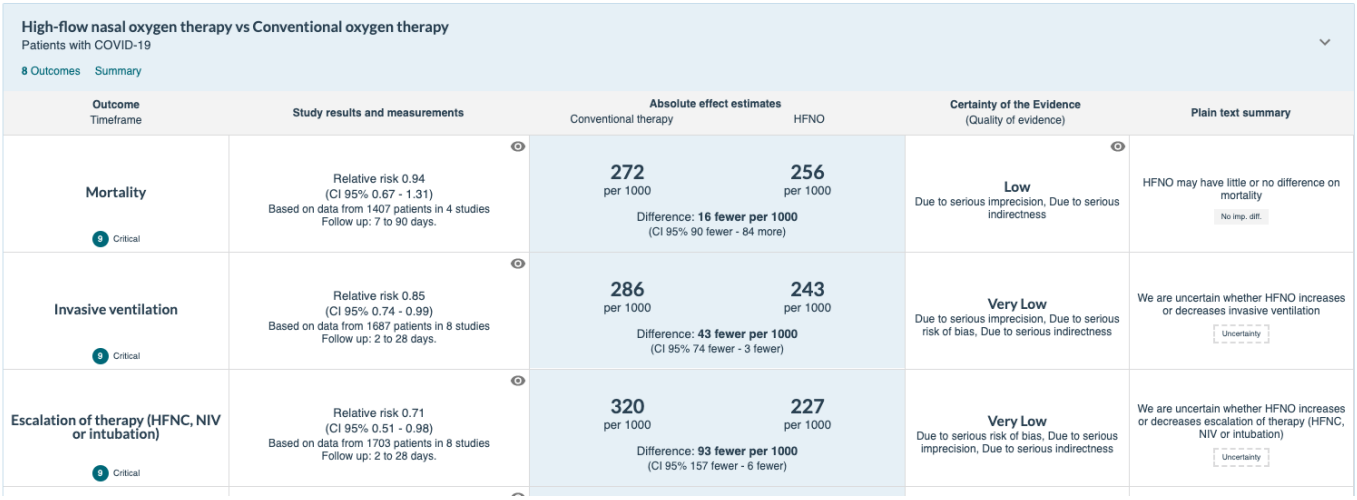
Table 1 Standard phrases for the plain text summary in MAGICapp

Cross point between certainty and size of effect	Important benefit/harm	Less important benefit/harm	No important benefit/harm or null effect
High	Improves or Worsens (alt. increases or reduces)	Slightly improves or worsens (alt. slightly increases or reduces)	Little or no difference
Moderate	Probably improves or worsens (alt. probably increases or reduces)	Probably slightly improves or worsens (alt. probably slightly increases or reduces)	Probably little or no difference

Low	May improve or worsen (alt. may increase or reduce)	May slightly improve or worsen (alt. may slightly increase or reduce)	May have little or no difference
Very Low	We are uncertain whether [intervention] improves or worsens (increases/ reduces) [outcome]		
No / rare events	There were too few who experienced the [outcome], to determine whether [intervention] made a difference		
No studies	No studies were found that looked at [outcome]		

The standardised summary of finding tables in MAGICapp emphasise "absolute effect estimates" for dichotomous outcomes, displaying the number of people per 1000 people expected to have the outcome in the control and intervention groups. Wherever possible, these estimates were calculated using the overall relative effect estimate and the baseline risk in the control groups in the included studies.

Figure 2. Example of MAGICapp summary of findings table



Assessing certainty of the evidence

The certainty assessment of the body of evidence for each outcome was performed using the GRADE approach. Using this approach, the certainty of evidence for each outcome was rated as 'high', 'moderate', 'low' or 'very low' based on a set of established criteria. The final rating of certainty of evidence was dependent on the factors briefly described below.

Study design limitations: The risk of bias was first examined at the level of each individual study and then across the studies contributing to the outcome. For randomised trials, certainty was first rated as 'high' and then downgraded by one ('moderate') or two ('low') levels, depending on the minimum criteria met by the majority of the studies contributing to the outcome.

Inconsistency of the results: The similarity in the results for a given outcome was assessed by exploring the magnitude of differences in the direction and size of effects observed in different studies. The certainty of evidence was not downgraded when the directions of the findings were similar and confidence limits overlapped, whereas it was

downgraded when the results were in different directions and confidence limits showed minimal or no overlap.

Indirectness: The certainty of evidence was downgraded when there were serious or very serious concerns regarding the directness of the evidence, that is, whether there were important differences between the research reported and the context for which the recommendation was being prepared. Such differences were related, for instance, to populations, interventions, comparisons or outcomes of interest.

Imprecision: This assessed the degree of uncertainty around the estimate of effect. As this is often a function of sample size and number of events, studies with relatively few participants or events, and thus wide confidence intervals around effect estimates, were downgraded for imprecision.

Publication bias: The certainty rating could also be affected by perceived or statistical evidence of bias to underestimate or overestimate the effect of an intervention as a result of selective publication based on study results. Downgrading evidence by one level was considered where there was strong suspicion of publication bias.

Reviewers may downgrade the certainty of evidence by one or two levels based on the aforementioned factors. If the evidence base consists of observational studies with no study limitations reviewers may also rate the certainty of evidence up based on:

- large magnitude of effect
- dose-response gradient, and
- all plausible confounding would reduce the observed effect (or increase the effect, if a null effect was observed).

Certainty of evidence assessments are defined according to the GRADE approach:

- **High certainty:** We are very confident that the true effect lies close to that of the estimate of the effect;
- **Moderate certainty:** We are moderately confident in the effect estimate. The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different;
- **Low certainty:** Our confidence in the effect estimate is limited. The true effect may be substantially different from the estimate of the effect; and
- **Very low certainty:** We have very little confidence in the effect estimate. The true effect is likely to be substantially different from the estimate of effect.

Going from evidence to recommendations

The GRADE process specifies two categories for the strength of recommendations, based on how confident the guideline panel is that the "desirable effects of an intervention outweigh undesirable effects across the range of patients for whom the recommendation is intended":

- Strong recommendations, where guideline authors are certain that the evidence supports a clear balance towards either desirable or undesirable effects.
- Conditional recommendations, where the guideline panel is uncertain about the balance between desirable and undesirable effects.

These strong or conditional recommendations can either be for or against an intervention. Guideline panels may also choose to make no recommendation regarding an intervention, or recommend that an intervention only be used in research. The GRADE handbook identifies three instances where panels may make no recommendation:

- the confidence in effect estimates is so low that the panels feel a recommendation is too speculative;
- the trade-offs are so closely balanced, and the values and preferences and resource implications not known or highly variable, and the panel is unable to decide on the direction of a recommendation; and
- two options have very different undesirable effects, and individual patients' reactions to these consequences are likely to be so different that assessing

'typical' values and preferences is unhelpful.

Recommendations to only use an intervention in research can be made when the intervention is promising but there is insufficient evidence of benefit. The GRADE handbook outlines three conditions that should be met when recommending an intervention only be used in research:

- there is currently insufficient evidence to support a decision for or against an intervention;
- further research has large potential for reducing uncertainty about the effects of the intervention; or
- further research is thought to be of good value for the anticipated costs.

The seven main factors used to determine the strength of recommendations are:

- the balance between desirable and undesirable consequences
- confidence in the estimates of effect (certainty of evidence)
- confidence in values and preferences and their variability
- resource use (cost)
- equity
- acceptability
- feasibility

Judging the balance between desirable and undesirable consequences involves considering both the best estimates of the magnitude of desirable and undesirable effects and outcome importance to the relevant population. If the best estimates of the effects of an intervention point to large desirable effects and no or minimal undesirable effects, then the recommendation will likely be strong. However, if there are large desirable and undesirable effects, then a conditional recommendation may be needed. These effects should be considered when accounting for patient preferences, values and how important these effects are for patients.

Rating the certainty of evidence requires considering the same factors that are considered for individual outcomes. These factors are judged across all the prioritised outcomes, taking into account the relative importance of these outcomes. For values and preferences, the guideline panel considers uncertainty about values and preferences based on the available evidence, in addition to their consideration of the extent to which patient values and preferences are likely to vary.

Considerations of cost and resource utilisation are similar to considerations of clinical outcomes, where the guideline panel should consider the most important resource implications, provide estimates of the difference between intervention and control, and make explicit judgements about the quality of evidence informing these estimates. An important consideration is also if the use of an intervention for COVID-19 will adversely impact the use of the intervention for other indications.

When addressing equity, it will be considered whether there is plausible reason to anticipate differences in effects for certain groups or settings, for example Aboriginal and Torres Strait Islander people or rural/remote settings. The panels will also consider how acceptable the interventions are to stakeholders and how feasible the interventions are to implement. As part of those considerations' potential shortage of the suggested intervention will be discussed.

Appendix 3. Taskforce Member Organisations on the National Steering Committee and Endorsing the Guideline

Cochrane Australia	
Allied Health Professionals Australia (AHPA)	Australasian Association for Academic Primary Care (AAAPC)
Australian Association of Gerontology (AAG)	Australasian College of Emergency Medicine (ACEM)
Australian College for Infection Prevention and Control (ACIPC)	Australasian Society for Infectious Diseases (ASID)
Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists (ASCEPT)	Australian and New Zealand College Anaesthetists (ANZCA)
Australian and New Zealand Intensive Care Society (ANZICS)	Australian & New Zealand Society for Geriatric Medicine (ANZSGM)
Australian College of Midwives (ACM)	Australian College of Nursing (ACN)
Australian College of Rural and Remote Medicine (ACRRM)	Australian Primary Health Care Nurses Association (APNA)
Australasian Sleep Association (ASA)	Australian Society of Anaesthetists (ASA)
National Aboriginal Community Controlled Health Organisation (NACCHO)	Royal Australian College of General Practitioners (RACGP)
Royal Australasian College of Physicians (RACP)	Thoracic Society of Australia and New Zealand (TSANZ)
Australian College of Critical Care Nurses (ACCCN)	Society of Hospital Pharmacists of Australia (SHPA)
Australian COVID-19 Palliative Care Working Group (ACPCWG)	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Thrombosis and Haemostasis Society of Australia and New Zealand (THANZ)	College of Emergency Nurses Australasia (CENA)
Royal Australasian College of Surgeons	Australasian College of Paramedicine (ACP)
Palliative Care Australia (PCA)	CRANAplus

Appendix 4. Consumer Panel Expression of Interest

Members of National COVID19 Clinical Evidence Taskforce Consumer Panel

The Guidelines

As part of the National COVID19 Clinical Evidence Taskforce, we are developing living Australian guidelines for the clinical care of people with COVID-19. The current version of the guidelines is available at https://covid19evidence.net.au/ and new and revised recommendations are being produced each week.

This is a world-leading effort to translate research into practice in a complex health area that is evolving rapidly. The Taskforce brings together relevant peak clinical bodies within Australia and is linked with international evidence review efforts.

The guidelines team is led by Dr Britta Tendal based at Cochrane Australia, Monash University and is overseen by a Guidelines Leadership Group which provides strategic direction to the guideline development program. The Guidelines Leadership Group includes two consumer representatives.

The Panel

A Consumer Panel, co-convened by the Consumers Health Forum of Australia and the Taskforce, is being formed to advise the Guidelines Leadership Group. It will be co-chaired by the Guidelines Leadership Group consumer representatives.

The Role

We are looking for eight experienced consumer representatives to for the Consumer Panel and advise on national guideline development for treatment of COVID-19. These consumer representatives will:

- Join online, fortnightly, 1.5-2 hour meetings of Consumer Panel and read papers for these meetings provided 2-3 days before the meeting
- Provide strategic consumer advice to the guideline development program, including contributing ideas for clinical questions to be addressed, views on high priority topics, and feedback on guideline recommendations as they are developed

The Person

We need consumer representatives who:

- Are familiar and confident with conversations about research evidence and health care
- Are available immediately and for the next 6 months
- Are based in Australia
- Represent the diversity of the Australian population
- Are confident using online meeting platforms like Zoom, and with receiving documentation via email, etc.

Patient experience relevant to COVID-19 (for example intensive or critical care, or pneumonia, or other serious acute respiratory illness) or guideline development would be an additional benefit.

Appendix 5. Taskforce Conflicts of Interest Policy

National Covid-19 Clinical Evidence Taskforce

Conflict of Interest Policy

The NHMRC Act 1992 defines a conflict of interest as '*any direct or indirect pecuniary or non-pecuniary interest'.* A conflict of interest does not preclude an individual's involvement within a particular group; however, to ensure the independence and integrity of decision-making processes and for transparency, all relevant interests must be declared and managed appropriately.

For further information on conflicts of interest, please visit the NHMRC 'Guidelines for Guidelines' website at https://www.nhmrc.gov.au/guidelinesforguidelines/plan/identifying-and-managing-conflicts-interest

1. Scope of COI policy

   The Conflicts of Interest policy applies to all individuals who participate in the decision-making process as it relates to the development of guidelines within the National Taskforce for COVID-19 project. This includes but is not limited to: Members of the National Steering Committee, National Guideline Leadership Group, Expert Guideline Panel, National Executive Team and the Expert Methods Team, and peer reviewers.

2. The process of disclosing COIs

   Any individual who participates in decision making processes relating to work undertaken within the project is required to complete a 'Declarations of Interest' form and return it to the project manager of the project either (a) prior to attending their first meeting (for members of committees, GDGs or other groups formed under the auspices of the project), or (b) either before or at the time of submission of comments/feedback in relation to a body of work (for example, peer reviewers). Members need to disclose all relevant interests within the previous five (5) years.

3. Identifying conflicts of interest

   The completed 'Declarations of Interest' form for each member will be reviewed by the project manager and to determine if any entries within the form constitutes a conflict of interest. A Conflict Management Committee (CMC) will assess declarations if a potential conflict is indicated. The CMC will be comprised of individuals with expert knowledge of COI management. The chair of the CMC will make the final decision as to whether a conflict of interest requires the development of a management plan for that individual.

4. Management of conflicts of interest

Based on an assessment of members' conflicts of interests, a judgement will be made regarding that members' accepted level of participation within the guideline development group. A substantial conflict of interest, such as ongoing financial compensation by a private company with strong links to the topic of interest, will require that member to cease their involvement within the group; however one-off $500 honorarium from a company making products not related to the topic of the guideline may be permitted. Individuals who have specific conflicts as relates to defined sections within a guideline (e.g. the members' spouse is employed by the manufacturer of a medical device that is the subject of a specific recommendation) may be required to leave the room and omit themselves from the decision making process for that topic. Any disagreements by an individual flagged as having a conflict of interest that precludes their involvement within a decision-making process should be raised with the project manager. This will then be reviewed by the CMC and a decision made as to whether to uphold the decision to exclude the individual or overturn the decision and thereby allow the individual to participate in the decision-making process.

All declarations of interest and a description of how conflicts of interest were managed will be publicly available with the guideline.

5. As per NHMRC guidance, committee chairs should have no conflicts of interest and the majority (> 50%) of committee members should also be free of conflicts of interest.

In relations to disbursements over the preceding five years, individuals who were deemed to have significant conflicts met the following pre-specified criteria:

Membership of advisory boards for corporations whose products or services are related to the guideline topics of that have a commercial or other interest in the Clinical Guideline for which the members is contributing to; or

Received grants, wither single or multiple, from entities who had commercial interests in the clinical guideline topic to the cumulative value of $5000 or more per annum; or

Received funding from entities that had commercial interest in the clinical guideline topic for consulting services or to present or attend conferences or meetings relating to the topic of the guideline to the cumulative value of $5000 or more per annum.

Appendix 6. Taskforce Conflicts of Interest COI Form

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

Australian National COVID-19 Clinical Evidence Taskforce

Declaration of interest

Name / Position			
Employment			
Relevant Committee / Group	☐ National Steering Committee	☐ Expert Guideline Panel	☐ National Executive Team
	☐ National Guideline Leadership Group	☐ Expert Methods Team	☐ Peer reviewer
	☐ Other (details)		
Role (member, chair, ex-officio)			

Financial Interests

Note: Disclose support ONLY from entities that could be affected financially by the published work, such as drug companies, or foundations supported by entities that may have a financial stake in the outcome. Public funding sources, such as government agencies or academic institutions need not be disclosed. Time period for disclosure is within 5 years from when this form is completed.

Type of Interest	Source of funding (provide sponsor names)	Title or theme of project / activity. If activity was linked to a specific product, please name the product. Ie, "fees for speaking about product X or consulting regarding product X	Period of activity (whether current, include date range)	Value of payment (AUD):
Research Grants / Contracts				
Advisory boards				
Consulting / Honoraria				
Speakers' fees or honoraria				
Paid authorship				
Meeting attendance /paid travel/receipt of meals				
Intellectual Property (patents, licenses, royalties)				

Stock options / holdings				
Private practice or professional income				
Unpaid consultancies and/or in-kind support				
Family member employment/financial interests				

Organizational Interests

Conflicts of interest may also arise if guideline development group members serve as representatives of additional organisations (e.g. not meeting criteria listed above) with a pecuniary or non-pecuniary interest in the guideline recommendations. Declare all relevant relationships including:

Type of Interest	Type of relationship (e.g. employment, leadership, position, membership, etc)	Description
Relationship with organisations with financial links or affiliations with industry groups which stand to benefit from or may be affected by guideline recommendations (eg, professional organization)		
Relationship with organisations which advocate known industry or policy positions		
Relationships of Immediate family members		

Other *Are there any other relevant interests, factors, or circumstances that are not addressed above?*

Additional information *Is there any additional information you would like to provide relating to the above declarations of interest?*

Appendix 7. Conflict of Interest Summaries

National Guidelines Leadership Group

Name	Nature and Company	Significant conflicts	Recommendations
Julian Elliott	Professional: Covidence (Veritas Health Innovation Ltd)	No	Yes
Sutapa Mukherjee	Advisory Boards: Board member of Australasian Sleep Association	No	Yes
Joshua Vogel	Nil	No	Yes
Allen Cheng	Grants: Janssen Craig, Covance; Professional: Australasian Society for Infectious Diseases; Memberships: Australian Health Protection Prinicipal Committee, ICEG, Communicable Diseases Network of Australia	No	Yes
Steve McGloughlin	Nil	No	Yes
Mark Morgan	Consulting: Expert Committee for Quality Care, RACGP Organisational interest: Royal Australian College of General Practitioners, Australian Association for Academic Primary Care, Gold Coast PHN, Gold Coast GP.		Yes
Allan Glanville	Organisational Interest: Past President of Thoracic Society of Australa and New Zealand	No	Yes
Karen Booth	Advisory Boards: Presdient APNA; Memberships: ACIPC, AAPM	No	Yes
Paul Myles	Nil	No	Yes
Chris O'Donnell	Memberships: Australia College of Nursing, Australia College of Nurse Practitioners, Australian Institute of Digital Health	No	Yes
Ewen McPhee	Nil	No	Yes
Jason Agostino	Nil	No	Yes
Lyn Byers	Advisory Boards: Board member CRANA+, Secretary CARPA, Memberships: Member of ACM, Friend of NRHA, Member of Central Aus Health Advisory Committee NT Govt	No	Yes
Rosalind Elliott	Memberships: Member of the Australian College of Critical Care Nurses	No	Yes
Peter Cameron	Nil	No	Yes
Peter Fowler	Nil	No	Yes
Leeroy William	Nil	No	Yes
Jane Phillips	Nil	No	Yes
Brett Mitchell	Research Grant: Covidien; Consulting: Australia College of Infection Prevention and Control, MSD; Meeting attendance: IPS Conference, GAMA Infection Control Workshops, Australia College of Infection Prevention and Control (ACIPC)	No	Yes
Megan Cooper	Nil	No	Yes
Meera Agar	Grants/Consulting: Cancer Australia, Department of Health, SPHERE, NHMRC, Australian Cancer Research Foundation, NSW Govt; Advisory Boards: NPS MedicineWise, Palliative Care Australia, Clinical Oncological Society of Aust, Cancer Symptons Trials, TGA Opioid Regulatory, Australian Advisory Council on the Medical use of Cannabis; Professional: Palliative Care Australia Board, Australian Society of Opthalmology	No	Yes

Guidelines Leadership Group

Name	Nature and Company	Significant conflicts	Recommendations
Wayne Varndell	Research: UNSW Neuroscience, Mental Health and Additions and SPHERE, Prince of Wales Hospital Foundation, Nurse and Midwifery Strategy Funding Initiatives, Ministry of Health and the Emergency Care Institute, Health Workforce Australia; Paid Authorship: Elsevier; Intellectual Property: Book - Professional Transitions in Nursing; Professional: College of Emergency Nursing Australasia	No	Yes
Ian Whyte	Nil	No	Yes
Michael Parr	Advisory Boards: Deputy Chair Australia Resuscitation Council	No	Yes
Caroline Homer	Research grants: NHMRC grants; Advisory Boards: Department of Health and Ageing and Perinatal Society of Australia and NZ; Consulting: Editor in Chief - Women and Birth journal; Meeting attendance: NHMRC Council	No	Yes
Vijay Roach	Nil	No	Yes
Brendan McMullan	Nil	No	Yes
Asha Bowen	Nil	No	Yes
Sarah Larkins	Research grants: DFAT, NHMRC. Organisational interest: Royal Australian College of General Practitioners, Australian Association for Academic Primary Care.	No	Yes
Vasi Naganathan	Advisory Boards: President - ANZSGM	No	Yes
Rebecca Randall	Professional: RACP employee; Membership: RACP	No	Yes
Lucy Burr	Organisational interest: Thoracic Society of Australia and New Zealand	No	Yes
Mark Frydenberg	Grants: NHRMC; Professional: Private Practice; Advisory Boards: Board of Directors Member USANZ, Board member Proiate Cancer Foundation Australia, Board member Cabrini Foundation; Memberships: RACS Council Member,	No	Yes
Marty Nichols	Advisory Boards: Australasian College of Paramedicine	No	Yes
Carol Hodgson	Research grants: NHMRC/MRFF; Advisory Boards: Australia and Nz Intensive Care Research Centre; Consultancies: Arjo; Organisational relationships: International Sepsis Guidelines	No	Yes
Josh Davis	Research grants: Abbvie	Yes	No
Bridget Barber	Nil	No	Yes
Eleanor Horton	Nil	No	Yes

Steering Committee

Name	Nature and Company	Significant conflicts	Recommendations
Sharon McGowan	Grants: Bayer, Boehringer Ingelheim, Meditronic, Allergan Australian, Bristol-Myers Squibb, Bupa, CCPE real estate, Nestle Health services, NiB Foundation, Pfizer Australia; Advisory Boards: Stroke Alliance Australia; Speaker fees: Boehringer Ingelheim; Meeting attendance: Council of Ambulance Authorities Australia, Global NCD Alliance, Florey, Boehringer Ingelheim, Siemens, Sanofi; Professional: World Stroke Organisation, Stroke Society of Australia, ACDPA, ASC	No	Yes
Joseph Doyle	Grants: Gilead Sciences, AbbVie, Merck, Bristol Myer Squibb; Consulting: Gilead Sciences, AbbVie, Merck; Advisory Boards: Virology Committee - Australasian Society for Infectious Diseases	Yes	No
Anthony Holley	Nil	No	Yes
Vanessa Beavis	Nil	No	Yes
Stephan Groombridge	Professional: RACGP	No	Yes
Ken Griffin	Professional: Australian Primary Health Care Nurses Association	No	Yes
Suzi Nou	Nil	No	Yes
Dawn Casey	Nil	No	Yes
Marina Buchanan-Grey	Nil	No	Yes
Marita Cowie	Nil	No	Yes
Tanya Buchanan	Nil	No	Yes
Sabina Knight	Organisational interests: Australian College of Nursing, CRANAPlus, Western Queensland PHN, Rural Heallth Education Network	No	Yes
Nicola Ballenden	Nil	No	Yes
Alison Hodak	Professional: Australian College of Critical Care Nurses	No	Yes
Nicola Lewis	Nil	No	Yes
Kristin Michaels	Professional: SHPA	No	Yes
Alan Young	Nil	No	Yes
Rohan Greenland	Nil	No	Yes
Philip Russo	Research Grants: NHMRC Early Career Fellowship, Cardinal Health Australia Industry Grants, Cabrini Foundation, Commonwealth DoH, Meditronics, Rosemary Norman Foundation, Senver (Cathtag); Advisory Boards: Healthcare Associated Infection Advisory Committee, Australian Commission for Safety and Quality in Health Care; Consulting: Johnson & Johnson, Surgical Site infection Advisory Committee; Speaker fees: Essity; Professional: President ACIPC	No	Yes

Steering Committee

Name	Nature and Company	Significant conflicts	Recommendations
Sally Green	Nil	No	Yes
Megan Sarson	Professional: ACHDO	No	Yes
Julia Morphet	Nil	No	Yes
Terri-Lee Barrett	Professional: President of Australian College of Midwives	No	Yes
Vase Jovanonovska	Nil	No	Yes
Danijela Gnjidic	Nil	No	Yes
James Beckford Saunders	Memberships: National Aged Care Alliance, IAGG	No	Yes
Peter Morley	Advisory Boards: Australian Resuscitation Council, Scientific Advisory Committee	No	Yes
Mark Frydenberg	Advisory Boards: Australasian College of Paramedicine	No	Yes
Ryan Lovett	Stocks: Lovett Family Holdings Pty Ltd; Professional income: SA Health - Wellbeing SA, Skerric Pty Ltd; Professional: Australasian College of Paramedicine	No	Yes
Anita Hobson-Powell	Advisory Boards: AHPA, NASRP, Qld Academy of Sport, Exercise and Sports Science Australia	No	Yes

Disease-Modifying Treatment and Chemoprophylaxis Panel

Name	Nature and Company	Significant conflicts	Recommendations
Amanda Gwee	Meeting attendence: MSD	No	Yes
Karin Leder	Nil	No	Yes
Jane Davies	Nil	No	Yes
Ian Seppelt	Research grants/contracts: NHMRC; Advisory boards: MSD	No	Yes
Bridget Barber	Nil	No	Yes
Dan Ewald	Consulting: Johnson and Johnson; Meeting attendance: RACGP	No	Yes
Bradley Wibrow	Nil	No	Yes
Trisha Peel	Consulting: Australian Inity LTD; Meeting attendance: Merck Sharp and Dohme	No	Yes
Chris Raftery	Nil	No	Yes
Megan Rees	Nil	No	Yes
Tom Snelling	Nil	No	Yes
James McCarthy	Research grants: Merck kga, 60 Degrees Pharmaceuticals	Yes	No
Gail Matthews	Research grants: GILEAD, Abbvie	Yes	No
James McMahon	Research Grants: GILEAD, VIIV, MSD, Amgen, Shire, NHMRC, ACH2, NIH/NIAID, Amfar, LMCF	Yes	No
Jason Roberts	Research grants: MSD, The Medicines Company, Qpex, MRFF, RBWH Foundation; Advisory boards: MSD; Consulting: MDS, Pflzer, Discuva, Accelerate Diagnostics, Biomerieux	Yes	No
Josh Davis	Research grants: Abbvie	Yes	No
Michelle Giles	Research grants/contracts: GILEAD	Yes	No

Hospital and Acute Care Panel

Name	Nature and Company	Significant conflicts	Recommendations
Lucy Burr	Professional: Thoracic Society of Australia and New Zealand	No	Yes
Simon Hendel	Advisory boards: Governance Committee, Patient Care Acedemy, Ambulance Victoria; Meeting attendance: Saudi National Truama Conference; Professional: Australian and New Zealand College of Anaethetists, Australian Society of Anaesthetists, Clinical Research Fellow at National Truama Research Institute	No	Yes
Kiran Shekar	Nil	No	Yes
Peter Wark	Research Grants: NHMRC Australia, National Institute of Health (USA), GSK; Advisory boards: Astra Zeneca, Boehringer Ingelheim, GSK	Yes	No
Allan Glanville	Professional: Past President of Thoracic Society of Australa and New Zealand	No	Yes
Owen Robinson	Nil	No	Yes
Nicky Gilroy	Professional: MSD advisory board	No	Yes
Chantel Sharland	Nil	No	Yes
Bronwyn Avard	Professional: ANZICS board	No	Yes
Kelly Cairns	Nil	No	Yes
Paul Myles	Nil	No	Yes
Sally McCarthy	Professional: Past President of ACEM	No	Yes
Robert O'Sullivan	Professional: ANZSGM	No	Yes

Critical Care Panel

Name	Nature and Company	Significant conflicts	Recommendations
Steve McGloughlin	Nil	No	Yes
Priya Nair	Professional: Australia and New Zealand College of Intensive Care Society	No	Yes
Carol Hodgson	Research grants: NHMRC/MRFF; Advisory Boards: Australia and Nz Intensive Care Research Centre; Consultancies: Arjo; Organisational relationships: International Sepsis Guidelines	No	Yes
Craig French	Member of Medicam Advisory Committtee LifeBlood	No	Yes
Ed Litton	Member ANZICS	No	Yes
Sandra Peake	Nil	No	Yes
Sue Huckson	Professional: ANZICS	No	Yes
Rose Jaspers	Professional: ACCCN; Other: Personal relationship facilites manager Aspen Pharmaceuticals	No	Yes
Jon Iredell	Nil	No	Yes
Stephen Macdonald	Professional: Australia College for Emergency Medicine	No	Yes
Kim Hansen	Nil	No	Yes
Melissa Ankravs	Research grants/contracts: Juno Pharmaceuticals; Consulting: Hospira/Pftzier	No	Yes
Ian Seppelt	Research grants/contracts: NHMRC; Advisory boards: MSD	No	Yes
Carrie Janerka	Nil	No	Yes

Primary and Chronic Care Panel

Name	Nature and Company	Significant conflicts	Recommendations
Mark Morgan	Consulting: Expert Committee for Quality Care, RACGP; Professional: Royal Australian College of General Practitioners, Australian Association for Academic Primary Care, Gold Coast PHN, Gold Coast GP.	No	Yes
Sarah Larkins	Research grants: DFAT, NHMRC. Professional: Royal Australian College of General Practitioners, Australian Association for Academic Primary Care.	No	Yes
Georgina Taylor	Professional:Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, Australian Medical Association	No	Yes
Jason Agostino	Nil	No	Yes
Dan Ewald	Consulting: Johnson and Johnson; Meeting attendance: RACGP	No	Yes
Paul Burgess	Professional: NT Department of Health, Northern Territory PHN, Australia Healthcare & Hopsitals Association	No	Yes
David Peiris	Advisory boards: Royal Australian College of General Practitioners National Faculty of Aboriginal and Torres Strait Islander Health; Professional The George Institute for Global Health	No	Yes
Penny Burns	Professional: Member of Australian Technical Advisory Group on Immunisation (ATAGI) COVID-19 Working Group	No	Yes
Carmel Nelson	Nil	No	Yes
Ineke Weaver	Nil	No	Yes
Kirsty Douglas	Advisory board: ACT Medicare Local/ACT CHN Research: RACGP	No	Yes
Louis Peachey	Professional: Australian College of Rural & Remote Medicine	No	Yes
Lyn Byers	Advisory Boards: Board member CRANA+, Secretary CARPA, Professional: ACM, NRHA, Member of Central Aus Health Advisory Committee NT Govt	No	Yes
Sabina Knight	Professional: Australian College of Nursing, CRANAPlus, Western Queensland PHN, Rural Heallth Education Network	No	Yes
Lucie Walters	Nil	No	Yes
Mieke van Driel	Professional: NPS Medicinewise Clinical Intervention Advisory Group, Therapeutic Guidelines respiratory writing group	No	Yes

Pregnancy and Perinatal Care Panel

Name	Nature and Company	Significant conflicts	Recommendations
Dr Vijay Roach	Nil	No	Yes
Prof Caroline Homer	Research grants: NHMRC grants; Advisory Boards: Department of Health and Ageing and Perinatal Society of Australia and NZ; Consulting: Editor in Chief - Women and Birth journal; Meeting attendance: NHMRC Council	No	Yes
Dr Clare Whitehead	Nil	No	Yes
Dr Michelle Giles	Research grants/contracts: GILEAD	Yes	No
A/Prof Philippa Middleton	Professional NHMRC National Pregnnacy Care Guidelines Group	No	Yes
Prof Jeremy Oats	Nil	No	Yes
Dr Teena Downton	Nil	No	Yes
Dr Wendy Burton	Nil	No	Yes
A/Prof Nolan McDonnell	Nil	No	Yes
Prof Adrienne Gordon	Professional: Stillbirth Centre of Research Excellence & Safer Baby Bundle Program	No	Yes
Ms Glenda Gleeson	Nil	No	Yes
Dr Jenny Hunt	Nil	No	Yes
Jackie Kitschke	Nil	No	Yes

Paediatrics and Adolescent Care Panel

Name	Nature and Company	Significant conflicts	Recommendations
Brendan McMullan	Nil	No	Yes
Asha Bowen	Nil	No	Yes
Nan Vasilunas	Nil	No	Yes
David Tingay	Nil	No	Yes
James Best	Nil	No	Yes
Vimbai Kapuya	Nil	No	Yes
Lorraine Anderson	Nil	No	Yes
Catherine Keyte	Nil	No	Yes
Danielle Wurzel	Research grants: Murdoch Childrens Research Institute; Professional: Thoracic Society of Australia and New Zealand	No	Yes
Simon Craig	Professional: ACEM, PREDICT network	No	Yes
Nick Fancourt	Consulting: Pfizier / ERT; Meeting attendance: Pfizier through MCRI	No	Yes
Simon Erickson	Consulting: NHMRC COVID-19 guidelines; Author ANZICS COVID-19 guidelines	No	Yes
Zoy Goff	Consulting: Society of Hospital Pharmacists Australia	No	Yes
Penny Burns	Professional: Australian Technical Advisory Group on Immunisation COVID-19 Working Group	No	Yes

Older People and Palliative Care Panel

Name	Nature and Company	Significant conflicts	Recommendations
Meera Agar	Grants/Consulting: Cancer Australia, Department of Health, SPHERE, NHMRC, Australian Cancer Research Foundation, NSW Govt; Advisory Boards: NPS MedicineWise, Palliative Care Australia, Clinical Oncological Society of Aust, Cancer Symptons Trials, TGA Opioid Regulatory, Australian Advisory Council on the Medical use of Cannabis; Professional: Palliative Care Australia Board, Australian Society of Opthalmology	No	Yes
Richard Lindley	Nil	No	Yes
Natasha Smallwood	Research grants: Fisher &Paykel	No	Yes
Michael Chapman	Nil	No	Yes
Leeroy William	Nil	No	Yes
Patsy Yates	Nil	No	Yes
Deidre Morgan	Nil	No	Yes
Phillip Good	Professional: Ausralia and New Zealand Society of Palliative Medicine, Royal Australiasian College of Physicians	No	Yes
Penny Tuffin	Nil	No	Yes
Vasi Naganathan	Professional: President Ausralia and New Zealand Society for Geriatric Medicine	No	Yes
Mandy Callary	Professional: Southern Cross Care, Ausralia and New Zealand Society for Geriatric Medicine	No	Yes
Velandai Srikanth	Research grants: NHMRC	No	Yes
Elizabeth Whiting	Nil	No	Yes
Peter Jenkin	Nil	No	Yes

Consumer Panel

Name	Nature and Company	Significant conflicts	Recommendations
Rebecca Randall	Professional: RACP employee; Membership: RACP	No	Yes
Eleanor Horton	Nil	No	Yes
Richard Brightwell	Nil	No	Yes
Joanne Muller	Nil	No	Yes
Elizabeth Robinson	Advisory Board: MHRA	No	Yes
Lynda Condon	Nil	No	Yes
Adam Ehm	Advisory Boards: Taskforce BBV's Sexual Health and Covid-19, Melbourne HIV Cure Consortium, Protocol Steering Committee NIVO-LD Study; Speaking fees: Living Positive Victoria; Meeting attendance: Living Positive Victoria; Professional: IPC Health; Memberships; AFAO, Living Positive Victoria, NAPWHA	No	Yes
Monica Ferrie	Professional: Genetic Alliance Australia and Genetic Rare Disease Network, AIDH	No	Yes
Amria Deshpande	Nil	No	Yes
Lara Pullin	Nil	No	Yes
Adele Witte	Nil	No	Yes
Bronwyn Morris Donovan	Nil	No	Yes
Sue Whicker	Memberships: RACGP	No	Yes

Expert Advisory Group

Name	Nature and Company	Significant conflicts	Recommendations
Anoop Enjeti	Speaking: Bayer, Sanofi, Alexion; Professional: THANZ	No	Yes
Huyen Tran	Advisory boards: Sanofi	No	Yes
Chris Ward	Advisory boards: Aspen Pharmaceuticals, Bayer, Boehringer Ingelheim. Meeting attendance: Pfizier	No	Yes
Prahlad Ho	Research grants: BMS/Pfizier; Speaking fees: Thrombosis Forum; Professional: THANZ	No	Yes
James McFadyen	Research grants: Consulting:	No	Yes
Chee Wee Tan	Professional: THANZ	No	Yes
Eileen Merriman	Research grants: Sanofi; Speaking: Bayer, Boehringer; Meeting attendance: Sanofi	No	Yes
Helen Savoia	Nil	No	Yes
Briony Cutts	Nil	No	Yes
Adam Holyoak	Nil	No	Yes
Katrina Williams	Nil	No	Yes
Helen Liley	Professional: Australian Resusitation Council, International Liasion Committee on Resusitation, Perinatal Society of Australia and New Zealand.		
Christina Boros	Nil	No	Yes
David Burgner	Nil	No	Yes
Theresa Cole	Professional: Australiasian Society of Clinical Immunology, National Blood Authority	No	Yes
Andrew Kelly	Advisory boards: Actelion Pharamaceuticals MORE	No	Yes
Catriona Melville	Speaking: Bayer; Paid aurthorship: Wiley-Blackwell; Meeting attendance: Bayer	No	Yes
Deborah Bateson	Advisory boards: MSD, Bayer; Speaking: Bayer	No	Yes
Magdalena Simonis	Nil	No	Yes
Martha Hickey	Research grants: QUE Oncology, Madoora; Speaking: Mayo Clinic	No	Yes

Cardiac Arrest Working Group

Name	Nature and Company	Significant conflicts	Recommendations
Peter Morley	Advisory Boards: Australian Resuscitation Council, Scientific Advisory Committee,	No	Yes
Craig Fairley	Nil	No	Yes
Minh Le Cong	Nil	No	Yes
Brett Hoggard	Nil	No	Yes
Samantha Bendall	Nil	No	Yes
Dan Ellis	Nil	No	Yes
Andrew Pearce	Nil	No	Yes
Neil Ballard	Nil	No	Yes
Neel Bhanderi	Nil	No	Yes
Priya Nair	Professional: Australia and New Zealand College of Intensive Care Society	No	Yes
Lyn Byers	Advisory Boards: Board member CRANA+, Secretary CARPA, Memberships:Member of ACM, Friend of NRHA, Member of Central Aus Health Advisory Committee NT Govt	No	Yes
Simon Craig	Professional: ACEM, PREDICT network	No	Yes

Technology Advisory Group

Name	Nature and Company	Significant conflicts	Recommendations
Hugh Williams	Shares: SMSF, UniSuper, CSLI	No	Yes
Dan Draper	Professional: MedicalDirector	No	Yes
Kelvin Hill	Other: Stroke Foundation - Collaboration with MAGIC & Covidence	No	Yes
Sarah Norris	Memberships: Medical Services Advisory Committee (MSAC) Professional: Hereco	No	Yes
Bronwyn Morris-Donovan	Nil	No	Yes
Rhiannon Tate	Professional: Australian Living Evidence Consortium	No	Yes
Britta Tendal	Research grants: Veritas Health Innovations	No	Yes

Internal Team

Name	Nature and Company	Significant conflicts	Recommendations
Julian Elliott	Professional: Covidence (Veritas Health Innovation Ltd)	No	Yes
Rhiannon Tate	Professional: Australian Living Evidence Consortium	No	Yes
Britta Tendal	Research grants: Veritas Health Innovations	No	Yes
Steve McDonald	Research grants: NHMRC, Cochrane; Consulting: NHMRC	No	Yes
Tari Turner	Nil	No	Yes
Sarah Norris	Memberships: Medical Services Advisory Committee (MSAC) Professional: Hereco	No	Yes
Bronwyn Morris-Donovan	Nil	No	Yes
Eloise Hudson	Nil	No	Yes
Sharon Gurry	Nil	No	Yes
Joshua Vogel	Nil	No	Yes
David Fraile Navarro	Nil	No	Yes
Heath White	Nil	No	Yes
Samantha Chakraborty	Nil	No	Yes
Saskia Cheyne	Nil	No	Yes
Henriette Callesen	Nil	No	Yes
Tanya Millard	Nil	No	Yes
Melissa Murano	Research grants: NHMRC; Consulting: Palladium	No	Yes
Declan Primmer	Nil	No	Yes
Simon Turner	Nil	No	Yes
Jaspreet Sidhu	Nil	No	Yes
Alexis Poole	Research grants: Intensive Care Foundation Project, Diabetes Australia; Meeting attendance: La Jolla Pharamceuticals	No	Yes
Samantha Timms	Nil	No	Yes
Shauna Hurley	Nil	No	Yes
Sue Whicker	Memberships: RACGP	No	Yes

Appendix 8. National COVID-19 Clinical Evidence Taskforce Principles of Collaboration and Partnership.

Version 1.0

[Excerpt]

Membership of the Jurisdictional Liaison Group

Commonwealth, State and Territory governments and government agencies or authorities are eligible to become members of the Taskforce Jurisdictional Liaison Group (JLG). The overall purpose of the JLG is to ensure that there is mutual awareness of the evidence surveillance and clinical guidance work of the Taskforce, and any relevant policy initiatives or position statements published by government. Whilst the development of guidance by the Taskforce will adhere to GRADE methods the Taskforce is aware that recommendations arising from the Taskforce have the potential to (a) not be fully aligned with the position of one or more departments/agencies on a particular aspect of care, or (b) be associated with barriers to implementation in one or more settings/jurisdictions. It is intended that the establishment of the JLG will provide a confidential forum for the discussion of such issues.

The key roles of the JLG are as follows:

1. Early identification of implementation issues:

- *For the Taskforce: to provide early awareness of draft recommendations before they are approved by the National Steering Committee: to receive early advice from the jurisdictions regarding implementation issues associated with particular recommendations; to respond to the feedback and delay publication of an evidence-based recommendation if appropriate (e.g. to ensure supply of named medicines or equipment).*
- *For Governments: to receive early awareness of candidate recommendations (under embargo); to provide timely feedback on any implementation issues associated with a draft recommendation from the perspective of each jurisdiction; to initiate appropriate governmental responses to address the implementation issues, according to responsibility.*

2. Dialogue regarding priority issues to be addressed by Taskforce:

- *For the Taskforce: to communicate to government the high priority topics identified by the Taskforce and specific clinical questions currently under review.*

- *For Governments: to communicate to the Taskforce priority issues that government would like the Taskforce to consider adding to the evidence review workplan, and to advise on evidence review work being undertaken by the jurisdictions that may be of relevance to the work of the Taskforce.*

Appendix 9. Jurisdictional Liaising Group contacts (as at 21 October 2020)

First name	Surname	Government Entity	Jurisdiction
David	Abbott	Dept of Health, HMRO	C/Wealth
Cleola	Anderiesz	Cancer Australia	C/Wealth
Bruce	Bolam	VIC DHHS	VIC
Megan	Burley	Department of Health	WA
Vanessa	Clements	Ministry of Health	NSW
Sandra	Cochrane	National Blood Authority	C/Wealth
Jane	Cook	TGA - Medicines Division	C/Wealth
Anne	Duggan	ACSQHC	C/Wealth
Jillann	Farmer	Clinical Excellence Queensland	QLD
Chantal	Ferguson	Department of Health	WA
Kwun	Fong	MSAC ESC	C/Wealth
Darren	Gibson	Department of Health	WA
Lyn	Gilbert	ICEG advising AHPPC	C/Wealth
Beth	Gubbins	VIC DHHS	VIC
Daniel	Heredier	State Health Incident Coordination Centre	WA Health
Robert	Herkes	ACSQHC	C/Wealth
Monica	Holdsworth	Safer Care Victoria	VIC
Jenny	Houltram	PBAC	C/Wealth
Kirsten	Howard	PBAC ESC	C/Wealth
Robyn	Hudson	Safer Care Victoria	VIC
Clare	Huppatz	Department of Health	WA
Megan	Keaney	Dept of Health	C/Wealth
Wendy	Keech	Health Translation SA	SA
Angela	Kelly	Department of Health	WA
Liz	Kenny AO	Queensland Clinical Networks	QLD
Christopher	Leahy	ACSQHC	C/Wealth
Jean-Frederic	Levesque	Ministry of Health	NSW
Michael	Levitt	Department of Health	WA
Felicity	Loxton	Safer Care Victoria	VIC
Nigel	Lyons	Ministry of Health	NSW
Alex	Markwell	Queensland Clinical Senate	QLD
Alison	McMillan	CNO/ICEG advising AHPPC	C/Wealth
Keith	McNeil	Queensland Health	QLD
Kathy	Meleady	ACSQHC	C/Wealth
Vivienne	Milch	Cancer Australia	C/Wealth
Caroline	Miller	SAHMRI (advising SA CHO)	SA
Brett	Mitchell	ICEG advising AHPPC	C/Wealth
Steve	Morris	NPS Medcine Wise	C/Wealth
Sarah	Nesbit	VIC DHHS	VIC
Dervla	O'Regan	Safer Care Victoria	VIC
John	Paul	Dept of Health, HMRO	C/Wealth
Paula	Pesci	Department of Health	WA
Paddy	Phillips	SA Health	SA
Rebecca	Power	Safer Care Victoria	VIC

Philip	Russo	ICEG advising AHPPC	C/Wealth
Becs	Saxton	VIC DHHS	VIC
Alicia	Segrave	MSAC	C/Wealth
Melanie	Shakespear	Dept of Health, HMRO	C/Wealth
Diana	Shipp	ACSQHC	C/Wealth
Nick	Simpson	Dept of Health	C/Wealth
Masha	Somi	Dept of Health, HMRO	C/Wealth
Kim	Stewart	ACSQHC	C/Wealth
Michael	Stone	National Blood Authority	C/Wealth
Kim	Sutherland	Ministry of Health	NSW
Brett	Sutton	VIC DHHS	VIC
Terry	Symonds	VIC DHHS	VIC
Bronwyn	Walker	NPS MedcineWise	C/Wealth
Euan	Wallace	Safer Care Victoria	VIC
Steve	Waller	ACSQHC	C/Wealth
Robyn	Ward	MSAC	C/Wealth
Steve	Wesselingh	SAHMRI (advising SA CHO)	SA
Andrew	Wilson	Safer Care Victoria	VIC
Andrew	Wilson	PBAC	C/Wealth
Rushika	Wirasinha	Dept of Health, HMRO	C/Wealth
Elizabeth	Young	VIC DJPR	VIC
Vacant- TBA	*Meeting with Cath Stoddard TBC*		*NT*
Vacant- TBA	*Meeting with Tony Lawlor requested*		*TAS*
Vacant- TBA	*Meeting with Kerryn Coleman TBC*		*ACT*

	A comprehensive summary of the proposed recommendation, underlying evidence, synthesis and interpretation of the evidence and process of developing the recommendation (GRADE) was provided to members of the JLG under embargo. JLG members were invited to provide feedback on any issues that had not yet been considered by the Taskforce which could impact on the implementability of the recommendation as proposed (see Appendix C).
Thurs 4 June	Recommendation approved by the Steering Committee. Guideline update published (guideline version 7.0) and national communique issued.

Appendix 10 and 11. Removed CONFIDENTIAL

Appendix 12. Individuals Involved in Guideline Development

National Guidelines Leadership Group

Name	Gender	State	Representating	Clinical Specialty	Role on GLG
Julian Elliott	M	VIC	N/A	Infectious Diseases	Co-Chair
Sutapa Mukherjee	F	SA	ASA(Sleep)	Respiratory and Sleep Medicine	Co-Chair
Joshua Vogel	M	NSW	N/A	Maternal and Perinatal Health	Deputy Chair
Allen Cheng	M	VIC	ASID - new rep/ was advisor	Infectious Diseases	Member
Steve McGloughlin	M	VIC	ANZICS	Intensive Care	Member
Mark Morgan	M	QLD	RACGP	General Practice	Member
Allan Glanville	M	NSW	TSANZ	Thoracic Medicine	Member
Karen Booth	F	VIC	APNA	Primary Care Nursing	Member
Paul Myles	M	VIC	ANZCA/ASA(Anaesthesia)	Anaesthesia	Member
Chris O'Donnell	M	QLD	ACN	Nursing	Member
Ewen McPhee	M	QLD	ACRRM	Rural/Remote Medicine	Member
Jason Agostino	M	ACT	NACCHO	Indigenous Health	Member
Lyn Byers	F	NT	CRANAplus	Remote Nursing	Member
Rosalind Elliott	F	NSW	ACCCN	Critical Care Nursing	Member
Peter Cameron	M	VIC	ACEM	Emergency Medicine	Member
Peter Fowler	M	TAS	SHPA	Pharmacy	Member
Leeroy William	M	VIC	ACPCWG (medical)	Palliative Care Medicine	Member
Jane Phillips	F	NSW	ACPCWG (nursing)	Palliative Care Nursing	Member
Brett Mitchell	M	NSW	ACIPC	Infection Prevention and Control	Member
Megan Cooper	F	ACT	ACM	Midwife	Member
Meera Agar	F	NSW	ACPCWG	Palliative Care Medicine	Member
Wayne Varndell	M	NSW	CENA	Clinical Nurse Consultant–Emergency	Member
Ian Whyte	M	NSW	ASCEPT	Clinical Pharmacology and Toxicology	Member
Michael Parr	M	NSW	ARC	Clincal Care/ICU	Member
Caroline Homer	F	VIC	N/A	OBGYN	Panel Chair
Vijay Roach	M	NSW	N/A	Midwifery	Panel Chair
Brendan McMullan	M	NSW	N/A	Paed ID	Panel Chair
Asha Bowen	F	WA	N/A	Paed ID	Panel Chair
Sarah Larkins	F	QLD	N/A	General Practitioner and Rural Medicin	Panel Chair
Vasi Naganathan	M	NSW	ANZSGM	Geriatrics	Member
Rebecca Randall	F	NSW	N/A	NA	Consumer Rep
Lucy Burr	F	QLD	HAC	Respiratory and Sleep Physician	HAC

National Guidelines Leadership Group

Name	Gender	State	Representating	Clinical Specialty	Role on GLG
Mark Frydenberg	F	VIC	RACS	Urologist	Member
Marty Nichols	M	NSW	ACP	Paramedic Educator	Member
Carol Hodgson	F	VIC	AHPA	ICU Physiotherapist	Member
Josh Davis	M	NSW	DMTC Co-Chair	Infectious Diseases	DMTC
Bridget Barber	F	QLD	DMTC Co-Chair	Infectious Diseases	DMTC
Eleanor Horton	F	QLD	Consumer Co-Chair	Nursing	Consumer Rep

National Steering Committee

Name	Gender	State	Representative For	Position	Role on SteerCo
Sharon McGowan	F	VIC	ALEC	Executive Committee Member	Chair
Joseph Doyle	M	VIC	ASID	Board Member	Member
Anthony Holley	M	QLD	ANZICS	President	Member
Vanessa Beavis	F	NZ	ANZCA	President (New)	Member
Stephan Groombridge	M	VIC	RACGP	eHealth & Quality Care Manager	Member
Ken Griffin	M	VIC	APNA	CEO	Member
Suzi Nou	F	NT	ASA(Anaesthesia)	President	Member
Dawn Casey	F	ACT	NACCHO	Deputy CEO	Member
Marina Buchanan-Grey	F	ACT	ACN	Representative	Member
Marita Cowie	F	QLD	ACRRM	CEO	Member
Tanya Buchanan	F	NSW	TSANZ	CEO	Member
Sabina Knight	F	QLD	CRANAPlus	Representative	Member
Nicola Ballenden	F	VIC	ACEM	Executive Director, Research and Policy	Member
Alison Hodak	F	SA	ACCCN	President	Member
Nicola Lewis	F	NSW	RACP	General Manager	Member
Kristin Michaels	F	VIC	SHPA	CEO	Member
Alan Young	M	VIC	ASA(Sleep)	President	Member
Rohan Greenland	M	ACT	ACPCWG	CEO	Member
Philip Russo	M	VIC	ACIPC	President	Member
Sally Green	F	VIC	Cochrane Australia	Co-Director	Member
Megan Sarson	F	VIC	THANZ	Secretary	Member
Julia Morphet	F	VIC	CENA	Executive Director	Member
Terri-Lee Barrett	F	WA	ACM	President	Member
Vase Jovanonovska	F	VIC	RANZCOG	CEO	Member
Danijela Gnjidic	F	NSW	ASCEPT	President	Member
James Beckford Saunders	M	VIC	AAG	CEO	Member
Peter Morley	M	VIC	ARC	Chair	Member
Mark Frydenberg	M	VIC	RACS	Professor	Member
Ryan Lovett	M	SA	ACP	Executive Director	Member
Anita Hobson-Powell	F	QLD	AHPA	CEO	Member

Disease- Modifying Treatment Chemoprophalaxis Panel

Name	Gender	State	Clinical Specialty	Role on Panel
Josh Davis	M	NSW	Infectious Diseases	Co-Chair
Bridget Barber	F	QLD	Infectious Diseases	Co-Chair
Amanda Gwee	F	VIC	Paediatrics Infectious Diseases & Pharmacologist	Member
Karin Leder	F	VIC	Infectious Diseases	Member
Jane Davies	F	NT	Infectious Diseases	Member
Ian Seppelt	M	NSW	Intensive Care	Member
Dan Ewald	M	NSW	General Practitioner	Member
Bradley Wibrow	M	WA	Intensive Care	Member
Trisha Peel	F	VIC	Infectious Diseases	Member
Chris Raftery	M	QLD	Nursing	Member
Megan Rees	F	VIC	Respiratory	Member
Tom Snelling	M	NSW	Infectious Diseases	Member
James McCarthy	M	VIC	Infectious Diseases	Member
Gail Matthews	F	NSW	Infectious Diseases	Member
James McMahon	M	VIC	Infectious Diseases	Member
Jason Roberts	M	QLD	Pharmacy	Member
Michelle Giles	F	VIC	Pregnancy Infectious Diseases	Member

Critical Care Panel

Name	Gender	State	Clinical Specialty	Role on Panel
Steve McGloughlin	M	VIC	Intensive Care and Infectious Disease	Co-Chair
Priya Nair	F	NSW	Intensive Care	Co-Chair
Carol Hodgson	F	VIC	Physiotherapist (Intensive Care)	Deputy Chair
Craig French	M	VIC	Intensive Care	Member
Ed Litton	M	WA	Intensive Care	Member
Sandra Peake	F	SA	Intensive Care	Member
Sue Huckson	F	VIC	Intensive Care	Member
Rose Jaspers	F	VIC	Critical Care Nursing	Member
Jon Iredell	M	NSW	Infectious Diseases	Member
Stephen Macdonald	M	WA	Emergency Medicine	Member
Kim Hansen	F	QLD	Emergency Medicine	Member
Melissa Ankravs	F	VIC	Pharmacy	Member
Ian Seppelt	M	NSW	Intensive Care	Member
Carrie Janerka	F	WA	Emergency Nurse	Member

Hospital and Acute Care Panel

Name	Gender	State	Clinical Specialty	Role on Panel
Lucy Burr	F	QLD	Respiratory Physician	Co-Chair
Simon Hendel	M	VIC	Anaesthetist & Trauma Consultar	Deputy Co-Chair
Kiran Shekar	M	QLD	Intensive Care	Deputy Co-Chair
Paul Myles	M	VIC	Anaesthetist	Member
Peter Wark	M	NSW	Respiratory Physician	Member
Allan Glanville	M	NSW	Respiratory Physician	Member
Owen Robinson	M	WA	Infectious Diseases	Member
Nicky Gilroy	F	NSW	Infectious Diseases	Member
Chantal Sharland	F	SA	Critical Care Nursing	Member
Bronwyn Avard	F	ACT	Intensive Care	Member
Kelly Cairns	F	VIC	Pharmacy	Member
Sally McCarthy	F	NSW	Emergency Medicine	Member
Robert O'Sullivan	M	QLD	Geriatrician	Member

Care of Older People and Palliative Care Panel

Name	Gender	State	Clinical Specialty/Job title	Role on Panel
Meera Agar	F	NSW	Palliative Medicine Physician	Co-Chair
Richard Lindley	M	NSW	Academic Geriatrician	Co-Chair
Natasha Smallwood	F	VIC	Respiratory Physician	Deputy Chair
Michael Chapman	M	ACT	Palliative Medicine Physician	Members
Leeroy William*	M	VIC	Palliative Medicine Physician	Members
Patsy Yates*	F	QLD	Palliative Care Specialist (Nursing)	Members
Deidre Morgan	F	SA	Occupational Therapist (Palliative Care)	Members
Phillip Good	M	QLD	Palliative Medicine Physician	Members
Penny Tuffin	F	WA	Advanced Practice Palliative Care Pharmacist	Members
Vasi Naganathan	M	NSW	Geriatrician	Members
Mandy Callary	F	SA	Geriatrician	Members
Velandai Srikanth	M	VIC	Geriatrician	Members
Elizabeth Whiting	F	QLD	Geriatrician	Members
Peter Jenkin	M	SA	Aged Care Nurse Practitioner	Members

Pregnancy and Perinatal Care Panel

Name	Gender	State	Clinical Specialty	Role
Vijay Roach	M	NSW	Obstetrics & Gynaecology	Co-Chair
Caroline Homer	F	VIC	Midwife, Maternal & Perinatal Health	Co-Chair
Clare Whitehead	F	VIC	Obstetrics & Gynaecology Specialist	Deputy Co-Chair
Michelle Giles	F	VIC	Pregnancy Infectious Diseases	Deputy Co-Chair
Philippa Middleton	F	SA	Perinatal epidemiology	Member
Jeremy Oats	M	VIC	Obstetrics & Gynaecology	Member
Teena Downton	F	NSW	General Practice (Rural & Remote)	Member
Wendy Burton	F	QLD	General Practice	Member
Nolan McDonnell	M	WA	Obstetric Anaesthesia	Member
Adrienne Gordon	F	NSW	Neonatalogy	Member
Glenda Gleeson	F	NT	Midwifery, remote health	Member
Jenny Hunt	F	VIC	Public Health Physician (Aboriginal Health)	Member
Jackie Kitschke	F	SA	Midwifery	Member

Primary and Chronic Care Panel

Name	Gender	State	Clinical Specialty/Job title	Role on Panel
Mark Morgan	M	QLD	General Practitioner	Co-Chair
Sarah Larkins	F	QLD	General Practitioner and Rural Medicine Specialist	Co-Chair
Georgina Taylor	F	NT	General Practitioner	Deputy Chair
Jason Agostino	M	ACT	General Practitioner and Epidemiologist (Aboriginal and Torres Strait Islander Health)	Member
Dan Ewald	M	NSW	General Practitioner	Member
Paul Burgess	M	NT	Public Health Physician	Member
David Peiris	M	NSW	General Practitioner	Member
Penny Burns	F	NSW	General Practitioner	Member
Carmel Nelson	F	QLD	Rural and Remote Medicine Specialist	Member
Ineke Weaver	F	QLD	General Practitioner	Member
Kirsty Douglas	F	ACT	General Practitioner	Member
Louis Peachey	M	QLD	General Practitioner	Member
Lyn Byers	F	NT	Remote Area Nurse	Member
Sabina Knight	F	QLD	Remote Area Nurse	Member
Lucie Walters	F	SA	General Practitioner	Member
Mieke van Driel	F	QLD	General Practitioner	Member

Paediatric and Adolescent Care Panel

Name	Gender	State	Clinical Specialty/Job title	Role on Panel
Brendan McMullan	M	NSW	Paediatric Infectious Diseases	Co-Chair
Nan Vasilunas	F	SA	Paediatric Infectious Diseases	Deputy Co-Chair
David Tingay	M	VIC	Neonatologist	Deputy Co-Chair
Asha Bowen	F	WA	Paediatric Infectious Diseases	Co-Chair
Penny Burns	F	NSW	Urban General Practise Doctor	Member
James Best	M	NSW	Rural General Practise Doctor	Member
Vimbai Kapuya	F	NSW	Rural General Practise Doctor	Member
Lorraine Anderson	F	WA	Remote General Practise	Member
Catherine Keyte	F	QLD	Paediatrics ICU Nursing	Member
Danielle Wurzel	F	VIC	Paediatrics Resp Physician	Member
Simon Craig	M	VIC	Paediatrics Emergency Physician	Member
Lorelle Malyon	F	QLD	Paediatrics Emergency Nurse	Member
Nick Fancourt	M	NT	Gen Paediatrician	Member
Zoy Goff	F	WA	Paediatrics Pharmacist	Member
Simon Erickson	M	WA	Paediatrics Intensivist	Member

Consumer Panel

Name	Gender	State	Role on Panel
Rebecca Randell	F	VIC	Co-Chair
Eleanor Horton	M	QLD	Co-Chair
Adam Ehm	M	VIC	Member
Lara Pullin	F	QLD	Member
Lynda Condon	F	NSW	Member
Monica Ferrie	F	VIC	Member
Adele Witt	F	QLD	Member
Amrita Deshpande	F	QLD	Member
Elizabeth Robinson	F	SA	Member
Richard Brightwell	M	WA	Member
Joanne Muller	F	VIC	Member

Appendix 13. NHMRC requirements

Part A – Governance and stakeholder involvement

Mandatory requirement	Fulfilled	Location
A.1 - The organization/s responsible for developing and publishing the guideline is/are named	Yes	Guideline[5]
A.2 - Sources of funding for guideline development, publication and dissemination are stated	Yes	Guideline
A.3 - A multidisciplinary group that includes end-users, relevant disciplines and clinical experts is convened to develop the purposes, scope and content of the guideline, and the process and criteria for selecting members are described	Yes	Guideline
A.4 - Consumers participate in the guideline development, and the processes employed to recruit, involve and support consumer participants are described	Yes	Guideline, Technical Report (TR)
A.5 - A complete list of all the people involved in the guideline development process is provided, including the following information for each person: name, profession or discipline, organizational affiliation and role in the guideline development process	Yes	Guideline
A.6 - Potential competing interests are identified, managed and documented, and a competing interest declaration is completed by each member of the guideline development group	Yes	Guideline
A.7 - A list of organisations formally endorsing the guideline is provided	Yes	Guideline
Desirable requirement	**Fulfilled**	**Location**
A.2.1 - The amount and percentage of total funding received from each funding source is stated	No	-
A.4.1 - The guideline development process includes participation by representatives of Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities (as appropriate to the clinical need and context), and the processes employed to recruit, involve and support these participants are described	Yes	Guideline

Part B – Scope and purpose

Mandatory requirement	Fulfilled	Location
B.1 - The purpose of the guideline is stated, including the clinical questions (see requirement C.1), issue or problems the guideline addresses	Yes	Guideline and TR
B.2 - The health care setting to which the recommendations apply is described, including the health system level (e.g. primary care, acute care) and clinical stage (e.g. whether the guideline covers prevention, screening, assessment, treatment, rehabilitation or monitoring).	Yes	Guideline and TR
B.3 - The intended end users of the guideline are clearly defined, and any relevant exceptions are identified	Yes	Guideline and TR
B.4 - The population to which the guideline recommendations will apply is defined (e.g. children, adolescents, adults or older adults) and population subgroups for which specific information is required are identified and described	Yes	Guideline and TR

[5] Guideline refers to the online guideline at: https://covid19evidence.net.au/ and https://app.magicapp.org/#/guideline/4186

B.5 - Issues relevant to Aboriginal and Torres Strait Islander peoples (such as particular risks, treatment considerations or sociocultural considerations) are identified and described.	Yes	Guideline and TR
Desirable requirement	**Fulfilled**	**Location**
B.5.1 - Issues relevant to special-needs groups such as culturally and linguistically diverse communities or groups with low socioeconomic status (e.g. particular risks, treatment considerations or sociocultural considerations) are identified and described	Yes	Guideline

Part C – Evidence Review

Mandatory requirement	**Fulfilled**	**Location**
C.1 - Clinical questions addressed by the guideline are stated in a structured and consistent format to define the boundaries of the topic, i.e. by specifying the relevant population, intervention/s (e.g. treatment/s or diagnostic test's), comparator/s and outcomes measured.	Yes	Guideline
C.2 - Systematic searches for evidence are undertaken and the search strategy is documented, including the search terms and databases searched.	Yes	Guideline, TR
C.3 - The population groups specified in the search strategy include Aboriginal and Torres Strait Islander peoples and any population subgroups that have been identified (see Requirement B.4 and B.5)	Yes	Guideline, TR
C.4 - The publication period covered by the searches is stated, and the latest date is within 12 months of the first day of public consultation and within 20 months of submission of the final draft guideline to NHMRC for approval	Yes	Guideline, TR
C.5 - The inclusion and exclusion criteria used to select studies for appraisal are described	Yes	Guideline, TR
C.6 - For each clinical question, the developer has provided an evidence table, which summarises the systematic assessment and critical appraisal of all studies that meet the inclusion criteria (i.e. the body of evidence on which a recommendation will be based). Each evidence table should include information on study design, outcomes, level of evidence, the findings of meta-analysis (if performed) and other relevant information	Yes	Guideline
C.7 - For each clinical question, the developer has provided an evidence statement form, which documents the synthesis and evaluation of the body of evidence to determine the grade of each recommendation, according to an NHMRC-approved method (NHMRC grades for recommendations or GRADE).	Yes	Guideline
C.8 - For each recommendation, the developer has provided an evidence summary, which briefly states the outcomes of each clinical study on which the recommendation was based, their level of evidence and reference details.	Yes	Guideline
C.9 - A recommended date for future update of the guideline is identified	Yes	Guideline
Desirable requirement	**Fulfilled**	**Location**
C.3.1 - The population groups specified in the search strategy include groups such as culturally and linguistically diverse communities or other groups for whom specific sociocultural factors (including ethnicity, gender, age, disability,	Yes[6]	Guideline

[6] Searches are updated daily and prospectively for priority questions

socioeconomic status and location) in treatment or prevention outcomes should be considered.		
C.3.2 - Search strategies include search terms to identify evidence related to consumers' perceptions and experiences.	No	-
C.3.3 - Dependent on the guideline scope, the search strategies designed to identify evidence for all relevant alternatives for screening, prevention, diagnosis of treatment of the condition addressed by the guideline, including relevant complementary and alternative medicine approaches.	No (out of scope)	-
C.3.4 - Search strategies include search terms to identify evidence related to cost effectiveness and resource implications of practice	No	-
C.8.1 - If gaps in the evidence are identified during the evidence review, these are described in the guideline and areas for further research are noted.	Yes	Guideline

Part D – Guideline recommendations

Mandatory requirement	Fulfilled	Location
D.1 - The wording of recommendations is specific, unambiguous, clearly describes the action/s to be taken by users and matches the strength of the body of evidence	Yes	Guideline
D.2 – The wording of recommendations is written in plain English and is consistent throughout the guideline	Yes	Guideline
D.3 – For each evidence-based recommendation, the supporting references are listed and the grade of recommendation is indicated according to an NHMRC-approved method (NHMRC grades for recommendations or GRADE)	Yes	Guideline
D.4 – Recommendations formulated in the absence of quality evidence (where a systematic review of the evidence was conducted as part of the search strategy) are clearly labelled as such. The preferred term for this type of recommendation is a consensus-based recommendation.	Yes	Guideline
D.5 – Any further recommendations included in the guideline, where the subject matter is outside of the scope of search strategy, are clearly labelled as such. The preferred term for this type of recommendation is practice point.	Yes	Guideline
D.6 – The method used to arrive at consensus-based recommendations or practice points (Requirements D.4 and D.5) (e.g. voting or formal methods, such as Delphi) is documented.	Yes	Guideline
D.7 – Areas of major debate about the evidence and the recommendations are identified and the various significant veiwpoints are outlined in the guideline text (even if the guideline development working group members eventually reached a decision).	Yes	Guideline
D.8 – The strengths and limitations of the body of evidence reviewed are described in the guideline text and areas of uncertainty are acknowledged	Yes	Guideline
D.9 – The guideline acknowledges current national guidelines approved by NHMRC or endorsed by major authorities, and any deviations from these are explicitly noted in the guideline text and the rationale provided.	Yes	Guideline
D.10 – Where a guideline makes any recommendation/s specifying intervention/s that are not available or restricted in Australia, the text clearly indicates this, and the developer has consulted with the relevant authority/ies (see Requirements F.3).	Yes	Guideline

D.11 – Where evidence is identified showing that Aboriginal and Torres Strait Islander peoples or other population groups have specific treatment or prevention outcomes, this evidence is clearly identified and considered in the formulation of the recommendations.	Yes	Guideline
D.12 – The harms (risks or side effects) and benefits of each recommended intervention and its alternatives are described in the guideline text and the rationale for the recommendation is explained.	Yes	Guideline
D.13 – Any safety, legal or potential misuse issues related to the clinical recommendations are identified and described in the guideline text.	Yes	Guideline
D.14 – The potential impact of each recommendation on clinical practice or outcomes is described in the text	Yes	Guideline
D.15 – The guideline and recommendations have been assessed by at least two reviewers, independent of the guideline development process, using the AGREE II instrument.	TBC	-
Desirable requirement	**Fulfilled**	**Location**
D.2.1 – Recommendations are formulated using consistent grammar, syntax and wordings, so they can readily be adapted for electronic implementation strategies (e.g. electronic decision support systems and automatic data collection).	Yes	Guideline
D.8.1 – Recommendations that are likely to be affected by new evidence after the guideline has been approved (e.g. major clinical trials underway at the time of guideline publication) are identified and the implications for the guideline recommendations are explained in the guideline text.	Yes	Guideline
D.9.1 – Clinical recommendations that deviate from current practice are identified	Yes	Guideline
D.11.1 – Where evidence is identified showing that sociocultural factors (including ethnicity, gender, age, disability, socioeconomic status and location) affect treatment or prevention outcomes (see Requirement C.3.1), this evidence is clearly identified and considered in the formulation of the recommendations.	Yes	Guideline
D.12.1 – Absolute measures of both efficacy and harm are stated for each management option where evidence is available, e.g. expressed as number needed to treat (NNT), number needed to screen (NNS), or number needed to harm (NNH) as relevant to the recommendation	Yes	Guideline
D.13.1 – Ethical issues are considered when formulating the recommendations and any such issues identified and described	Yes	Guideline
D.16 – If evidence for complementary and alternative medicine options is identified, the risks and benefits of these are stated in the guideline text and appropriate recommendations included.	Yes	Guideline
D.17 – If there is a lack of rigorous evidence for a complementary and alternative medicine/therapy commonly used in practice, this is explicitly stated in the guideline text.	Yes	Guideline
D.18 – Recommendations that consider consumer self-management options are included, where relevant	Yes	Guideline
D.19 – Recommendations emphasise consumer and carer involvement in treatment and care decisions, where relevant.	Yes	Guideline

Part E – Guideline structure and style

Mandatory requirement	Fulfilled	Location
E.1 – The guideline includes a title page listing: (a) the date of publication; (b) the authorship (organization or individuals); (c) the publisher; (d) copyright information including the copyright holder; (e) address for requesting permission to reproduce material in text; (f) the ISBN number; (g) a preferred citation for the guideline publication.	Yes	Guideline
E.2 – The guideline is easy to navigate and includes a table of contents	Yes	Guideline
E.3 – The guideline includes a brief (e.g. 1-page) plain English summary	Yes	Guideline[7]
E.4 – The guideline includes an executive summary that lists all recommendations and their grade using an NHMRC-approved method (NHMRC grades for recommendations or GRADE)	Yes	Guideline
E.5 – A glossary of technical terms, acronyms and abbreviations is provided, and terms are used consistently throughout the guideline	Yes	Guideline
E.6 – Where medicines are mentioned in the guideline, generic names are used and brand names are avoided	Yes	Guideline
E.7 – The document design and layout enables recommendations to be identified easily within text	Yes	Guideline
E.8 – References in the text are clearly identified and the citations clearly listed. For electronic references, the source location (e.g. website address) and date accessed is stated	Yes	Guideline
E.9 – Chapter and heading levels are consistent, clearly distinguishable by the document design and layout, and assist with the navigation throughout each topic of the guideline	Yes	Guideline
E.10 – The guideline information is sequenced in a logical manner which is applicable to the intended end user	Yes	Guideline
E.11 – The technical report is either (i) included in the guideline document, or (ii) provided in a readily accessible location, such as a website, which is indicated in the guideline	Yes	Guideline
E.12 – The administrative report is either (i) included in the guideline document, or (ii) provided in a readily accessible location, such as a website, which is indicated in the guideline.	Yes	Guideline
Desirable requirement	**Fulfilled**	**Location**
E.2.1 – An index is included	Yes	Guideline
E.2.2 – If the guideline is published in PDF format, bookmarks are provided to facilitate navigation	Yes	Guideline
E.2.3 – If the guideline is published as a webpage, hyperlinks are provided to facilitate navigation	Yes	Guideline
E.3.1 – Plain English is used for all guideline text	Yes	Guideline
E.4.1 – A summary of recommendations is available as a separate document, and the guideline text states where to obtain this document	Yes	Guideline
E.7.1 – The design of the guideline (printed or electronic) is suitable for people with visual impairment	Yes	Guideline

[7] See "Introduction" on guideline at MAGICapp website

Part F – Public Consultation

Mandatory requirement	Fulfilled	Location
F.1 – The process for public consultation on the draft guideline complies with Section 14A of the Commonwealth National Health and Medical Research Council Act 1992 and accompanying regulations	Yes	Guideline
F.2 – Details of submissions received during public consultation and the response of the guideline development working group to the submissions (including whether, why and how the guideline was altered) are provided as a separate document to the NHMRC.	Yes	Guideline
F.3 – During the public consultation period, the developer has undertaken and documented consultation with (i) the Director-General, Chief Executive or Secretary of each state, territory and Commonwealth health department; (ii) relevant authority/ies, when a guideline makes any recommendation/s specifying interventions that are not available or restricted in Australia (see Requirement D.10)	N/A	-
F.4 – The developer has identified and consulted with key professional organisations (such as specialty colleges) and consumer organisations that will be involved in, or affected by, the implementation of the clinical recommendations of the guideline	Yes	Guideline
Desirable requirement	**Fulfilled**	**Location**
F.2.1 – A version of the public consultation submission summary is publicly available, with submissions de-identified	Yes	Guideline (Appendix)

Part G – Dissemination and implementation of guidelines

Mandatory requirement	Fulfilled	Doc/pub in
G.1 – A plan for the dissemination of the guideline is submitted as a separate document from the clinical practice guideline	Yes	Dissemination plan (in TR)
G.2 – Key recommendations that are most likely to lead to improvements in health outcomes are highlighted for consideration in implementation	Yes	Dissemination plan (in TR)
Desirable requirement	**Fulfilled**	**Location**
G.3 – A practical implementation plan is provided as a separate document, based on considerations of the Australian health care context and identification of appropriate organization/s where the key recommendations may be directed	No	Under development
G.4 – Resources to support implementation of the guidelines are developed, such as summaries and other tools for different health care professionals, and the guideline indicates where these can be obtained	Yes	Flowcharts
G.5 – Accompanying consumer information is provided	No	-
G.6 – Versions of the plain English summary and consumer information are available in different languages, if appropriate	No	-
G.7 – Suggestions for local adaptation and adoption of the guideline are provided	No	-
G.8 – Measures are developed for determining the extent to which key guideline recommendations are implemented	Yes	TR
G.9 – An evaluation strategy is developed and described to assess the extent to which guideline recommendations are adopted into routine practice	Yes	TR