Using the ACCORD guideline to report consensus research

What medical writers need to know
Disclosure

William T. Gattrell is an employee of Bristol Myers Squibb

Patricia Logullo is a member of the UK EQUATOR Centre, based in the University of Oxford; EQUATOR promotes the use of reporting guidelines, many of which are developed using consensus methods, and she is personally involved in the development of other reporting guidelines

Niall Harrison is an employee of OPEN Health Communications

Tim Warren is an employee of Triducive Partners Limited

At the outset of the work, Niall Harrison was an employee of Ogilvy Health UK and William Gattrell was an employee of Ipsen
Introduction

Niall Harrison
Today’s objectives

- Understand the value of reporting guidelines for medical writers
- Be aware of the variety of consensus methods available
- Learn how ACCORD can support the reporting of studies using consensus methods
# Agenda

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<tr>
<th>Timing</th>
<th>Topic</th>
<th>Speaker</th>
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<tbody>
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<td>10 minutes</td>
<td>Introduction</td>
<td>Niall Harrison</td>
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<td>Patricia Logullo</td>
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<td>Panel and Q&amp;A</td>
<td>All</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Summary and close</td>
<td>William Gattrell</td>
</tr>
</tbody>
</table>
ACCORD steering committee

Will Gattrell
Bristol Myers Squibb

Niall Harrison
OPEN Health

Patricia Logullo
University of Oxford and EQUATOR

Esther J. van Zuuren
Leiden University Medical Centre

Amy Price
Stanford School of Medicine Patient Editor, BMJ

Paul Blazey
University of British Columbia, Vancouver, Canada

Christopher C. Winchester
Oxford PharmaGenesis

David Tovey
Journal of Clinical Epidemiology

Keith Goldman
AbbVie

Amrit Pali Hungin
University of Newcastle

Ellen L. Hughes
Camina Communications
Poll

1. How confident are you in using reporting guidelines?

2. How experienced are you with studies using consensus methods?
How reporting guidelines help medical writers

William Gattrell
Early example of a controlled trial

“One on the 20th of May 1747, I selected twelve patients in the scurvy, on board the Salisbury at sea. Their cases were as similar as I could have them. They all in general had putrid gums, the spots and lassitude, with weakness of the knees...

Two were ordered each a quart of cyder a day. Two others took twenty-five drops of elixir vitriol three times a day ... Two others took two spoonfuls of vinegar three times a day ... Two of the worst patients were put on a course of sea-water ... Two others had each two oranges and one lemon given them every day...

The consequence was, that the most sudden and visible good effects were perceived from the use of oranges and lemons”

Treatise on Scurvy. James Lind, 1753
Poor reporting in scientific publications

“... incompleteness of evidence is not merely a failure to satisfy a few highly critical readers. It not infrequently makes the data that are presented of little or no value.”

“We believe there is a need to improve the reporting on Delphi studies, along the lines of a CONSORT-like guideline, as is used for randomized controlled trials.”

“In one in three published clinical trials on covid-19 drugs, the quality of reporting of adverse events was low or very low.”

What is a reporting guideline?

A reporting guideline provides the minimum list of information needed to ensure a manuscript can be:

- Understood by the reader
- Replicated by a researcher
- Used by a healthcare professional to help make a clinical decision
- Included in a systematic review and/or meta analysis.
A note of caution

A reporting guideline is not a tool to measure the quality of reporting\(^1\)

Reporting guidelines do not provide guidance on study design

A well-\textit{reported} study may not be a well-\textit{designed} study

Evolution of reporting guidelines

Early attempts at reporting guidelines for RCTs, with limited impact.1,2


CONSORT 1996
Not free to read!

MOOSE
STARD
CONSORT 2001

36 CONSORT extensions
CONSORT 2022 update

Numerous reporting guidelines on EQUATOR


Asilomar & SORT3,4 guidelines for RCTs, developed independently

QUORUM (replaced by PRISMA)
Major reporting guidelines often provide additional resources

### CONSORT 2010 checklist of information to include when reporting a randomised trial

<table>
<thead>
<tr>
<th>Section/Topic</th>
<th>Item No.</th>
<th>Checklist item</th>
<th>Reported on page no.</th>
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<tbody>
<tr>
<td>Title and abstract</td>
<td>1a</td>
<td>Identification as a randomised trial in the title</td>
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<tr>
<td></td>
<td>1b</td>
<td>Structured summary of trial design, methods, results, and conclusions as specific guidance was CONSORT for abstracts</td>
<td></td>
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<tr>
<td>Introduction</td>
<td>2a</td>
<td>Scientific background and explanation of rationale</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2b</td>
<td>Specific objectives or hypotheses</td>
<td></td>
</tr>
<tr>
<td>Methods</td>
<td>3a</td>
<td>Description of trial design (such as parallel, factorial) including allocation ratio</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3b</td>
<td>Important changes to methods after trial commencement (such as eligibility criteria), with reasons</td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>4a</td>
<td>Eligibility criteria for participants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4b</td>
<td>Settings and locations where the data were collected</td>
<td></td>
</tr>
<tr>
<td>Interventions</td>
<td>5</td>
<td>The interventions for each group with sufficient details to allow replication, including how and when they were administered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5a</td>
<td>The interventions for each group with sufficient details to allow replication, including how and when they were administered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5b</td>
<td>Any changes to trial outcomes after the trial commenced, with reasons</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5c</td>
<td>How sample size was determined</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5d</td>
<td>Sample size</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5e</td>
<td>When applicable, explanation of any interim analyses and stopping guidelines</td>
<td></td>
</tr>
<tr>
<td>Randomisation</td>
<td>6a</td>
<td>Method used to generate the randomisation sequence</td>
<td></td>
</tr>
<tr>
<td>Sequence</td>
<td>6b</td>
<td>Type of randomisation; details of any restriction (such as blocking and block size)</td>
<td></td>
</tr>
<tr>
<td>Allocation</td>
<td>6c</td>
<td>Mechanism used to implement the randomisation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6d</td>
<td>Allocation concealment mechanisms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6e</td>
<td>Who generated the randomisation sequence, who enrolled participants, and who assigned participants to interventions</td>
<td></td>
</tr>
<tr>
<td>Blinding</td>
<td>10</td>
<td>If done, who were blinded after assignment to interventions (for example, participants, care providers, those who collected data)</td>
<td></td>
</tr>
</tbody>
</table>

**Methods**

**Item 3a. Description of trial design (such as parallel, factorial) including allocation ratio**

**Example**—“This was a multicenter, stratified (6 to 11 years and 12 to 17 years of age, with imbalanced randomisation [2:1]), double-blind, placebo-controlled, parallel-group study conducted in the United States (41 sites).”

**Explanation**—The word “design” is often used to refer to all aspects of how a trial is set up, but it also has a narrower interpretation. Many specific aspects of the broader trial design, including details of randomisation and blinding, are addressed elsewhere in the CONSORT checklist. Here we seek information on the type of trial, such as parallel group or factorial, and the conceptual framework, such as superiority or non-inferiority, and other related issues not addressed elsewhere in the checklist.

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Summary

- Reporting guidelines are available for most study types
- Using them will improve the quality of reporting in your manuscript
- Often, supporting materials are available:
  - Explanation & Elaboration document
  - Downloadable templates
  - Translations
- See EQUATOR Network: https://www.equator-network.org/
An overview of consensus methods

Tim Warren
Better decisions, actioned...
...the benefit of Consensus
What does a Medical Team do?
Links scientific and clinical results to patient outcomes...

Insights gained improve return on investment and create a strong competitive edge...

Gathers feedback on the product’s market potential and patient need from the earliest stages of its development...

Adds value during a product’s development and lifecycle...

But is there … should there be more?
US and EU Physicians Rate Patient Outcomes and Real-World evidence as the Key Prescribing Criteria

...on a par with the product’s safety profile!

Percentage of nonsurgical physicians rating criteria as important or very important

- **Patient outcomes**: 84% (US) vs 81% (EU)
- **Real-world evidence**: 88% (US) vs 83% (EU)
- **Safety profile**: 89% (US) vs 88% (EU)

Source: Bain Europe Front Line of Healthcare Survey, 2016
Opinion

- Systematic reviews of randomised controlled trials (RCTs)
- Non-analytical studies, e.g. case reports, case series
- QoL studies
- Time in motion studies
- Real-world data, audits and registries
- Health economic models
- Retrospective studies
- Guidelines
- Patient stories
- HTA guidance
- High quality systematic reviews
- Systematic reviews of randomised controlled trials (RCTs)
- Well conducted case control or cohort studies
- High quality meta-analysis
- Health policy
A genuine leader is not a searcher for consensus, but a moulder of consensus.

Martin Luther King, Jr.
A simple *PubMed* search (using MeSH terms) demonstrated the number of published RCT studies versus consensus studies in 2021\(^1\).
Consensus decision-making is a process that builds trust and creates ownership and commitment.

An effective consensus process (consensus-building) is inclusive and engages all participants.

Consensus decisions can lead to better quality outcomes that empower the group or community to move forward to create **their future together**.

Benefits to consensus decision making, https://extension.umn.edu/leadership-development/benefits-consensus-decision-making
ACCORD
Accurate Consensus Reporting Document
“Evidence based on expert opinion remains a necessary component in the armamentarium used to determine the answer to a clinical question”
How to achieve consensus

Meetings

NGT

Delphi

Rigor
## How to achieve consensus

### Meetings
- Easy to organise
- Need to be well run to avoid going off-piste
- Cynicism about why (and who) made decisions
- Confidential in nature limiting impact of decisions reached
- Round tables may be published

### Ad Board
- Require organisation and compliance
- More specificity
- Potential skepticism about bias and outputs achieved

### NGT
- Require organisation and compliance (similar to ad board)
- Create a higher-quality decision than a vote decision or a decision by a single individual
- Enables a group to take advantage of all members' ideas
- Structured, specific and inclusive

### Delphi
- Require independent facilitator
- Do not involve a Chairperson and mitigate dominance
- Inclusive and engages all participants
- Allows for testing, learning and iteration
- Confidence in outputs because clarity as to HOW/WHY they were included

### Limited external impact
- Often confidential
- Can be published
- Can be published

### Empowers the group or community to move forward to create their future together
The Nominal Group Technique (NGT) was initially conceived by Andrew H. Van de Ven and Andrew L. Delbecq in their 1975 book *Group techniques for program planning: A guide to nominal group and Delphi processes*.

The Nominal Group Technique (NGT) is a brainstorming framework that encourages equal contribution from stakeholders and facilitates group consensus on key issues, problems, and their solutions.
The Nominal Group Technique (NGT)

1. Generation of ideas
2. Round-robin recording of ideas
3. Group discussion of ideas
4. Group ranking of ideas
5. Tallying of ranking with group
6. Review of ranking/plan for output

Clarity
Confusion
Originating in the US
Systematic and iterative
Aggregate opinions from diverse experts
Preserves anonymity

Many treatment or management guidelines have been developed using the Delphi method.
Delphi consensus is robust, credible & widely accepted

Delphi consensus is a recognised approach already applied regularly to healthcare situations

“Addresses complex healthcare issues where research based evidence is incomplete or unobtainable”

International Journal of Pharmacy Practice

BSG consensus guidelines on the management of Inflammatory Bowel Disease in adults

September 2019

Consensus guidelines for managing the airway in patients with COVID-19

March 2021
Delphi consensus is well recognised and credible

Key features of the Delphi method:
- Structured information flow
- Role of the independent facilitator
- Anonymity of the participants
- Regular and structured feedback
- Peer-review acceptance
Delphi consensus approach

Insightful, iterative, interactive & amplifying approach

1. Scoping meeting / literature review
   - Clearly define the problem (& goal)

2. First steering group meeting
   - Engage experts & develop statements

3. Online Delphi survey
   - Test & amplify with peers (participants)

4. Further steering group meeting
   - Experts analyse results & provide recommendations

5. Core manuscript & associated comms
   - Communicate and support to drive change

Revision of statements (further rounds of testing, if required)
Delphi consensus anticipated benefits

Validated outputs from Delphi consensus studies can be readily developed into a wider communication campaign and support the objective

What can be achieved

✓ Data (Evidence Level 4) to robustly support the core argument
✓ Content for medical education, communication & campaigning via PR activities
✓ Credible basis & strong platform to mobilise advocacy in support of behaviour change needed
The types of opportunities for this approach are:

- Establishing a focus on unmet clinical needs
- Stimulating and supporting optimal healthcare practice
- Supporting new/updated healthcare policy
- Defining patient cohorts

- Identifying risk factors of disease
- Identifying barriers to access
- Developing pathways
- Understanding future research needs

- Developing expert guidelines
- Understanding and mobilising medical advocacy
- Establishing new practice
- Exploring practical applications to evidence-based medicine

Case studies at triducive.com
Delphi is a robust, powerful & applicable communication & research approach

It is not suitable in all healthcare situations, but any situation requiring...

- Better understanding
- Better decisions
- Better relationships
- Better actions

...must be assessed so that the feasibility for Delphi communications can be expertly explored.
Better decisions, actioned...
...the benefit of Consensus
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<td>William Gattrell</td>
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The development and structure of the ACCORD checklist

Niall Harrison
Background: why ACCORD?

A comprehensive reporting tool is needed because numerous methods are used to assess consensus.

How it started

Guidelines for reporting of a consensus?

Niall Harrison
02-05-2021 11:21
Hi all... has anyone ever come across generalized guidance i.e. a checklist for writing up and report a...

1. Guidelines for reporting of a consensus?

Posted 02-05-2021 11:21
Hi all — has anyone ever come across generalized guidelines on the difference between “consensus”. Internet therapy area-specific guidelines, but nothing general.

I don’t think this exists, and I think the reason it implies certain requirements for the resulting paper

So any suggestions?

Niall Harrison

Quality assessment of guidelines/recommendations developed using Delphi methodology

William T. Gottschall, Sarah J. Clements, Danielle Sheard

Spence Biopharma Ltd, Abingdon, UK; Oxford Brookes University, Oxford, UK; Costello Medical, Cambridge, UK

OBJECTIVE

To assess the quality of the methodology and transparency of reporting of published guidelines/recommendations developed using the Delphi methodology.

BACKGROUND

The Delphi is increasingly used in health and medicine to develop shared understanding definitions and recommendations. 1

The Delphi is a sequential, iterative process of knowledge development, which involves soliciting feedback from experts to refine the existing consensus until consensus is reached. 2

This paper describes a validated methodology for developing consensus guidelines and recommendations developed using the Delphi method. We assessed the quality and transparency of reporting in the publication.

METHODS

A Medline search for “Delphi consensus” was conducted on 15 March 2021, and studied the study identified from 15 April 2021.

All relevant studies were screened according to a pre-defined criteria (Table 1). 3

A full protocol methodology was developed based on relevant publication recommendations. 4

The Delphi method was used to develop consensus guidelines and recommendations for the treatment of mild to severe depression in adult patients, and NASEM, a working checklist for clinical consensus guideline developed. 5

1 Consensus was used to assess the methodological quality and transparency of reporting in the existing guidelines.

Box 1

What is the Delphi method?

The Delphi method is a process in which a group of experts reach a consensus through a series of structured interactions. Each participant is asked to provide their opinions and feedback in writing, and this feedback is then compiled and summarized before being shared with the group for further discussion. This process is repeated until a consensus is reached.

Figure 1: Potential modifications to the key features of classical Delphi

Figure 2: Examples of consensus guidelines
The objective of ACCORD

• Develop a **reporting** guideline relevant for ...

All types of consensus methods

All areas of health research

Researchers anywhere in the world
Project overview and timeline: protocol

2021
- EQUATOR and OSF registration
- SC invitations
- Protocol development
- Protocol published

2022

2023

Project overview and timeline: SLR

2021
- EQUATOR and OSF registration
- SC invitations
- Protocol development

2022
- Protocol published
- SLR

2023
- SLR published

Project overview and timeline: checklist

2021
- EQUATOR and OSF registration
- SC invitations
- Protocol development

2022
- Protocol published¹
- SLR
- SLR published²
- Ethics approval
- SC surveys
- Draft checklist
- Delphi invites

2023
- Delphi surveys
- Final checklist
Project overview and timeline: publication

2021
- EQUATOR and OSF registration
- SC invitations
- Protocol development
- Protocol published

2022
- SLR
- SC surveys
- Draft checklist
- Delphi invites
- Delphi surveys
- Final checklist
- Guideline submitted

2023
- Guideline preprint
- Pilot study
- Drafting E&E
# Self-identified Delphi panel demographics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Round 1 (n=58) 21 October–4 November 2022</th>
<th>Round 2 (n=54) 21 December 2022–16 January 2023</th>
<th>Round 3 (n=51) 10–27 Feb 2023</th>
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</thead>
<tbody>
<tr>
<td>Gender, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>31 (53.4)</td>
<td>28 (51.9)</td>
<td>28 (54.9)</td>
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<tr>
<td>Male</td>
<td>27 (46.6)</td>
<td>25 (46.3)</td>
<td>22 (43.1)</td>
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<tr>
<td>Non-binary</td>
<td>0</td>
<td>1 (1.9)</td>
<td>0</td>
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<tr>
<td>Prefer not to say</td>
<td>0</td>
<td>0</td>
<td>1 (2.0)</td>
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<tr>
<td>Geographic location of current primary residence and work, n (%)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td>3 (5.2)</td>
<td>3 (5.6)</td>
<td>2 (3.9)</td>
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<tr>
<td>Asia</td>
<td>4 (6.9)</td>
<td>4 (7.4)</td>
<td>4 (7.8)</td>
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<tr>
<td>Europe</td>
<td>31 (53.4)</td>
<td>28 (51.9)</td>
<td>26 (51.0)</td>
</tr>
<tr>
<td>North America</td>
<td>16 (27.6)</td>
<td>15 (27.8)</td>
<td>15 (29.4)</td>
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<tr>
<td>Oceania</td>
<td>1 (1.7)</td>
<td>1 (1.9)</td>
<td>1 (2.0)</td>
</tr>
<tr>
<td>South America</td>
<td>3 (5.2)</td>
<td>3 (5.6)</td>
<td>3 (5.9)</td>
</tr>
<tr>
<td>Background*, n (%)</td>
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<td></td>
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<tr>
<td>Clinician</td>
<td>16 (27.6)</td>
<td>14 (25.9)</td>
<td>13 (25.5)</td>
</tr>
<tr>
<td>Journal editor</td>
<td>8 (13.8)</td>
<td>6 (11.1)</td>
<td>8 (15.7)</td>
</tr>
<tr>
<td>Patient partner†</td>
<td>6 (10.3)</td>
<td>6 (11.1)</td>
<td>5 (9.8)</td>
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<tr>
<td>Policymaker</td>
<td>3 (5.2)</td>
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<td>Publications professional</td>
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<td>Researcher</td>
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<td>24 (47.1)</td>
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<tr>
<td>Other‡</td>
<td>11 (19)</td>
<td>6 (11.1)</td>
<td>8 (15.7)</td>
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## Addressing gaps identified by the SLR

<table>
<thead>
<tr>
<th>Panel composition</th>
<th>Definition of consensus</th>
<th>Roles and responsibilities</th>
<th>Conflicts of interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>M3. Explain the criteria for panellist inclusion and the rationale for panellist numbers. State who was responsible for panellist selection.</td>
<td>M12. State the definition of consensus (for example, number, percentage, or categorical rating, such as ‘agree’ or ‘strongly agree’) and explain the rationale for that definition.</td>
<td>M2. Describe the role(s) and areas of expertise or experience of those directing the consensus exercise.</td>
<td>O1. List any endorsing organisations involved and their role.</td>
</tr>
<tr>
<td>M4. Describe the recruitment process (how panellists were invited to participate).</td>
<td>R4. Report the final outcome of the consensus process as qualitative (for example, aggregated themes from comments) and/or quantitative (for example, summary statistics, score means, medians and/or ranges) data.</td>
<td>M5. Describe the role of any members of the public, patients or carers in the different steps of the study.</td>
<td>O2. State any potential conflicts of interests, including among those directing the consensus study and panellists. Describe how conflicts of interest were managed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M19. State if the steering committee was involved in the decisions made by the consensus panel.</td>
<td>O3. State any funding received and the role of the funder.</td>
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# Comparison with other checklists

<table>
<thead>
<tr>
<th></th>
<th>Title/abstract</th>
<th>Introduction</th>
<th>Methods</th>
<th>Results</th>
<th>Discussion</th>
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<td>3</td>
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<td>PRISMA</td>
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<td>2</td>
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<td>11</td>
<td>4</td>
<td>6</td>
<td>43</td>
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<td>STROBE</td>
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<td>2</td>
<td>9</td>
<td>5</td>
<td>4</td>
<td>1</td>
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</table>
Summary

• ACCORD is the first reporting guideline applicable to all consensus-based studies

• ACCORD provides authors with a tool to improve the completeness and transparency of reporting consensus exercise

• Reporting consensus studies with greater clarity and transparency may enhance trust in the recommendations made by consensus panels
Examples of good consensus reporting

Patricia Logullo
Exercise!

Forensics of a reporting guideline checklist
How to make sure a paper is adhering — complete
M3. Explain the criteria for panellist inclusion and the rationale for panellist numbers. State who was responsible for panellist selection.
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S1 Table: Noteworthy changes in ARRIVE 2.0, compared to the original ARRIVE guidelines published in 2010

<table>
<thead>
<tr>
<th>ARRIVE 2.0</th>
<th>Original ARRIVE</th>
<th>Reason for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Items</td>
<td>All Items</td>
<td>We reordered items and split them in two sets based on their importance to assess the reliability of the study. There is no ranking within each set, items are ordered logically.</td>
</tr>
</tbody>
</table>

| ARRIVE Essential 10                                                                 |
|-----------------------------------------|-----------------|-------------------------------------------------|
| Item 1 – Study design                   | Item 6 – Study design | We removed the reference to steps taken to minimise the effects of bias (formerly subitem 6b). All information about randomisation is now in item 4 and all information about blinding is now in item 5. |
| Item 2 – Sample size                    | Item 10 – Sample size | We clarified that the number of experimental units might be different from the number of animals. Independent replications are now mentioned with the results (item 10) to prevent any confusion with biological replicates. |
| Item 3 – Inclusion and exclusion criteria | Item 15 – Numbers analysed | We added a new subitem on *a priori* inclusion and exclusion criteria, evidence shows that ad hoc exclusion of data can lead to false positive results [1]. We clarified that the N number in each analysis might be different from the number of animals. We renamed the item to better reflect content. |
| Item 4 – Randomisation                  | Item 11 – Allocating animals to experimental groups | All references to randomisation were consolidated in this item for clarity. We rewrote the text to include the randomisation procedure which was covered separately in the study design (formerly item 6). We clarified that experimental units are allocated to group, rather than animals. |

*Use Tables and Figures!*  
*Use Supplementary!*
R5. List any items or topics that were modified or removed during the consensus process. Include why and when in the process they were modified or removed.

“Ultimately, four indicative questions were excluded due to being answered by past research. The questions pertained to (1) what interventions are most effective for reducing post-traumatic symptoms among survivors of sexual violence/abuse, (2) the relationship between experiencing sexual violence/abuse and having addiction issues, (3) whether exposure to sexual violence/abuse leads to short-term and/or long-term mental health problems other than PTSD, and (4) the relationship between experiencing sexual violence/abuse and having eating disorders and/or obesity. (...) Before rankings were finalised, a vote was conducted to merge two thematically related questions concerning how physical healthcare and mental health services could become more ‘trauma informed’ (see questions ranked as ‘7’ in online supplemental material 3).”
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Discussion

All
Summary and close

William Gattrell
Today’s conclusions

- Reporting guidelines provide a minimum list of information needed to ensure a study can be understood, replicated, and used.

- A range of consensus methods, including more and less rigorous approaches, are used to support healthcare decision-making.

- ACCORD is the first reporting guideline applicable to all types of consensus methods, and can be used in combination with other reporting tools.