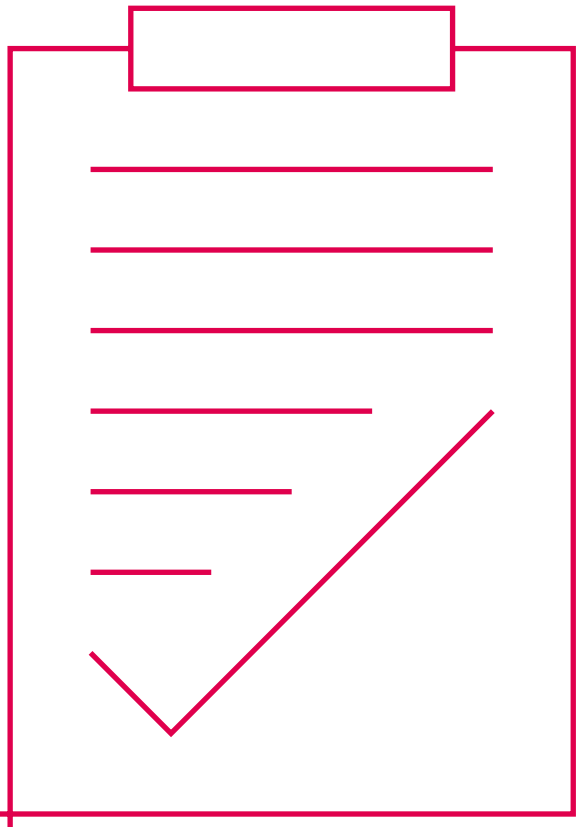
Academy of Medical Royal Colleges

April 2017

College Guidelines

What are the key success factors for their development and implementation?



Contents

Executive summary

The medical royal colleges and faculties invest considerable time and resources into the development of clinical guidelines. Therefore taking steps to understand what factors can improve their ultimate implementation and acceptance is essential. This short paper shares the key findings from a study involving all the medical royal colleges, faculties and a number of NHS Trusts. It seeks to describe the factors that have emerged as significant in improving best practice in guideline development and dissemination.

A number of factors have emerged, which, when acted on, should enhance the quality and take-up of college and faculty clinical guidelines. Eight key actions have been identified. The first four relate to the development of guidance and the latter four to its implementation:

1. Select topics mindfully
2. Follow common standards
3. Use a common format and style
4. Allow for local clinical judgement
5. Communicate effectively
6. Evaluate implementation
7. Measure success against outcomes
8. Link college/faculty functions effectively

Introduction

The Academy, together with the medical royal colleges and faculties, other healthcare institutions, the NHS and its Arm's Length Bodies issues guidance to their members and healthcare staff more generally on a regular basis. The guidance covers an extensive range of topics from commissioning secondary care in England to iron deficiency anaemia.

The production of clinical guidance documents is a major activity of all the medical royal colleges and faculties, although those that are smaller tend not to develop their own but rather work in collaboration with other organisations including the National Institute for Health and Care Excellence (NICE).

The National Guideline Centre (NGC), hosted by the Royal College of Physicians and the National Guideline Alliance (NGA) at the Royal College of Obstetricians and Gynaecologists consists of a multidisciplinary health research team funded by NICE. Both the NGC and NGA are overseen by a governance partnership between medical royal colleges, faculties and stakeholder organisations relevant to the topics and specialties the respective centres are responsible for.

The NGC and NGA are commissioned to develop NICE guidelines. NICE guidelines provide care standards within the NHS in England and Wales for healthcare professionals, patients and their carers on the prevention, treatment and care of people with specific diseases and conditions. The NGC specialises in guidance for acute and chronic conditions and delivers a large work programme covering a wide variety of clinical and service delivery topics. The NGA specialises in guidelines for cancer, mental health and women's and children's health, developing 15 guidelines at any one time.

While an abundance of guidance documentation exists, how individual documents are received by their intended audience and what elements improve the likelihood of uptake or implementation is little understood and poorly documented. It is recognised that this is a crowded landscape given the number of organisations producing guidance documentation often aimed at the same healthcare staff.

This project sought to identify which factors are important to improving the overall effective implementation of guidance documents produced by the medical royal colleges. Broughton and Rathbone[1] considered what makes a good clinical guideline and concluded that good guidelines can change clinical practice and influence patient outcomes, but the way they are developed, implemented and monitored, influences the likelihood that they will be followed.

A survey was conducted of all the medical royal colleges and faculties to ascertain how they approached the development and dissemination of clinical guidelines. The majority of colleges and faculties participated. Further to this, a number were approached to discuss the topic in more detail and to identify examples of good practice. The Medical Directors of three diverse NHS organisations were also interviewed in order to determine what factors improve the potential for a new clinical guideline document to be adopted into practice.

From an analysis of the information gathered, a number of factors have emerged, which should enhance the quality and take-up of college and faculty clinical guidelines. It should be noted that many examples of existing clinical guidance are considered to be helpful by those who are responsible for leading their implementation at a local level. A summary of the survey results can be found at Appendix 1.

Developing college guidance

Select guidance topics mindfully

Guidance topics are selected in various ways, from identifying gaps in the availability of guidance on a subject, identifying the need for an update (many review publications every three years), suggestions from college members, and changes in government policy. Most frequently, new topics are identified as a result of the availability of new evidence.

Users of guidance indicated that topical subject areas which speak to clinicians about something they recognise to be true and have experience with on the ground will have more chance of being implemented successfully. This is particularly so for those clinicians who are not highly specialised in the area concerned. The ability to develop guidance that reflects recent developments is also valued. A number of those interviewed reported that the most effective examples of guidance are those which deal with a real problem and have a clear scope such as the Ebola guidance developed jointly with PHE (see Appendix 2, F).

When considering developing new guidelines, the following questions should be considered:

1. *Does this piece of guidance supersede all previous guidance on the topic?*
2. *Is it a good thing to do?*
3. *What are the consequences of not doing it?*

Follow common standards

A number of guideline manuals exist and are accepted and regularly adopted both locally and internationally. They include the accepted international tool, The appraisal of guidelines for reporting and evaluation (AGREE II)[2] , The NICE guidelines manual[3] and the Scottish intercollegiate guidelines network (SIGN 50)[4]. More recently, the Surgical Specialty Associations and the Royal College of Surgeons of England have developed and published their own guidance process manual[5]. This was developed with reference to the NHS Evidence Accreditation Process[6], SIGN 50 Guideline Developer's Handbook, AGREE Criteria and existing NHS evidence accredited clinical guidance and commissioning guidance process manuals.

A comparative review of different approaches to clinical practice guideline development[7] concluded that there was strong agreement between the handbooks on the key elements of an evidence-based process, these can be summarised by the following actions:

- *Establish a development group*
- *Draw on a strong evidence base*
- *Consult with relevant stakeholders and organisations before publication*
- *Develop clear, practical recommendations*
- *Peer review guidance content*
- *Adopt a sign-off process*
- *Review regularly and update.*

The subject of currency and regular review of guidance documents was raised by both medical royal colleges, faculties and users. Users were unclear what standards, if any, colleges and faculties adopted with regard to updating and/or removing guideline documentation. Some reported that they review guidelines on a three-yearly basis and update where necessary. What was unclear was how transparent the approaches are to users of the information, whether using electronic or hard copies. This is an area that needs to be reviewed.

Use a common format and style

The survey indicated that few colleges and faculties have a policy relating to the length of guidance documentation and half of all that is produced runs to between 25 and 50 pages in length. Given that recipients are time-constrained, the key messages and recommendations contained in the guideline document need to jump off the page and engage the reader. This will also help the generalist who is bombarded with new information from all directions and can find it difficult to identify the 'must do's' from the plethora of material they receive. The inclusion of a good Executive Summary is highly valued, as are flow charts, algorithms, diagrams and infographics. The Medical Directors suggested including a list flagging whom the document should be sent to at the front of any new guidelines.

As guidance will make the most difference where it can change practice at a specialist or unit level and lead to quality improvement, it is imperative to produce it with the intended user in mind, whether this is a trainee or consultant doctor or another professional critical to making the change happen.

Often recipients at Trust level cut and paste material into local documentation. Flow charts and diagrams are useful for this purpose and ensure that the original intention is not diluted.

While the majority of colleges and faculties use a guidance template, this is not a standard. Users suggested that a common style/format would aid the scanning and assimilation of the material. While we may be some years away from an agreed common template, the colleges and faculties should work to ensure a more common style by adopting the following points:

- *Focus on the intended audience*
- *Ensure guidance recommendations are easy to carry out, intuitive and in the right order*
- *Write in plain English, clearly and concisely*
- *State what the do's and don'ts are*
- *Engage lay and patient input (but ensure this has no vested interests)*
- *Keep at a high level those aspects which are important for generalists to take note of and action*
- *Use flow charts, algorithms and diagrams where these are helpful*
- *Provide solutions and tools where possible*
- *Clearly state the intended service improvement outcome.*

Allow for local clinical judgement

Guidelines should leave some flexibility to allow for clinical judgement and adaptation to local circumstances. If the material does not provide the flexibility to adapt or has not taken account of implementation across a range of differing environments, then clinicians and Trusts will justify why it cannot be adopted in the local context.

Those with least expertise will stick more rigidly to guidelines[8], whereas experienced clinicians have more confidence in adapting guidelines without losing the principles intended.

Implementing College and faculty guidance

Communicate effectively

Colleges and faculties use a wide range of methods to disseminate guidance documents. From e-mail to social media, websites, on-line communities and clinical networks to newsletters, conferences, events and in some instances via media coverage.

Some colleges and faculties are experimenting with podcasts and webinars, which can make the material more accessible and user-friendly e.g. guidance on the management of domestic violence [See Appendix 2, J].

Consider the role of wider healthcare professionals e.g. nurses, pharmacists, ODPs etc. in implementing guidance recommendations and flag early within the guidance document which healthcare professionals need to have access to it.

Trust Medical Directors receive guidance documentation on almost a daily basis. These arrive from a multitude of sources including the medical royal colleges and faculties. They share the material in a number of ways including:

- *Forward to the appropriate Clinical Director*
- *Flag at clinical management board meetings*
- *Forward to other appropriate clinical professionals e.g. nursing director.*

Evaluate implementation

Evidence suggests that it takes an average of 17 years for research evidence to reach clinical practice.[9,10] Most guidance is focused on amending practice which can save lives, improve the quality of a patient's life, improve patient care and resource utilisation. Therefore, the emphasis of guidance implementation needs to be on how to reduce this timeline.

Evaluating how guidelines are implemented provides those who create guidance with valuable feedback on how the material has been accepted and adopted in practice. This will help to drive continuous improvement in the process, content and style.

A number of colleges and faculties have a regular process for clinical audit in place.

When newly developed guidelines are published and disseminated, there seems to be little evidence that colleges and faculties gather feedback about implementation to measure its success or understand obstacles. The Trust Medical Directors interviewed did not recall having been asked for feedback on guideline documents. If they are asked they would channel any such request to the appropriate Clinical Director who would be able to gather feedback for colleges and faculties to measure the impact of any guidance.

Measure success against outcomes

By starting with the desired outcome in mind, it will be simpler to design into the process how they can be measured. An approach currently in use examines the links in the relationship between publication and subsequent events, activities, processes and practices evolving over time which directly mention the guideline material.

As Big Data becomes more readily accessible with access to GP records and developments in informatics and IT, there will be greater ease in measuring outcomes. This will simplify the process of ascertaining whether the application of a new guideline led to the desired change in practice and improved patient outcomes.

Link College or faculty functions effectively

Some of the colleges and faculties interviewed reported that their Examinations Department rarely set questions relating to new guidelines that they had issued, suggesting that there was a low level of communication and collaboration between the two functions within the college. Colleges and faculties should make an effort to include aspects of new guidance in exams in the future in order to:

— *Demonstrate that guidelines and the implementation of them are important.*
— *Ensure that trainee doctors have the incentive to become familiar with new guidance issued by their College or faculty.*

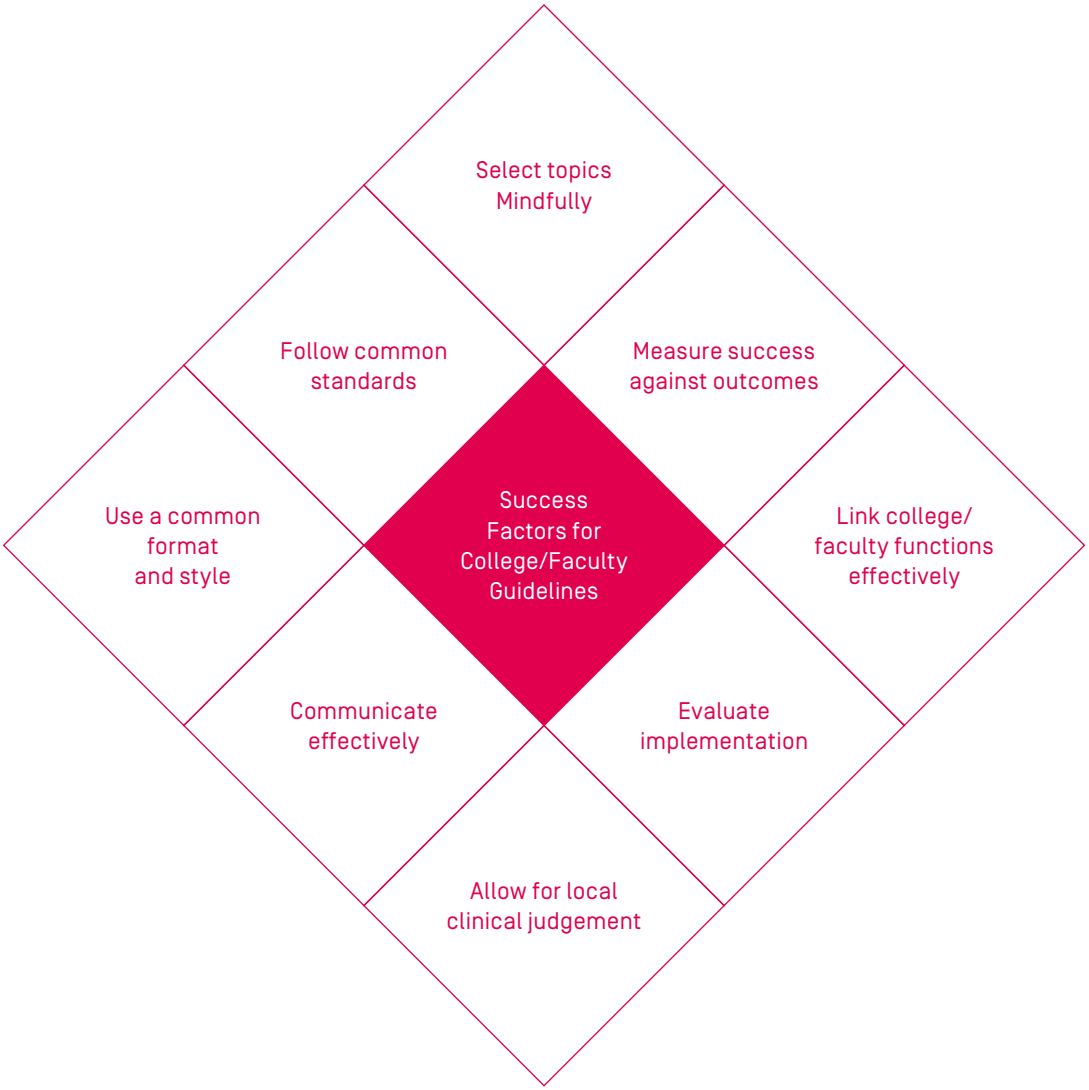
Conclusions

Figure 1 illustrates the eight key actions identified as those to consider in order to improve the quality and successful implementation of College and faculty guidelines.

It is hoped that the findings published here will be helpful to the medical royal colleges and faculties in the development and implementation of guidelines as it provides baseline data of current practice.

The medical royal colleges and faculties are all at different stages in developing their approaches to producing guidance. However, a more consistent and common approach would be welcomed by NHS organisations as they seek to implement the guidelines and improve practice.

Figure 1. Eight key actions to consider when making guidance



Appendix 1

What makes guidance effective? Survey responses

1. On average, how many guidance documents does the College produce and issue each year?

None	0%
1 - 5	36%
6 - 10	21%
More than 10	43%
	n=14

2. How are the topics for a guidance document chosen?

	Never	Sometimes	Frequently
College member's suggestion	0%	71%	29%
Availability of new evidence	0%	21%	79%
Change of government policy	14%	57%	29%
			n=14

3. Is there a clear governance process for agreeing the selection of topics?

No	7%
Partial	43%
Comprehensive	50%
	n=14

4. Thinking of the development and production of College guidance documentation, do you follow specific standards for guideline development methodology (e.g. AGREE II, SIGN 50 etc.)?

Yes	69%
No	31%
	n=13

5. Who is involved in the development of College guidance?

Thematic analysis of the responses received showed that the following groups are mainly involved developing college guidance:

- *Faculty members*
- *Stakeholders*
- *Lay representatives*
- *Other College reps*
- *College President*
- *Quality manager*
- *Policy Manager*
- *College sub-committees or Boards*
- *Other medical colleges*
- *Multi-professional colleagues*
- *Patients*
- *Carers*

n=14

6. Is the content subject to peer review?

Never	0%
Sometimes	0%
Frequently	36%
Always	64%
	n=14

7. Are completed guidance documents subject to a sign-off process within the College?

Never	0%
Sometimes	0%
Frequently	14%
Always	86%
	n=14

8. What types of guidance documentation does the College produce?

	Never	Sometimes	Frequently
Clinical	7%	36%	57%
Policy	7%	72%	21%
Operational	0%	79%	21%
			n=14

9. What status does College guidance have?

	Never	Sometimes	Frequently	Always
Mandatory	38%	54%	0%	8%
Advisory	0%	7%	22%	71%
				n=14

10. Does the College use a specific style template for guidance documentation?

Never	14%
Sometimes	22%
Frequently	21%
Always	43%
	n=14

11. Thinking of the last two years, what is the average length of each of your College guidance documents?

Less than 5 pages	0%
5 - 10 pages	17%
10 - 25 pages	33%
25 - 50 pages	50%
More than 50 pages	0%
	n=12

12. Does the College have a policy relating to the length of guidance documents?

No	86%
Yes	14%
	n=14

13. Do you produce College guidance in a variety of formats?

	No	Yes
Hard copy	29%	71%
Electronic	0%	100%
Web-based	21%	79%
		n=14

14. What methods does the college use to disseminate new guidance documents?

	No	Yes
College Website	0%	100%
Email to College members	7%	93%
Social media	7%	93%
		n=14

15. How does the College generate local buy-in and endorsement (e.g. within NHS Trusts)?

A number of methods were indicated including:

- *Through Fellows and Members*
- *Involvement of clinicians, lay members and other relevant organisations in the development of guidance*
- *Through Clinical Directors and Medical Directors*
- *Launch conferences and events.*
- *Training/education*
- *National audits to ensure departments are using the standards/guidelines.*
- *Through commissioning (i.e. the Service Specification).*
- *Accreditation scheme based on the recommendations in the Guidelines for Provision of Anaesthetic Services (GPAS).*

n=11

16. Does the College undertake monitoring of the uptake as a result of releasing guidance documentation?

Never	23%
Sometimes	62%
Frequently	15%
Always	0%
	n=13

17. Does the College evaluate the impact of each new guidance document?

Never	31%
Sometimes	46%
Frequently	15%
Always	8%
	n=13

18. Does the College request feedback from its membership about each new piece of guidance?

Never	15%
Sometimes	62%
Frequently	15%
Always	8%
	n=13

19. Where the College does request feedback, does it include information about ...

	Never	Sometimes	Frequently	Always
Quality	0%	64%	27%	9%
Content	0%	55%	36%	9%
Ease of use	9%	64%	27%	0%
Change to practice	0%	80%	20%	0%
Change to outcomes	0%	73%	27%	0%
				n=11

20. In your opinion, what has made any individual College guidance particularly successful or unsuccessful?

A wide range of responses were received. Notable comments include:

- *Practical advice for clinicians; providing solutions and tools where possible, clear concise writing style, ensuring consultation with all relevant stakeholders, organisations prior to publication.*
- *Ease of implementation.*
- *Achieves buy in from clinicians*
- *Is not unnecessarily long*
- *Has clear service improvement outcomes*
- *Is achievable*
- *Does not take autonomy away from the clinician*
- *Ability to guide clinical decision making and to reduce variation in practice, whilst empowering the patient to be an agent for change*
- *Address an important question*
- *Are evidence based*
- *Well written (including input from end-users such as patients)*
- *Produce recommendations that are easily understood.*

n=12

Appendix 2

Examples of guidelines mentioned during interviews as examples of good practice

A. Royal College of Physicians Intercollegiate Stroke Working Party (2012) *National Clinical Guideline for Stroke*. www.rcplondon.ac.uk/guidelines-policy/stroke-guidelines [accessed 29 March 2016]

B. NICE Guidelines NG31, 2015 (2015) *Care of dying adults in the last days of life* www.nice.org.uk/guidance/ng31 [accessed 29 March 2016]

C. RCGP (2013) *Social Media Highway Code.* Viewed at www.rcgp.org.uk/social-media [accessed 27 March 2016] This has been widely welcomed as it provides guidance on what you can and shouldn't say and where the boundaries are

D. Royal College of General Practitioners (2015) *TARGET Antibiotics Toolkit*. www.rcgp.org.uk/clinical-and-research/toolkits/target-antibiotics-toolkit.aspx [accessed 29 March 2016] Pen V antimicrobial prescribing - notable example since investment was made into explaining the reasons to patients

E. Royal College of Obstetricians and Gynaecologists (2015) *Female Genital Mutilation and its Management (Green-top Guideline No. 53*). www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf [accessed 29 March 2016]

F. Royal College of Emergency Medicine (2014) *Ebola guidance for emergency departments.* www.rcem.ac.uk/Shop-Floor/Clinical%20Guidelines/College%20Guidelines [accessed 29 March 2016]

G. Royal College of Emergency Medicine (2014) *Crowding in emergency departments.* www.rcem.ac.uk/Shop-Floor/Clinical%20Guidelines/College%20Guidelines [accessed 29 March 2016]

H. Royal College of Pediatrics and Child Health (2013) *Child protection companion.* www.rcpch.ac.uk/improving-child-health/child-protection/about-child-protection-companion/about-child-protection-comp [accessed 29 March 2016]

I. Academy of Medical Royal Colleges (2014) *Promoting Value Report: a doctor's guide to cutting waste in clinical care.* www.aomrc.org.uk/general-news/protecting-resources-promoting-value.html [accessed 29 March 2016]

J. Heart of England Foundation Trust's Emergency Department (2014) *Domestic Violence: An overview of the NICE Guidance.* www.heftemcast.co.uk/domestic-violence-an-overview-of-the-nice-guidelines [accessed 29 March 2016]

Annex A
Examples of College guideline methodologies

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[accessed 29 March 2016]

Royal College of Paediatrics and Child Health (2016) *Setting standards for development of clinical guidelines in paediatrics and child health*
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www.rcr.ac.uk/sites/default/files/docs/general/pdf/Standards_guidance_2010.pdf
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http://www.rcem.ac.uk/RCEM/Quality_Policy/Clinical_Standards_Guidance/RCEM_Guidance/RCEM/Quality-Policy/Clinical_Standards_Guidance/RCEM_Guidance.aspx?hkey=862bd964-0363-4f7f-bdab-89e4a68c9de4
[accessed 30 March 2016]

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Acknowledgements

With thanks to all the medical royal colleges and faculties and in particular to,

Wendy Russell, Academy of Medical Royal Colleges

Donna Kinnair, Royal College of Nursing

Jane Dacre and Rachel Downing, Royal College of Physicians

David Richmond, Royal College of Obstetricians and Gynaecologists

Mike Pringle, Royal College of General Practitioners

Adrian Boyle and Sam McIntyre, Royal College of Emergency Medicine

Callum McInnes, Royal College of Surgeons of Edinburgh

Paul Healy, NHS Confederation

Umesh Prabhu, Wrightington, Wigan and Leigh NHS Foundation Trust

David Throssell, Sheffield Teaching Hospitals NHS Foundation Trust

Tim Ojo, Sussex Partnership NHS Foundation Trust

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