

1 **Practitioners' views on primary care evidence in clinical guidelines: mixed methods study**

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29 **Abstract:**

30 **Background:** Clinical practice guidelines are widely used in primary care, yet are not always based on
31 applicable research.

32 **Aim:** To explore primary care practitioners' views on the applicability to primary care patients of
33 evidence underpinning National Institute for Health and Care Excellence (NICE) guideline
34 recommendations.

35 **Design:** Delphi survey and focus groups.

36 **Method:** Delphi survey of the perceived applicability of 14 guideline recommendations rated before
37 and after a description of their evidence base, followed by two focus groups.

38 **Results:** General practitioners (GPs) significantly reduced scores for their perceived likelihood of
39 pursuing recommendations after finding these were based on studies with low applicability to
40 primary care, but maintained their scores for recommendations based on highly applicable research.
41 GPs reported they were more likely to use guidelines where evidence was applicable to primary care,
42 and less likely if the evidence base came from a secondary care population. Practitioners in the focus
43 groups accepted that guideline developers would use the most relevant evidence available, but
44 wanted clearer signposting of those recommendations particularly relevant for primary care patients.
45 Their main need was for brief, clear, and accessible guidelines.

46 **Conclusion:** Guidelines should specify the extent to which the research evidence underpinning each
47 recommendation is applicable to primary care. The relevance of guideline recommendations to
48 primary care populations could be more explicitly considered at all three stages of guideline
49 development: scoping and evidence synthesis, recommendation development, and publication. The
50 relevant evidence base needs to be presented clearly and concisely and easy to identify way.

51

52 **How this fits in:**

53 Clinical practice guidelines are intended to improve the quality of patient care, but general
54 practitioners do not always follow guidelines. The evidence base for most guidelines is derived from
55 research conducted on secondary care populations in secondary care settings. This study shows that
56 GPs regard the setting of evidence for guidelines as relevant to their use, and are more likely to use
57 guideline recommendations where the evidence is applicable to their population. Clearer description
58 of the applicability of research to primary care patients in a brief accessible guideline format may
59 result in improved implementation in primary care, and help to maintain the currently high levels of
60 trust in NICE guidance.

61

62 **Introduction**

63 Clinical practice guidelines are recommendations intended to improve the quality of patient care
64 and should be based on a systematic review of the current relevant available evidence and an
65 assessment of the benefits and harms of alternative care options (1). Guidelines are seen as one of
66 the key foundations for quality improvement in England and internationally (2), but their impact on
67 clinical practice has been variable (3, 4).

68 GPs do not always follow guidelines (5-8), attributing their decisions to concerns about relevance
69 and feasibility, and that strict exclusion criteria in clinical trials may reduce generalizability to the
70 broader primary care patient population (9-12). Some guidelines have been found to have limited
71 applicability to general practice settings (10, 11, 13, 14). Other identified barriers to guidelines
72 adherence by primary care practitioners include lack of awareness, unfamiliarity, and disagreement
73 with recommendations (13-16), and concern that the increasing use of guidelines as performance
74 measures can distort patient centred clinical practice(17). General practitioners were more likely to
75 follow evidence based guideline recommendations rather than those not based on research
76 evidence, and wanted more transparency about the research base (9, 15, 18). However, barriers and
77 consequent efforts to improve uptake of guidelines may be different in different settings (19).

78 The National Institute for Health and Care Excellence (NICE) is the chief national source of clinical
79 guidance for England and Wales (20). NICE makes considerable efforts to assist primary care
80 practitioners to use relevant evidence for their patients, including web-based guidance for general
81 practice and primary care professionals about keeping abreast of new NICE guidelines, and monthly
82 summaries of guidelines which are particularly relevant for primary care. NICE provides different
83 versions of their guidelines, with the full detailed guideline being clearly differentiated from briefer
84 versions for clinicians, the public and commissioners. More recently, NICE has been responsible for
85 managing the Quality and Outcomes Framework (QOF), a pay for performance scheme for British
86 general practice which takes clinical guidelines as the starting point for the development of clinical
87 indicators (21).

88 We have previously reported that NICE guideline recommendations for primary care were not
89 always based on research conducted on, or generalisable to, primary care populations (22, 23), and
90 in this study we aimed to find out whether that mattered to primary care practitioners. We
91 therefore aimed to explore primary care practitioners' views of the applicability of primary care
92 evidence in NICE guidelines.

93

94 **Methods**

95 There were two main stages, a two-round online Delphi survey of general practitioners (GPs) to test
96 the impact of additional information on practitioner views(24), followed by two focus groups with
97 GPs and nurses, to explore the findings from the Delphi survey in more detail.

98 **Recruitment**

99 For the online Delphi we aimed to recruit 30 GPs nationally through adverts placed in the Society for
100 Academic Primary Care (SAPC) and Royal College of General Practitioners (RCGP) newsletters, and
101 regionally through the Primary Care Research Network in the East of England. This population was
102 targeted for their likely interest and expertise in the study topic.

103 For the two focus groups we aimed to recruit 8-10 participants for each focus group, and excluded
104 those who had already responded to the Delphi. A total of 115 practices in Norfolk and Waveney
105 were invited by the Primary Care Research Network (PCRN). Participants were purposively sampled

106 for their professional background and expertise (25, 26), and then all consenting respondents were
107 utilised in the study.

108 **Online Delphi survey**

109 Delphi techniques allow experts to express individual views on complex material in a structured and
110 systematic way, and test the extent of change of view (or not) as a consequence of additional
111 feedback; this can be used to develop consensus but can also be used to test the stability and range
112 of expert views(27). The survey was piloted on a small group of general practitioners. Two rounds of
113 the final survey were administered online using *SurveyMonkey* (28) between November 2012-
114 January 2013. The survey (Appendix 1) included demographic questions including involvement with
115 guidelines and then two main sections, first about the applicability of primary care evidence, and
116 then about attributes that might affect guideline use.

117 All recommendations used had been previously assessed as clinically relevant to primary care by at
118 least two GP reviewers, as described elsewhere (23). First, participants were presented with the full
119 text of 14 primary care relevant recommendations from NICE guidelines and asked to rate each
120 recommendation on a scale of 1-9 for applicability to their primary care patients, with 1 being not
121 likely to use with their patients) and 9 being highly likely to use. An electronic link to each full NICE
122 guideline was given for reference. After participants had rated each recommendation, they were
123 given a brief summary of the applicability to primary care of the supporting evidence, and then
124 asked to rate the recommendation again.

125 The recommendations were purposively selected to include a range of high, medium and low
126 applicability of the evidence base to primary care patients. The applicability of evidence for each
127 recommendation was rated as low if evidence for the recommendation was supported by no studies
128 conducted on primary care or community populations, medium if supported by up to half of the
129 studies, and high if the majority of the studies cited as evidence had their participants selected from
130 primary care or the community, as described elsewhere (23). Recommendations were presented in
131 the survey in a random order (Appendix 1).

132 In the second component of the Delphi, participants were asked to rate on a scale of 1-5 (with 1
133 being “strongly disagree that this attribute is most likely to encourage use of clinical guideline” and 5
134 being “strongly agree”) a list of 16 attributes affecting guideline use, collated from the literature and
135 arranged under four categories. The participants were also asked to provide free text comments,
136 which were analysed thematically.

137 After the first round, each participant was sent the mean scores, as well as their own scores, and
138 then asked to re-rate both the recommendations and the attributes in a second round. The
139 difference in mean scores before and after reading the evidence summary was tested using a paired
140 t-test, after tests for normality in Stata/SE (29).

141 **Focus groups**

142 Results from the Delphi panel were used to develop a focus group topic guide (SEE APPENDIX 2).
143 Guideline attributes identified as important for the implementation and applicability of primary care
144 recommendations, including the importance of primary care research, were explored with two focus
145 groups, one with GPs and the other with primary care nurses. The focus groups were held separately
146 to allow free expression of views, particularly from practice nurses who are usually employees of
147 GPs, but the data from both groups were analysed together.

148 The focus groups were conducted during January and February 2013 and were facilitated by an
149 independent researcher to ensure impartiality, assisted by a member of the research team (AA).

150 They were taped and transcribed, and then analysed thematically using NVivo software (30) by two
151 of the researchers (AA, AH) using the framework approach (31, 32).

152 **Results**

153 **Online Delphi survey**

154 Twenty-eight GPs agreed to take part in the Delphi panel, of whom ten were recruited through
155 national, and 18 through regional approaches. 25/28 (89%) completed the first round and 21/25
156 completed the second round. The participants represented a broad range of experience in general
157 practice, with most being service GPs (80%) with no experience of guideline development (88%)
158 (Table1).

159 *Insert table 1*

160 **Recommendation ratings for applicability to primary care patients**

161 Mean ratings for the recommendations' applicability to primary care patients were lower after
162 presentation of evidence for those recommendations where the summary disclosed that less than
163 half of the studies were applicable to primary care populations. Mean ratings remained the same or
164 increased for recommendations where the majority of cited publications were applicable to primary
165 care populations (Table 2). While the majority of respondents altered their ratings modestly (raising
166 or lowering by 1-2 points) after reading the evidence summary, few respondents didn't change their
167 initial ratings. Ratings did not change substantially in the second round, and are not given here.

168 Participants' free text comments included that the wording of some recommendations was complex
169 or not clearly defined, and that a GP 'user' perspective should be included at all stages of guideline
170 development. Some were concerned about the UK applicability of the studies, and not just primary
171 care applicability. Many respondents considered having some evidence is better than having no
172 evidence, and others commented on the importance of clinical experience when implementing
173 guidelines.

174 *"Overall it appears that I am less critical [than other respondents to the Delphi] of guidelines that do*
175 *not originate specifically from primary care – but my reasons for this are 'laissez-faire' rather than*
176 *believing other sources are more important. Overall I considered whether the guideline was in*
177 *keeping with what, for other reasons, I believe to be good practice, and/or whether it complies with*
178 *the old adage "first, do no harm". Most of the recommendations considered met these criteria (e.g.*
179 *prescription of thiamine): if the guidelines were suggesting radical change to practice or invasive*
180 *treatments I would be much less likely to give them credence without rigorous evidence." GP (Delphi)*

181 *Insert table 2*

182 **Attributes affecting guideline use**

183 GPs rated nearly all 16 factors as likely to encourage guideline use, including 'Study outcomes used
184 are relevant and important to primary care population' (Table 3). The notable exception was
185 'Evidence underpinning recommendation comes from secondary care population', which was the
186 only attribute with a mean score of less than 3/5. Attributes relating to guideline accessibility such as
187 clarity, brevity and accessible format scored highly. Scores did not change in the second round.

188 *Insert table 3*

189 **Focus groups**

190 Ten GPs and ten primary care practice nurses agreed to take part, and six GPs (three men and three
191 women) and ten nurses (all women) , all from different practices, attended. Four themes were
192 identified: 'guideline use', 'evidence base', 'barriers to use', and 'pay for performance'.

193 1. Guideline use

194 Primary care practitioners in general and nurses in particular were positive about guidelines and
195 used them where there was clinical uncertainty, often in short formats.

196 *Insert quotes*

197 2. Evidence base

198 Primary care practitioners rarely looked at the evidence behind recommendations unless the
199 recommendation seemed very different from their normal practice.

200 *Insert quotes*

201 Few had detailed understanding of guidelines formulation with regard to wording and how it's used
202 to reflect strength of evidence.

203 *Insert quotes*

204 Participants were aware of the need to interpret research findings for primary care and were
205 pragmatic about this, and hopeful that future guidelines would have more primary care evidence
206 and greater clarity about inevitable gaps in evidence. There was support for clearer labelling of
207 primary care based evidence.

208 *Insert quotes*

209 Applicability of evidence

210 Some participants argued that good evidence from secondary care could not be realistically
211 implemented in a primary care population.

212 *Insert quotes*

213 3. Barriers to use

214 Participants saw the number of guidelines, time available, and limits of evidence as constraints on
215 their practical use and appraisal of guidelines. They highlighted that guidelines mostly addressed the
216 management of specific conditions post-diagnosis, while primary care practitioners predominantly
217 deal with comorbidities and symptoms pre-diagnosis. They wanted guidelines to be short and clear.

218 *Insert quotes*

219 4. Pay for performance

220 The UK's national primary care pay for performance scheme or 'quality and outcomes framework'
221 (QoF) was identified as a key driver for compliance with guideline recommendations, though some
222 concerns were expressed about the impacts of this on professional practice and the associated
223 opportunity cost. Limited resources may impede on primary care practitioners' ability to explore
224 aspects of clinical care beyond QoF incentivised practice and this could be a hindrance to
225 implementation of non- QoF guidelines.

226 *Insert quotes*

227

228 Overall, NICE guidelines were viewed favourably as a major source of practice guidance. Participants
229 commented on the large numbers of guidelines, their need for concise summaries, the advantages
230 of user-friendly web based versions, and the need to identify relevant guidelines quickly when
231 uncertainty drove usage. The groups felt they had to trust the process of derivation and the
232 comprehensive uploading of relevant guidelines, as they had little time to check either background
233 or the availability of guidance. There was considerable evidence of individuals and practice teams
234 trying to be systematic about updating local protocols and templates in line with new guidance, but
235 with concern about the time and feasibility of this given the pressures of work and numbers of
236 guidelines. Streamlining of local protocols across the team, between practices, and with secondary
237 care, and the requirement to meet multiple guidelines as well as QoF indicators all presented
238 additional challenges.

239

240 **Discussion**

241 Delphi participants considered that recommendations based on evidence from primary care
242 populations were more applicable to their patients than those with no or little primary care evidence.
243 Focus groups wanted clearer signposting of how applicable guideline evidence was for primary care,
244 and expected significant involvement of primary care practitioners in scoping and developing
245 guidelines. Primary care practitioners were constructively critical of the lack of evidence and lack of
246 explicit declaration of this, and took a pragmatic view of implementing guidance. Brevity, clarity and
247 accessibility were important guideline attributes.

248 **Strengths and limitations**

249 This study is the first systematic interrogation of primary care practitioner views on the applicability
250 of primary care evidence in NICE guidelines for primary care. The study demonstrates that there are
251 ways in which primary care practitioners perceive that these guidelines could be made more
252 relevant and thus have more impact upon clinical practice. The participants were likely to be
253 interested in guideline work or they would not have volunteered to take part in the study, and so the
254 results of this study are likely to represent a relatively well informed and 'guideline positive' set of
255 respondents.

256 **Comparison with existing literature and implications for research and practice**

257 Our findings about attributes that influence the use of guidelines in primary care agree with previous
258 research, which highlighted clarity and clinical applicability of a guideline as important (9, 18, 33, 34).
259 NICE recommends exploring and assessing the applicability to primary care patients under the
260 "indirectness domain" of the modified GRADE criteria, "assessing the degree of differences between
261 the population, intervention, comparator for the intervention and outcome of interest" (35). This
262 exploration of generalisability to the target population is also described in the AGREE II tool criteria
263 (36) which national clinical guideline developers are expected to use, and the NICE guidelines
264 manual (37). Despite these intentions and efforts to make guideline evidence applicable to primary
265 care, this study has shown that primary care practitioners would like clearer descriptions of the
266 applicability of evidence to primary care patients.

267 Other countries have used different approaches to developing guidelines for primary care, some of
268 which may have potential benefit internationally. The New Zealand hand book for primary care
269 compiles relevant recommendations from several guidelines (38) producing a type of "umbrella
270 guideline" that has been recommended to NICE by the WHO review programme (39). The Dutch
271 College of General Practitioners also produces national clinical guidelines that are dedicated to

272 primary care (40). These models have potential to improve the accessibility of relevant guidance for
273 primary care.

274 We suggest that primary care relevance should be more explicitly considered at all three main stages
275 of guideline development: scope & evidence synthesis, recommendation development, and
276 publication. This builds on the guidance NICE issues its guideline developers as part of their quality
277 assurance process (37). At the stage of scoping the content of the guideline and evidence synthesis,
278 primary care relevance should be considered from the outset of the initial scoping exercise and be
279 clearly reported to the guideline development group. Ideally there would be input from primary care
280 professionals with relevant content expertise and contextual understanding to interpret the existing
281 evidence and its applicability to their patients. If the scope identified that the guideline had primary
282 care relevance, then the initial review questions for the evidence search and the early findings
283 should be specifically considered for applicability to primary care, with primary care routinely
284 considered as a sub-group in the search. When an initial review question is relevant to primary care,
285 the relevant population should be defined by primary care setting, severity of illness, or risk group in
286 the search strategy and data extraction, and findings reported if evidence is not located.

287 At the stage of recommendation development, any limitations or lack of evidence in relevant
288 populations (e.g. defined by primary care setting, severity of illness, or risk group) should be
289 specified in the summary of evidence tables. The 'evidence to recommendations' statement should
290 be specific about where primary care research has or has not been reported, and recommendations
291 where applicable primary care evidence was lacking should be clearly badged. Recommendations
292 should be concise, with a clear pathway back from recommendations to research evidence, to allow
293 users to "drill down" into the detail more easily.

294 In the final published guideline, the target population should be clearly stated (e.g. defined by
295 primary care setting, severity of illness, or risk group), and the relevance to that population of all
296 recommendations and intended users clearly described. The published guideline should show which
297 recommendations are supported by consensus, and which by research. It should specify the extent
298 to which the research is applicable to specific populations including primary care, and openly
299 acknowledging uncertainty where present in the guideline development group or the available
300 evidence. All guidelines should be peer reviewed with respect to the clarity with which the relevance
301 of recommendations to primary care is described. We acknowledge primary care evidence is often
302 limited and that evidence from other settings should then be used but, if this is the case, this should
303 be highlighted as a research recommendation in the final guideline.

304 Primary care practitioners have a high level of trust for NICE guidelines, but were less likely to trust
305 and want to use those recommendations with low applicability of evidence to primary care. Clearer
306 description of the applicability of research to primary care patients, ideally within a brief accessible
307 guideline format, may result in improved guideline implementation in primary care, and help to
308 maintain the currently high levels of trust in NICE guidance.

309

310 **Acknowledgements**

311 This paper presents independent research funded by the National Institute for Health Research
312 (NIHR) under its Research for Patient Benefit (RfPB) Programme (Grant Reference Number PB-PG-
313 0110-21051). The views expressed are those of the author(s) and not necessarily those of NICE, the
314 NHS, the NIHR or the Department of Health.

315 NHS Norfolk and subsequently South Norfolk Clinical Commissioning Group acted as host
316 organisation for the grant, and project Sponsor.

317 We are grateful to all participating professionals for their contribution to the study.

318 Keith Paterson and Penny Vicary from Public and Patient Involvement in Research (PPIRes)
319 contributed to the conduct of the study and brought a helpful lay perspective to this research.
320 PPIRes is hosted by South Norfolk CCG and formerly by NHS Norfolk.

321 **Ethical approval**

322 The study was approved by Cambridge Central Research Ethics Committee Ref 11-EE-0213.

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Guideline use:

"When you want to find something out or you're unsure of something, you might go in retrospect and then look at the guidelines and see what you perhaps should have done but to learn from the guideline" (GP).

"I actually no longer read what NICE has got to say about it, I go to one of those ...digest websites which condenses it into one screen and I can read it off of there and if I detect anything that I would do differently, then I go back and I will expose myself to the whole guideline which is otherwise too hard work to read" (GP).

"... just use the quick reference. And we get email alerts with the new guidance that's come out or been updated and we usually see if there's anything relevant.....if there's anything I need to use, I go and have a look at it then" (Nurse).

Evidence base (a): *"So where there is evidence, I'm sure they do a fab job and I don't need to read the evidence myself to believe them" (GP).*

"I've looked once at the ... behind the guidance, I think it was for cardiovascular risk screening and I have to say I really wouldn't look forward to doing it again because there were 382 pages to trawl through and it pulled every aspect of each screening tool to bits" (GP).

"Well you might do, that's a point ... if it was something completely different, you might just want to look at the evidence base I think. If it was quite a different way of treating somebody I think I would have a look at the evidence base then" (Nurse).

Evidence base (b):

"I think as time goes on and more research is done in primary care that that evidence needs to contribute towards the guidelines so it's not just secondary care" (Nurse).

"I've been happy to rely on the NICE guidelines for the evidence that they've reviewed. And I'm sure they did a great job of reviewing that with the best-available methods to rate evidence but what you can't see is the gap, which bit is the bit that they just picked out of thin air because they have to cover that area because there is no evidence? And if there is no evidence, then they can say whatever they think is necessary, which is no better than what I can say on the subject" (GP).

Evidence base (c) *"Certainly where you're using NICE guidance, it would be nice to know that they've been done with the thought of general practice in mind" (GP).*

Applicability of evidence:

"think if you're doing it, again depending on the subject area, if you did look at all the evidence you'd not find much ... it's so skewed towards what's being done in secondary and tertiary centres and not again what's happening in the real world with GP patients and what's ... like say the number of patients that are not taking their Adacal, I mean how many people have probably done little audits on that? But there's probably not a research paper out there that NICE would be able to get their hands on to say 'Well look, the evidence there' but people don't take ... if they haven't got the evidence, they can't do ..." GP

"I was the only GP on that guideline. And the problem that we'd got, we had with the guideline, was that NICE were brilliant at looking at all of the evidence but a lot of the evidence was from America, a lot of the evidence was from various European countries. There was very, very little research from the UK and even less of any research from Primary Care populations. So there was no evidence to base a Primary Care guideline on. So we had to go with what was available and had to keep adapting. But you were only there as the one GP trying to bring it back to the real world, well actually you know, what's realistic and what sounds realistic and what they think is an ideal and what is actually realistic is very different". GP

Barriers to use

"I think there's just too many for us to follow any more than just 1% if you like" (GP).

"So you wouldn't ever go to the guideline unless you'd had that diagnosis in your head" (GP).

"I think the problem is if you've got somebody who's got several comorbidities and you're trying to do one but it doesn't sit well with another one maybe" (Nurse).

"And also keeping it to sort of one sheet of A4 format or a flow chart, a flow chart with a patient pathway" (GP).

"I don't think it's dealt with by NICE particularly. I don't think it's dealt with by NICE, comorbidity" Nurse

Pay for performance

"with the diabetes you know, the NICE recommendations on ACE inhibitors and statins and things like this, GPs have tended to go to do because they have their QOF box to tick that they've done these things" (GP).

"I think to be fair, a lot of it's targeted towards QOF when you're writing a template" (Nurse).

Table 1: Delphi survey participants' characteristics

Gender: Male	12 (48%)
Female	12 (48%)
Prefer not to say	1 (4%)
Years as a GP: <5 yrs	5 (20%)
5-15	5 (20%)
15-25	8 (32%)
25-35	7 (28%)
Primary role: Service GP	20 (80%)
Academic GP	1 (4%)
Other	4 (16%)
Practice host research Yes	18 (72%)
No	6 (24%)
Don't know	1 (4%)
Postgraduate degree Yes	5 (20%)
No	20 (80%)
Guideline development involvement Yes	3 (12%)
No	22 (88%)

Table 2: Delphi ratings for the recommendations' applicability to primary care patients, before and after reading a summary of relevance of the evidence base to primary care (PC) patients.

NICE guideline & recommendation number	PC relevant /total studies (n)	Mean rating before evidence (range)*	Mean rating after evidence (range)*	Difference after seeing evidence (95%CI)
Low PC relevance of studies¹				
CG100/R17(Alcohol & thiamine)	0/2	7.2 (4-9)	5.6 (2-9)	-1.6**(1.14-2.22)
CG101/U4(Long acting muscarinic antagonist in COPD)	0/1	7.7 (5-9)	6.0 (2-9)	-1.7**(1-2.44)
CG101/U1(Post bronchodilator spirometry in COPD)	0/2	7.5 (5-9)	6.0 (2-9)	-1.5** (0.86-2.18)
CG108/R27(Offer ACE inhibitors & β blockers for heart failure)	0/7	7.8 (3-9)	6.9 (1-9)	-0.9** (0.35-1.49)
CG116/ R11(Trial elimination of the suspected food allergen)	0/10	6.2 (3-9)	4.6 (2-9)	-1.6** (1.08-2.17)
CG122/R 1.1.2.1(Serum CA125 in PC in ovarian cancer)	0/6	7.9 (5-9)	5.8 (2-9)	-2.1** (1.34-2.90)
Medium PC relevance of studies²				
CG127/R15(Ambulatory BPM to confirm hypertension)	20/50	7.5 (2-9)	6.5 (2-9)	-1.0** (0.24-1.76)
CG127/R16(Home BPM to confirm hypertension)	3/8	7.4 (4-9)	6.4 (2-9)	-1.0** (0.56-1.52)
CG122/R 1.1.1.2(Test women with persistent symptoms for ovarian cancer)	9/16	7.7 (5-9)	7.1 (3-9)	0.6** (0.05-1.23)
CG123/R1.3.1.1(Ask people who may have depression 2 questions)	11/20	6.6 (1-9)	6.6 (1-9)	0 (-0.38-0.46)
High PC relevance of studies³				
CG108/R3(Measure serum natriuretic peptides in heart failure)	2/3	8.2 (6-9)	8.3 (6-9)	+0.1 (-0.27-0.27)
CG95/R1.2.1.3(Acute coronary syndrome)	3/4	7.8 (5-9)	7.8 (4-9)	0 (-0.18-0.26)
CG102/R 1.2.2(Children & meningitis without rash & antibiotics)	4/5	7.1 (2-9)	7.4 (2-9)	+0.3 (-1.02-0.54)
CG101/U2(Consider alternative diagnosis if FEV1/FVC is <0.7)	4/4	7.2 (4-9)	7.6 (3-9)	+0.4 (-1.1-0.28)

*Scores were on a scale from 1-9. ** Statistically significant using paired t-test

1 = completely irrelevant recommendation, not be likely to implement

9 = trusted recommendation, are likely to use, highly relevant to patients

1. Low PC relevance of studies= none of the studies cited as evidence for the recommendation had population selected from primary care or the community.

2. Medium PC relevance = Up to half of the studies cited as evidence had their participants selected from PC or the community.

3. High PC relevance = Majority of the studies cited as evidence had their participants selected from PC or the community.

Table 3: Scores for attributes affecting guideline use

Factors related to the guideline topic	Mean rating (range)
Primary care setting indicated in guideline title	4.2 (2-5)
Priority in a primary care setting	4.3 (2-5)
Focus of guideline recommendations on clinical presentation and diagnosis	3.8 (2-5)
Perceived need for change in clinical practice in a certain area	4.2 (3-5)
Factors related to guideline characteristics:	
Produced by a reputable body or authority	4.5 (3-5)
General practitioners involved in development of guideline	4.4 (3-5)
An organisation of which I am a member was involved in the guideline production	3.5 (2-5)
Guidance consistent with other available sources or my previous practice	3.9 (2-5)
Factors related to the accessibility of the Guideline:	
Easy to access or in a format I recognise so I can find key information quickly	4.7 (4-5)
Recommendations are written in a clear, logical, and well organised manner	4.7 (4-5)
Executive summary or clear algorithm showing clinical recommendations	4.6 (4-5)
Not too long	4.4 (3-5)
Factors related to the evidence on which the recommendations are based	
Study outcomes used are relevant and important to primary care population	4.5 (2-5)
Evidence underpinning recommendation comes from secondary care population	2.8 (1-5)
Link from evidence to recommendation is clear and logical and easy to find	4 (2-5)
Applicability to primary care population e.g. severity of disease and comorbidity is taken into consideration and discussed	4.5 (2-5)

Appendix 1

Online Delphi Survey

NICE Delphi- revised 20/11

Healthcare

Design Survey Collect Responses Analyze Results

Edit Survey

Preview Survey Send Survey »

To change the look of your survey, select a theme below.

Aqua Create Custom Theme

TITLE & LOGO

Edit Title + Add Logo

NICE guideline online Delphi- Round 1

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Background

Many thanks for agreeing to take part in our 2 stage Delphi panel. We appreciate you completing the questionnaire, which should not take more than 15 minutes. The aim of the study is to improve NICE guideline development and the relevance of guideline recommendations to managing patients seen in primary care settings. The evidence base used for guidelines is not always derived from research in primary care, and the relevance and applicability of recommendations for patients in primary care settings has been questioned. This Delphi process is looking into your views on this, using specific guidelines as examples. In the first round, we are asking you to rate some NICE guideline recommendations, as well as some factors related to your guideline use. After this round we will be collating responses and providing feedback to you and all our panellists, testing consensus across the group of panellists.

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General information

The following section asks some details about you and your current role. Any contact details you provide will be confidential, and will only be used by the researcher to feedback results to you. Your individual details or responses will not be identified by any of the other panellists

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Q1 Edit Question Move Copy Delete

Personal details

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Q2 Edit Question ▼ Add Question Logic Move Copy Delete

***Gender**

Male

Female

Prefer not to say

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Q3 Edit Question ▼ Add Question Logic Move Copy Delete

***Years since qualified as a general practitioner**

Other (please specify)

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Q4 Edit Question ▼ Add Question Logic Move Copy Delete

Would you describe your primary role as:

Service GP

Other (please specify)

Academic GP

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Q5 Edit Question ▼ Add Question Logic Move Copy Delete

***Do you hold a postgraduate academic degree? i.e. Master, MD, PhD**

Yes (if yes give details)

No

If yes (please specify)

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Q6 Edit Question ▼ Add Question Logic Move Copy Delete

Does the practice where you work primarily host research?

Yes

No

I don't know

Any details

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Q7 Edit Question ▼ Add Question Logic Move Copy Delete

Have you previously ever been involved in guideline development?

Yes No

Other (please specify)

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Guideline recommendations rating

In this section we will be asking you to rate a sample of NICE recommendations from various guidelines that have been specifically selected by a panel of GPs as relevant to patient groups/ conditions managed in primary care. Please rate each recommendation according to the relevance of each recommendation to your practice/ patients. By "relevant" we mean how much you would trust the advice or guidance contained in the recommendation to be applicable to your typical primary care patient.

Rate each recommendation on a scale from 1 - 9. A score of 9 would mean a recommendation that you trust, are likely to use, and find highly relevant to your patients, while a score of 1 means the recommendation is completely irrelevant and you would not be likely to implement it with your patients. You are asked to rate each recommendation twice: first after reading the recommendation, and then again after reading a very brief summary of the evidence base for the recommendation. At the end of each recommendation there is a link to the full guidance for you to consult if you feel you need to.

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Q8 Edit Question ▼ Add Question Logic Move Copy Delete

*** 1a) CG 95 (Chest pain of recent onset):**
Recommendation 1.2.1.3:
"Initially assess people for any of the following symptoms which may indicate an ACS (acute coronary syndrome), pain in the chest and/or other areas (for example, the arms, back or jaw) lasting longer than 15 minutes, chest pain associated with nausea and vomiting, marked, sweating, breathlessness, or particularly a combination of these, chest pain associated with haemodynamic instability, new onset chest pain, or abrupt deterioration in previously stable angina, with recurrent chest pain occurring frequently and with little or no exertion, and with episodes often lasting longer than 15 minutes."

If you require any more information, the full guidance can be viewed [here](#)

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Evidence base

Evidence: Four studies including 3 systematic reviews and one cohort study. Two of the systematic reviews and the cohort study used patients from primary care and emergency care

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Q9 Edit Question Add Question Logic Move Copy Delete

***1b) Having read a summary of evidence source, can you please re rate the same recommendation?**

- | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| (1) Not relevant | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) Highly relevant | N/A |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Any comments

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Recommendation rating (cont.)

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Q10 Edit Question Add Question Logic Move Copy Delete

***2a) CG100 (Alcohol-use disorders- Diagnosis and clinical management of alcohol-related physical complications): R17:**

"Offer thiamine to people at high risk of developing, or with suspected, Wernicke's encephalopathy. Thiamine should be given in doses toward the upper end of the 'British national formulary' range. It should be given orally or parenterally as described in recommendations 1.2.1.2 to 1.2.1.4."

If you require more details, the full guidance can be viewed [here](#).

- | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| (1) Not relevant | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) Highly relevant | N/A |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Any comments

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Evidence base

Evidence: Two studies that recruited cases of Wernicke's encephalopathy admitted to hospital for treatment. Neither study included patients from primary care setting.

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Q11 Edit Question ▼ Add Question Logic Move Copy Delete

2b) Having read a summary of evidence source, can you please re rate the same recommendation?

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Recommendation rating (cont.)

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Q12 Edit Question ▼ Add Question Logic Move Copy Delete

***3a) CG101 (Chronic obstructive pulmonary disease-Management of chronic obstructive pulmonary disease in adults in primary and secondary care):**

U4:

"Offer once-daily long-acting muscarinic antagonist (LAMA) in preference to four-times-daily short-acting muscarinic antagonist (SAMA) to people with stable COPD who remain breathless or have exacerbations despite using short-acting bronchodilators as required, and in whom a decision has been made to commence regular maintenance bronchodilator therapy with a muscarinic antagonist."

If you require more details, the full guidance can be viewed [here](#)

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Evidence base

Evidence: One study of patients over 40 years of age from secondary care centres in the Netherlands and Belgium, which excluded patients with asthma, allergic rhinitis, atopy, elevated eosinophils, supplemental oxygen, a recent upper respiratory tract infection, or a significant disease other than COPD

+ Add Question ▼

Q13 Edit Question ▼ Add Question Logic Move Copy Delete

3b) Having read a summary of evidence source, can you please re rate the same recommendation?

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Recommendation rating (cont.)

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Q14 Edit Question ▼ Add Question Logic Move Copy Delete

***4a) CG101 (Chronic obstructive pulmonary disease- Management of chronic obstructive pulmonary disease in adults in primary and secondary care):**

U1:

"Measure post-bronchodilator spirometry to confirm the diagnosis of COPD".

If you require more details, the full guidance can be viewed [here](#)

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Evidence base

Evidence: Two observational studies of patients over 40, one of patients from five Latin American cities and the other of patients from UK hospitals

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Q15 Edit Question Add Question Logic Move Copy Delete

*4b) Having read a summary of evidence source, can you please re rate the same recommendation?

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
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Any comment

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Recommendation rating (cont.)

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Q16 Edit Question Add Question Logic Move Copy Delete

*5a) CG101 (Chronic obstructive pulmonary disease- Management of chronic obstructive pulmonary disease in adults in primary and secondary care) :

U2 :

“Consider alternative diagnoses or investigations in: older people without typical symptoms of COPD where the FEV1/FVC ratio is < 0.7, younger people with symptoms of COPD where the FEV1/FVC ratio is ≥ 0.7”.

If you require more details, the full guidance can be viewed [here](#)

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comment

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Evidence base

Evidence: Four cross sectional studies, all included patients from community and primary care.

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Q17

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***5b) Having read a summary of evidence source, can you please re rate the same recommendation?**

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Recommendation rating (cont.)

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Q18

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***6a) CG102 (Bacterial meningitis and meningococcal septicaemia- Management of bacterial meningitis and meningococcal septicaemia in children and young people younger than 16 years in primary and secondary care):**

Recommendation 1.2.2:

“Transfer children and young people with suspected bacterial meningitis without non-blanching rash directly to secondary care without giving parenteral antibiotics”.

If you require more details, the full guidance can be viewed [here](#)

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Evidence base

Evidence: Five studies, three of which included patients in primary care or pre hospital. One systematic review with two thirds of its included studies restricted to primary care patients.

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Q19 Edit Question ▼ Add Question Logic Move Copy Delete

*6b) Having read a summary of evidence source, can you please re rate the same recommendation?

- (1) Not relevant
- (2)
- (3)
- (4)
- (5)
- (6)
- (7)
- (8)
- (9) Highly relevant

Any comment

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Recommendation rating (cont.):

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Q20 Edit Question ▼ Add Question Logic Move Copy Delete

*7a) CG108 (Chronic heart failure- Management of chronic heart failure in adults in primary and secondary care):

R3:

“Measure serum natriuretic peptides (B-type natriuretic peptide [BNP] or N-terminal pro-B-type natriuretic peptide [NTproBNP]) in patients with suspected heart failure without previous MI”.

If you require more details, the full guidance can be viewed [here](#)

- (1) Not relevant
- (2)
- (3)
- (4)
- (5)
- (6)
- (7)
- (8)
- (9) Highly relevant
- N/A

Any comments

Text input field for comments

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Evidence base

Evidence: Three systematic reviews, two included many studies from primary care, and one of the two was specifically about diagnosis of heart failure, with modelling of implications of different diagnostic strategies in primary care.

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Q21 Edit Question ▼ Add Question Logic Move Copy Delete

***7b) Having read a summary of evidence source, can you please re rate the same recommendation?**

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Recommendation rating (cont.):

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Q22 Edit Question ▼ Add Question Logic Move Copy Delete

***8a) CG108 (Chronic heart failure- Management of chronic heart failure in adults in primary and secondary care):**

R27:

“Offer both angiotensin-converting enzyme (ACE) inhibitors and beta-blockers licensed for heart failure to all patients with heart failure due to left ventricular systolic dysfunction. Use clinical judgement when deciding which drug to start first”.

If you require more details, the full guidance can be viewed [here](#)

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Evidence base

Evidence: Seven clinical trials that all recruited patients with moderate to severe heart failure from secondary care.

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Q23 Edit Question ▼ Add Question Logic Move Copy Delete

***8b) Having read a summary of evidence source, can you please re rate the same recommendation?**

(1) Not relevant (2) (3) (4) (5) (6) (7) (8) (9) Highly relevant N/A

Any comments

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Recommendation rating (cont.):

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Q24 Edit Question ▼ Add Question Logic Move Copy Delete

***9a) CG116 (Food allergy in children and young people- Diagnosis and assessment of food allergy in children and young people in primary care and community settings):**

Recommendation 1.1.11:

“Based on the results of the allergy-focused clinical history, if non-IgE-mediated food allergy is suspected, trial elimination of the suspected allergen (normally for between 2–6 weeks) and reintroduce after the trial. Seek advice from a dietician with appropriate competencies, about nutritional adequacies, timings of elimination and reintroduction, and follow-up”.

If you require more details, the full guidance can be viewed [here](#)

Any comments

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Evidence base

Evidence: Ten studies and expert consensus, All the studies were low quality, secondary care and non UK. The guideline acknowledged that evidence for patch testing was all taken from secondary or specialist settings and may not be directly applicable to a diverse primary care population.



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Q25 Edit Question ▼ Add Question Logic Move Copy Delete

9b) Having read a summary of evidence source, can you please re rate the same recommendation?

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Recommendation rating (cont.):

+ Add Question ▼

Q26 Edit Question ▼ Add Question Logic Move Copy Delete

* 10a) CG122 (Ovarian cancer- The recognition and initial management of ovarian cancer):

Recommendations 1.1.2.1:

“Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer (see section 1.1.1).”

If you require more details, the full guidance can be viewed [here](#)

Any comments

Text input field for comments

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Evidence base

Evidence: Six systematic reviews of secondary care studies. There was no direct evidence about the performance of serum CA125 test, ultrasound and pelvic examination in primary care.

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Q27

Edit Question ▼

Add Question Logic

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***10b) Having read a summary of evidence source, can you please re rate the same recommendation?**

(1) not relevant

(2)

(3)

(4)

(5)

(6)

(7)

(8)

(9) highly relevant

N/A



Any comments

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Recommendation rating (cont.):

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Q28

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***11a) CG122 (Ovarian cancer- The recognition and initial management of ovarian cancer):**

Recommendation 1.1.1.2:

“Carry out tests in primary care (see section 1.1.2) if a woman (especially if 50 or over) reports having any of the following symptoms on a persistent or frequent basis – particularly more than 12 times per month: • persistent abdominal distension (women often refer to this as ‘bloating’) • feeling full (early satiety) and/or loss of appetite • pelvic or abdominal pain • increased urinary urgency and/or frequency”

If you require more details, the full guidance can be viewed [here](#)

(1) Not relevant

(2)

(3)

(4)

(5)

(6)

(7)

(8)

(9) Highly relevant

N/A



Any comments

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Evidence base:

Evidence: Sixteen studies most were retrospective. Eight of the studies plus a systematic review, included women presenting in primary care or population based surveillance studies. The remaining seven studies were secondary care based.

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Q29 Edit Question ▼ Add Question Logic Move Copy Delete

* 11b) Having read a summary of evidence source, can you please re rate the same recommendation?

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
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Any comments

Text input field for comments

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Recommendation rating (cont.)

+ Add Question ▼

Q30 Edit Question ▼ Add Question Logic Move Copy Delete

* 12a) CG123 (Common mental health disorders- Identification and pathways to care):

Recommendation 1.3.1.1:

"Be alert to possible depression (particularly in people with a past history of depression, possible somatic symptoms of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically: • During the last month, have you often been bothered by feeling down, depressed or hopeless? • During the last month, have you often been bothered by having little interest or pleasure in doing things? If a person answers 'yes' to either of the above questions consider depression and follow the recommendations for assessment".

If you require more details, the full guidance can be viewed [here](#)

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

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Evidence base:

Evidence: Twenty studies, 11 of which included patients seen in primary care or community clinics. The rest of the studies were secondary care based.

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Q31

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***12b) Having read a summary of evidence source, can you please re rate the same recommendation?**

- | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| (1) Not relevant | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) Highly relevant | N/A |
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Any comments

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Recommendation rating (cont.)

+ Add Question ▼

Q32

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13a) CG127 (Hypertension- The clinical management of primary hypertension in adults):

Recommendation 15:

“When using ABPM to confirm a diagnosis of hypertension, ensure that at least two measurements per hour are taken during the person’s usual waking hours (for example, between 08:00 and 22:00).Use the average value of at least 14 measurements taken during the person’s usual waking hours to confirm a diagnosis of hypertension”

If you require more details, the full guidance [here](#)

- | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| (1) Not relevant | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) Highly relevant | N/A |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Any comments

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Evidence base:

Evidence: Over 50 studies, of which 20 recruited patients from primary care or the general population. However, none of the primary care studies were UK based. The two UK studies were secondary and tertiary care.

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Q33

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***13b) Having read a summary of evidence source, can you please re rate the same recommendation?**

- | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| (1) Not relevant | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) Highly relevant | N/A |
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Any comments

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Recommendation rating (cont.)

+ Add Question ▼

Q34

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***14a) CG127 (Hypertension- The clinical management of primary hypertension in adults):**

Recommendation 16:

“When using HBPM to confirm a diagnosis of hypertension, ensure that: for each blood pressure recording, two consecutive measurements are taken, at least 1 minute apart and with the person seated and blood pressure is recorded twice daily, ideally in the morning and evening and blood pressure recording continues for at least 4 days, ideally for 7 days. Discard the measurements taken on the first day and use the average value of all the remaining measurements to confirm a diagnosis of hypertension”.

If you require more details, the full guidance can be viewed [here](#)

- | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| (1) Not relevant | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) Highly relevant | N/A |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Any comments

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Evidence base:

Evidence: Eight studies, all non UK. Three of these studies included population based cohorts and the rest were secondary care patients.

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Q35 Edit Question ▼ Add Question Logic Move Copy Delete

***14b) Having read a summary of evidence source, can you please re rate the same recommendation?**

(1) Not relevant	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9) Highly relevant	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Any comments

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Section 3: Your general views on guideline use and attributes

In this section we are asking about your use and views of guidelines.

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Q36 Edit Question ▼ Add Question Logic Move Copy Delete

***How often would you ESTIMATE that you refer to NICE guidelines during your clinical practice?**

Never
 Weekly
 Less than once a month

More than once a week
 Monthly

Other (please specify)

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Guideline attributes

Below is a list of guideline attributes identified from the literature that could affect primary care practitioners' use of guidelines. The attributes have been divided into different categories presenting various aspects of the guideline. With a specific focus on NICE guidelines, please rate each factor on a scale of 1-5 (5 being you strongly agree that this attribute is mostly likely to encourage you to use a clinical guideline and 1 being least likely to encourage you to use a guideline). Each section also allows you to opt for 'don't know/unsure'. At the end of each section there is a space for you to provide any comments or add any other factors you think are relevant.

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Q37 Edit Question ▼ Move Copy Delete

*** Guideline topic:**

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not sure/ don't know
Primary care setting indicated in guideline title	-	-	-	-	-	-
Priority in a primary care setting	-	-	-	-	-	-
Focus of guideline recommendations on clinical presentation and diagnosis	-	-	-	-	-	-
Perceived need for change in clinical practice in a certain area	-	-	-	-	-	-

Any comments or other factors

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Q38 Edit Question ▼ Move Copy Delete

*** Guideline characteristics:**

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not sure/ don't know
Produced by a reputable body or authority	-	-	-	-	-	-
General practitioners involved in development guideline	-	-	-	-	-	-
An organisation of which I am a member was involved in the guideline production	-	-	-	-	-	-
Guidance consistent with other available sources or my previous practice	-	-	-	-	-	-

Any comments or other factors

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Q39 Edit Question ▼ Move Copy Delete

*** Accessibility of the guideline**

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not sure/ don't know
Easy to access or in a format I recognise so I can find key information quickly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recommendations are written in a clear, logical, and well organised manner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Executive summary or clear algorithm showing clinical recommendations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not too long	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Any comments or other factors	<input type="text"/>					

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Q40 Edit Question ▼ Move Copy Delete

*** The evidence on which the recommendations are based:**

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not sure/ don't know
Study outcomes used are relevant and important to primary care population	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Evidence underpinning recommendation comes from secondary care population	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Link from evidence to recommendation is clear and logical and easy to find	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Applicability to primary care population e.g. severity of disease and co-morbidity is taken into consideration and discussed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Any comments or other factors	<input type="text"/>					

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Q41 Edit Question ▼ Move Copy Delete

Other attributes:

In the space below please describe any factors that you think are relevant which are not mentioned in the above list.

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Appendix 2

NICE guidelines- Focus group topic guide

Welcome & introduction of researchers

Purpose of focus group

Telling participants the general purpose of the focus group and the time estimate will be 1 hour

Reminding participants that their answers will be used for research remain confidential, and that their names will remain anonymous.

Get them to sign consent form

Starting (warm up) questions

Do you ever read a guideline? Do you use guidelines? How many times you think you referred to guidelines in the last month?

What do you think of NICE guidelines?

Can you think of any recent examples where you referred to NICE to guidelines for consultation? And how did you find that?

Main discussion topic

What is your first reaction when you receive a new NICE guideline?

How do you identify recommendations that relevant to you?

What do you consider when you decide to adopt or use a certain guideline or recommendation? (Prompts here will be the list of factors identified from the literature and rated by the Delphi panel; characteristics, accessibility, evidence base)

How do you access guidelines and which version do you read (if you do)? do you ever check the GP representation on the development group, do you ever read the evidence to recommendation section?

If the evidence for a recommendation for use in primary care comes from studies done on secondary care, does this change your mind?

Going back to the earlier examples of good or bad recommendations encountered recently, why do you think these particular recommendations were good/ bad?

If you were to change something about current guidelines, what would you change?

What would make NICE guidelines more usable in general practice?