JRCALC Clinical Practice Guidelines

Guideline development process
March 2023

Approved at NASMeD 2nd March 2023

1. Introduction

The methodology adopted by AACE (Association of Ambulance Chief Executives) for the development of Clinical Practice Guidelines by JRCALC is designed to broadly follow the criteria used by the AGREE II (Appraisal of Guidelines for Research and Evaluation in Europe) collaboration to identify good quality guidelines: http://www.agreetrust.org/ with the final guidelines written as practical guidelines to assist clinicians when assessing and treating patients.

This methodology sets out a specific standard, common to all clinical practice guidelines developed on behalf of AACE and acts as a reference for members of guideline development sub-groups as they formulate a specific guideline. The full methodology is set out in Appendix 1, a summary process algorithm in Appendix 2 and details of the process is set out below.

2. Guideline selection

NASMeD (National Ambulance Service Medical Directors), the ALPG (Ambulance Lead Paramedic Group) and APN (ambulance pharmacy network) will advise AACE of clinical guidelines or medicines which need updating and those clinical conditions which need a new guideline. Clinical topics will be identified through a variety of means including user feedback, the monitoring of serious incidents (SIs) within individual UK Ambulance Service NHS Trusts, preventing future death directives (PFDs) issued by coroners, new or updated NICE/SIGN guidelines, new evidence, changes to ILCOR/RCUK guidance and through other national mechanisms. With regard to medicines, if a medicine is discontinued or when the Specialist Pharmacy Service (SPS) suggests a review of a medicine in line with national PGDs then a review would take place. In addition, the JRCALC (Joint Royal Colleges Ambulance Liaison Committee) will provide their extensive clinical expertise and advice on potential new clinical developments, new evidence and to ensure that the guidelines capture the most up to date best practice.

Dates that guidelines were issued or updated will be monitored by JRCALC and an archive of guidance will be maintained that allows for academic and legal review of changes. The general intent is that guidelines and medicines will be reviewed and updated if necessary, at least every 3 years.

3. Guideline development groups

JRCALC will propose which specialities and expertise will be required for each specific guideline development and in particular will draw upon its members along with clinical, academic, pharmacist or other colleagues to form an expert clinical guideline development group. Appropriate levels of

paramedic input will be required for all guideline development groups. Each guideline development group should consider incorporating a mix of the following skills:

- A subject matter lead from the JRCALC committee to act as the guideline group lead or to act as a link to the JRCALC committee.
- Specialist clinical expertise (e.g. medical, surgical, etc.)
- A pharmacist (e.g. via the ambulance pharmacists network APN)
- Relevant specialist expertise (e.g. police, social services, mental health etc.)
- Relevant patient input (e.g. disease-specific patient support groups)
- Academic support for the literature search and review by the Library and Knowledge Service (LKS) for NHS Ambulance Services in England
- Practical experience and understanding of the delivery of care relevant to that guideline
- Communication and team working abilities
- Critical appraisal skills

4. Guideline Chair

The chair will either be a JRCALC member, or approved by the JRCALC committee as an appropriate guideline group chair. The Chair of a guideline development group must ensure that all members of the group feel able to contribute fully to the guideline development process and should be aware that the guideline will be recommended for implementation across the UK and should ensure that the widest possible range of views are considered.

5. Guideline development group members

Guideline development group members must make a full commitment to the time required and tasks involved in developing the guideline and must be responsible for raising any areas of new evidence or any concerns to the Chair.

Guideline development members will be sent a letter requesting their acceptance of responsibilities including:

1. To respond to requests to contribute to guideline development, meeting attendances (virtual or face to face) or other communications within a reasonable time frame.
2. To keep all correspondence, discussions or other communications confidential within the group.
3. Not to share drafts of Guidelines outside the development group unless specifically authorised to do so.
4. To declare any conflicts of interest, including any connections to current or proposed studies or research

6. Peer review

All final draft guidelines will be reviewed by the JRCALC committee. Their review will broadly follow the AGREE II format and any feedback will be noted and consensus agreed. If no changes are made then this will also be recorded along with approval of the guideline.

7. Approvals process

All new and updated guidance will be approved by the JRCALC committee members. Guidance may have been previously tabled for discussion around areas where there is a lack of clinical evidence or where consensus may need to be sought.

Following JRCALC committee approval, the guideline will also be reviewed by NASMeD to allow further expert review. This will provide confidence that any risk of bias within the development process has been minimised. The final version of the guideline will then be signed off by NASMeD and released for publication.

8. Timelines

It is planned that for any new or updated guideline or medicine the process should be completed within 3 months. It must be noted that there may be exceptions to this, but the JRCALC chair should be notified of any anticipated delays so that a discussion can take place about providing additional support or including changes to the chair or individual guideline group members. It also must be noted that guideline group members are all volunteers and have competing priorities on their time.

Following JRCALC and then NASMeD approval, notification will be sent to the following groups for information and comments on any inaccuracies or major issues at least 4 weeks prior to publication on the JRCALC App.:

- NASMeD
- Ambulance lead paramedic group (ALPG)
- Ambulance pharmacists' network (APN)
- National education network for ambulance services (NENAS)
- Ambulance trust named JRCALC App leads

A proposed publishing date will be given. If this date changes, further notification will be given of a revised date. This may happen for example if the Publishers have a technical issue with the App that is unforeseen.

On the day of publication NASMeD, ALPG, APN, NENAS and JRCALC App leads will all be notified.

9. Equality impact assessments

An EIA will be completed for each new or updated guideline and saved in the AACE storage folders.

10. Recommendations for research

At the completion of any updated or new guidance, any new recommendations for research will be considered and if any guideline-specific recommendation are identified, will be forwarded to the national ambulance research steering group chair (NARSG) for information.

Appendix 1

The guideline development process.

The full process for the development of individual guidelines is set out below and has been designed to broadly follow the AGREE II criteria on which is based. (AGREE II: Advancing guideline development, reporting and evaluation in healthcare. *Parallel publications in progress*). It is the responsibility of each guideline development group to ensure that the process is adhered to and that it is clearly documented so that the full process can be audited.
It should be noted that the finished guideline will not have all the components of the development process written within it, but these will be documented as part of the process and saved by AACE as a record.

Section 1: Scope and purpose

1. *The overall objective(s) of the guideline is (are) specifically described.*

   The overall objective(s) of the guideline should be described in detail and the expected benefits from the guideline should be specific to the clinical problem or health topic. A description of the context in which the guideline should be included as well as any specific exclusion criteria when the guideline should not be used when appropriate.

   For example, a specific statement could be:

- Providing guidance on the most effective therapeutic treatment and management of patients with exacerbation of COPD in the pre-hospital environment.

- The opening paragraphs of the guideline should contain a description of its scope and purpose. The rationale or need for the guideline should also be considered prior to the commencement of the guideline review or for any new guideline.

2. *The clinical condition(s) covered by the guideline is (are) specifically described.*

   A detailed description of the condition(s) covered by the guideline should be provided along with any specific information that is relevant to the pre-hospital presentation of the condition(s)

3. *The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.*

   A clear description of the patient population covered by the guideline should be provided. The age range, gender, clinical description, and comorbidity may be provided.

   For example:

   This guideline on the management of feverish children is only applicable to children over the age of 3 months and under the age of 12.

Section 2: Stakeholder involvement

4. *The guideline development group includes individuals from all relevant professional groups.*

   This item refers to the professionals who were involved at some stage of the development process. Information about the composition, discipline, and relevant expertise of the guideline development group should be provided to demonstrate all relevant groups are represented, providing expertise in all aspects of the patient's care before reaching hospital.

5. *The views and preferences of the target population (patients, public, etc.) have been sought.*

   The expectations and experiences of patients should inform the development of guidelines. There are a number of ways to ensure that these perspectives are included in the guideline including expert patients, stakeholder review of draft documents, interviews or consultations and literature reviews of current patient preferences. Where patient groups review draft versions of the guidelines a copyright agreement must be obtained prior to the release of documents. The guideline should include evidence that patient consultation has taken place and an equality impact assessment should be made during the development of the guideline.

6. *The target users of the guideline are clearly defined.*

   The UK Ambulance Service Clinical Practice Guidelines are developed specifically for use within the UK by Ambulance Service Trusts and this should be clearly stated within the

guideline. However, other target users can be defined such as pre-hospital doctors so that the reader can see if the guideline is relevant to them.

Section 3: RIGOUR OF DEVELOPMENT

7. Systematic methods were used to search for evidence.

A description of the search strategy must be included and this should include the search terms, sources (e.g. MEDLINE, CINAHL etc.), databases of systematic reviews and other guidelines. The search strategy should be as comprehensive as possible to remove bias and should be based upon a clear set of focused clinical questions. The formulation of these questions is the responsibility of the guideline development group but should be structured using the PICO format:

Patients or population to which the question applies

Intervention being considered for these patients

Comparison(s) to be made between those receiving the intervention and another group who do not receive the intervention

Outcome(s) these should be objective in nature but can also include outcomes which are important to patients.

Once the search strategy has been formulated the literature search will then be undertaken on behalf of the guideline development group.

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8. The criteria for selecting the evidence are clearly described.

The criteria for the inclusion or exclusion of evidence identified by the search should be provided. These criteria must be described explicitly and any reasons for the inclusion or exclusion of evidence must be clearly explained, e.g. guideline sub-groups may decide not to include evidence from studies based in countries where the results are not deemed as transferable to UK prehospital clinical practice.

9. The strengths and limitations of the available evidence are clearly described.

A clear statement highlighting the strengths and weaknesses of the available evidence must be provided. Any tool or methods used to assess for bias within the evidence base must be clearly described. Additionally the use of any formal instruments (e.g. GRADE) to grade the evidence must be clearly stated.

10. The methods for formulating the recommendations are clearly described.

The guideline should include a description of the methods used to formulate the evidence. These may include informal consensus or voting systems or formal techniques such as Delphi. Any areas of disagreement should be discussed along with the resolutions.

11. The health benefits, side effects, and risks have been considered in formulating the recommendations.

The guideline should consider health benefits, side effects, and risks when formulating the guidelines. For example, a guideline on the management of asthma may include a section on the use of steroidal treatment. The benefits of any proposed treatment should be measured against the need to rapidly convey the patient to hospital.

12. There is an explicit link between the supporting evidence and the guidelines.

An explicit link between the guideline and the evidence on which they are based should be included. The clinician should be able to identify the evidence relevant to each recommendation. This will be supported by appropriate references in the guideline.

13. The guideline has been externally reviewed by experts prior to its publication.

Where deemed appropriate subject experts will be recruited at the same time as the guideline development sub-group and prior to the publication of each guideline they will peer review the proposed guidance and any recommendations will be commented on. Any actions taken should be clearly described as should any review suggestions that were not acted on and why. The peer review should be made available by AACE along with details of guideline development.

14. A procedure for updating the guideline is provided.

Updating a guideline will normally be within 3 years of publication, however if new evidence is known or likely to be becoming available, an earlier review date may be proposed and agreed.

Section 4: CLARITY OF PRESENTATION

15. The guidelines are specific and unambiguous.

The guideline should provide a clear description of clinical care in an appropriate situation and which patients it is applicable to. It is important to note that there may be instances where the evidence is uncertain and this should be noted in the development of the guideline.

16. The different options for management of the condition are clearly presented.

A guideline that targets the management of a disease which can present with differing severities should describe the possible options for treatment. These possible options should be clearly presented in the guideline. For example, a recommendation on the management of asthma may contain the following treatment alternatives:

a. Treatment with salbutamol
b. Treatment with salbutamol and steroids
c. Treatment with salbutamol, steroids and adrenaline.

17. Key recommendations are easily identifiable.

Clinicians should be able to find the most relevant recommendations easily. The guideline will be published in a format where the key clinical information designed for use at the point of care can be easily located and will be supported by the background information. Any guideline that has been updated will contain a key changes section so that the developments can be readily identified.

The treatment options must address the main question(s) that have been covered by the guideline and can be identified in different ways. For example, they can be summarized in a box, typed in bold, underlined or presented as flow charts or algorithms.

Section 5: APPLICABILITY

18. The guideline describes facilitators and barriers to its application.

There may be facilitators or barriers that will impact on the application of guideline recommendations e.g. a guideline on the management of major trauma may be dependent on the proximity of a major trauma centre and a certain amount of variation may be required at a local level to ensure that, where possible, patient care is not affected by local geography.

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19. The guideline provides advice and/or tools on how the guideline can be put into practice.

For a guideline to be effective it needs to be disseminated and implemented with additional materials. For example, these may include: a summary document, a quick reference guide, educational tools, results from a pilot test or a gap analysis. Any additional materials should either be provided with the guideline or their whereabouts clearly signposted.

20. The potential resource implications of applying the guideline have been considered during its development.

A new guideline may take into consideration current economic factors and any resource implications may also be considered. However the actual implementation and/or decision to adopt a new guideline within an ambulance trust is the role of NASMeD and individual trust medical directors and boards. JRCALC guidance is based on clinical evidence and not financial or economic considerations.

21. The guideline presents monitoring and/or auditing criteria.

Measuring the application of guideline recommendations can facilitate their ongoing use and wherever possible this should be derived from the key recommendations included in the guideline.

Section 6: EDITORIAL INDEPENDENCE

22. There is no external influence on the content of the guideline

There should be an explicit statement that the views or interests of any funding body have not influenced the final recommendations.

23. Competing interests of guideline development group members have been recorded and addressed.

There should be an explicit statement that all group members have declared whether they have any competing interests.

Appendix 2