1 2	Practitioners' views on primary care evidence in clinical guidelines: mixed methods study
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- 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.

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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.

Introduction

62

- 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
- assessment of the benefits and harms of alternative care options (1). Guidelines are seen as one of
- the key foundations for quality improvement in England and internationally (2), but their impact on
- 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.

94 **Methods**

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- 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.

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
- 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
- those who had already responded to the Delphi. A total of 115 practices in Norfolk and Waveney
- were invited by the Primary Care Research Network (PCRN). Participants were purposively sampled

- 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
- 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
- of expert views(27). The survey was piloted on a small group of general practitioners. Two rounds of
- 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
- guidelines and then two main sections, first about the applicability of primary care evidence, and
- 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
- 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
- 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
- being "strongly disagree that this attribute is most likely to encourage use of clinical guideline" and 5
- being "strongly agree") a list of 16 attributes affecting guideline use, collated from the literature and
- arranged under four categories. The participants were also asked to provide free text comments,
- which were analysed thematically.
- 137 After the first round, each participant was sent the mean scores, as well as their own scores, and
- then asked to re-rate both the recommendations and the attributes in a second round. The
- difference in mean scores before and after reading the evidence summary was tested using a paired
- t-test, after tests for normality in Stata/SE (29).

Focus groups

141

- 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
- 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
- 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
- independent researcher to ensure impartiality, assisted by a member of the research team (AA).

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

 Results

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

160

159 Insert table 1

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
- increased for recommendations where the majority of cited publications were applicable to primary
- care populations (Table 2). While the majority of respondents altered their ratings modestly (raising
- 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
- or not clearly defined, and that a GP 'user' perspective should be included at all stages of guideline
- 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.
- "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
- 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
- the old adage "first, do no harm". Most of the recommendations considered met these criteria (e.g.
- 179 prescription of thiamine): if the quidelines were suggesting radical change to practice or invasive
- 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
- 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
- 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
- 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
- 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
- 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
- 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
- deal with comorbidities and symptoms pre-diagnosis. They wanted guidelines to be short and clear.
- 218 Insert quotes
- 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

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228 229 230 231 232 233 234 235 236 237 238	Overall, NICE guidelines were viewed favourably as a major source of practice guidance. Participants commented on the large numbers of guidelines, their need for concise summaries, the advantages of user-friendly web based versions, and the need to identify relevant guidelines quickly when uncertainty drove usage. The groups felt they had to trust the process of derivation and the comprehensive uploading of relevant guidelines, as they had little time to check either background or the availability of guidance. There was considerable evidence of individuals and practice teams trying to be systematic about updating local protocols and templates in line with new guidance, but with concern about the time and feasibility of this given the pressures of work and numbers of guidelines. Streamlining of local protocols across the team, between practices, and with secondary care, and the requirement to meet multiple guidelines as well as QoF indicators all presented additional challenges.
239240	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

College of General Practitioners also produces national clinical guidelines that are dedicated to

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

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

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

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

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

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321 Ethical approval

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

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418 Box 1: Focus group quotes

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 (400/)
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	Mean rating before evidence	Mean rating after evidence	Difference after
recommendation number	(n)	(range)*	(range)*	seeing evidence (95%CI)
Low PC relevance of studies ¹	(/	(1.0.1.80)	(86)	(55756.)
CG100/R17(Alcohol &	0/2	7.2 (4-9)	5.6 (2-9)	-1.6**(1.14-
thiamine)				2.22)
CG101/U4(Long acting	0/1	7.7 (5-9)	6.0 (2-9)	-1.7**(1-2.44)
muscarinic antagonist in COPD))			
CG101/U1(Post bronchodilato	r 0/2	7.5 (5-9)	6.0 (2-9)	-1.5** (0.86-
spirometry in COPD)				2.18)
CG108/R27(Offer ACE	0/7	7.8 (3-9)	6.9 (1-9)	-0.9** (0.35-
inhibitors & β blockers for				1.49)
heart failure)				
CG116/ R11(Trial elimination of	of 0/10	6.2 (3-9)	4.6 (2-9)	-1.6** (1.08-
the suspected food allergen)				2.17)
CG122/R 1.1.2.1(Serum CA125	5 0/6	7.9 (5-9)	5.8 (2-9)	-2.1** (1.34-
in PC in ovarian cancer)				2.90)
Medium PC relevance of stud	ies²			
CG127/R15(Ambulatory BPM	20/50	7.5 (2-9)	6.5 (2-9)	-1.0** (0.24-
to confirm hypertension)				1.76)
CG127/R16(Home BPM to	3/8	7.4 (4-9)	6.4 (2-9)	-1.0** (0.56-
confirm hypertension)				1.52)
CG122/R 1.1.1.2(Test women	9/16	7.7 (5-9)	7.1 (3-9)	0.6** (0.05-1.23)
with persistent symptoms for				
ovarian cancer)				
CG123/R1.3.1.1(Ask people	11/20	6.6 (1-9)	6.6 (1-9)	0 (-0.38-0.46)
who may have depression 2				
questions)				
High PC relevance of studies ³				
CG108/R3(Measure serum	2/3	8.2 (6-9)	8.3 (6-9)	+0.1 (-0.27-0.27)
natriuretic peptides in heart				
failure)				
CG95/R1.2.1.3(Acute	3/4	7.8 (5-9)	7.8 (4-9)	0 (-0.18-0.26)
coronary syndrome)				
CG102/R 1.2.2(Children &	4/5	7.1 (2-9)	7.4 (2-9)	+0.3 (-1.02-0.54)
meningitis without rash &				
antibiotics				
CG101/U2(Consider	4/4	7.2 (4-9)	7.6 (3-9)	+0.4 (-1.1-0.28)
alternative diagnosis if				
FEV1/FVC is <0.7				

^{*}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.

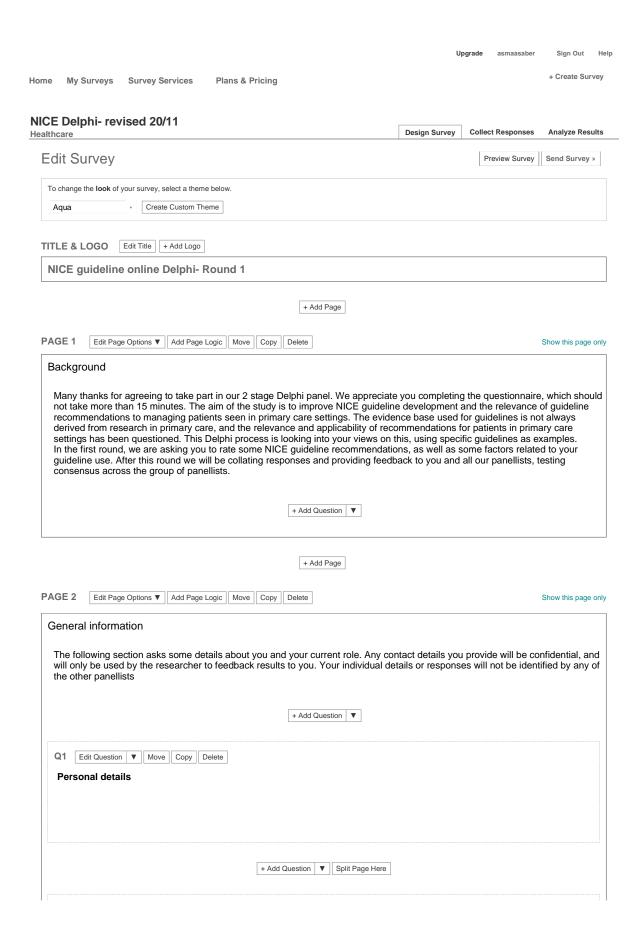
^{3.} High PC relevance = Majority of the studies cited as evidence had their participants selected from PC or the community.

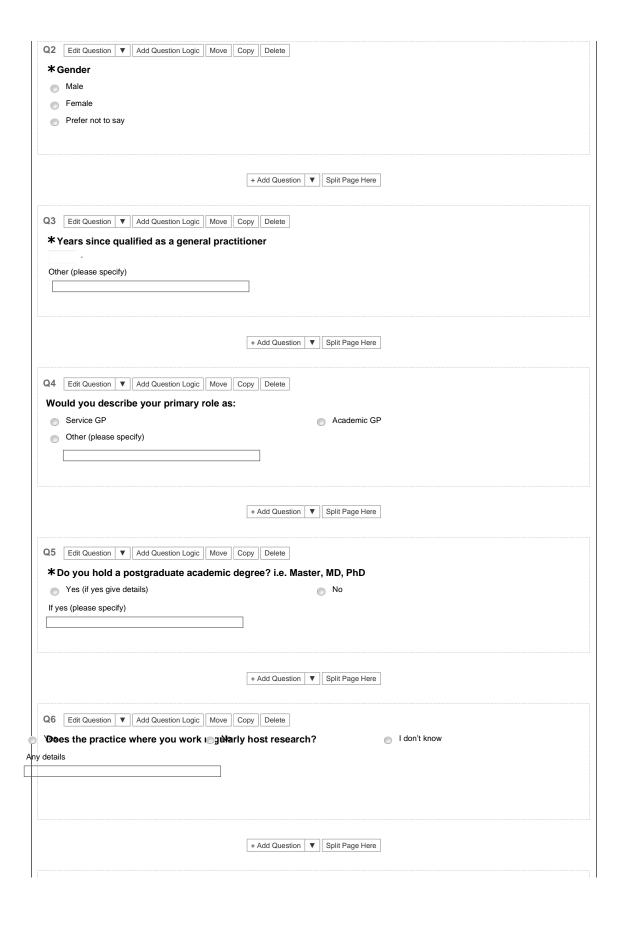
Table 3: Scores for attributes affecting guideline use

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	3.8 (2-5)
diagnosis	
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	3.5 (2-5)
the guideline production	
Guidance consistent with other available sources or my previous	3.9 (2-5)
practice	, ,
Factors related to the accessibility of the Guideline:	
Easy to access or in a format I recognise so I can find key	4.7 (4-5)
information quickly	
Recommendations are written in a clear, logical, and well	4.7 (4-5)
organised manner	
Executive summary or clear algorithm showing clinical	4.6 (4-5)
recommendations	
Not too long	4.4 (3-5)
Factors related to the evidence on which the recommendations a	re based
Study outcomes used are relevant and important to primary care	4.5 (2-5)
population	
Evidence underpinning recommendation comes from secondary	2.8 (1-5)
care population	
Link from evidence to recommendation is clear and logical and	4 (2-5)
easy to find	
Applicability to primary care population e.g. severity of disease	4.5 (2-5)
and comorbidity is taken into consideration and discussed	

Appendix 1

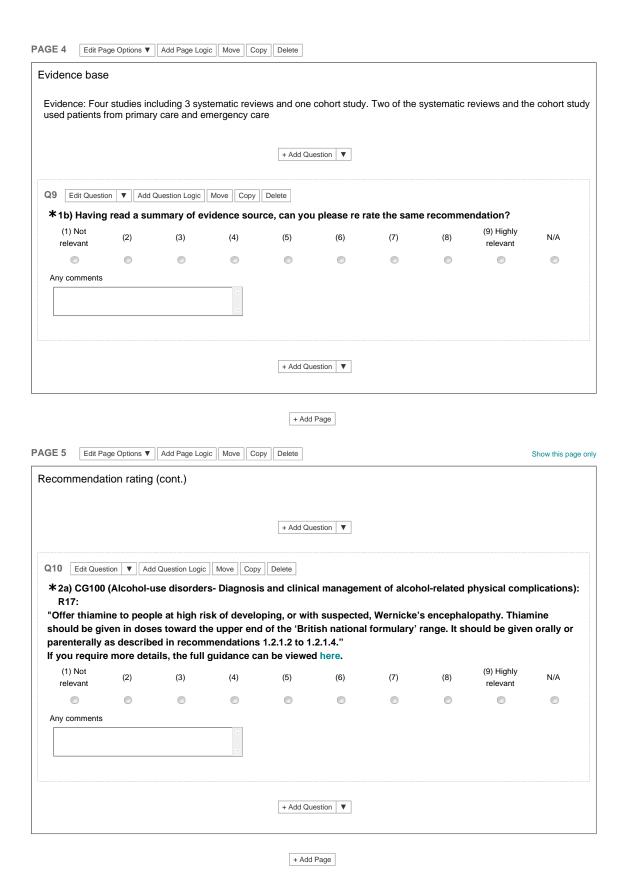
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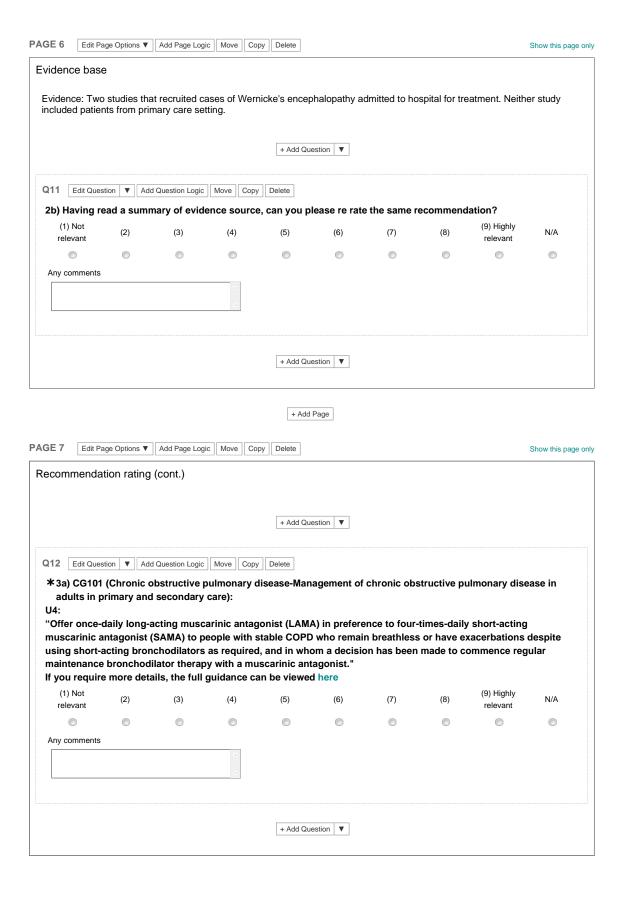


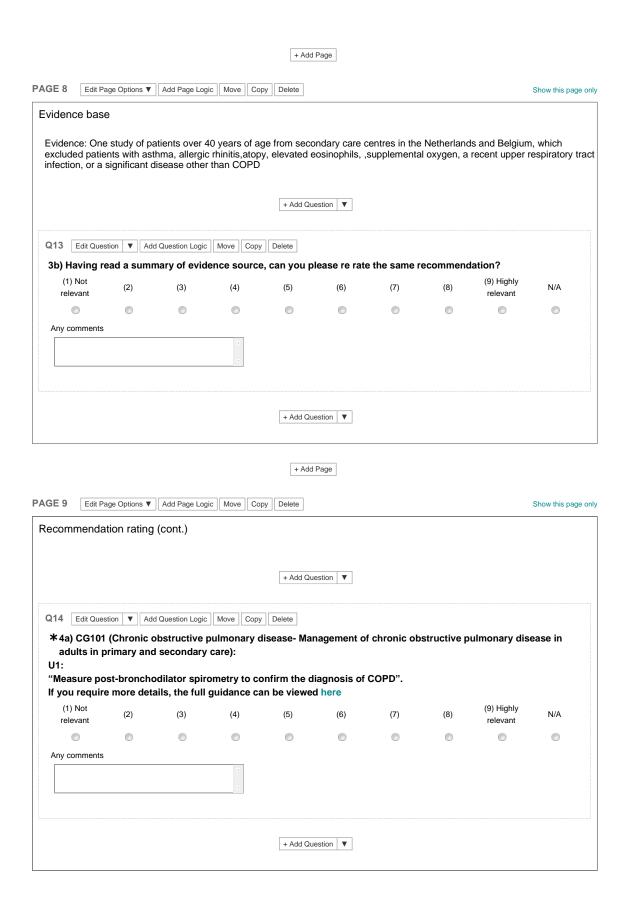


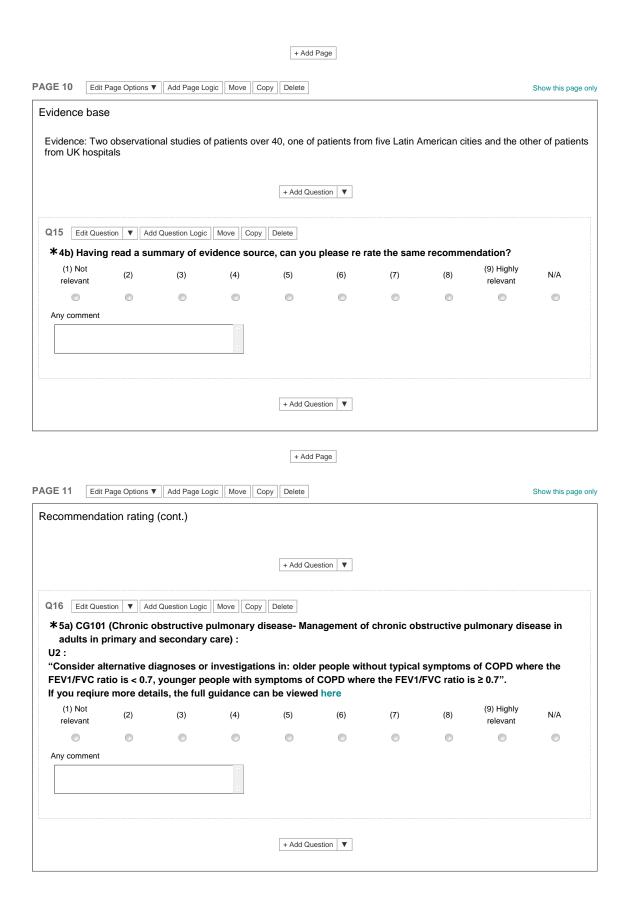
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		n on a scale	from 1 - 9. A	A score of 9 v	would mean	a recommen	dation that	you trust, are li	kely to use
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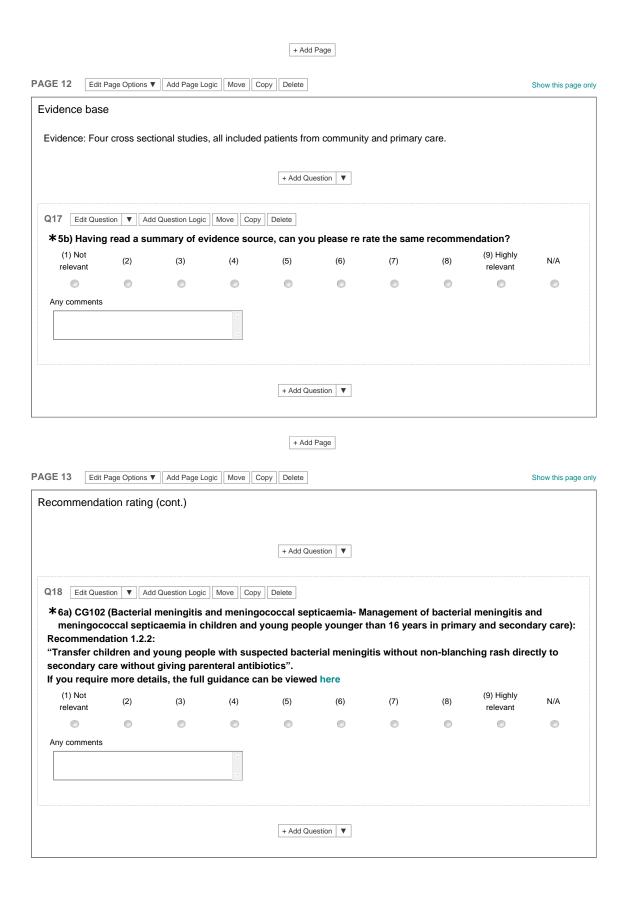
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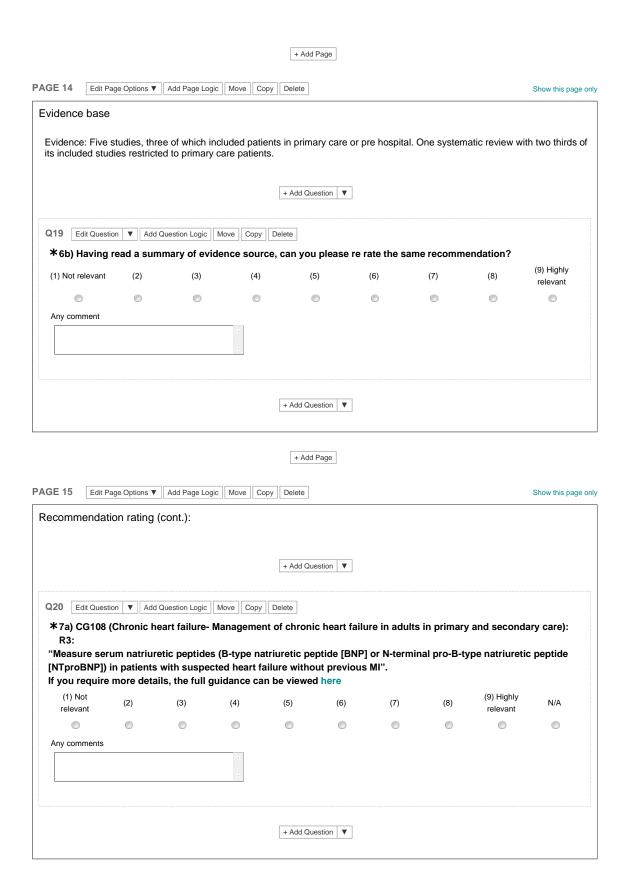


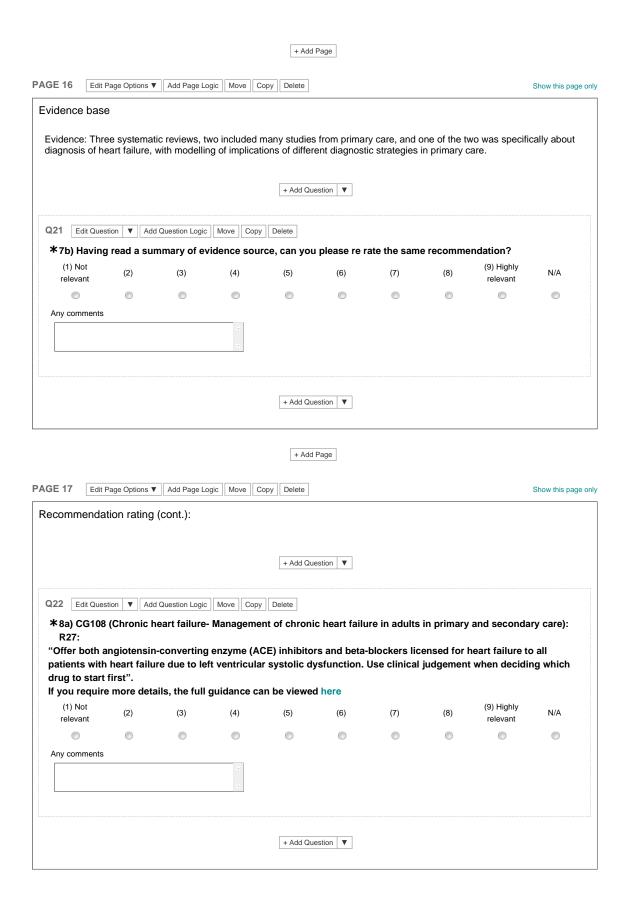




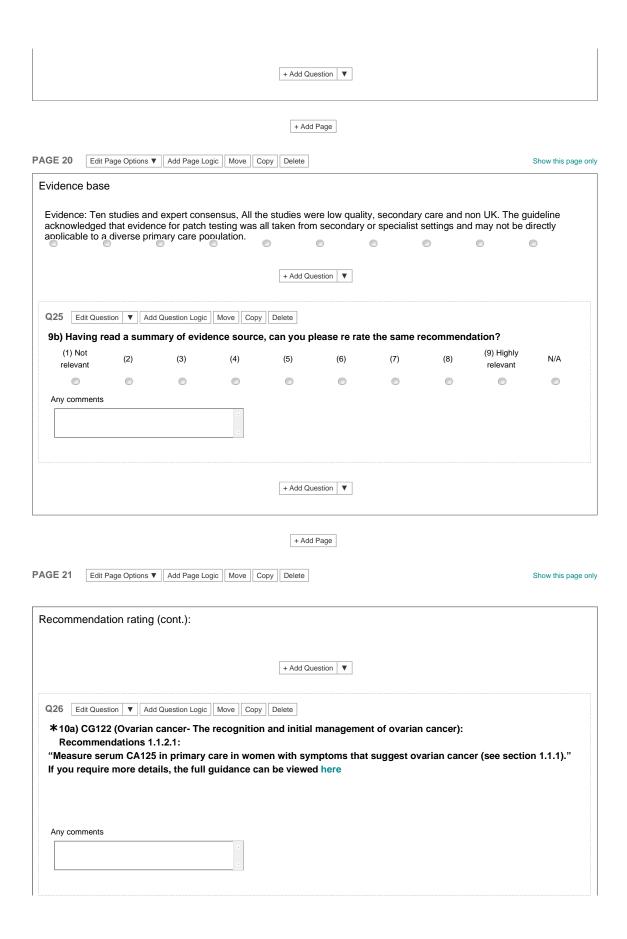


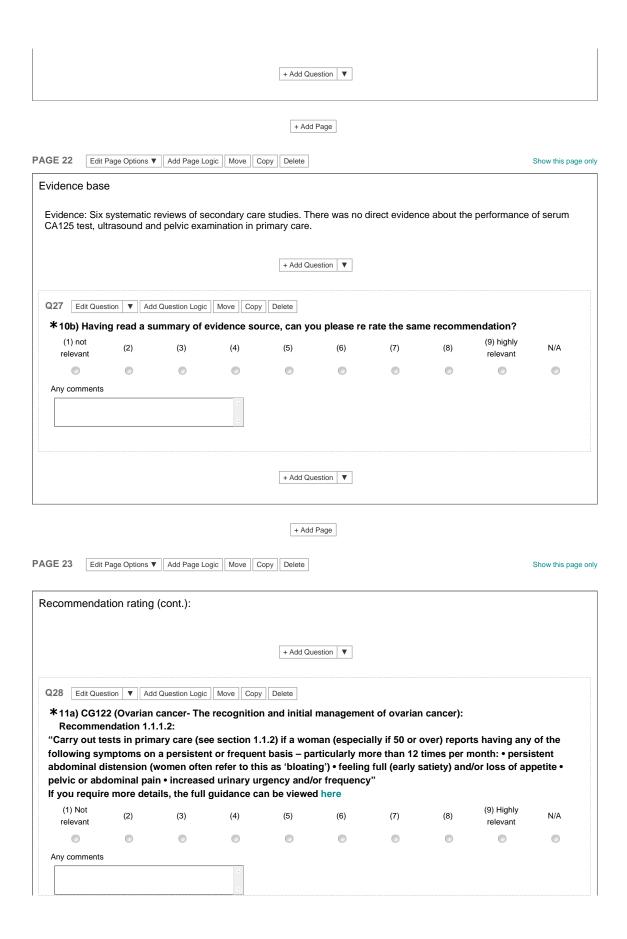




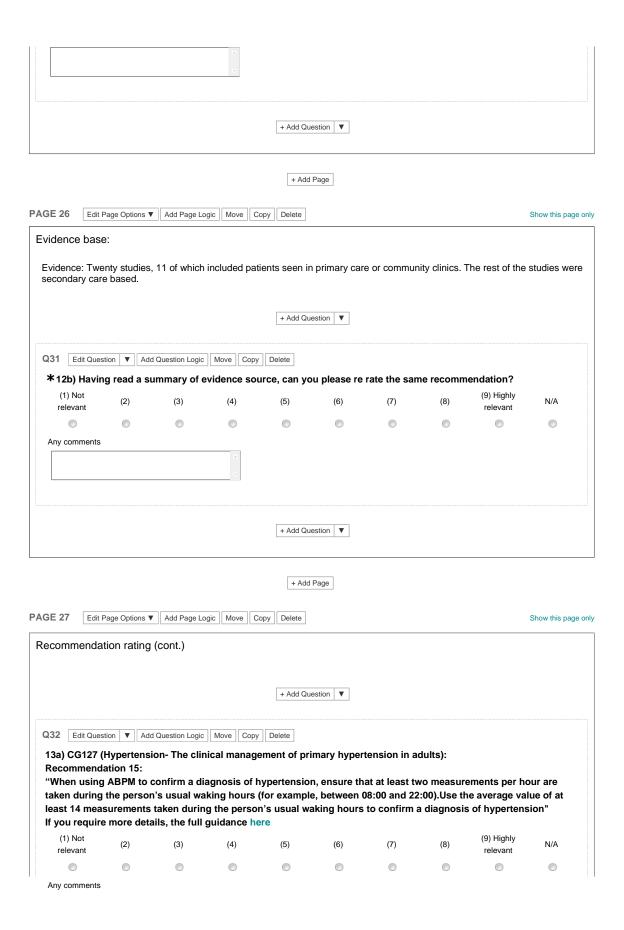


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Guideline attributes						
Below is a list of guideline attributes identified from the literature: The attributes have be divided into different categories presenting guidelines, please rate each factor on a scale of 1-5 (5 being you you to use a clinical guideline and 1 being least likely to encourage for 'don't know/unsure'. At the end of each section there is a space think are relevant. + Add Queen Add Que	g various a I strongly a ge you to u ce for you t	spects of gree that se a guid	the guideli this attribu eline). Eac	ne. With a te is mostly h section a	specific f y likely to also allow:	ocus on NICE encourage s you to opt
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	0	-	-		-	-
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	-		0		-	-
Any comments or other factors						
+ Add Question ▼	Split Page F	Here				
Q38						
★ Guideline characteristics:						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not sure/ don't know
Produced by a reputable body or authority	-	0	0	0	0	-
General practitioners involved in development guideline	0	0	0	0	0	-
An organisation of which I am a member was involved in the guideline production		0		0	0	-
Guidance consistent with other available sources or my previous practice	0	-			0	-
Any comments or other factors						

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k Accessibility of the guideline						
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not sure/ don't know
Easy to access orin a format I recognise so I can find key information quickly			0		0	
Recommendations are written in a clear, logical, and well organised manner			0		0	
Executive summary or clear algorithm showing clinical recommendations		0	0		0	
Not too long			0		0	
Any comments or other factors						
+ Add Question ▼	Split Page H	Here				
40 Edit Question ▼ Move Copy Delete						
40 Edit Question ▼ Move Copy Delete kThe 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	n —	-	-	-	0	-
Evidence underpinning recommendation comes from secondary care population	0	0			0	-
Link from evidence to recommendation is clear and logical and easy to find		-	-	-		
,						-
Applicability to primary care population e.g. severity of disease and co-						-
Applicability to primary care population e.g. severity of disease and comorbidity is taken into consideration and discussed		-	0	-	0	
Applicability to primary care population e.g. severity of disease and comorbidity is taken into consideration and discussed			0	-		
Applicability to primary care population e.g. severity of disease and co- morbidity is taken into consideration and discussed		0	-		-	0
Applicability to primary care population e.g. severity of disease and comorbidity is taken into consideration and discussed		-	-		-	
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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 you 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 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?