Understanding RCEM Best Practice Guidelines

Christopher Humphries [1], Adrian A Boyle [2], James France [3], Paul Hunt [4]

Royal College of Emergency Medicine (RCEM) Best Practice Guidelines are produced by a variety of special interest groups or convened expert advisory groups which sit under the umbrella of the College's Quality in Emergency Care Committee (QECC).[1] They are produced to bridge the gap between systematically derived evidence-based recommendations and the need for emergency clinicians to provide quality care and advice to patients, or to respond to evolving trends.

Unlike National Institute for Health and Care Excellence (NICE) guidelines, which are costly to produce, incorporate calls for evidence, formal evidence searches and economic evaluation, and take significant periods of time to produce, RCEM guidance is produced by volunteer members. The RCEM working groups and committees are often required to produce guidance at pace, making recommendations where only limited evidence exists or on the basis of expert opinion.

These guidelines go through a peer-review process (being circulated both within the guideline group and all members of the wider QECC for comment) before having amendments made, formatting finalised and being published on the RCEM website. Subsequent comment on published guidelines is welcomed, and consideration is given to amending guidelines where new evidence is identified which impacts on recommendations. Guidelines are also subject to a review date, after which they should be reviewed with regard to relevance and the need to update.

Care is taken to restrict the scope of guidelines to practice within emergency departments. If interface with other professional groups or clinical specialties is required for the purposes of the guidance, then collaboration is invited from suitable representatives to ensure that potential issues are anticipated wherever possible. Cobadging of guidelines does occur although this is rare, as the process of taking guidelines through multiple non-aligned governance processes can lead to significant delays.

The opportunity to begin publishing Best Practice Guidelines in the *Emergency Medicine Journal* is a welcome one, which we hope will improve dissemination of recommendations, act to invite greater engagement with the College and encourage shared learning to drive high-quality care.[2] Some limited changes have been required, the most notable of which is introducing a classification system for key recommendations. The most applicable classification system for retrospective use was felt to be the Strength of Recommendation Taxonomy (SORT), which has some similarities to the system currently employed by the American College of Emergency Physicians.[3 4] SORT is a patient-oriented recommendation grading system, with well-defined algorithms for assessing the strength of recommendations. In contrast to some alternative systems (such as Grading of Recommendations, Assessment, Development, and Evaluations - GRADE), it does not require author systematic reviews when making recommendations.[5]

We would like to take this opportunity to express our sincere appreciation to everyone who has volunteered their time in the past, or will do so in the future for the production of RCEM Best Practice Guidelines which continue to play a key role in supporting staff to provide the best possible care for patients. We look forward to welcoming proposals to the committee, and working together with RCEM members and the *EMJ* readership to identify areas for guideline development and to promote quality improvement.

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