

HDA EVIDENCE BASE

**PROCESS AND QUALITY STANDARDS MANUAL FOR
EVIDENCE BRIEFINGS**

Third edition

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SECTION 1

INTRODUCTION AND BACKGROUND

The Health Development Agency (HDA) was established as a Special Health Authority in 2000, following the publication of the *Saving Lives: Our Healthier Nation* White Paper (Department of Health, 1999), and operated from this time until the end of March, 2005. One of the Agency's core functions was to build the evidence base in public health and health improvement, particularly with regard to the effective reduction of health inequalities.

To fulfil this function, the HDA developed a web-based database called HDA Evidence Base (HDA-EB), to disseminate the best available evidence on what works to improve health and reduce health inequalities. The database contained syntheses of review level data, reviews themselves where electronically available (or links to them), and other resources and links to evidence based public health practice. It was launched early in 2001 with the intention of further development to bring together the best available evidence on public health improvement as part of the larger Public Health Electronic Library (PHEL) project.

The HDA-EB database contained:

- pdf files of recent systematic and other reviews of effectiveness (if they were available in the public domain)
- Topic-specific evidence briefings, based on collation and synthesis of review level data prepared by the HDA's Evidence & Guidance Directorate.

The website itself also contained a gateway to other sources of evidence for public health.

Topic priorities for the project were determined by a number of factors and documents, including:

- Choosing health: Making healthier choices easier (the public health white paper)
- The Department of Health's Research and Development Strategy for Public Health
- The NHS Plan
- The Priorities and Planning Framework
- The Department of Health's Public Service Agreement
- Tackling health inequalities: A programme for action
- Topic-specific National Service Frameworks (NSFs)

(Please refer to the publications section of the Department of Health website:

<http://www.dh.gov.uk/PublicationsAndStatistics/Publications/fs/en> for document details.)

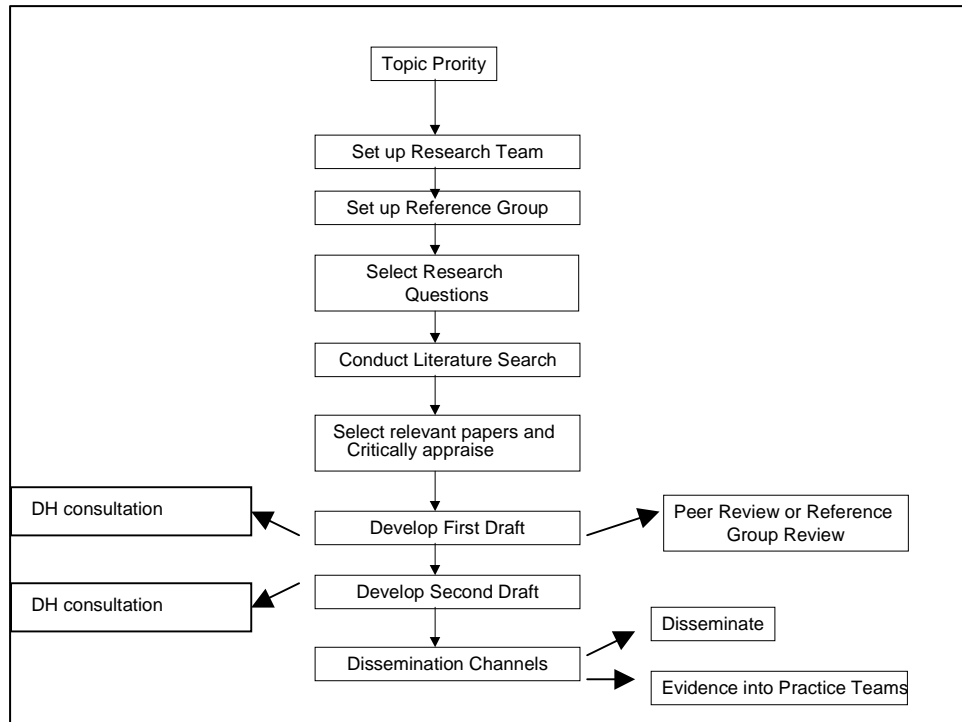
Meeting the priorities set out in these documents required the HDA's evidence base to be up-to-date and responsive, surveying a wide landscape of public health matters, with a focus on reducing inequalities. This manual describes the process and methodology developed to produce one part of the overall HDA evidence project - evidence briefings. The procedure was formulated and developed over time and across different projects at the HDA, to ensure that conclusions were based on a sound, reliable, transparent and replicable method. An overview is presented in figure 1.1.

Development of the evidence briefing methodology began in early 2001, and the first briefing (on alcohol, now replaced by a second edition) was published in June 2002. A series of further briefings followed:

Prevention and reduction of alcohol misuse	Jun 2002
Health impact assessment (HIA)	Oct 2002
Teenage pregnancy and parenthood	Feb 2003
HIV prevention	Mar 2003
Prevention and reduction of accidental injury in children and older people	Jun 2003
Promoting breastfeeding	Jun 2003
Prevention of low birth weight	Jul 2003
Management of obesity and overweight	Oct 2003
Prevention of sexually transmitted infections (STIs)	Jan 2004
Ante- and post-natal home visiting programmes	Feb 2004
Smoking and public health	Apr 2004
Drug use prevention among young people	Sept 2004
Youth suicide prevention	Oct 2004
Increasing physical activity among adults	Feb 2005

At the time of writing, further evidence briefings on second hand smoke, housing, and the second edition on prevention and reduction of alcohol misuse were in press,

Figure 1 Overview of the procedure for producing evidence briefing documents



SECTION 2

AIMS AND OBJECTIVES

2.1 Aims and objectives of HDA-EB & evidence briefings

The primary aim of the HDA-EB project was:

- To collate, host and disseminate the best available evidence on interventions to improve public health and reduce health inequalities, in order to strengthen local and national public health action on tackling health inequalities, and build public health knowledge and capacity to tackle health inequalities.

Evidence briefing documents aimed to:

- Identify all relevant review level data about the effects of interventions, with particular reference to disadvantaged and vulnerable groups, in a topic area
- Review the evidence provided in these papers
- Highlight conflicting evidence, gaps in the evidence and make recommendations about future research and commissioning.

The HDA evidence project also generated other products:

- *Evidence reviews*: these are narrative or other kinds of review or syntheses of multiple evidence sources drawn from different research traditions. The protocols for the construction of these documents are in the early stage of development and will be described in a future document.

2.2 Aims and objectives of the manual

This manual was developed as a guide for both HDA researchers and collaborating partners to the production of evidence briefings. Guidance is provided on:

- Developing a topic area and producing an Evidence briefings
- Setting up reference groups
- Searching for reviews
- Appraising and synthesising results
- Writing a brief.

The manual contains guidance and documentation required to undertake each step of this process. Where it has not been possible to include certain documents in the manual, their location is noted.

This manual is a stand-alone document for researchers and complements existing manuals developed by the HDA to aid with the undertaking of research and dissemination of information.

SECTION 3

OVERVIEW OF THE PROCESS

3.1 Introduction

This section provides an overview of the process of developing and producing an evidence briefing paper.

3.2 Building the evidence base – The HDA process

The HDA-EB database and evidence briefings were aimed at public health policy and decision makers, practitioners, and researchers. Four streams of work contributed to the development of the project as a whole:

Stream 1: Projects (including the creation of a Public Health Evidence Steering Group (PHESG) and its Methodologies Reference Group) aimed at building the methodological and epistemological structures for the collation and interpretation of evidence for public health.

Stream 2: Projects engaged in mapping and synthesizing review-level evidence in priority topic areas (including evidence briefings)

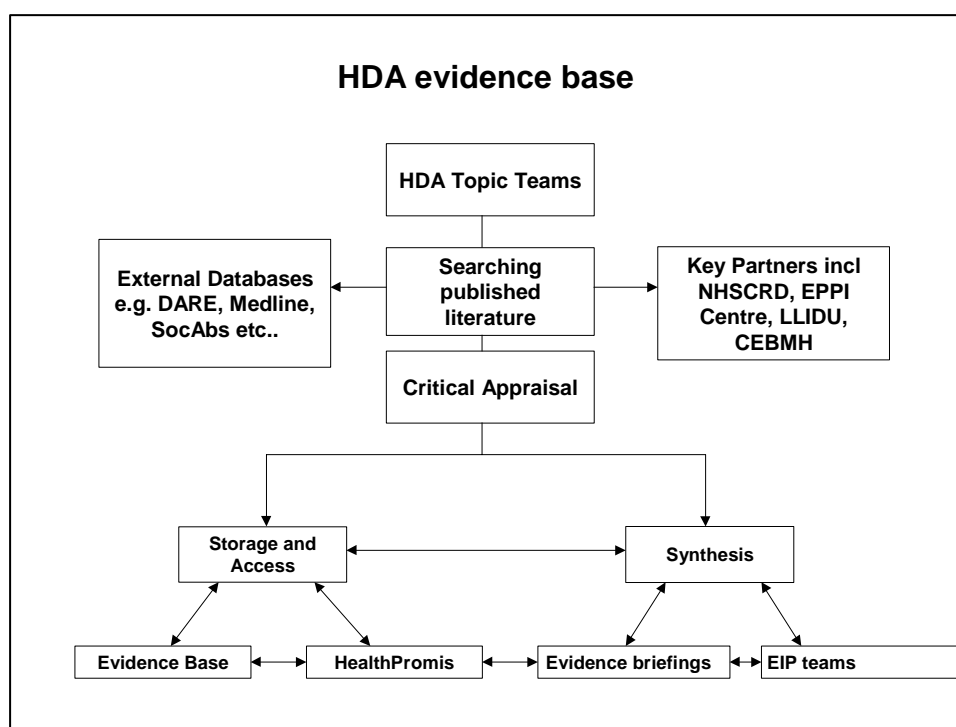
Stream 3: Projects concerned with dissemination via electronic and web media:

- developing and maintaining a web gateway to international sources of evidence
- managing and updating the database itself
- developing quality assurance protocols for the site's form and content, and linking in with the PHEL project.

Stream 4: Projects concerned with transferring learning from Evidence briefings and methodological work into practice.

Figure 3.1 below illustrates how these different strands of work relate to each other, and how each contributes to the HDA-EB project as a whole.

Figure 3.1. Building the evidence base in the HDA



3.2 Developing evidence briefings

The stages set out below illustrate the activities and procedures that need to be completed in order to produce an evidence briefing.

3.2.1 Topic priority

Topics for inclusion are determined at the start of the business year. Factors that influence topic selection are:

- National public health targets and priorities
- Forthcoming and recent government strategies and frameworks
- Key partnerships

3.2.2 Set up a research team

Once a topic has been selected, a project team is formed consisting of research and public health specialists. The objectives of the team are to:

- Identify key national documents such as relevant national service frameworks and policy documents
- Formulate the guiding research questions that the team will pursue
- Develop topic-relevant search terms
- Identify potential reference group members.
- Write the evidence briefing

3.2.3 Set up reference group

Reference groups should consist of research, public health and government topic specialists, and practitioners. Their role is to

- Monitor the progress of the project team
- Inform the content of the brief
- Review the final document.
- Advise on appropriate dissemination channels

- Advise on developing the evidence into practice
 - Quality control of the process on behalf of the Public Health Evidence Steering Group
- Invitations to external parties to join the reference group should come from director level.

3.2.4 Select research questions

Once the topic has been selected and the teams formed, the research questions that form the basis of the brief are selected, usually on the basis of priorities identified in current policy and practice, and prevailing inequalities in a topic area. Two documents need to be produced at this stage:

- A project information sheet, containing information about the team members, outline, scope, group members, milestones and progress to date.
- A protocol sheet, detailing research questions, databases to be searched, scope, search terms and inclusion / exclusion criteria.

Both of these documents should be kept live and updated for the duration of the project, and kept for 5 years on project completion.

3.2.5 Conduct literature search

A literature search is undertaken to identify all relevant review material on the topic. A set of core search terms, a process for identifying topic-specific search terms, and a protocol identifying relevant databases to aid staff in implementing searches (developed by HDA Research and Information specialists) should be used in this process (see section 6).

3.2.6 Conduct critical appraisal

Critical appraisal is conducted on the material selected in the literature search. The research team scan the results (title and abstract) to identify all relevant review-level data that focuses on effectiveness. Two or more team members, who must agree that a paper is relevant, make selections. This produces a 'short-list' of papers that are potentially relevant.

Selected papers are then obtained, read and critically appraised again by two more members of the team (a third reader will always be used where two readers cannot agree on the merit of a paper) using a critical appraisal tool developed specifically for this purpose (see section 7). Papers are graded and utilised according to the outcomes of this process.

3.2.7 Synthesis and development of evidence briefings

The research team re-read the reviews that survive the critical appraisal process, and prepare an *evidence briefing* for each topic. This document should contain:

- A synthesis of the evidence
- Discussion of the strengths and weaknesses of the evidence
- Identification of any gaps in the evidence base
- An assessment of how up to date the evidence is
- Identification of consensus or dispute around the evidence
- Recommendations for new primary or secondary research, and broad policy implications

Each briefing is then disseminated in at least two different formats, via a number of channels, as follows:

- In summary form to key practitioners and stakeholders
- As a full text document to key policy and decision makers
- As a PDF file via the HDA-EB website, the Public Health Electronic Library (PHEL), HealthPromis (refer to <http://www.publichealth.nice.org.uk/>)
- Via conference papers and articles in peer-reviewed and professional press.

SECTION 4

PRORITY AND PROGRAMME SETTING

4.1 Introduction

A number of factors influenced the topics on which briefing papers were written within any given year. The most influential policy drivers included:

- Choosing health: Making healthier choices easier (the public health white paper) http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor
- The Department of Health's A Research and Development Strategy for Public Health
- The NHS Plan
- The Priorities and Planning Framework
- The Department of Health's Public Service Agreement
- Tackling health inequalities: A programme for action

(Please refer to the publications section of the Department of Health website:

<http://www.dh.gov.uk/PublicationsAndStatistics/Publications/fs/en> for document details.)

The Department of Health's 'A Research and Development Strategy for Public Health' (April 2001) identified the role of HDA as:

- Maintaining an up to date map of the evidence base of public health and health improvement advising on the setting of standards in the light of evidence for public health and health promotion practice
- Effective and authoritative dissemination of evidence to practitioners

Chapter thirteen of the NHS Plan focuses on improving health and reducing inequalities.

Several key areas were highlighted:

- Infant and childhood mortality
- Child poverty
- Surestart
- Cancer (with emphasis on cancer prevention via screening especially for breast, cervical and colorectal neoplasms)
- CHD

A number of other areas are indicated, noted by Kelly (2001):

'There is a focus on teenage pregnancy, antenatal and neo-natal screening, and HIV. Reductions in smoking and improving diet and nutrition (with a special emphasis on fruit and vegetable consumption) are also noted. The HDA is identified as having a special role in reducing obesity and increasing physical activity. Drug and alcohol misuse and associated crime are mentioned. Potential ways of dealing with these problems are linked to partnerships with local authorities in respect of neighbourhood renewal, the Healthy Communities Collaborative and a leadership programme for Health Visitors. Mental health is signalled as important. In respect of CHD, smoking is targeted as a critical area, with a strong emphasis on speeding up treatment and getting more people into surgery. Finally, special provision for the elderly population is pinpointed with an emphasis on dignity, privacy, good supportive palliative care and extending access to services.'(Kelly, 2001)

Finally, the Priorities and Planning Framework and the Public Service Agreement place reducing inequalities in health at the heart of Government policy.

4.2 Programme Development

The work plan for each year of operation reflected these broad policy directions, as well as other political imperatives that inevitably arise and need to be responded to. Topics also reflect NSFs and other public health policy directives.

SECTION 5

SETTING UP THE RESEARCH TEAM AND REFERENCE GROUP

5.1 Introduction

The team leader and members were responsible for the production of the evidence briefing, using the procedures set out here, and for handing over their work and learning to any subsequent project that aims to disseminate findings or get them into practice. Without a defined team consisting of researchers and health specialists, it is impossible to develop an effective and thorough evidence briefing. Reference groups provide vital input from research and practice fields into the briefing paper development process. This section provides information on the formation of these groups and their roles.

A two-tier arrangement was put in place for HDA-EB:

- There was an overarching Public Health Evidence Steering Group (PHESG) with membership drawn from universities, Public Health and Research and Development Divisions of the Department of Health, and other government departments, public health practitioners, representatives of the main research funding bodies, the NHS Centre for Review and Dissemination, the Cochrane and Campbell Collaborations, EPPICentre, other UK and WHO representatives. There were two regional Associate Directors on the Steering Group along with a number of researchers and information specialists from the HDA. A high-ranking official from the Department of Health – or their nominee - chaired the group on behalf of the Chief Medical Officer for England. This group advised on the broad strategic direction of the HDA-EB project, and had a remit to quality assure the processes developed by the Agency to construct the evidence base.
- For each topic area covered (e.g. accidental injuries, drugs, alcohol, HV/AIDS) there was a reference group. Groups reported to the PHESG, and consisted of a mixture of academics, practitioners and officials with an interest and expertise in the field along with a variety of members of interest groups and potential users of the evidence base. The main tasks of the reference group were to quality control the content of the evidence base and guide the production of evidence briefings.

5.2 Setting up research teams

Each research team ideally consisted of a minimum of three people: a team leader, a research specialist and a public health specialist. The team leader reported directly to the Director of evidence and guidance.

The team were responsible for researching the topic and developing hypotheses in response to the research questions. Research teams were located in the HDA, or in an HDA Evidence and Guidance Collaborating Centre.

5.3 Setting up a reference group

The members of a reference group are selected by the team leader, often in discussion with the Director, Head of Research, Department of Health lead or other key informant. They should be identified as stakeholders in the relevant area from:

- relevant documents (Policy, recent research papers, practice reports etc)
- conferences via other contacts in the area.

Groups consisted of research, public health, government and practice topic specialists where possible, although there was variation across topics. Groups numbered at least four stakeholders.

Reference groups had a number of roles:

- Provide direction to the research team
- Monitor the progress of the project team
- Help formulate research questions
- Suggest relevant research documents

- Give specific insight into the topic area and user needs
- Inform the content of the brief
- Review the final document

Initial contact was made with potential members via the Directors office, to inform them of the project and its aims, and invite their membership. Once agreed, initial meetings were set up. All reference group meetings were chaired by the Director, and attended by at least two of the team. At this first meeting, terms of reference for the project were drafted and agreed, and the scope of the project would have been discussed, along with research questions and focus.

Terms of Reference (ToR) for the group contained background information on the project, the group's role, information on membership, chairing of the group, the membership process (by invitation/nomination), the type of expertise required, and how often the group were to meet. TOR were reported to the PHESG.

There were no set guidelines on how much involvement the reference group had in the development of the brief, this was dependent on the team and the level of input each felt was necessary. In some cases, comments from members of the group were included in the peer review feedback, in others the peer review was done externally.

Equally, there was no set number of times that the group should meet – group membership was identified and agreed early on in the project, and some groups met at this early stage. For other teams, it was appropriate for them to meet for the first time once a first draft of the Evidence briefing had been prepared. Some groups met only once, others on a number of occasions as the project developed.

Under normal circumstances, reference group members were reimbursed for expenses. Those involved in the peer review process received a nominal payment.

Figure 5.1 provides an example of the TORs for the teenage pregnancy and parenthood reference group.

Figure 5.1: TOR for the teenage pregnancy and parenthood reference group

Teenage Pregnancy and Parenthood Reference Group

(JUNE 2002)

Terms of Reference

Background
 The Health Development Agency (HDA) was established following the publication of the White Paper *Saving Lives: Our Healthier Nation*. Included in HDA's functions outlined in the White Paper, were two tasks: maintaining an up to date map of the evidence base for public health and health improvement; and, in the light of the evidence, advising on the setting of standards for public health and health promotion practice. In April 2001 the Department of Health published *A Research and Development Strategy for Public Health*. This notes that the HDA will manage and develop a range of database driven websites. These will help to provide a new framework for delivering evidence and syntheses of evidence, especially in relation to inequalities in health and in the priority areas identified in the White Paper.

The Teenage Pregnancy and Parenthood Reference Group is established to help HDA discharge its responsibilities with respect to developing the evidence base on teenage pregnancy and parenthood.

Membership
 The Director of Research and Information at the Health Development Agency will chair the steering group.
 Membership will be by invitation
 The membership will reflect, as far as possible, a spectrum of expertise in all types of research relevant to teenage pregnancy prevention, and improving outcomes for teenage parents.

The group will meet at least twice: once to receive and comment on the first draft of the Evidence briefing paper, and again to receive and comment on the second draft and related work.

Role

The role of the Reference Group is:

- To consider the broad strategic direction of the development of the evidence base in teenage pregnancy prevention and improving outcomes for teenage parents
- To advise and guide the HDA in its development of the evidence base briefing paper on teenage pregnancy and parenthood, to ensure that it is comprehensive, useful and relevant to practitioners and policy makers
- To provide peer commentary on the first draft of the teenage pregnancy and parenthood brief
- To receive and comment on the second draft of the briefing paper

Reference groups were involved in informing and guiding the following outputs:

- The evidence briefing
- A dissemination plan

SECTION 6

LITERATURE SEARCHING

6.1 Introduction

A comprehensive literature search is vital to provide a thorough understanding of current thinking on the selected topic. This section aims to provide:

- An overview of the process of conducting literature searches
- Who should be involved
- Details of core literature searching strategies used
- The range of databases scanned
- The storage of literature once it is found

6.2 Overall Aim of the Literature Searching Process

Literature searches aim to identify:

- High quality systematic reviews
- Meta-analysis and other 'reviews' that provide information about what works to improve health and reduce health inequalities.

6.3 Who is Involved

The overall responsibility for developing literature searches lies with the public health intelligence team (PHIT). This team includes a range of information specialists, officers and librarians. To help with the process, PHIT works closely with research specialists at the HDA and other external agencies identified as having expertise in this area.

6.4 Working in Partnership

To date the Evidence and Guidance directorate works in partnership its collaborating centres and also undertakes a number of searches in house.

The collaborating centres and the PHIT actively support the evidence base project by carrying out a range of literature searches across the topic areas identified in section 4. The HDA also works with the CCs on the continual development and refinement of search strategies used as part of the evidence base project and quality assures any literature search strategies prior to collaborating centre running a search..

6.5 Step by Step Process

Steps one to five provide a brief overview of the literature search process as a whole:

1. *Developing core search strategies* - the PHIT work with the CCs to develop and produce a range of core search strategies for use in searching electronic databases identified as relevant to the evidence base project.

2. *Developing topic specific search strategies* – research specialists with lead responsibility for particular topic areas work with the PHIT and the external agencies to identify topic specific and common terms for their areas. In so doing core strategies are adapted to maximize the number of relevant reviews retrieved by the search.

3. *Searching electronic databases* - the external agencies carry out the searches using a core set of electronic databases as identified in this protocol. The CCs work with the PHIT to identify any additional databases relevant to their topic areas. No filtering of results takes place and research leads are supplied with a complete set of references, with only duplicates removed.

4. *Storing search results on Reference Manager* –the complete set of references arising from the search process are uploaded onto Reference Manager for storage and utilisation during the critical appraisal process.

5. *Transferring the evidence base to externally available websites and databases* – once the critical appraisal process is complete, the PHIT transfer details of studies from Reference Manager to the principal databases used to disseminate the evidence base project. The PHIT

transfer material onto the relevant databases according to how individual studies have been categorised during the appraisal process. The critical appraisal tool categorises studies as follows (see section 7 for more detail):

- To be included as *data* where the whole of the review is judged to be of high quality (typically a systematic review or meta-analysis where research questions, methods and analysis are completely transparent and replicable, such reviews form part of the core material upon evidence based statements in the Evidence briefing Document are based).
- To be included as data, although of lesser quality than those in the above category i.e. reviews in which there is some clear methodological and analytical data, although not sufficient information for the searches, selections and analysis to be replicated. (Reviews judged to be 1 or 2 will automatically be included in the HDAEB Evidence Base Website whether or not it exists in a format that we can make available for downloading. Where it cannot be made available like this we will provide a link to another database [e.g. to DARE], or failing that simply a reference with an explanation.)
- To be included in the Evidence briefing Document as background or context. It may occasionally be appropriate to recommend that reviews in this section should also be made available on HDAEB.
- To be included in only in HealthProm/s database.
- To be excluded

6.6 The HDA Evidence Base Core Search Strategy protocol

The strategy below should be constructed for each of the topic areas under consideration.

The elements numbered 1-5 represent the different stages for each part of the strategy, rather than the actual phrases or indexing and / or thesaurus terms. Each element would encapsulate the range of appropriate indexing or thesaurus terms. And, for each particular indexing / thesaurus term, we would also construct the equivalent free text phrase with the appropriate use of connectors like 'adj'. This ensures that, regardless of available indexing or thesaurus terms within each separate database, the search strategy remains comparable in scope. An HIV search strategy is shown below for illustrative purposes.

1. General and specific terms to describe the topic/disease area, e.g. HIV, obesity, drugs, ecstasy, alcohol, HIA, etc
2. Topic-specific prevention/interventions, e.g. HIV prevention, food restriction, diet therapy, safer sex promotion, slimming clubs, condom provision, needle exchange, nicotine replacement, etc
3. a) Specific health promotion/prevention activities/interventions, e.g.:

Policy/legal/economic/social polity
e.g. law on consensual sex, anti-discrimination re sexuality
taxation
sponsorship
packaging
licensing
Community safety
Promotion
Pricing
Changing attitudes
Support
Education – classroom, seminar, etc
Group work
Leaflet
Mass media/advertising/campaign
Peer education

One-to-one advice/counseling
Outreach
Harm minimisation
Skills development
Facilitation interventions – e.g. training professionals
Community and organisational development

b) Generic health promotion/public health terms, e.g.:

Public health
Health promotion
Behaviour therapy
Primary prevention
Preventative health services
Preventative medicine
Primary health care
Health education
Intervention
Behaviour modification
Early intervention education
Education
Health services
Community safety
Attitude change
Lifestyle change

4. Any particular Setting or Target Population for focus (if applicable), e.g.:

Populations

Infants
Children
Children in care/looked after
School excludes
Persistent truants
Children of drug using parents
Young people
Under 25s
11-15
16-18
19-24
Older people
Women
pregnant women
Ethnic groups
African
Zambia
Zaire
Kenya
Tanzania
Uganda
Zimbabwe
Asian
Socio-economic groups
Homeless
homeless young people
Men
young men (hetero)
Men who have sex with men
gay men

young gay men
non-gay-identified men
People with (diagnosed) HIV infection/AIDS
Sex workers/prostitutes
male
female
Injection Drug Users
Offenders
young offenders
Healthcare workers

Settings

Family
Education
secondary school
university/college
Workplace
Health
primary care (gp)
hospital
antenatal clinic
gum clinic
treatment centers/clinics (hiv/aids)
workplace for healthcare workers
Needle exchanges
Social Groups
Pubs and Clubs etc
Public Sex Environments (PSEs) – cruising sites, cottages, backrooms, saunas
Help lines
Internet – websites, discussion groups/ mailing lists
Street
Community (e.g. gay community)
Prisons

5. Exclusions, e.g. developing countries, treatment, drug therapy, Africa, etc.

6. Review Strategy for the database in question

7. Limits: 1996 to date; human; English language

The search strategy is connected thus:

((2 OR ((3a OR 3b) AND 1)) AND 4 NOT 5) AND 6) AND 7

Once this search has been completed, a sub-search for references related to inequalities should be performed, e.g. inequalities, low income, minority, etc.

Individual search strategies employed in the compilation of individual evidence based briefing papers are detailed in the briefing papers themselves (see <http://www.publichealth.nice.org.uk/>), and are also stored in a central deposit at this location.

SECTION 7 SELECTION AND APPRAISAL OF DATA

7.1 Introduction

HDA-EB contained three distinct resources: Evidence briefings, HDA-EB (the data base driven website itself) and HealthPromis. This section provides a description of the critical appraisal process used to identify and select papers for inclusion in the HDA evidence briefings (review of reviews).

7.2 Overview of the critical appraisal process

The general procedure for identifying and selecting papers for inclusion in HDA evidence briefings is presented schematically below:

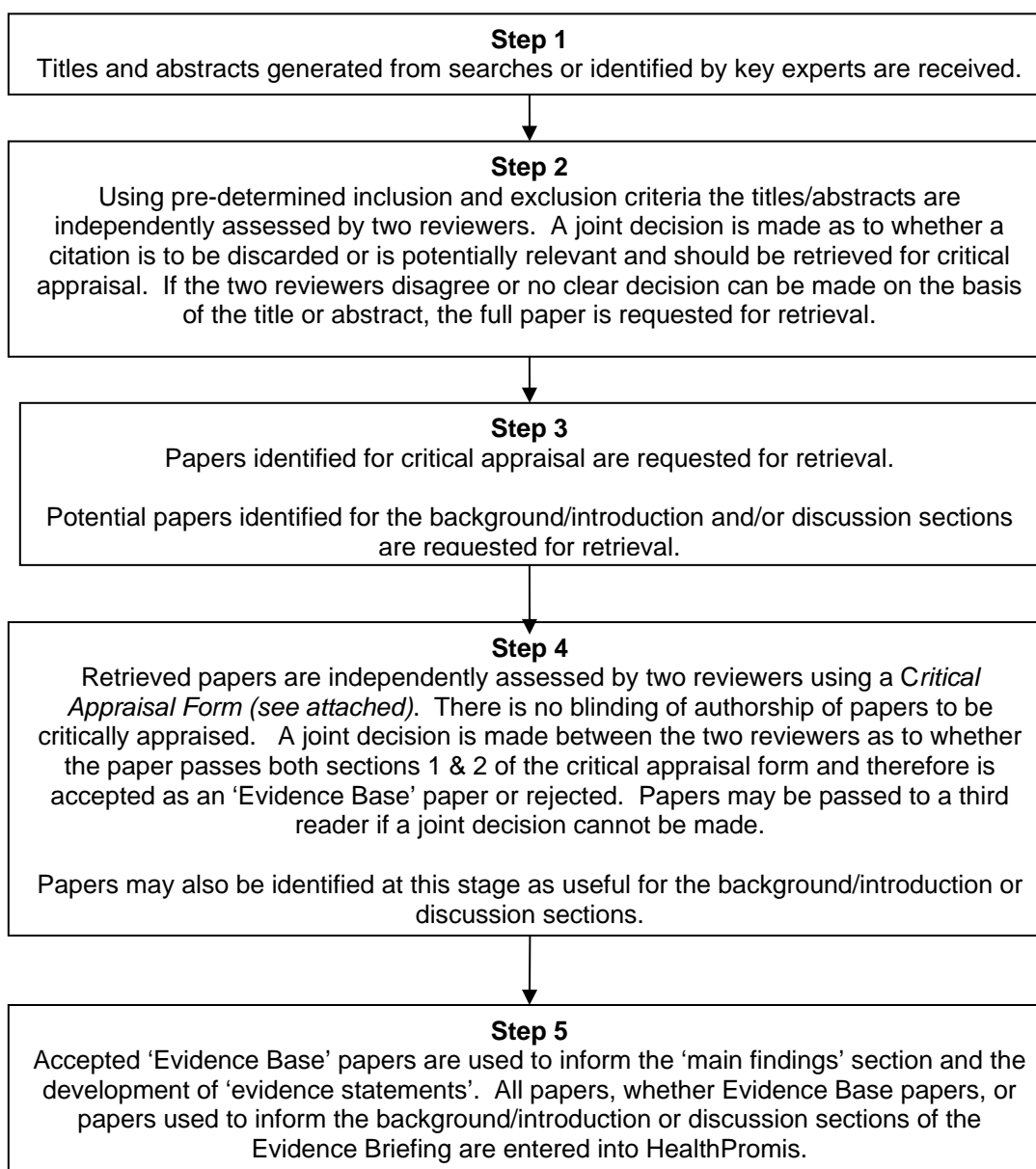


Figure 7.1 The critical appraisal process

The above diagram outlines the steps taken during the critical appraisal process. On occasion, often for pragmatic reasons, adaptations to the above may be undertaken. For example, in some topic areas there is limited review level material and/or limited review level material which passes both part one and two of the critical appraisal form. In these cases the reviewers may decide to generate a 'supplementary findings' section from papers which although relevant to the topic area, failed to meet our critical appraisal threshold. However, it is important to stress that evidence statements are not derived from these papers as it is acknowledged that the process by which methodologically inadequate supplementary papers are included in an Evidence Briefing is not wholly objective and transparent.

7.3 Using the critical appraisal form

The critical appraisal process seeks to identify the extent to which the identified papers address both the briefing's research question and passes the briefing's requisite inclusion/exclusion criteria using the following threshold rules:

- Systematicity – does the review apply a consistent and comprehensive approach?
- Transparency – is the review clear about the processes involved?
- Quality – are the appropriate methods and analysis undertaken?
- Relevance – is the review relevant in terms of focus (i.e. populations, interventions and settings)?

A two-stage critical appraisal form (see below) is used to guide reviewers in their identification of relevant papers. If a paper passes stage one - initial inclusion criteria (*transparency* and *systematicity* of the review methodology), then the reviewer proceeds to stage two of the form - an assessment of the *quality* and *relevance* of the findings section of the paper. Only those papers passing both stages of the critical appraisal form are accepted for inclusion in the briefing.

Two independent reviewers assess each paper, complete the form and then meet to discuss and decide if the paper is accepted or not. No attempt to persuade each other is made and where there is disagreement about whether to accept a paper it is passed to a third independent reviewer for assessment. A majority decision then determines if the paper is accepted or not. While it is acknowledged that it is impossible to make this a wholly objective process as subjective judgements are ultimately made when using the critical appraisal form, the use of two or three (if required) independent reviewers aims to minimise subjectivity. All completed critical appraisal forms are retained for audit purposes for a period of five years.

7.4 Part one of the critical appraisal form

Figure 7.1 The data selection process

Part one of the form contains three subsections:

- The first covers basic descriptive features of the paper under assessment, for example, what type of paper does it purports to be – a systematic review, meta-analysis and the type of research questions the paper is attempting to address, for example causation, cost analysis or effectiveness issues.
- The second sub-section assesses if the paper has a clearly focused aim and/or research question and provides sufficient information about the intervention, population group and associated outcomes.
- The final subsection helps the reviewer assess whether the literature search strategy undertaken was systematic and comprehensive.

The reviewer determines, using this information and whether or not it is relevant to the briefings research question and inclusion/exclusion criteria, if it is worth continuing to assess the paper and complete stage two of the form. If a paper fails at this stage reviewers are encouraged to briefly summarise the main reasons in the space at the bottom of the first page. At this point the reviewer is prompted to indicate if they have checked the papers reference list for other potentially relevant papers that need retrieving.

7.5 Part two of the critical appraisal tool

If the paper passes the first part of the form then the second part is completed. Part two of the form is composed of two sub-sections:

- This first sub-section entails assessing whether the paper is explicit about the criteria used to assess the rigour of its included studies, the appropriateness of the analytical tools used and the transparency and comprehensiveness of any findings presented.
- The final subsection on this part of the form assesses the generalisability, quality and relevance of the papers findings to the UK setting.

Again using this information the reviewer determines if the paper is of sufficient quality and relevance bearing in mind the briefings research question and inclusion/exclusion criteria to be accepted as an 'Evidence Base' paper. If the paper passes part two and is accepted as an Evidence base' paper then any key points which need to be included when writing up the findings section and/or caveats identified should be added to the form.

Generally, only those papers passing both stages of the critical appraisal form are accepted for inclusion in the briefing. However, in situations in which a paper passes all the quality criteria but elicits a series of 'no' or 'unsure' responses to the 'Relevance to the UK' section of the form it may be accepted for inclusion in the briefing, although the findings and evidence statements produced would include caveats to reflect the limitations associated with generalisability of the data.

If the appraiser is unsure about whether to accept a paper they have the option of referring the paper to a 'third party' for further independent assessment. A brief summary of why the paper is being passed to a third reviewer should be entered into the space at the bottom of the form.

If a paper fails the second part of the form the reviewer needs to briefly summarise the main reasons why in the space provided at the bottom of this page.

Figure 7.2 The Critical Appraisal Tool

HDA Evidence Base - Critical Appraisal Tool

Authors _____

Title: _____

Source: _____

Relevance to topic			
Does this paper address your topic area? Unsure	Yes	No	
Circle whether the paper is a:			
• Systematic review			
• Meta-analyses			
• Syntheses			
• Other review? (please specify)			
Does it address (circle as appropriate)?			
• Effectiveness (interventions and treatments)			
• Causation			
• Monitoring and surveillance trends			
• Cost			
• Other (please specify)			
Transparency			
Did the paper have a clearly focussed aim or research question?	Yes	No	Unsure
Consider whether the following are discussed:	Yes	No	Unsure
• The population studied	Yes	No	Unsure
• Inequalities	Yes	No	Unsure
• The interventions given	Yes	No	Unsure
• The outcomes considered			
Sytematicity			
Do the reviewers try to identify all relevant English language studies? Consider whether details are given for:	Yes	No	Unsure
• Databases searched	Yes	No	Unsure
• Years searched	Yes	No	Unsure
• References followed up	Yes	No	Unsure
• Experts consulted	Yes	No	Unsure
• Grey literature searched	Yes	No	Unsure
• Search terms specified			
• Inclusion criteria described			
Is it worth continuing?	Yes	No	
Why/why not?			
Quality			
Did the authors assess the quality (rigour) of the included studies?	Yes	No	Unsure
Consider whether the following are used:	Yes	No	Unsure

<ul style="list-style-type: none"> ▪ A rating system ▪ More than one assessor 	Yes	No	Unsure
<p>If study results have been combined, was it reasonable to do so?</p> <p>Consider whether the following are true:</p> <ul style="list-style-type: none"> • Are the results of included studies clearly displayed? • Are the studies addressing similar research questions? • Are the studies sufficiently similar in design? • Are the results similar from study to study (test of heterogeneity)? • Are the reasons for any variation in the results discussed? 	Yes	No	Unsure
<p>What is the overall finding of the review? Consider:</p> <ul style="list-style-type: none"> ▪ (How the results are expressed (numeric – relative risks, etc) ▪ Whether the results could be due to chance (p-values and confidence intervals) 			
<p>Are sufficient data from individual studies included to mediate between data and interpretation/conclusions?</p>	Yes	No	Unsure
<p>Does this paper cover all appropriate interventions and approaches for this field (within the aims of the study)? If no, what?</p>	Yes	No	Unsure
Relevance to UK			
<p>Can the results be applied/are generalisable to a UK population/population group?</p> <ul style="list-style-type: none"> ▪ Are there cultural differences from the UK? ▪ Are there differences in health care provision with the UK? ▪ Is the paper focused on a particular target group (age, sex, population sub-group etc)? 	Yes	No	Unsure
	Yes	No	Unsure
	Yes	No	Unsure
	Yes	No	Unsure
Accept for inclusion onto HDA Evidence Base?	Yes	No	Refer to third party
Additional comments:			

SECTION 8

HOW TO SYNTHESISE

8.1 Overview

Some good general principles for synthesising the findings of primary research (see, for example, Harden, 2001) also apply to the activity of synthesising secondary level research (reviews). These are:

- **The research questions of your Evidence Briefing should determine the scope of your review**

If your evidence briefing focuses on intervention effectiveness alone, or if there are plenty of good systematic reviews of effectiveness in your area that also included information about inequalities and cost-effectiveness, then it may be possible to rely solely on data from systematic reviews in preparing your briefing. Otherwise, it may be appropriate to include data from a wider variety of review-level sources, including meta-analyses, reviews of effectiveness, literature reviews, and so on.

- **The critical appraisal form should guide your conclusions about the quality of the review and the reliability of its content**

The critical appraisal form (CAF) interrogates all reviews under broad headings of relevance, systematicity, and transparency. Whatever the category of review you are considering, it should be possible to use the CAF to provide an assessment within these headings. This assessment should guide your conclusions about the review itself, and the data it contains.

- **Points of consensus and difference between reviews should guide your interrogation**

Where reviews, either from the same or different categories, agree, it may be useful to look at the similarities and differences between the populations covered, the transparency and systematicity of their methodology, their inclusion criteria and their scope. It may be notable if, for example, a very rigorous systematic review of effectiveness and a narrative review reach the same conclusions given their different scope and methods. Equally, where two reviews employing either similar (eg two systematic reviews of effectiveness) or different methodologies (eg one systematic and one narrative) reach very different conclusions, these should be thoroughly investigated and reported with reference to the CAF.

- **Be transparent – qualify everything**

Where overriding conclusions are drawn from the review-level literature, it is a good idea to be explicit about the type of review that has informed them. It would be pointless to pretend that the process of producing an Evidence Briefing is an objective one since this is patently not the case. However, we can be really clear about where a subjective decision or conclusion has been drawn, and what has informed it. High levels of transparency in our method make for a more reliable document, and will also provide the reader with enough information to draw their own conclusions about the quality of our work.

8.3 Synthesising the findings from similar types of review

Where the data pool for an Evidence Briefing is restricted to just one type of review, it should be relatively straightforward to synthesise the findings. The points above should guide the process, and conclusions should reflect the application of the CAF to a set of similar reviews.

8.4 Synthesising the findings from different types of review

This is a more complex process, and similar in principle to attempts to synthesise the findings from different forms of primary research into systematic reviews. Again, the points above and the CAF should guide the process, but it is important that the authors acknowledge the differences in scope and method of different types of review, and clearly categorise them for the reader. If the reviews are in agreement, then it would seem sensible to use the strongest review-level evidence (ie good quality systematic reviews) as the focus of an evidence statement, and to use the findings of weaker review study designs (eg literature reviews) to support it. If reviews do not concur, or if the same primary studies are interpreted differently across reviews, then this needs to be clearly discussed within the synthesis and further work carried out if necessary to investigate reasons for differential interpretation.

8.3 Synthesising the findings from similar types of review

Where the data pool for an evidence briefing is restricted to just one type of review, it should be relatively straightforward to synthesise the findings. The points above should guide the process, and conclusions should reflect the application of the CAT to a set of similar reviews.

8.4 Synthesising the findings from different types of review

This is a more complex process, and similar in principle to attempts to synthesise the findings from different forms of primary research into systematic reviews. Again, the points above and the CAF should guide the process, but it is important that the authors acknowledge the differences in scope and method of different types of review, and clearly categorise them for the reader. If the reviews are in agreement, then it would seem sensible to use the strongest review-level evidence (ie good quality systematic reviews) as the focus of an evidence statement, and to use the findings of weaker review study designs (eg literature reviews) to support it. If reviews do not concur, or if the same primary studies are interpreted differently across reviews, then this needs to be clearly discussed within the synthesis and further work carried out if necessary to investigate reasons for differential interpretation.

8.5 Evidence statements

A number of Evidence Briefings have categorised the evidence statements about the effectiveness of interventions were derived from the findings of their papers. It should be stressed that the evidence statements are not those of the review authors, but rather are based on their review findings and should be referenced accordingly. Each evidence statement categorises the evidence of effectiveness as follows:

- *Evidence of effectiveness*: derived from the review-level literature where the results were all in agreement using the review authors own words;
- *Currently, a lack of evidence of effectiveness*: applied to interventions in the review-level literature which showed no current impact on outcomes
- *Conflicting evidence*: derived from the review-level literature where the interpretation and/or conclusions of the review papers and/or primary studies within review paper/s were not in agreement.

Where appropriate details can be included of the type of outcome measure used to validate the findings summarised in the evidence statements. For example, in the smoking cessation literature, both validated objective measures (eg detection of nicotine or cotinine levels) and weaker subjective measures (eg self reported behaviour) have been used to assess effectiveness of interventions, and the results are not always concordant.

A table summarising the evidence statements by topic area/theme can also be included.

8.6 Quality assurance

There are a number of safeguards in place to ensure the quality of Evidence Briefings. These are:

- The CAT itself, which allows for a clear and transparent assessment of review quality
- Reference groups (which report to the PHESG), which will check and guide the briefing
- Peer review, which will guide the development and content of final drafts
- User feedback on the final briefings, via the HDA EB website.

All of these will help us to refine and shape our work, making it more transparent, relevant and reliable. In addition, all data and documents (including completed critical appraisal forms and peer reviews) relating to each briefing should be stored for a minimum of 5 years..

Reference:

Harden, A (2001) The fine detail: conducting a systematic review. In S Oliver & G Peersman (Eds) *Using research for effective health promotion practice*. Milton Keynes: Open University Press.

SECTION 9

HOW TO STRUCTURE THE EVIDENCE BRIEFING

9.1 Introduction

It is important that Evidence briefings are informative, reliable, accessible and developed in a consistent format and style. Their production is one of the most important things the HDA undertakes, and will continue to be so for several years in terms of making a difference and in terms of our ability to influence strategy and policy in public health. This section aims to provide guidance on the structuring and writing of EB briefs and provide an EB briefing template.

The process of writing the brief should precede the preparation of guidance. The preparation of guidance is subject to a separate protocol, but follows from the review of the evidence.

9.2 Audiences

Briefing documents have several audiences. Depending on the topic, these could be:

- The Public Health Division in the Department of Health
- The Research and Development Division of the Department of Health
- Users of our web sites
- Practitioners – for example, health promotion workers, practice nurses, OHN and surestart co-ordinators
- Members of any reference group which may have been established to support the work in the particular topic area
- CRD York University
- EPPI Centre, London University
- UK Cochrane Centre
- Medical Research Council (MRC)
- Economic and Social Research Council (ESRC)
- The HDAs Public Health Evidence Steering Group (PHESG)

Briefing documents must therefore be of a uniformly high standard, and be authoritative and clear.

9.3 Evidence Base Briefing Papers Template

Below is a generic structure for all Evidence briefing papers.

Abstract

All titles will require an abstract which will not form part of the printed version. This is to be used on HealthPromis.

Foreword (generic):

This foreword is current as of 03/03/05, but may be subject to amendment. An up-to-date version may be obtained from Mike Kelly or Iain Moir at the HDA.

The Health Development Agency (HDA) was established in 2000. Since then it has been engaged, among other things, in building the evidence base in public health with a special focus on reducing inequalities in health. Since the HDA's establishment, the Wanless Report (Wanless 2004) has further highlighted the need for appraising the effectiveness of public health interventions, not only to reduce inequalities but also to maximize cost-effectiveness. The government's recent white paper Choosing Health (Department of Health 2004) similarly reiterates the importance of building and maintaining an evidence base for public health. From April 2005 the HDA's evidence base work will continue under the auspices of the National Institute for Clinical Excellence (NICE).

The HDA has therefore taken on the task of mapping and synthesising the evidence for the effectiveness of interventions to improve health and reduce health inequalities, across priority areas of public health. In April 2001 the Department of Health published its Research and Development Strategy. It has developed a number of ways of taking a systematic approach to compiling the evidence, identifying gaps and making the evidence base accessible. The

evidence briefing series is one of the ways in which the HDA Evidence Base is disseminated (full details of the process of developing the Evidence Base and the associated methodological activities can be found in: (Graham & Kelly 2004; Kelly et al. 2002; Kelly et al. 2003; Kelly, Speller, & Meyrick 2004; Killoran & Kelly 2004; Swann et al. 2003).

This evidence briefing is a review of reviews of the effectiveness of housing interventions for promoting positive health outcomes. The necessity for reviewing reviews, or tertiary-level research, stems from the proliferation over the last decade, or more, of systematic and other types of review in medicine and public health. The HDA has published other evidence briefings that deal with teenage pregnancy and parenthood, HIV prevention, the prevention of sexually transmitted infections, management of obesity and overweight, prevention of low birth weight, breastfeeding, accidental injuries in children and older people, public health interventions for increasing physical activity among adults, smoking and public health, drug misuse, youth suicide prevention and health impact assessment.

Taken together these briefings provide a comprehensive synthesis of the evidence drawn from systematic and other kinds of reviews. They are available on the HDA's website – www.hda.nhs.uk/evidence – and the electronic versions are updated on a regular basis as new evidence becomes available.

These evidence briefings have been based on evidence drawn from systematic and other kinds of reviews. This means that the type of evidence that does not traditionally find its way into reviews has not been considered in detail for these documents. In another HDA Evidence Base series, called evidence reviews, the scope of the coverage is extended to primary research and other kinds of evidence and other types of study. Evidence reviews on resilience, transport, maternal and child nutrition, drug misuse prevention, accidental injury prevention for children and chronic illness are currently in preparation.

The construction of the HDA Evidence Base has involved collaboration with a number of partners who have interests and expertise in practical and methodological matters concerning the drawing together of evidence and its dissemination. In particular the HDA would like to acknowledge the following: the Centre for Reviews and Dissemination at the University of York; the EPPI-Centre at the Institute of Education at the University of London; Health Evidence Bulletins Wales; the ESRC UK Centre for Evidence Based Policy and Practice at Queen Mary College, University of London and its nodes at the City University London and the MRC Public Health Sciences Unit at the University of Glasgow; members of the Cochrane and Campbell collaborations; the United Kingdom and Ireland Public Health Evidence Group and the members of the Public Health Evidence Steering Group. This latter organisation acts as the overall guide for the HDA's evidence-building project. The co-operation of colleagues in these institutions and organisations has been of significant help in the general work in preparing the framework for how we assess the evidence. The HDA is, however, responsible for the presentation and organisation of the material in the briefings.

We would also like to express our gratitude to the Housing and Health Evidence Base Reference Group as well as to HDA colleagues who assisted in organising the literature searches.

Every effort has been made to be as accurate and up to date as possible in the preparation of this briefing. However, we would be very pleased to hear from readers who would like to comment on the content or on any matters relating to the accuracy of the briefing. We will make every effort to correct any matters of fact in subsequent editions. Comments can be made by using our website, www.hda.nhs.uk/evidence¹

Professor Michael P. Kelly
Director of Evidence and Guidance
Health Development Agency

¹ This site is no longer available. HDA research and evidence work, and the process of consultation, is available at <http://www.publichealth.nice.org.uk/>

Department of Health. Choosing Health: making healthier choices easier. The Stationery Office, London. 2004.

Graham, H. and Kelly, M. Health inequalities: concepts, frameworks and policy. Health Development Agency publication.

Kelly, M., Chambers, J., Huntley, J., and Millward, L. (2003) Method 1 for the production of Effective Action Briefings and related materials. Health Development Agency Publication.

Kelly, M., Speller, V., and Meyrick, J.(2004) Getting evidence into practice in public health. Health Development Agency Publication.

Kelly, M., Swann, C., Killoran, A., Naidoo, B., Barnett-Paige, E., and Morgan, A. (2002) Methodological problems in constructing the evidence base in public health. Health Development Agency publication.

Killoran, A. and M. Kelly. (2004) "Towards an evidence-based approach to tackling health inequalities: the English experience." Health Education Journal 63 : 7-14.

Swann, C, Falce, C, Morgan, A., Kelly, M., and Powell, G. (2003) HDA Evidence base: Process and Quality standards manual for evidence briefings. 2nd edition. Health Development Agency Publication.

(please refer to: <http://www.publichealth.nice.org.uk/page.aspx?o=507020> for HDA Evidence Base key papers)

Wanless, D. (2004) Securing good health for the whole population. HM Treasury, London. Available at:http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm

Executive Summary (which will also stand alone as an Evidence briefing summary)

Provides an overview and contain details of the evidence base website

Key findings at national and local level

Provides research recommendations

Provides policy implications

Main general references

Although it is tempting to include copious amounts of information in the summary, it is important to keep the summary brief relative to the size of the overall briefing.

Introduction

Context and aims

Methodology

Types of evidence presented

Electronic databases used in the preparation of the briefing

Search strategy

Selection criteria

Method of generating evidence statements

Method of grading studies and/or evidence statements (if used)

What are the limitations of the methodology?

What are the limitations of this study?

Evidence

Listing of papers included in review

Subdivided by topic, setting or category

Key research findings

Discussion of:

Research into inequalities

Cost-effectiveness research

Gaps in the research evidence



If available/relevant

Recommendations for research

Primary research

Systematic reviews/meta-analyses

Policy implications

Glossary

References

Systematic reviews/meta-analysis

Non-systematic reviews, books and reports

Appendix

Include here a copy of any critical appraisal or data extraction tools used

Usually a full example search strategy is reproduced as an appendix

5. Any other comments

10.2 Resolving peer reviewers comments

Generally, reviewers comments fell into three main categories.

- Those that could be easily attended to and require minor amendments
- Those that could be attended to, but require substantive amendments
- Those that could not be attended to, because they were outside of the remit of the briefing, or in conflict with other reviewers comments

When peer review commentaries were received, the research team met (with the Director if necessary) to decide which of these categories comments fall into.

Where comments fell into the first two of these categories, the research team attempted to address them all. If comments fell into the third category, the team considered returning to the reviewer to clarify a comment as a first step. Where differences in opinions of two or more reviewers meant that comments fell into the third category, the team took a view as to whether to amend the offending section or not. This view was informed by the scope of the original project, and our own remit as a directorate.

10.3 Following peer review

If amendments were substantive, the team would return the second draft of the briefing to the reviewers for further comment or for a second review. It was good practice to send a covering note identifying what changes have been made since the first draft. If second reviews were sought, the same qualifying process applied.

Once a final draft was agreed by the team, sign-off was sought from the HDA E&G director.

It was also important to keep the relevant officials at the Department of Health informed, and for them to have sight (in a consultative capacity) of the briefing once it had reached a second draft stage. In certain circumstances it was appropriate to involve senior officials earlier if the topic has policy sensitivity. In the case of Collaborating Centres, the HDA acted as the channel of communication with the Department of Health.

The Publications Review Group also required sign-off at Chair or Chief executive level – please refer to the PRG process for information.

SECTION 11 TRANSFER OF KNOWLEDGE

11.1 Overview

Up to three versions of the evidence briefings were prepared and disseminated, as follows:

- Summary briefing: the executive summary of the document, also disseminated as a hard-copy stand alone document. Disseminated to key stakeholders and practitioners
- Full version Evidence briefing, hard copy: Disseminated to key researchers, policy and decision makers
- Full version Evidence briefing, PDF file: Disseminated via the HDA-EB website and PHEL.

The content and learning from the evidence briefings was also disseminated through:

- Conference papers and presentations at national and international events
- Articles in the peer-reviewed and professional press
- Evidence Into Practice Teams and advice for practice

This section of the manual outlines how to draw up a dissemination plan, and includes the most up-to-date work on transferring learning from the Evidence briefings via Evidence Into Practice Teams.

11.2 Dissemination plans

Once the evidence briefing was in its final draft form, following peer review and amendment, a dissemination plan was drawn up. This was done with guidance from public health advisor team members, the DH lead (if there was one), and the reference group. A dissemination plan should simply stipulate:

- How many hard copies of the full version should be produced
- How many copies of the executive summary should be produced
- Who each should be sent to

This plan was agreed with the reference group and director, and passed on to the communications team.

At the same time, copies of all reviews and background papers used in preparing the Evidence briefing were passed on to the HealthPromis team, for inclusion in their bibliographic database.

11.3 Evidence into Practice

The HDA recognised that the findings from reviews of reviews are limited in directly informing policy and practice. To this end, it was engaged in developing ways to assist professionals in generating and using different kinds of evidence. These took account of the myriad other factors that influence local decision-making and attempted to identify the barriers and facilitators to using evidence to improve practice. Specifically, in 2003 it piloted a methodology for developing guidance which combined the findings from published evidence (from Evidence Briefings) with practitioner fieldwork meetings about what is feasible (see Kelly and Speller, 2003 <http://www.publichealth.nice.org.uk/page.aspx?o=507020>). In 2004/5, the HDA took this work forward in developing *Effective Action Briefings* in a number of areas. From April 2005, these methodologies for developing guidance have been incorporated into the operating model of the Centre for Public Health Excellence at the new National Institute for Health and Clinical Excellence (NICE) (see <http://www.publichealth.nice.org.uk/page.aspx?o=CPHEOperatingModel>).

SECTION 12

GLOSSARY OF TERMS

The glossary below is adapted from resources developed for and contained on the Public Health Electronic Library (PHEL – <http://www.phel.org.uk>) and on HDA-EB (<http://www.publichealth.nice.org.uk/page.aspx?o=evidencelibrary>). This glossary is developmental, and new terms will be added as appropriate.

Audit: A process which involves the examination or review of practices, processes or performances in a systematic way to establish the extent to which they meet predetermined criteria. The procedure includes identifying problems, developing solutions, making changes to practice, then reviewing the whole operation or service again. Audit may be carried out on a specific service (eg accident and emergency services); be a formal review of an organisations or individual's accounts; or, an examination of their compliance with laws, regulations or policies or the terms of an award.

Benchmark: A measure or standard to which an activity, performance, service or result can be compared. Benchmarking is the term given to the process of measuring standards of actual performance against those achieved by others with broadly similar characteristics. The aim is to improve quality so that other organisations or services can raise their own performance to that of the best.

Best value: Best value is a scheme that aims to improve standards in local government. Local authorities owe the statutory duty of best value to local people, both as taxpayers and customers of local authority services. In meeting this duty a local authority is required to consult local people, review all its services regularly, measure its performance and produce a performance plan, which is audited independently. Achieving best value is not just about economy and efficiency, but also about the effectiveness and quality of local services. Office of the Deputy Prime Minister.

Case control studies: A research study in which people with a particular disease or condition are identified and compared with one or more control groups who do not have the disease or condition. Data are collected, for example by searching back through people's medical records or asking them to recall their own history about past exposure to possible causal factors such as smoking. The aim is to discover possible causes of the disease.

Chronic: Describes a disease, condition or health problem which persists over a long period of time. The illness may recur frequently and in some cases may lead to partial or permanent disabilities. Examples include, arthritis, diabetes and hypertension.

Clinical: Involving the care, treatment or study of patients. Clinical care is usually provided in hospitals and clinics.

Clinical governance: Initiative to ensure high quality healthcare is being delivered. It is a statutory duty placed on all NHS organisations with the aim of assuring high standards of care, safeguarding patients against poor performance and reducing variations between providers of services. All NHS organisations have to continuously monitor and improve clinical care, and identify and deal with substandard services.

Clinical trials: Clinical trials are research studies designed to test the safety and/or effectiveness of drugs, medical devices, treatments, or preventive measures in humans.

Clinicians: Healthcare professionals who are directly involved in the care and treatment of patients; for example, nurses, doctors, therapists, midwives.

Cochrane collaboration: International network of nine research centres of which the UK Cochrane Centre is a member. Its function is to develop, maintain, and disseminate up-to-date information from systematic reviews of health care trials. The main output of the collaboration is the Cochrane Library. Cochrane Collaboration - <http://www.cochrane.org>

Cohort studies: A research study, in which group(s) of people identified by certain characteristics or statistical factors such as age, are followed and observed over a long period of time. A typical study may involve recruiting an initially health group (cohort) of people exposed to different levels or not at all to a particular risk factor (eg cigarette smoke) for a disease (eg lung cancer). The participants are followed up for a number of years to compare how many in each group develop a particular disease or other outcome.

Commissioning : Process in which health service and local authority agencies identify local needs for services and assess them against the available public and private sector provision. Priorities are decided and services are purchased from the most appropriate providers

through contracts and service agreements. As part of the commissioning process services are subject to regular evaluation.

Control groups: A group of people who, for the sake of comparison are not given the treatment, service or other intervention that the researcher is interested in. For example a study may divide people into two groups – an 'experimental group' which is given a new drug and a 'control group' who receive the standard drug treatment or a placebo. The results from the two groups are then compared.

Critical appraisal: The process of appraising a piece of research or a review for the quality of its method and content, generally used in order to make judgements about study or review quality, and intervention effectiveness.

Data sets: Sets of information, usually in numerical form, which are presented in such a way that they can be readily analysed and conclusions drawn from the data. A minimum data set is a widely agreed upon and generally accepted set of terms and definitions making up a core of data acquired for medical records and used for developing statistics for different types of analyses and users. For example sets of data have been developed for birth and death certificates and for hospital care.

Delphi method: A method of sampling aimed at consulting and obtaining expert opinion without face-to-face meetings. Initial questions are circulated usually to a panel of experts (by phone, post, fax or e-mail). Further questions and responses are progressively refined in the light of responses to each round of questions. The aim is to reduce the number of available options or solutions and arrive at an agreed view on an issue or problem without allowing anyone to dominate or influence the process.

Demography: The study of populations, particularly size, density, fertility, mortality, growth, age, distribution and migration.

Deprived areas: Regions or areas characterised by significantly higher levels of unemployment and lower rates of income per head compared with the national average.

Determinants of health: The wide range of personal, social, economic and environmental factors which determine the health status of people or communities. They include health behaviours and lifestyles, income, education, employment, working conditions, access to health services, housing and living conditions and the wider general environment.

Dissemination: The active process of distributing information such as evidence or practice advice, to ensure maximum exposure to and uptake by relevant groups of people.

Epidemiology: The quantitative study of the causes, distribution, prevention and control of disease in populations. Epidemiologists collect and examine medical data and spot health trends to establish which diseases are on the increase and where, which treatments work and which do not.

Evaluation: Assessing if an intervention (for example a treatment, service, project, or programme) achieves its aims. The results of evaluations can help in decision-making and in planning future policies. Process evaluation is an ongoing examination of the intervention from its conception to its delivery and includes staff performance, methods, activities, effectiveness and efficiency. Outcome evaluation is an assessment of the immediate or midterm effects of an intervention or some aspect of an intervention.

Evidence base: The best current research information available based on a systematic analysis of the effectiveness of a treatment, service or any other intervention and its use, in order to produce the best outcome, result or effect. In practice this means an approach to service provision development centred on ensuring that users are given the most effective and appropriate provision as indicated by currently available research findings.

Evidence-based guidance: Guidance in specific areas that is based on evidence from research, reviews etc.

Experimental research: Experimental research is the most scientifically rigorous type of research. It attempts to establish cause and effect and generally uses objective quantitative data such as height, weight or blood pressure. Experimental research designs are widely used for drug trials- for example to test if taking a particular medicine reduces blood pressure.

Expert group reports: Reports from expert or working groups that include expert opinion, evidence from research and reviews.

Government Offices for the Regions (GORs): Nine offices established throughout England to bring together the regional work of various Government departments and manage their expenditure programmes. Their function is to provide sustainable economic development and regeneration. Their work cover areas such as neighbourhood renewal, local transport issues, housing, road scheme decisions, land use planning and rural affairs. The Offices work in

partnership with local people and organisations to improve the competitiveness, prosperity and quality of life in their areas.

Health gain: A measured improvement in the health of an individual person or a population group. This method of expressing improved health outcomes can be used to show the relative advantage of one treatment or intervention (eg drugs, screening, vaccination, change in diet) over another in producing the greatest health gain.

Health impact assessment (HIA): Health impact assessment determines how a proposal will affect health and can be used as a practical way to influence decision makers. The process involves: developing screening criteria to select policies or projects for assessment; profiling the areas and communities affected; applying a pre-defined model of health to predict potential impacts; evaluating the options and making recommendations for action. Recommendations to improve the proposal are produced as part of the assessment. Health Development Agency. Health impact assessment - <http://www.publichealth.nice.org.uk/page.aspx?o=HIAGateway>

Health inequalities: The gap in health status, and in access to health services, between different social classes and ethnic groups and between populations in different geographical areas. Department of Health. Health inequalities <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/fs/en>

Health Promotion: The process of enabling people to increase control over and improve their health. As well as covering actions aimed at strengthening people's skills and capabilities, it also includes actions directed towards changing social, environmental conditions to prevent or to improve their impact on individual and public health. Department of Health. Public health -

Health technology assessment: Health technology assessment is a multi-disciplinary field of policy analysis which studies the medical, social, ethical and economic implications of the development, dissemination and use of health technology. NHS. Health technology assessment - <http://www.ncchta.org/>

Incidence: A measure which of the number of new cases of a disease, divided by the total population at risk of getting the disease during a certain time period. It is the number of instances of persons falling ill during a given time in a specified population. It is often expressed as rates per million population.

Indicator: A statistic or marker that has been chosen to monitor health or service activity. For example the number of women attending for breast cancer screening or the number of deaths from coronary heart disease in a defined population.

Literature reviews: Also known as narrative reviews. Interpretive reviews of the literature in specific areas, usually without a specific literature search or synthesis methodology.

Meta-analyses: Reports on specific areas where research results from various sources have been collated, often systematically, and subjected to a form of statistical analyses in order to ascertain overall effects or impact of an intervention, policy or programme.

Morbidity: Morbidity rates are the number of cases of an illness, injury or condition within a given time, usually one year. It is also the ratio of sick persons to well persons in a defined population.

Mortality: The proportion of deaths in a defined population.

Narrative reviews: see literature reviews

National Service Frameworks (NSFs): National Service Frameworks (NSFs) establish a set of minimum national standards for clinical quality and access to services for the major care and disease groups. Their aim is to improve performance and reduce local variations in care standards. Each NSF is developed with the assistance of an expert reference group, which brings together health professionals, service users, and carers, health service managers, partner agencies and others. NSFs are implemented locally as part of Health Improvement and Modernisation Plans. National Service Frameworks: <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/fs/en#4804536>

Needs assessment: A systematic process by which NHS organisations or local authorities use information to judge the health of their population and then decide what services should be provided to meet local needs. The aim is to identify unmet needs that can affect health (eg access to services, inadequate housing, untreated diseases etc) and make recommendations about ways to address these needs.

Outcome: The effect of policies, social conditions, or health service procedures on a community, population group or person or, the impact of medical treatment on a patient.

Practice advice: similar to evidence based guidance.

Prevalence: The number of people with a disease at a given time, or at any time in a specified

period, divided by the number of people at risk from that disease. It is often expressed as rates per million population.

Qualitative research: Research methods that use non-numeric information. They tend to examine subjective meanings and interpretation, focusing on "how" and "why" type questions such as how do people feel about issues or why do they behave in a particular way. Qualitative research can answer questions such as what stops people smoking, whereas quantitative research can answer the question what proportion of people have tried to give up. Examples of qualitative research methods include in-depth interviews, focus groups, participant observation and action research.

Quantitative research: Research methods that gather information in numeric form, based on measuring and counting. It answers questions such as how many people visit their GPs each year; what proportion of children has had the MMR vaccination.

Randomised control trials: Studies in which participants are randomly allocated to either a treatment, (or other intervention such as screening) or, a control group which doesn't receive the treatment or intervention. Both groups are followed up for a specific period. The outcomes, which are specified at the outset, (eg weight loss, reduction in heart attacks) are measured to determine any difference between the two groups.

Reviews of effectiveness: Similar to systematic reviews, but without the systematic search methodology ie. A narrative style review focusing on effectiveness.

Risk factor: Any social, economic, (eg poverty) biological, (eg inheriting a breast cancer gene), behavioural, (eg smoking) or environmental (eg poor housing, pollution) factor that is associated with or can cause an increased risk of a particular disease, illness or injury. Some risk factors including smoking or a sedentary lifestyle can be controlled, others such as age or inherited genes cannot.

Socio-economic status: Description of a person's position in society which uses criteria such as income, level of education achieved, occupation, value of property owned etc.

Stakeholders: People who have an interest in an organisation, its activities and its achievements or organisations which have an interest in wider partnerships or issues. Examples of stakeholders include customers, partners, employees, shareholders, the Government, the voluntary sector, the NHS, local government, schools and businesses.

Systematic reviews of effectiveness: Analyses of 'what works' in specific areas that are based on literature searches in which sources of both published and unpublished research are systematically searched, and the studies found through the search process graded according to the quality of their methodology and analysis. The 'grading' system for research quality can vary from review to review, but is most often based on a hierarchy in which the results from randomised controlled trials are positioned as the most reliable forms of evidence.

Variable: An attribute or characteristic of a person that takes on different values (ie any quantity that varies such as age, weight, pulse rate) within the group that is being studied.

SECTION 13

Resources and further reading

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Note:

This document contains references to historical information on the world wide web. Every effort has been made to update these references, however in the event that a web address is no longer valid please check on the public health section of the NICE website <http://www.publichealth.nice.org.uk> for further information.