

CSG Agenda & [Open Access] Background Papers

2016 Colloquium, Seoul, Korea
Thursday 20th to Saturday 22nd
October 2016

Day One – Thursday 20th October (09:00 – 18:00)
Venue: Grand Hilton, Seoul
353 Yeonhui-ro, Seodaemun-gu, Seoul, South Korea
Room: White Heron

Day Two – Friday 21st October (08:15 – 18:00)
Venue: Grand Hilton, Seoul
Room: Flamingo

Day Three – Saturday 22nd October (08:30 – 18.00)
Venue: Grand Hilton, Seoul
Room: Flamingo



Agenda

Thursday 20th October (09:00 – 18:00)

CSG Strategy Day

Financial Planning & Oversight for Trustees (with Sarah Watson):

2020 Scenario Planning & Priority Setting (with Mark Wilson, Sarah Watson & David Tovey)

See [Report A: Strategy to 2020 in 2017 \[RESTRICTED ACCESS\]](#); and [Report B: 2016 Budget Projection, Background to 2017 Budget and Financial Scenarios to 2020 \[RESTRICTED ACCESS\]](#) - which follow immediately after this agenda.

Friday 21st October (08:15 – 18:00)

1. Welcomes, Apologies, Declarations of Interest and Approval of the Agenda
2. Co-Chairs' Report (I)
3. Election of CSG Co-Chair (CSG Members Only - without CF) [RESTRICTED ACCESS] (D)
4. Cochrane Library Oversight Committee (CLOC) Report [RESTRICTED ACCESS] (I)
5. Central Executive Team Reports, Including:
 - 5.1 2016 Strategy to 2020 Targets Update (I)
 - 5.2 Editor in Chief's Update including:
 - 5.2.1 CEU Report on Review Quality [OPEN ACCESS] (I)
 - 5.2.2 Targeted Update Report [OPEN ACCESS] (I)
 - 5.2.3 Project Transform & Covidence (I)
 - 5.3 New Rehabilitation Field Application [OPEN ACCESS] (D)
 - 5.4 Communications & External Affairs Department Reports:
 - 5.4.1 Spokesperson Policy Revision [OPEN ACCESS] (D)
 - 5.4.2 Update on Partnerships [RESTRICTED ACCESS] (I)
 - 5.4.3 Update on Membership [OPEN ACCESS] (I)
 - 5.4.4 CPAC/Events Network [OPEN ACCESS] (D)
 - 5.5 Risk Management Report (Q4) [RESTRICTED ACCESS] (D)
6. Finance
 - 6.1 2016 Financial Year Update [RESTRICTED ACCESS - see [Report B](#) document for CSG Strategy day] (I)
 - 6.2 Trading Company Directors' 2015 Report & Financial Statements [OPEN ACCESS] (I)
 - 6.3 Appointment of Cochrane Auditors - Consideration of the Recommendation from the Finance, Investment & Audit Committee [OPEN ACCESS] (D)
 - 6.4 Cochrane Canada Update [RESTRICTED ACCESS] (I)
 - 6.5 Proposed 2017 Strategy to 2020 Targets [RESTRICTED ACCESS - see [Report A](#) document for CSG Strategy day] (D)
 - 6.6 2017 Plan and Budget [RESTRICTED ACCESS] (D)
7. Cochrane-Wiley Publishing Update:
 - 7.1 2016 Work Plan Update [RESTRICTED ACCESS] (I)
 - 7.2 Publishing Management Team Dashboard [OPEN ACCESS] (I)
8. Governance Reform [OPEN ACCESS] (D)

Including: Update and Review of documentation

Saturday 22nd October (08:30 – 18:00)

9. Future Evidence Systems: Cochrane & Big Data [RESTRICTED ACCESS] (I)
 - 9.1 Open Research Data [OPEN ACCESS] (I)
10. Innovations Update:
 - 10.1 Linked Data Commercialisation Strategy [RESTRICTED ACCESS] (D)
 - 10.2 Online Learning Modules Business Case [RESTRICTED ACCESS] (D)
 - 10.3 Cochrane Response Update Report [RESTRICTED ACCESS] (D)
11. Knowledge Translation Strategy [OPEN ACCESS] (I)
12. Structure & Function Review:
 - 12.1 Covering note [OPEN ACCESS] (I)
 - 12.1 Paper 1: Creating a more sustainable review production system for the Cochrane Library [OPEN ACCESS] (D)
 - 12.2 Paper 2: Cochrane's Geographic Presence [OPEN ACCESS] (D)
 - 12.3 Paper 3: Cochrane Fields: An Update on proposals [OPEN ACCESS] (I)
13. AGM Preparation [OPEN ACCESS - see documents circulated by Sarah Watson on 30 September]
14. Any Other Business (Including review of decisions for dissemination)

CSG Only Time

(I) - Agenda Items for Information/report

(D) - Agenda Items for Decision or Strategic Discussion

CEU Report on Review Quality

Document prepared by: **Toby Lasserson
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Submitted to Steering Group: **October 2016**

Access: **Open Access**

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1 Background

This paper presents a report on recent CEU activities aimed at improving the quality of published reviews and some reflections on the quality of reviews coming through the screening team within the CEU since the launch of the integrated quality strategy¹. It highlights areas where we continue to see problems with implementation of methods and reporting, provides observations that help to explain why some issues have persisted, and puts forward recommendations that will help the CEU and the wider organisation to deliver the quality strategy.

2 Changes to Screening

The integrated quality strategy committed the CEU to move from screening all new reviews after sign off, in favour of a referral system. This was intended to encourage CRGs to nominate reviews for screening about which they had concerns, or those they thought would merit support in dissemination.

A small number of CRGs request regular input in sign-off decisions where Co-ordinating Editors are authors or where the group is in transition, for example through changes in leadership. The team also receives referrals from the Copy Edit Support service where concerns have been identified during the copy editing process.

In addition to the 'on demand' screening service, there are two further sources of reviews for screening. One CEU senior editor joins the Cochrane UK weekly call that reviews abstracts that have been signed off in the preceding week (the *Analysis of Review Group Outputs for decisions on dissemination and promotion* or 'ARGO') meeting). This meeting routinely identifies quality issues in review Abstracts.

In addition, we now only consider reviews for press releases if they have been screened by the CEU team. This adds substantially to the workload of the team but ensures that all reviews being considered for media dissemination are thoroughly appraised prior to publication, and has also occasionally identified substantive methodological issues that have required correction prior to publication. This process also enables us to identify high impact reviews and plan dissemination earlier in the process. It has also strengthened opportunities to work collaboratively with CRGs and the Cochrane Communications and External Affairs Department (CEAD) to disseminate evidence from Cochrane Reviews more effectively.

The team is therefore requested to screen reviews that would otherwise not have come into the screening process. Irrespective of the referral source, the CEU screening team present their findings to a broader group of CEU editors, the Methods Co-ordinator and the manager of the Copy Edit Support service every week. This forum has identified widespread concerns across a large number of reviews, many of which had not originally been referred by the CRG to the CEU team, but had nonetheless been submitted for copy editing. Rather than rely on copy-edit support as an additional layer of quality assurance we feel that this highlights the need for better recognition of key quality issues within the CRGs, and an appreciation of the distinction

¹ <http://editorial-unit.cochrane.org/sites/editorial-unit.cochrane.org/files/uploads/Cochrane%20Quality%20Assurance%20and%20Editorial%20Process%20Integrated%20Plan%2010%20FEB%202016.pdf>

between technical and copy editing, so that where appropriate, CRG teams can recognise when a review requires further work, or needs to be referred to the CEU for screening.

The move to screening by referral has reduced the number of reviews screened, but has altered the nature of the screening process. Between January and August 2016, 109 reviews and protocols were screened. This compares with 202 and 275 over the equivalent period in 2015 and 2014 respectively.

By inviting CRGs to refer reviews the CEU team is able to provide more timely input and has enabled the team to provide input into protocols and reviews being updated. The team feel that the changes have ensured that screening has become more supportive and focussed on CRG needs than it was previously.

The workload of the CEU team is therefore now heavily weighted towards problematic reviews, many of which exhibit substantial problems. Despite screening fewer reviews, the increase in complexity of those reviews, plus the increased attention given to reviews that are the object of media dissemination activities has meant that there have been limited opportunities to focus on developing guidance and other initiatives to improve quality. It is clear from conversations with colleagues from a number of CRG editorial bases that this mirrors quite closely their pattern of work.

Our experience also highlights the lack of opportunity to spot and address these problems earlier in the editorial process. We have managed to undertake 'in time' screening sessions with one CRG on a monthly basis, and a second CRG has requested help in moving this forward with their editorial team. When required, we have also held one to one calls with CRGs and review authors, to discuss the screening report for a specific review in person. Our experience has shown that this verbal discussion will resolve the quality issues quicker than circulating a written word report between the CRG, the review authors, and CEU team. We welcome the opportunity to work more collaboratively in this manner but doing so creates issues of scalability since we are unlikely to be able to roll this out individually to all of the remaining CRGs. In the future, such development activities will need to be focussed on fewer, larger groups or networks to ensure that the work is sustainable.

Most of the reviews referred for screening occur when editors are seeking advice about a problem, would like an independent view on a particular issue or have found it difficult to obtain methodological peer review. In some cases we have been approached to support a rejection decision, or following screening the CRG editors have decided to reject the review on the grounds of insufficient methodological quality.

3 Activities aimed at learning and quality development

Table 1 summarizes the editorial training activities undertaken by the team since the mid-year meetings in April:

Editorial Training Activity	Date	CEU Editor
Face to Face Training on 'CEU Screening' for the Stroke CRG Editors training day	April 2016	Nuala Livingstone
Presentation on the MECIR standards for the Learning and Support Department	April 2016	Toby Lasserson
Support for the GRADE Editor training resources for the Cochrane Learning and Support Department	April 2016	Newton Opiyo
Training sessions around screening with editors from	April 2016	CEU Quality Editors

Editorial Training Activity	Date	CEU Editor
Breast Cancer Group		team
Face to face training session on 'common errors in writing up a Cochrane Review' as part of the School of Education (QUB) systematic review training day	May 2016	Nuala Livingstone
Editorial training for the Cochrane Oral Health Group	June 2016	Toby Lasserson
Pilot editor clinic for the Development, Psychosocial and Learning Problems Group	June 2016	Toby Lasserson Nuala Livingstone
SoF and GRADE workshop during the 'Cochrane in Ireland' conference	June 2016	Nuala Livingstone
Training sessions around screening with editors from Anaesthesia, Critical Care and Emergency Medicine Group	June 2016 August 2016 September 2016	CEU Quality Editors team
Webinar for Cochrane Learning Live on "Common errors and best practice when writing a review protocol"	June 2016	Nuala Livingstone
Face to Face Training on 'CEU Screening' for the Schizophrenia CRG Editors training day	July 2016	Nuala Livingstone
Pilot editor clinic for the Airways Group	July 2016	Toby Lasserson Nuala Livingstone
Support for the LIXA (Learning Initiative for Experienced Authors) webinar on the subject of planning GRADE methods and SoF tables in Cochrane reviews	July 2016	Newton Opiyo
Training sessions around screening with editors from Incontinence Group	September 2016	CEU Quality Editors team
Drafted the operational guide to CEU review screening	October 2016	Nuala Livingstone
Second paper in the Screening Notes series, looking at common issues with Summary of Findings tables	October 2016	Newton Opiyo
Support for the Cochrane UK editor training day	October 2016	Toby Lasserson

4 Performance data

The change in emphasis of the screening work initiated in September 2015 means that the reviews undergoing screening is no longer representative sample of reviews at sign off: many are further from completion than in previous years, and understandably they exhibit more problems than would be expected to be found post sign off by the Co-ordinating Editors. This means that it is impossible to compare the findings from screening reports with those produced prior to September 2015 on a 'like for like' basis. In addition, following feedback from CRGs, and in order to simplify the messages, we have moved away from using global labels of 'major' or 'minor' amendments on reports in favour of listing items as 'must' or 'should' address. The changes have had important benefits in terms of the utility and timeliness of our screening but the downside is that we do not have comparative performance data, and in addition, we no longer have a comprehensive assessment of all new reviews. Our proposed changes to the pattern of work will ensure that in 2017 we re-establish more useful post sign-off performance data across the organisation.

As indicated above, recent experience of screening has persuaded us that quality problems with Cochrane Reviews are not limited to a small number of groups. Having worked with the 'high risk' groups, we believe that in each case processes or changes have been put in place that will begin to address the challenges.

However, in all of these groups and many others, continued monitoring is required. This has resulted in the CEU proposing two further changes to be enacted as part of the Structure and Function programme.

Firstly, we are proposing an increase in transparency in relation to quality issues identified in reviews that have been signed off for publication by CRG teams. Secondly, and allied to this, we propose to develop and institute a peri-publication check of all Abstracts, Plain Language Summaries, and Summary of Findings tables, leading to an aggregate score (out of 10) for each review. The check will also be used to identify examples of good practice and complex reviews.

5 Persistent sources of variation in quality

The sources of variation in quality we continue to see revolve around three main areas:

- implementation of methods
- interpretation of findings
- consistency and completeness of reporting in summary versions.

We commonly continue to see issues relating to a variable grasp of judging risk of bias and assessment of its impact on review findings, appropriate use of subgroup analysis, analysis of data from studies with non-standard designs such as cluster or crossover randomised trials, and studies with multiple treatment arms. The implementation of GRADE and Summary of Findings tables remains an area where we believe that targeted support (e.g. early piloting and independent review) is needed to promote learning.

Capacity is a contributory factor to the variation in review quality. We are aware that many groups would like better access to methodological support and the team would like to be in a position to provide an earlier, scalable solution. We recognise that the proposal for a Methods Support Team within the Structure and Function proposals, and the proposals to support wider involvement in the review production process by 'geographic' groups such as Centres and Fields (paper 2) also represent potential solutions for this.

The high volume of protocols and reviews relative to available resources within some CRGs suggests that for some Groups there are too many reviews that need input from too few available experts. This environment is inevitably going to place stress on internal quality assurance processes. We are looking to explore how we might effectively address these tensions in the planned pilot that separates production from editorial process.

6 Recommendations

In line with the Structure and function (paper 1) we will:

1. Develop an agreed rejection policy and process to help address continuing issues around volume and capacity. A rejection policy will support more sustainable, effective editorial process and provide greater impetus to produce better and more impactful reviews. We believe that an assertive policy will need to be clearly communicated to ensure that authors' expectations are actively managed.
2. Increase the transparency of quality assessments within the Cochrane community
3. Develop and implement a peri-publication check on abstracts and Summary of Findings tables accompanied by ongoing more detailed cyclical audits with a validated tool on published content.

4. Continue to work with colleagues within CRG teams and the Learning and Support Department to ensure that learning resources and opportunities are available for editorial teams, including 'real-time' screening sessions. We will deliver these in a sustainable manner, usually working with 'groups of groups' or networks.
5. Continue to provide an 'on demand' screening service and we will also screen high priority reviews from the Cochrane-wide prioritisation list and reviews being considered for media dissemination.

Targeted Updates

Final Report

October 2016

[Open Access]

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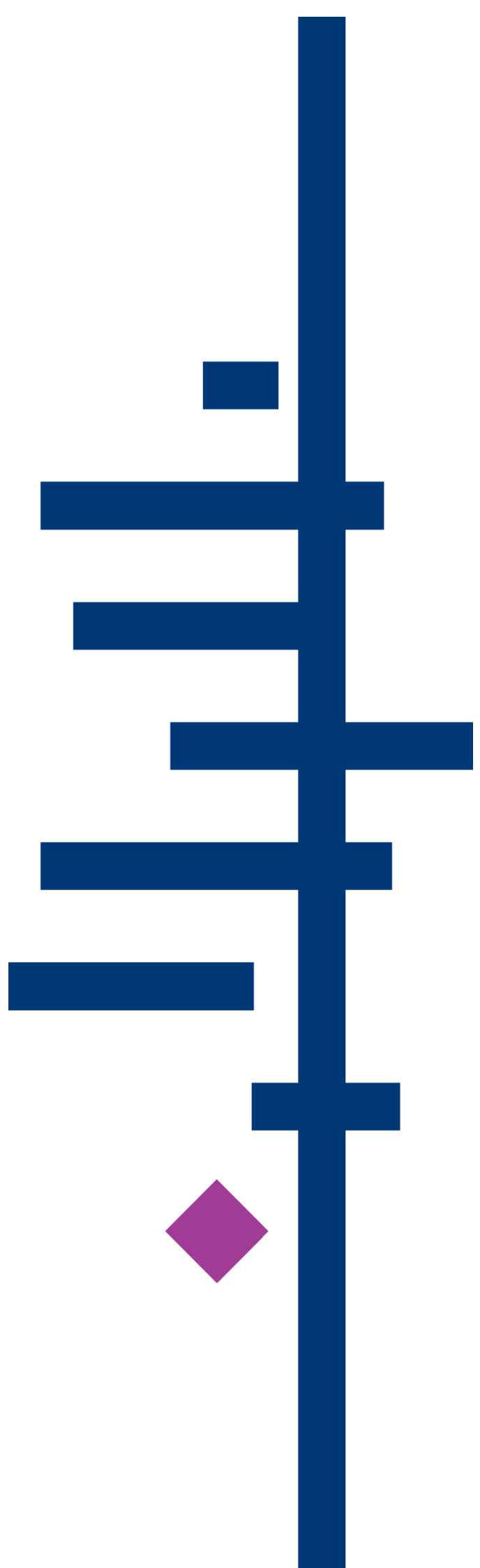


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Executive Summary

Introduction

Supported by the Cochrane Steering Group, this pilot project was conducted jointly by Enhance Reviews, the Cochrane Editorial Unit, Cochrane Innovations, and a CRG Coordinating Editor, and also involved a number of Cochrane Review Groups (CRGs). This project aimed to provide policy-makers, in particular guideline developers, with bespoke up-to-date information about specific questions addressed in existing Cochrane Reviews, but updated according to their requirements and timelines. 'Targeted Updates' are two-page documents that use the source Cochrane Reviews as their foundation, but focus on updating only one or two important comparisons, and up to seven most relevant outcomes. They include an updated Summary of Findings Table and a detailed plain language abstract. The search results, risk of bias assessments, analyses and references are made available as supplementary information, as they do not form part of the Targeted Update (TU) itself. Although TUs are not full Cochrane Review updates, Cochrane review methods are employed so that any new data can be subsequently used by review authors to facilitate a full Cochrane Review update if deemed appropriate.

The pilot consisted of three elements; (i) Part A – Concept and user testing, (ii) Part B – Targeted Update Production, and (iii) Part C – Acceptability testing.

To see the full original proposal of this project, please follow this link:

https://www.dropbox.com/s/bd6redodmbapqbm/10.%202014_12_04%20Focused%20Updates%20Proposal.docx?dl=0

Objective

To user-test 'Targeted Updates' with both Cochrane Review Groups and Guideline Developers, and to explore options for the sustainable production of Targeted Updates. This report will outline the main findings of this project.

What we have done

Part A – Concept and user testing with guideline developers

In 2015, seven semi-structured interviews with guideline developers, and four workshops (at the UK Cochrane symposium, Australasian Cochrane Symposium, Vienna Cochrane Colloquium and the Guideline International Network (GIN) Amsterdam meeting) were undertaken. The following key messages emerged:

- Cochrane is considered the 'go-to' resource due to our high quality standards but, although this meets their information needs, we are not making it easy for our policy-maker users.
- The main problem when sourcing systematic review evidence is timeliness, and most guideline developers seem to be resigned to the fact that the volunteer nature of Cochrane means that there is limited capacity for Cochrane to be responsive and update reviews within their required timelines.
- For those with the resources, the complexity of existing Cochrane reviews means that it can be more efficient to undertake evidence syntheses from scratch, rather than try to build on what Cochrane has already produced.

- This can lead to inefficiency and duplication amongst guideline developers with multiple updates related to Cochrane review questions being produced around the world.
- There is considerable interest from guideline developers to find mechanisms to work more closely with Cochrane.

The following positive observations were made by guideline developers about TUs:

- Could help internal evidence and systematic review teams with capacity problems.
- Could help meet tight commissioning deadlines and guideline updating schedules.
- Directly supports the currently favored approach for guideline recommendation-level updates, moving away from comprehensive full guideline updates.
- Could be an opportunity to avoid duplication and improve transparency and dissemination if TUs could be part of the Cochrane Library.
- Commissioned TUs can be used directly by decision makers; the format is more accessible and useable.
- Supports their need for tailored, fast and context-specific evidence. Commissioners also want a service 'where they can drive the timeline'.
- TUs could be easier to budget and plan for within restricted commissioning budgets.
- Suggest not limiting the concept to updates; the process would also work for new reviews.

Part B – Targeted Update Production

We engaged with seven Cochrane Review Groups, and two Guideline Developers to produce a total of 14 TU documents based on 11 Cochrane Reviews. Evidence was gathered on the efficiency and duration of time to complete each TU. The key findings include:

- The TU team produced 13 TU documents, and the CRGs produced 1 TU document.
- Early TU completion times and overall efficiency improved throughout the duration of the pilot as procedures were refined, as staffing improved, and as the TU team became more efficient.
- Work on complex reviews resulted in delays in TU production, indicating that not all reviews are suitable for TUs.
- Nearly all the participating CRGs experienced some difficulty engaging in the process due to their existing workload.
- Content expertise is essential, but frequently difficult to find. CRG involvement was crucial in identifying suitable experts.
- The design and presentation of TUs requires further consideration. One option is to offer a 'Menu' of available features, to allow guideline developers to select their own TU content and layout.
- The cost of updating a Cochrane Review in a form a TU document was approximately £6408.53 per Cochrane Review.

Part C – Acceptability testing

Participating CRGs and commissioners and the wider Cochrane Community were encouraged to supply views and feedback about the production, presentation and value of TUs.

Key observations include:

- Author and CRG involvement in TU production is valuable and improves the process and product, but improved mechanisms for author/CRG involvement, content expertise and TU peer-review are required.
- Authors and CRGs may value the opportunity provided by TUs to build closer relationships with guideline developers.
- Better technological assistance (e.g. improvements to Covidence; Task Exchange) could support the process.
- Some types of reviews may not be suitable for TUs.
- The process worked well for commissioners and met their information needs.
- Early clarity about the specific questions of interest to commissioners is critical, and mechanisms for effective liaison to ensure clarity about the commissioner's questions are required to avoid delays later in the process.
- An 'options menu' for commissioners could enable the development of a TU product, better tailored to the varying needs of different commissioners.
- Although TUs *could* precipitate or expedite priority updates, access to searches and already screened results is less helpful than access to new data extractions.
- For complex reviews, funds might be better used to support completion of the full review update, with a subsequent TU providing a valuable knowledge translation product.
- Clarity about the relationship between the TU and the source review/full review update is required to avoid confusion for users.
- Concerns about any potential problems of perceived competition between funded and unfunded outputs require further thought and will need to be resolved.
- Commissioners liked the focus, rapid production, and short, structured and concise layout, although they would value clear links with the source Cochrane review.
- TU publication/access issues require resolution.

Key points and recommendations

Overall, this pilot has demonstrated that TUs can provide a vital role in meeting the needs of key target audiences for Cochrane, but that production processes, access to appropriate content expertise, and access and publication issues all need careful consideration.

Our main observations are:

- TUs are important derivative products for Cochrane that meet the needs of commissioners, and there is clear demand from guideline developers for this type of work.
- TUs allow for tailoring of review products to the requirements of commissioners, which can be important where review objectives and commissioner objectives overlap but differ slightly.
- The usability and brevity of TU documents are much valued by commissioners, although careful attention and thought are still required to properly interpret the results.
- CRGs have varying levels of resources and, although they are generally keen to be involved in the production of TUs, suitable mechanisms to support their contribution need to be established which take account of this.
- TUs follow the same methods as the source review, which could help to expedite a full Cochrane review update.
- CRGs are generally keen to be involved in the production of TUs if suitable mechanisms to support their contribution can be established.

- Production of TUs would be well-suited to the Cochrane Response model, at least in the first instance.
- It is important that any future TU service is driven by the needs of commissioners, with CRG involvement wherever possible.

Next Steps/Implementation

1. We recommend that Cochrane Response is allowed to continue to offer TUs as a derivative product, and have the flexibility to produce a document tailored to the needs of commissioners.
2. We recommend that TUs are made available on the Cochrane Library, as the product is only likely to have true value if it is clearly recognized by Cochrane.
3. We recommend that the option to use TUs as a knowledge translation tool, as well as a way to expedite full review updates, is considered and further explored within the context of the Cochrane Knowledge Translation Strategy.

Part A – Concept and user testing

1.1. Background and scope

This section presents the findings from user research undertaken with guideline developers, the key target audience for TUs involved in this pilot. The main objective was to understand guideline developers' current use of Cochrane evidence and their interest in TUs.

We conducted seven semi-structured interviews in 2015 with guideline developers from a range of geographical locations, healthcare settings, and organization types.

Table 1: Guideline Developers Interviewed

Organisation type	Guideline Developer	Country
International government agency	WHO	International
National government agency	NICE	UK
	National Blood Authority	Australia
Healthcare insurer/provider	Kaiser Permanente	USA
Professional Society	American College of Physicians	USA
	Brazil Medical Association	Brazil
	European Society of Cardiology	Europe

We held four workshops in 2015, at the UK Cochrane symposium, Australasian Cochrane Symposium, Vienna Cochrane Colloquium and the Guideline International Network (GIN) Amsterdam meeting. 20 guideline organisations were represented across the 4 workshops with the highest representation at the GIN and Australasian Cochrane Symposium.

Table 2: 20 guideline organisations participating in 2015 workshops

Royal Dutch Pharmacy Society	Accident Compensation Corporation (Australia)
Norwegian Directorate of Health	Parenting Research Centre (Australia)
Kaiser Permanente National guidelines	Royal District Nursing Services Institute (Australia)
Kaiser Permanente Southern California	NHMRC
American Academy of Otolaryngology	Royal Australian College of General Practitioners
Clinical Guidelines Service GmbH	National Stroke Foundation
Knowledge Institute of Medical Specialists	Health Consult Australia
Cancer Center Netherlands	Children's Hospital at Westmead
Therapeutic Guidelines (Australia)	Royal Australian & NZ College of Psychiatrists
NICE UK	National Clinical Guideline Centre (UK)

We worked directly with two guideline groups; the National Blood Authority in Australia and the Norwegian Directorate of Health who commissioned TUs as part of the pilot (which was not anticipated in the proposal).

1.2. What did people say

The key findings for this user research are summarised under three main themes: Perception of Cochrane reviews, Use of Cochrane reviews, and Response to TUs.

Perception of Cochrane reviews

Overall there was **a positive perception of Cochrane reviews** with all guideline developers agreeing that Cochrane reviews have a high quality standard matching their requirements, and that Cochrane is the 'go-to' evidence resource. They reported that, in principle, Cochrane reviews can help them to expedite the updating of guideline recommendations whilst avoiding duplication of effort.

Use of Cochrane reviews

There are a **range of issues limiting the use of Cochrane reviews by guideline developers**. The main problem when sourcing systematic review evidence is timeliness, and most guideline developers seem to be resigned to the fact that the volunteer nature of Cochrane means that there is limited capacity for Cochrane to be responsive and update reviews within their required timelines.

They also highlighted the complexity in the way Cochrane reviews report their findings, sometimes restricting their use by non-methodologists. They noted that Cochrane reviews are often out of date, and also expressed frustration at the lack of formal mechanisms for accessing and sharing data to avoid duplication, as well as issues with topic prioritisation and sometimes poor question alignment with the needs of guideline developers.

As a result, **many guideline developers are updating Cochrane reviews themselves internally**, or may even start the review production process from scratch with updates more focused on specific questions, rather than build on what Cochrane has produced. These internally focused updates are often not published or only made available to local audiences, and there are no formal mechanisms for sharing the data or analysis with Cochrane or other guideline developers. There is strong interest from guideline developers to avoid this wasteful duplication of effort and find mechanisms for sharing data and publishing updates focused on specific questions.

Response to Targeted Updates

The feedback from guideline developers has been positive with a clear indication that **guideline developers are interested in having access to and using TUs**.

This has been further validated by two recent WHO commissioned reviews secured by Cochrane Response. The proposals included TUs as the interim deliverable for the guideline committee meetings, and were highlighted as a positive and unique service by the WHO commissioning team.

The following positive statements were made by guideline developers about TU:

- Could help internal evidence and systematic review teams with capacity problems.
- Could help meet tight commissioning deadlines and guideline updating schedules.

- Directly supports the new trend for targeted guidelines, with recommendation level updates, as guideline developers move away from large, comprehensive guidelines and full updates.
- Opportunity to improve dissemination and avoid duplication with publication of TUs as a Cochrane review within the Cochrane Library.
- Commissioned report can be used directly by decision makers, the format is more accessible and useable, and the information contained within the summary report is exactly what we need.
- Support their need for tailored, fast and context specific evidence. Commissioners want a service 'where they can drive the timeline'.
- Easier to budget and plan for within restricted commissioning budgets.
- Do not limit the concept to just updates, would work for both updates and new reviews.

The following issues and concerns were raised by guideline developers:

- The context for commissioning a TU needs to be clearer within the final published reports.
- Acknowledged that in complex situations, a TU would not be appropriate due the complexity of the PICO, the comparisons included, or the type of evidence needed. Therefore, we need to provide better guidance on when a TU is appropriate for a guideline developer.

Part B – Targeted Update production

2.1. Methods

A full description of the methodology used in this project can be found in **Appendix 1**.

2.2. Results

2.2.1. Outputs and review group involvement

A total of 14 TUs were produced as part of this Pilot, based on 11 Cochrane Reviews. A list of all 14 TUs, along with details on duration of time to complete, task responsibility, and involvement of guideline developers for each can be found in **Appendix 2**. Overall, we engaged with seven CRGs, four of whom volunteered for the original pilot, with three additional groups becoming involved following topic requests from two Guideline Developers.

For questions identified in partnership with a CRG or guideline developer, the length of time taken to complete the first full draft of the TU documents ranged from 2 weeks, to 28 weeks. The length of time taken to complete the peer review process for these documents ranged from 4 weeks to 19 weeks.

For questions directly commissioned by a guideline developer, the length of time taken to complete the first full draft of the TU documents ranged from 6 weeks, to 9 weeks. The length of time taken to complete the peer review process for these documents ranged from 1 day to 9 weeks.

A detailed description of the process for completing each TU can be found in **Appendix 3**.

The full collection of TU documents can be found by following this link:

<https://www.dropbox.com/sh/u3z9m1n295w9816/AABAtERX6dxIfyeJlNSFEeWNa?dl=0>

The TU team are also in the process of publishing all the TU documents online in the form of blog (please follow this link to see our latest blog <http://community.cochrane.org/news/targeted-updates-project-case-study>). It is possible that all the completed TU documents will be formally published in the Cochrane Library as part of a 'special collection', but that this is unlikely to happen until after the final report of the project is complete.

2.3. Discussion

Combining the evidence on duration of time to completion of each TU, and the efficiency in performing relevant tasks, some clear observations emerge. In every case, TU topics that were identified by CRGs took longer to complete than those resulting from questions commissioned by a guideline developer. We explore below some of the barriers and facilitators experienced in preparing TUs to time and target.

2.3.1. TU production

The TU team was capable of producing a higher number of TU documents than planned. The original intention was for the TU team to lead the production of eight TUs, and for the participating CRGs to lead the production of an additional eight TUs. However, in total, the TU team led the production 13 TUs, and the CRGs led the production of 1 TU.

2.3.2. The TU team

As part of the pilot study, the team were constantly adapting and developing the process and methods in response to experience and feedback. Some difficulties encountered by the TU team may have impacted on outcomes. For example, the TU team proposed to share the production work with the CRGs to explore which process worked best but, in the event, CRGs did not have capacity to produce the TU, usually providing a more supportive role. All TU team members had part-time roles only, so the project wasn't optimally staffed for taking primary responsibility for producing all TUs. Personnel changes during the lifetime of the project also caused some disruption, and all unanticipated issues took time for the team to discuss and to agree a course of action.

2.3.3. Working with volunteer CRGs

The initial stages of the pilot involved working only with the volunteer CRGs, whilst the TU team were establishing their processes and refining their understanding of the resources, management and information required. Topics for these TUs were identified by CRGs themselves, and much time was spent discussing suitability of reviews, the exact process by which TUs would be produced, and assigning task responsibility. Planned methods and agreed processes had to be adapted as the project progressed and workload increased and, over time, the team employed freelance study screeners and data extractors to improve efficiency.

All volunteer CRGs had a genuine interest in participating and all made significant efforts to contribute. TU production was always more streamlined when the CRG was willing and able to be involved in the process, as they provided essential content expertise, knowledge about the review and liaison with the authors. However, nearly all the participating CRGs experienced difficulty engaging in the process over the term of the project, largely due to their existing workload and priorities. Progress was often slow to begin with because there was a general lack of understanding regarding the rationale for TUs, the exact process by which they would be delivered, and the relationship between the source review and the TU. Different groups also had different levels of resources available to them, and those with limited capacity found it particularly difficult to meet the demands of the short timeframe necessary to produce a TU. As TU production was not their core business, CRGs often couldn't provide responses as quickly as required. The perspectives of participating CRGs and authors are explored in more detail in Part C of this report.

2.3.4. Working with Guideline Developers

Unlike CRG identified topics, guideline developer commissioned topics began with a clear research question and eligibility criteria already in place. Many of these TUs were completed later in the pilot, when the project had improved capacity and more standardised processes for production. They were also independently funded, enabling TU production to be led by the TU team, and therefore depended less on the CRG to develop topics and deliver the outputs.

Difficulties arose occurred when the guideline developers requested a different categorisation or definition of interventions and outcomes than the original review authors. For example, in one instance, the guideline developers had a different definition of 'high intensity' language therapy from the original review authors. We conducted the TU as per the requests of the guideline developer and, ultimately, the findings of the TU differed from the findings of the full Cochrane review. This was explained in the TU, with a note on the cover page that explicitly stated "*This Targeted Update is based on a Cochrane review that has a wider scope, included 57 studies, and*

concluded that language therapy of any intensity may be associated with improved language function compared to no treatment”.

One of the guideline developers, the Norwegian Directorate of Health, changed their list of prioritized reviews during the process, and subsequently requested a change to the commission, although the TU team were able to respond to this change efficiently and with minimal wasted effort. The team recognise that this is an accurate reflection of real- world experience; commissioner priorities can change rapidly and they often value opportunities to tailor their questions to their own requirements.

One time-consuming aspect of working with guideline developers was the negotiation of contracts. Delays were incurred in the work completed for the NBA due to uncertainties regarding the contract negotiation. To avoid delays like this in the future, Cochrane’s Finance and Core Services team would need to be involved and responsive from the outset. It is likely that, if the TU service were to continue, these processes would be officially set and prepared by Cochrane Response before any formal service was offered.

2.3.5. Time to completion

Duration of time to TU completion and overall efficiency improved over the course of the project as CRGs and others developed a greater awareness of TUs and improved understanding of their methods and purpose.

2.3.6. Conceptual and content differences between the source review and the TU

In all TUs, the process began by conducting an initial assessment of the latest version of the full Cochrane Review. When the initial assessment indicated that the review methods were appropriate, the search was already up to date, and the TU research question and eligibility criteria matched the original Cochrane Review exactly, the TU document could be produced quickly and efficiently.

However, problems frequently occurred when this initial assessment of the original review indicated that either (a) the original review methods were not appropriate; (b) the last search was run more than 12 months ago, and would therefore require updating before the TU could proceed, or; (c) the TU question and eligibility criteria requested by a guideline developer differed slightly from the original review questions. Any one of these three issues resulted in delays to completion.

The assessment tool originally developed for this pilot also sometimes failed to identify potential problems at the start of the process and required adaptation. One example of this was the Intensive Case Management Review completed with the Schizophrenia Group was delayed due to complexity issues that were not initially highlighted. A number of included studies in this review were published in Chinese. As we did not have the resources for translation, a large number of relevant studies could not be cross checked, or extracted. The phrasing of the inclusion criteria was somewhat open to interpretation and difficult to apply. Furthermore, in this instance the TU team was not able to liaise with the original review authors until the end of the process, resulting in a lack of clarification about the inclusion criteria.

The pilot has demonstrated that TUs may not be suitable for every type of Cochrane review. For some Cochrane reviews a TU would not be feasible, particularly in complex reviews, for the sole purpose of facilitating a full review update. In such instances, it may have been more appropriate

to decline that TU request, than to spend a disproportionate amount of time adapting the original review methods.

We were also unprepared for some issues that resulted in delays during the TU production. For example, if there was uncertainty regarding how to use GRADE for subgroup analyses, time was spent discussing the different options and consulting with other members of the CEU. However, as a result of the pilot, we would now either know how to address many of the issues likely to occur, or we would know whom to contact for advice and guidance.

2.3.7. Peer Review

Identifying Peer Reviewers who are both suitable and available proved to be particularly challenging for some targeted updates. Most TUs were reviewed by at least two experts. However, only one peer review was completed for two TUs. Every potential peer reviewer identified for these two TUs was either unresponsive, or unable to complete a peer review within 2 weeks, even with the monetary incentive. Future TUs must prepare for this challenge by identifying and confirming peer reviewers as early as possible in the process and, if necessary, with the assistance of the commissioning body.

2.3.8. Review Author Involvement

Originally, it was hoped that TUs would have a dual purpose, addressing guideline developer's priorities and helping CRGs to identify and update priority reviews by providing extracted data and study assessments for their authors. The project did not always succeed in involving authors, although this may, in part, be due to a general lack of awareness and understanding of the potential value of TUs. In addition, author involvement was usually mediated by the CRG, and we did not always have a direct channel of communication. More work was always required where PICO's differed when authors had less direct investment in the TU production. If the only purpose of a TU is to answer guideline developers' questions, then less input may be required from review authors/content experts as commissioners' requirements alone can be used to set the criteria. However, content expertise was critical, even if only delivered via independent peer review, or through engagement with the experts within the CRG and on the guideline panel. Where the TU is facilitating a full review update, it is essential that the review author plays a role in the process.

2.3.9. Presentation and Design

As indicated in the proposal, we planned to create and user-test 3-4 template designs for TUs. However, when we discussed the design with the Advisory Board, we were advised that this was an area of ongoing research by experienced groups, and to use this research to inform the content and design. We had a follow-up call with Sarah Rosenbaum where we identified several content and design elements from the SUPPORT summaries that could be used in TUs (e.g. Plain language statements in the Summary of findings tables, and the 'About this summary' section from the SUPPORT summaries), and elements that would be difficult to incorporate (e.g. always using risk ratios as the estimate of effect). A suggestion from Sarah was to take potential elements that might be included in a TU (e.g. Abstract, Summary of findings table, forest plots, figures representing absolute effects, risk of bias figures, 'What's new' section, 'About this summary' section etc.), and ask guideline developers which of these elements they would want to include in TU. It was notable that on more than one occasion, guideline developers asked the team to alter the presentation of the final document. For example, some requested that forest plots to be part of the final document, whilst others preferred the Summary of Findings table only. One concept that should be considered is to offer guideline developers a 'Menu' of the different features that could be presented in a TU

document, and allow guideline developers to design their own TU document according to their own requirements and preferences.

2.3.10. Publication

Several of those involved in the TU project have expressed their disappointment that the completed TU documents are not yet formally published. The TU team have begun to address this issue by publishing all the TU documents online in the form of blog (please follow this link to see our latest blog <http://community.cochrane.org/news/targeted-updates-project-case-study>). It is still possible that all the completed TU documents will be formally published in the Cochrane Library, but that this is unlikely to happen until after the final report of the project is complete.

2.3.11 Financial Implications

The TU team underspent the amount received from the Steering Group to conduct this pilot. The reasons for that were:

1. During the course of this project, the TU team received commissions from two different guideline developers to complete a total of five TUs. The National Blood Authority commissioned one TU for \$6,451 (Australian Dollars), and the Norwegian Directorate of Health commissioned 4 TUs at £4,950 each. These commissions amounted to £23,650.
2. Only 1 of the 14 completed TUs was led by the CRGs, and the remaining 13 TUs were led by the Targeted Update team

As a result, a total of £80,993.85, from the £134,500 awarded has been spent on the project, and £53,506.15 was returned to Cochrane.

Of that money, approximately £70,493.85 was spent on the direct production of 14 Targeted Update documents based on 11 Cochrane Reviews. Therefore, on average, it can be estimated that it cost £6,408.53 to produce Targeted Update documents for each of the 11 Cochrane Reviews. It should be emphasised that this is only an average, as some Cochrane Reviews required more time and resources than others to update in the form of a Targeted Update document.

Part C – Acceptability Testing

3.1. Background and scope

As part of the pilot, it was important to elicit and understand the views of those involved in the commissioning and production of TUs, as well as the wider Cochrane Community. All participating groups and organisations were advised of this at the beginning of the study and efforts were made to elicit views from those external to the project.

3.1.1 Feedback received

All participating CRG were offered the choice between an interview with TU team members (via phone or videoconference) or the opportunity to provide written answers to the interview and/or blog questions (the template form used to collect responses to the interview and blog questions can be found in Appendix 4). Seven CRGs were involved in the production of TUs. One participating CRG opted for a videoconference interview, while four others chose to provide their responses to the interview/blog questions in writing, or via correspondence. The remaining two CRGs were not able to provide feedback. Example TUs were also made available via a blog with a link to an online survey, and feedback was invited from the wider Cochrane Community (with only one response).

Type of involvement	Participant	Feedback provided
CRGs identified topics	Schizophrenia (CoEd)	Videoconference
	Skin (CoEd, editorial base and TU author)	Written
	Gynaecology and Fertility (editorial base)	Written
Commissioned topics	Injuries	None
	Stroke (CoEd, editorial base and review author team)	Written
	Common Mental Disorders (CMD, CoEd and editorial team)	Written
	Schizophrenia (CoEd excluding review author team)	Videoconference
	Fertility	None
TU commissioner	National Blood Authority (Australia)	Written
	Norwegian Directorate for Health	Written
Survey respondent	Anonymous	Survey response

3.2. What did people say

3.2.1. Acceptability testing within Cochrane

3.2.1.1 The process for completing TUs

Feedback from volunteer CRGs

The Gynaecology and Fertility Group were the first CRG involved and were initially unclear about the purpose and outputs of the TU project, feeling that this had affected their own communication with authors (though they recognised this was primarily due to the pilot nature of the project). Overall, the Skin Group indicated that, while the process may need some refining, “as a concept of

how to update a big review by concentrating on the most important points of comparison it has potential” and that it had been “a good catalyst for teams to get going on their full updates”. The TU topic suggested by the Schizophrenia Group provided support for a successful incentive award application, but the CoEd noted that during the subsequent full review update, errors (relating to application of the criteria for inclusion) were identified by the review author. *“Was it useful having two people essentially data extract? Yes, it was. Did it lead us down the wrong path? Yes, it did”.* The CoEd observed that *“detailed pedantic knowledge of reviewer”* reinforced the need for ongoing content expertise involvement as part of the TU process, but that capacity for this was always an issue. *“Of course we all need content expertise. But there’s only so much to go around”.* His view was that complex reviews, such as the one they had volunteered, are often not be suitable for TUs. The Gynaecology and Fertility Group shared this view, reporting that they would choose quite different reviews for TUs in light of the pilot experience.

Feedback from commissioned CRGs

The CMD Group had positive views on the process; it was largely as expected and, though the timeframe was a challenge, it was achievable. They reported that *“overall the teams on both targeted updates worked really well and efficiently together”.* They also reported trying to use Covidence during this pilot but, because the TU was based on an existing review, it did not work well and resulted in some extra work to edit the outputs. The Stroke Group provided extensive and valuable feedback on TU commissioning and production, particularly in view of the fact that a full review update was imminent and they would have been very much willing to work directly with guideline developers.

3.2.1.2 Challenges encountered/suggested improvements

Feedback from volunteer CRGs

The pilot nature of the project meant that guidance and information about the TU process and outputs could have been clearer, and improvements were made throughout the process. It might be of value to produce documentation that can be directly shared with authors and any other participants, so that roles and expectations on both sides are clear. The Gynaecology and Fertility Group thought that summary PDF needed SoFs and/or forest plots of main review outcomes to be really useful. They also observed that the TU format only works for single comparisons, but that it could be integrated with RevMan to develop a relatively simple TU format summary when a review or update is ready for publication. Schizophrenia felt strongly that TUs should follow the full and accurate review update, and only as a dissemination product.

Feedback from commissioned CRGs

CMD felt their main challenge was *“getting sufficient information regarding the inclusion criteria in a timely manner”*, and emphasised that it would be most helpful to *“peg down specifics about PICO at the earliest stage in the process”.* The Stroke authors expressed concern about the selection of reviews for TUs, especially when a full review update is already in process, as this could potentially result in duplication of effort. The authors suggested *“in future, prior to agreeing the scope for a CTU, there should be a thorough examination of whether relevant Cochrane reviews (and review updates) are already underway”.* Although this has always been a routine step in the TU process, in this instance, the commissioner was using their own definition of ‘Intensive’ Speech and Language Therapy (i.e., ≥ 5 times/week) and, as a result, the full review update did not address their specific question. The Stroke authors noted that close scrutiny of relevant Cochrane reviews was essential, and suggested that the TU team could support better direct interaction with the authors

themselves to avoid duplication of review activities and enable commissioners to choose which output they would prefer.

3.2.1.3 Implications for the management of the full Cochrane Review

Feedback from volunteer CRGs

The timeframe of the pilot was short, so limited information was available about resulting progress on any full review updates deemed appropriate. The Gynaecology and Fertility Group felt that their choice of reviews may have impacted on this, indicating that their *"authors are still working on the reviews themselves, had to get new searches, incorporate newly selected studies into their review etc. So clearly we could have chosen better reviews for the pilot"*. They noted though, *"it is always useful to have another perspective on screening and selection. We were encouraged to see that the Targeted Update team's selections matched those of our authors."* The Skin Group did not find access to updated searches helpful in supporting a full review update; *"we could probably handle that ourselves comfortably"*. The Schizophrenia Group CoEd suggested that, rather than working on the TU, most authors might prefer to work with their own CRG to update the full review and that TUs would be better used as a knowledge translation tool, rather than an updating tool. *"This is a 'cart before the horse'. I think Targeted Updates should come out of the full review, and not Targeted Updates precede the full review"*.

Feedback from commissioned CRGs

The CMD Group shared the screened updated search with the original review authors, although *"the authors were not planning to update this review at this time"*. Nevertheless, the overall process did highlight the potential priority of this topic for CMD, and they plan to liaise with authors to explore options for a full review update. The authors of the Stroke review identified several concerns that resulted in useful changes in the TU process, as well as the presentation of the TU document. In particular, the authors noted the *"clear discrepancies between the findings of the TU and the associated Cochrane systematic review"*, attributable to the different definition of 'Intensive' Speech and Language Therapy of interest to the NDH. The differences in conclusions were subsequently highlighted in the TU 'What's New' section, and further clarified in the 'Implications and Conclusions' section. The Stroke Group authors also raised questions about authorship and ownership of the TU and the original review, indicating that *"the two documents are at a high risk of being perceived as arising from the same review team"*. As part of the pilot, the TU documents were modified to include some variation of the following statement as part of the cover page:

"This Targeted Update document was prepared by (Targeted Update Author). Data were taken from the draft full review update that was carried out by the review authors and accepted for publication by the (Cochrane Review Group) editorial team. The abstract was adapted from the draft full review update".

Feedback from the survey (single respondent)

If a guideline developer wanted a TU, as a CRG member they would like to be involved in the process, by helping the TU team to establish and maintain a relationship with the original review authors, and by providing content expertise.

3.2.1.4 Use of financial incentives

Feedback from volunteer CRGs

The Skin Group felt that the monetary incentive to help complete the process, was, overall fair, acknowledging that *"if we had that level of funding to employ systematic review help for other*

reviews, it would make a huge difference to us". The Schizophrenia Group thought that review authors may not be willing to assist with a TU, even in exchange for money, as "no amount of money will resuscitate an exhausted reviewer". The CoEd felt that, because they received funding for both the TU and a subsequent full review update, more funding than was necessary had been used. "If we had true collaboration on funding, maybe could have had full review swiftly put through with an interesting product for the funders". Similarly, the Gynaecology and Fertility Group noted that "The financial incentive did not really work for us, although we thought it would. We did think the amount was appropriate."

Feedback from commissioned CRGs

The Stroke authors were unhappy that "an externally funded Cochrane activity will appear in the public domain before the unfunded full update". Although the authors were assured that their TU would not be made publicly available before their full review update, this did highlight potential problems around perceived competition between the two outputs. This will require further thought. The funding for the CMD Group was used for freelance screening and data extraction, and the group found this level of funding helpful to expedite the work.

3.2.1.5 The presentation and format of the TU document

Feedback from volunteer CRGs

The Skin Group liked the final product because they found it "refreshingly clear and easy to understand", and the "brevity is very welcome". They were however disappointed because of "the time lag from completion of the TUs to publication", which was much longer than they had expected, though they "understood this may be due to this being a pilot". Gynaecology and Fertility reported that "Everyone liked the format of the Targeted Update. Our consumer reviewer in particular liked the way they summarised the evidence and were easy to understand". Schizophrenia reported that the TU product "looked good" and could be of value for dissemination.

Feedback from commissioned CRGs

The CMD Group found the product "succinct, well presented, and clear answers to the targeted questions" and they were "really impressed with the output". They thought the "targeted and timely update of particular aspects of important reviews is really worthwhile". However, they felt that a separate section on quality assessment might be useful, as well as clearer presentation of the outcomes, as currently "you have to dig for them in the results and in the purple text on the 2nd page". The Stroke Group authors felt that the "methodologies underpinning the CTU and how these differ (if at all) from the Cochrane review" was unclear. This feedback resulted in increased clarity to the 'Supplementary Materials' document for all subsequent TUs, so that all necessary details were highlighted.

Feedback from the survey (single respondent)

This respondent found the TU "to a large extent" clearly presented and easy to read, and "to a moderate extent" sufficiently detailed and useful. They felt the Supplementary Materials were "to a moderate extent" clearly presented, sufficiently detailed and easy to read, and "to a small extent" useful. However, they believed that TUs would be of "limited value" in assisting with the prioritization of full Cochrane Reviews/Updates, and that they were also of "limited value" to patients and clinicians, and "not valuable" to guideline developers and funders.

3.2.2 Acceptability testing with commissioners

The feedback from the Norwegian Directorate for Health (NHD) about their experience of commissioning TUs was predominantly positive.

3.2.2.1. The process of commissioning and delivering TUs

These TUs were “*commissioned in order to reduce the work-load on the review team*”. They were “*very pleased with the customer engagement and responsiveness*”, although they suggested that an options menu might be valuable for commissioners. The NDH found the experience of working with the TU team “*inspiring*” and reported that they had “*enjoyed being part of Cochrane’s TU project*”.

3.2.2.2. Challenges encountered and suggested improvements

The NDH acknowledged that there was a delay in finalizing some of the commissions, due to the difficulty the TU team experienced in identifying relevant and available peer reviewers. They suggested that “*a possible solution may be to involve us in the search for peer reviewers at an earlier stage in the process*”. They also acknowledged that peer review is one of the less important features for them, as “*we put all our national guidelines out for an open national hearing*”. Finally, they thought that “*in the future, you may consider to have a pick and choose menu with possible content elements, including any time delay of delivery if choosing extra content elements*”.

3.2.2.3. Presentation and the value of different TU features

For the NDH, the most important features of a TU were the focused question, rapid production, and short, structured and concise layout, based on a Cochrane review. Peer review was important to them, but “*we put all our national guidelines out for an open national hearing, so the peer review [ranks lower than] price*”. They were also pleased with most aspects of the final document, including “*the design, layout and content elements*”. For all TUs, the NDH transfers the information into a local template to share electronically through an API (Application Programming Interface) and the current TU presentation allows for this. They “*would, however, also appreciate the possibility to link to the publication on the Cochrane website*.”

3.2.2.4. Funding of TUs

The NDH confirmed that they would be likely to commission more Cochrane TUs in the future, even if the price was to increase to as much as £10,000 per TU, although “*It would probably affect the total number of commissions, but we would still use and appreciate the opportunity to commission TUs when needed*”.

3.3. Discussion

Overall, commissioners and CRGs approved of the general concept of TUs, liked their presentation, and could see a significant role for them, either as tailored updates for decision-making, knowledge translation products, or both. The pilot yielded valuable information about the process of TU production, much of which has already resulted in changes. However, further work is required to develop greater clarity about the different elements of the process, the final presentation of the TU, and publication/access issues. In particular, we would need to establish improved mechanisms to ensure adequate content expertise, author input and CRG involvement throughout the process. Monetary incentives may be helpful to expedite specific stages of the TU process, but the optimal use of funds needs further consideration.

Key observations include:

The process of completing TUs

- The process of TU production piloted worked reasonably well, although still needs refining.
- Improved mechanisms for author/CRG involvement and content expertise are required
- Better technological assistance (e.g. improvements to Covidence; Task Exchange) could support the process.
- Some types of reviews may not be suitable for TUs.
- The process worked well for commissioners and met their information needs.
- The reported value of TUs, both to decision-makers and for CRGs and their authors, indicates that the process is worth refining to resolve some of the problems.

Challenges encountered and suggested improvements

- Guidance and procedures for accepting commissions for TUs/selecting suitable reviews requires further development, taking account of the feedback from this pilot.
- Early clarity about the specific questions of interest to commissioners is critical, and mechanisms for effective liaison to ensure clarity about the commissioner's questions are required to avoid delays later in the process.
- An 'options menu' for commissioners could enable the development of a TU product better tailored to the varying needs of different commissioners.
- Improved mechanisms for TU peer review, although not always critical to commissioners, are required.

Management of the full review

- Although TUs *could* precipitate or expedite priority updates, access to searches and already screened results is less helpful than access to new data extractions.
- Authors may or may not want to be involved in TU production and build better relationships with guideline developers/other commissioners; some authors feel strongly that they would want involvement, some may prefer to work only on their full published review update once the TU is complete, rather than contributing to the TU itself.
- In some circumstances, particularly for complex reviews, funds might be better used to support completion of the full review update, with a subsequent TU providing a valuable knowledge translation product.
- Clarity about the relationship between the TU and the source review/full review update is required to avoid confusion for users, particularly where there might be differences in the specific questions addressed. For commissioners, a link to the source review would be much valued.

Funding and use of financial incentives

- The funding available to groups was regarded as fair and reasonable and likely to make a difference to review production and updates generally, although not necessarily as a successful incentive for authors themselves.
- Concerns about any potential problems of perceived competition between funded and unfunded outputs require further thought and will need to be resolved.

- Commissioners expressed enthusiasm for future Cochrane TUs, even if the price were to increase up to £10,000 per TU, though TU unit costs could impact on number commissioned.

Presentation and the value of different TU features

- All respondents liked the final TU product, finding them clear, well presented, accessible, and of likely value to decision-makers as well as for dissemination.
- A separate section on quality assessment might be useful, either in the main document or in 'Supplementary Materials'.
- Commissioners liked the focus, rapid production, and short, structured and concise layout, although they would value clear links with the source Cochrane review.
- TUs do need to be easily and quickly accessible if they are to be of use; publication/access issues require resolution.

Conclusions and Recommendations

Overall, this pilot has demonstrated that TUs can provide a vital role in meeting the needs of key target audiences for Cochrane, but that production processes, access to appropriate content expertise and access and publication issues all need careful consideration. Although the overall process was slow to begin with, it steadily improved over time, and would continue to do so, as we learn more about the process. We would not yet recommend widespread implementation of TU production at this stage, as there are still some practicalities and outstanding issues that require further consideration. A list of the problems identified and potential solutions can be found in Appendix 5.

4.1 Key points and recommendations:

- TUs are important derivative products for Cochrane that meet the needs of commissioners, and there is clear demand from guideline developers for this type of work.
- TUs are of value to key target audiences and should be considered as a core Cochrane output.
- TUs allow for tailoring of review products to the requirements of commissioners, which can be important where review objectives and commissioner objectives overlap but differ slightly.
- The usability and brevity of TU documents are much valued by commissioners, although careful attention and thought are still required to properly interpret the results.
- As part of the commissioning process there could be greater clarity about the time necessary to produce a high quality reliable TU, although the time required may be negotiated with the commissioning body, and this may also impact on the agreed scope, methods and approach taken.
- Resources and processes must be agreed and formalised before services can be offered, to avoid unnecessary delays during the TU production process.
- There is a clear dichotomy between the views of guideline developers and the views of CRGs. Guideline developers were predominantly positive in their feedback, and interested in continuing to work with the Targeted Update team on future projects. CRGs were notably more mixed in their feedback, and were more likely to encounter difficulties whilst engaging in the project over the long term.
- Most CRGs like the general concept of TUs, and see their benefits, either in terms of acting as a catalyst for the full review update, or as a valuable dissemination opportunity, or both.
- CRGs have varying levels of resources and, although they are generally keen to be involved in the production of TUs, suitable mechanisms to support their contribution need to be established which take account of this.
- Monetary incentives can help move different aspects of the TU process forward.
- TUs follow the same methods as the source review, which *could* help to expedite a full Cochrane review update.
- Production of TUs would be well-suited to the Cochrane Response model, at least in the first instance.

4.2. Issues for further consideration:

- If a full review update is soon to be published on a topic of interest to commissioners, careful consideration must go into ensuring where a TU is appropriate in order to avoid unnecessary use of resources and subsequent confusion for readers.
- Commissioners may be willing to spend as much as £10,000 per TU, but unit costs need to reflect the level of work involved as well as ensuring access and availability to commissioners.
- Identifying suitable and willing Peer Reviewers is challenging, but commissioners could be approached for peer reviewer suggestions early in the TU process.
- Although frequently difficult to achieve, it is essential that review authors (or other appropriate CRG members) are involved in TU production to provide key knowledge about the review and content expertise.
- Assessments of the suitability of Cochrane Reviews for TUs require further development, for example, to avoid progressing TUs for large complex reviews, or reviews where current inclusion criteria are not completely clear. The option to 'decline' commissions should be available.
- Rather than acting as a catalyst, in some cases a full review update should be undertaken first, and the TU used instead as a knowledge translation tool.
- As the relationship between the TU and the source review can cause some confusion, both for readers and for authors, particular care must be taken throughout the process to ensure that authorship and ownership of both outputs are understood and agreed by all.
- The location, publication and accessibility of TUs needs resolving – should they be hyperlinked to/embedded within the review?
- Having a citable document is important to commissioners and authors. This needs to be considered in association with Impact Factor, which will have implications for authors' and CRGs willingness to contribute.
- Where the TU draws on a source review, use of existing wording from the source review (e.g. regarding methods) may be problematic for author teams if the TU is not linked in some way to the Cochrane Review.
- Consideration needs to be given to the inclusion of non-English language papers, particularly whether the costs and time associated with doing this can be justified for the preparation of a TU.
- Copy-editing of TUs is required, but the remit of copy-editors' needs refining for this type of document.

4.3. Next Steps/Implementation

1. We recommend that Cochrane Response is allowed to continue to offer TUs as a derivative product, and have the flexibility to produce a document tailored to the needs of commissioners.
2. We recommend that TUs are made available on the Cochrane Library, as the product is only likely to have true value if it is clearly recognized by Cochrane.
3. We recommend that the option to use TUs as a knowledge translation tool, as well as a way to expedite full review updates, is considered and further explored within the context of the Cochrane Knowledge Translation Strategy.

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Appendix 1

Methodology

Planned Methods

The original intention with this project was to engage with four volunteer Cochrane Review Groups (CRGs) with reviews of varying complexity. A total of four Targeted Updates were to be produced per CRG together with the Enhance Reviews team. Our initial goal was to for CRGs to identify four priority reviews in need of updating, for which a relationship has been built with guideline developers. This turns out to be a major challenge as CRGs relationship with guideline developers were unclear, and we set a minimum requirement for the CRGs to provide content expertise in developing the Targeted Updates. In addition, we aimed for CRGs to perform all tasks involved in producing a Targeted Update. Funds were to be provided to CRGs to support their input on the project. Our preferred model for this pilot was for CRGs and Enhance Reviews to perform two Targeted Updates each per CRG, so that we could assess whether there are any differences according to who has completed the tasks; however, this was dependent on the resources and staff available at each CRG, and therefore often not feasible. The Targeted Update tasks were allocated up to three weeks. This was to be followed by rapid peer-review within two weeks, and up to one further week for finalisation.

The original four CRGs that we aimed to engage with over the course of this project were the Skin Group, Gynaecology and Fertility Group, the Schizophrenia Group, and the Musculoskeletal Group.

Updated Methods

We presented the project at the UKCC meeting of 2014 and 2015, the Cochrane Colloquium in Vienna (2015), the Cochrane Australasian symposium (2015), and the GIN meeting in Amsterdam (2015). As a result, we received a lot of input from guideline developers. As a result, during the course of the pilot project, the methods were updated and adapted to incorporate additional demand from our stakeholders.

Two Guideline Developers, who were presented in one of our workshops, asked the Targeted Update team if they would be willing to create additional Targeted Updates of Cochrane Reviews on topics they considered high priority. As a result of this, we engaged with a further five CRGs. The National Blood Authority in Australia requested a Targeted Update of a review from the Injuries CRG, and the Norwegian Health Directorate requested four Targeted Updates in total, including a review from the Common Mental Disorders Group, the Fertility Regulations Group, the Stroke Group, and the Schizophrenia Group.

The methods for producing these Targeted Updates differed only slightly from the methods used in for the remaining Targeted Updates in this pilot.

Once the Targeted Updates were completed we analysed our overall project findings. Our planned outcomes were duration of time to complete, and efficiency in performing relevant tasks and documentation. All data and documentation collected during the production of Targeted Updates was shared with CRGs, which could be used to expedite the publication of a full update.

Completed Targeted Updates – Context

Gynaecology and Fertility Group

Question identified in partnership with a Cochrane Review Group

We liaised with this CRG to identify priority topics for a Targeted Update. The CRG returned to us and suggested a number of topics that could be suitable for a Targeted Update, informed by their knowledge of the current needs of guideline developers. It was agreed that we would proceed with two of these topics, both produced by the Targeted Update team.

The questions were agreed between the CRG and the Targeted Update team. We began this process by liaising with the original Cochrane Review's author team, and by conducting an initial assessment of the latest version of the full Cochrane Review. The Targeted Update team completed all tasks for both of the Targeted Updates with content expertise from the CRG. One of the selected Cochrane Review Titles, was split into two Targeted Updates, resulting in a total of three Targeted Updates from this CRG.

Schizophrenia Group

Question identified in partnership with a Cochrane Review Group

When we liaised with this CRG to identify priority topics for a Targeted Update, the CRG returned to us and suggested a complex review that could be suitable for a Targeted Update. Specific complexities included the large number of included studies not in the English language, and the complex methods associated with this review. It was agreed that we would proceed with this topic to explore how feasible it would be to complete a Targeted Update for such a challenging review.

We began this process by liaising with the CRG editorial base, and by conducting an initial assessment of the latest version of the full Cochrane Review. The Targeted Update team completed all tasks for both of the Targeted Updates and the CRG provided support with content expertise. Screening and data extraction of foreign language had to be outsourced, and due to time and resource constraints, could not be cross-checked by any member of the Targeted Update team.

Skin Group

Question identified in partnership with a Guideline Developer

We liaised with this CRG to identify priority topics for a Targeted Update, based on their existing relationships with guidelines developers. Following consultation with these guideline developers, the CRG returned to us and suggested a number of topics that could be suitable for a Targeted Update. It was agreed that we would proceed with three of these topics, two produced by the Targeted Update team, and one produced by the CRG.

The questions were agreed between the CRG, guideline developers and the Targeted Update team. We began this process by liaising with the original Cochrane Review's author team, who informed us that they were interested in beginning the process of updating the full review, and by conducting an initial assessment of the latest version of the full Cochrane Review. The CRG completed all tasks for one of the Targeted Updates internally, with guidance from the Targeted Update team. The Targeted Update team completed all tasks for two of the Targeted Updates with content expertise from the CRG.

Injuries Group

Question identified by a Guideline Developer – National Blood Authority

The National Blood Authority (NBA) in Australia developed the 'Patient Blood Management' (PBM) guidelines (<http://www.blood.gov.au/pbm-guidelines>). Although the guidelines were a substantial undertaking, they had an impact both clinically and financially. The NBA were keen to find efficient and cost-effective ways to keep the guidelines up-to-date, and assess different methodologies for updating (<https://www.blood.gov.au/pilot-project-update-pbm-guidelines>). After discussion with the Australasian Cochrane Centre, the PBM guidelines were identified as potential guidelines for Targeted Updates. The Australasian Cochrane Centre and Cochrane Editorial Unit identified Cochrane Reviews published since the PBMs were published, that might be relevant to PBM updates. The NBA prioritised one question that was related to a Cochrane review from the Injuries Cochrane Review Group (CRG). Following initial contact with the CRG, the Targeted Update team discovered that the review was in the process of being updated, and was almost ready for publication. We informed the NBA that the review was soon to be available, but they still asked the Targeted Update team to produce a Targeted Update for their question of interest. This was because (1) their question and PICO differed slightly from the full review update, and (2) they were interested in obtaining this information in a more accessible format.

We began this process by liaising with the original Cochrane Review's author team, and by conducting an initial assessment of the latest version of the full Cochrane Review. The coordinating editor of the injuries group was an author on the review of interest. Therefore, he was directly engaged in the project and involved in all discussions. The original review question was modified, as the NBA in this case were interested in a subgroup analysis of the results from the full review.

Stroke Group

Question Commissioned by a Guideline Developer – Norwegian Directorate of Health

The Norwegian Directorate of Health (NDH) were introduced to Targeted Updates during a workshop at 2015 Guideline International Network (GIN) meeting. This workshop was attended by a number of guideline developers. Immediately after the NDH contacted the Targeted Update team asking for four Targeted Updates to be produced in order to inform guidelines that they were in the process of developing. Following the initial expression of interest, the Targeted Update team liaised with Clare Glenton, the Director of Cochrane Norway, who thought that producing the Targeted Updates would reinforce their relationship with the NDH in Norway. A total of five research questions were identified by the NDH as priority topics. A PICO was developed for all five research questions. Four of these research questions were taken forward as Targeted Updates.

One of the four research questions identified as priority related to a review from the Stroke CRG. We began this process by liaising with the original Cochrane Review's author team, and by conducting an initial assessment of the latest version of the full Cochrane Review. This review was recently completed and ready for publication. However, it was still deemed necessary to produce a separate Targeted Update document, as the question being asked by the guideline developer differed slightly to the question asked by the full review. The Targeted Update team completed all tasks for the Targeted Update and the editorial base served us as content experts for this four Targeted Update.

Common Mental Disorders Group

Question Commissioned by a Guideline Developer – Norwegian Directorate of Health

A second research question identified as priority by the NDH related to a review from the Common Mental Disorders CRG. We began this process by liaising with the original Cochrane Review's

author team, and by conducting an initial assessment of the latest version of the full Cochrane Review. The question of interest to the NDH differed substantially to the original Cochrane review. In addition, this review had not been updated since 2007. Therefore, it was necessary to seek the involvement of the CRG editorial base, and particularly the Trial Search Coordinator (TSC). The TSC provided valuable involvement due to the complexity of topic or the number of references for the initial screening. The Targeted Update team completed all tasks for the Targeted Update with content expertise from the CRG. The selected Cochrane Review Title was split into two Targeted Updates.

Fertility Regulation Group

Question Commissioned by a Guideline Developer – Norwegian Directorate of Health

The third research question identified as priority related to a review from the Fertility Regulation CRG. We began this process by liaising with the original Cochrane Review's author team, and by conducting an initial assessment of the latest version of the full Cochrane Review. The CRG shared the latest version of the review with the Targeted Update team. This Cochrane Review had just been updated and published, consequently no searching, screening or data extraction work was required. During our assessment, after consulting the NDH, a decision was taken to make changes to the analyses by including some additional data that had been provided in a table, and by combining cluster RCTs with regular RCTs. The Targeted Update team completed the Targeted Update with the help of a statistician for the analyses and content expertise from the first author of the review.

Schizophrenia Group

Question Commissioned by a Guideline Developer – Norwegian Directorate of Health

The fourth research question identified as priority related to a review from the Schizophrenia CRG. We began this process by liaising with the original Cochrane Review's author team, and by conducting an initial assessment of the latest version of the full Cochrane Review. The CRG shared the latest version of the review with the Targeted Update team. The Targeted Update team completed all tasks for the Targeted Update with content expertise from the original author team.

Discontinued Targeted Updates

Musculoskeletal Group

One of the groups we worked with was the Musculoskeletal CRG. We liaised with this CRG to identify priority topics for a Targeted Update. CRG returned to us and suggested a number of topics that could be suitable for a Targeted Update. It was agreed that we would proceed with one of these topics, to be produced by the Targeted Update team. The length of time taken to organize meetings between all the interested parties, and to select a suitable review was a notable cause for concern. We began this process by liaising with the original Cochrane Review's author team, and by conducting an initial assessment of the latest version of the full Cochrane Review. Before work could continue further, the team received the commission from the Norwegian Directorate of Health to complete four Targeted Updates from their list of prioritized reviews. The Targeted Update Team agreed that, considering the length of time this review was likely to take, and the potential usefulness of working directly with a guideline developer commission for this pilot project, the priority for the project was to complete the commissioned Targeted Updates. Therefore, the Musculoskeletal group were informed we did not have the resources to work on this Targeted Update at this time, but that we may be able to return to the Update after the NDH work is completed.

Dementia and Cognitive Impairment Group

As previously stated, a total of five research questions were identified by the NDH as priority topics. A PICO was developed for all five research questions. Only four of these research questions were taken forward as Targeted Updates. The question that was not taken forward related to a review from the Dementia and Cognitive Impairment Group. Initially, the Dementia and Cognitive Impairment Group were willing to work with the Targeted Update team on this update, and we had begun this process by conducting an initial assessment of the latest version of the full Cochrane Review. However, before work could continue further, the NDH amended their list of prioritized reviews and asked that this review be replaced with another title.

Appendix 2

Cochrane Review Group	Targeted Update Title	Original Cochrane Review Publication Date	Inclusion Criteria	Work on TU began	Tasks Performed	Turn Around Time	Involvement of Guideline Developer
Gynaecology and Fertility	Clomiphene citrate in combination with gonadotropins for controlled ovarian stimulation in women undergoing in vitro fertilization (Original Cochrane Review Title: 'Clomiphene citrate in combination with gonadotropins for controlled ovarian stimulation in women undergoing in vitro fertilization').	2012	Randomised controlled trials (RCTs) of clomiphene citrate with gonadotropins (with or without mid-cycle antagonist) versus gonadotropins with gonadotropin-releasing hormone (GnRH) agonists for controlled ovarian stimulation in IVF or intracytoplasmic sperm injection (ICSI) treatment) were included. (Original Cochrane Review: No difference)	June 2015	Search Update: Targeted Update team Screening, Extraction, Data Synthesis: Targeted Update team Drafting the Targeted Update Document: Targeted Update team Peer Review: Gynaecology and Fertility Group	Time taken to complete planning of TU: 19 weeks and 4 days Time taken to complete first draft: 7 weeks Time taken to complete peer review: 19 weeks and 4 days Time taken to finalise TU post peer review: 12	None - Questions identified in partnership with a Cochrane Review Group

						weeks and 3 days	
Gynaecology and Fertility	GnRH agonists for women with endometrioma prior to assisted reproductive technology (Original Cochrane Review Title: 'Interventions for women with endometrioma prior to assisted reproductive technology').	2010	Randomised controlled trials of <u>GnRH agonists</u> versus expectant management for endometrioma prior to ART. (Original Cochrane Review: Randomised controlled trials of <u>any medical, surgical or combination therapy</u> versus expectant management for endometrioma prior to ART.)	June 2015	Search Update: Targeted Update team Screening, Extraction, Data Synthesis: Targeted Update team Drafting the Targeted Update Document: Targeted Update team Peer Review: Gynaecology and Fertility Group	Time taken to complete planning of TU: 19 weeks and 4 days Time taken to complete first draft: 7 weeks Time taken to complete peer review: 19 weeks and 4 days Time taken to finalise TU post peer review: 12 weeks and 3 days	None - Questions identified in partnership with a Cochrane Review Group

Gynaecology and Fertility	Surgery for women with endometrioma prior to assisted reproductive technology (Original Cochrane Review Title: 'Interventions for women with endometrioma prior to assisted reproductive technology').	2010	Randomised controlled trials (RCTs) of <u>any surgical treatment</u> or expectant management for endometrioma prior to ART were included. (Original Cochrane Review: Randomised controlled trials of <u>any medical, surgical or combination therapy</u> versus expectant management for endometrioma prior to ART.)	June 2015	Search Update: Targeted Update team Screening, Extraction, Data Synthesis: Targeted Update team Drafting the Targeted Update Document: Targeted Update team Peer Review: Gynaecology and Fertility Group	Time taken to complete planning of TU: 19 weeks and 4 days Time taken to complete first draft: 7 weeks Time taken to complete peer review: 19 weeks and 4 days Time taken to finalise TU post peer review: 12 weeks and 3 days	None - Questions identified in partnership with a Cochrane Review Group
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Schizophrenia	Intensive case management compared to non-intensive case management for severe mental illness (Original Cochrane Review Title: 'Intensive case management for severe mental illness') ¹	2010	All relevant randomised clinical trials (RCT) focusing on people with severe mental illness, aged 18 to 65 years and treated in the community-care setting, where ICM was compared to <u>non-intensive case management</u> (Original Cochrane Review: All relevant randomised clinical trials (RCT) focusing on people with severe mental illness, aged 18 to 65 years and treated in the community-care setting, where ICM was compared to <u>standard care and non-intensive case management</u> .)	July 2015	Search Update: Targeted Update team Screening, Extraction, Data Synthesis: Targeted Update team Drafting the Targeted Update Document: Targeted Update team Peer Review: Schizophrenia Group	Time taken to complete planning of TU: 23 weeks and 4 days Time taken to complete first draft: 28 weeks Time taken to complete peer review: 4 weeks	None - Questions identified in partnership with a Cochrane Review Group
Schizophrenia	Intensive case management compared to standard care for severe mental illness (Original Cochrane Review Title: 'Intensive case management for	2010	All relevant randomised clinical trials (RCT) focusing on people with severe mental illness, aged 18 to 65 years and treated in the community-care setting, where ICM was compared to <u>standard care</u> .	July 2015	Search Update: Targeted Update team Screening, Extraction, Data Synthesis: Targeted Update team Drafting the Targeted	Time taken to complete planning of TU: 23 weeks and 4 days Time taken to complete	None - Questions identified in partnership with a Cochrane Review Group

	severe mental illness'). ¹		(Original Cochrane Review: All relevant randomised clinical trials (RCT) focusing on people with severe mental illness, aged 18 to 65 years and treated in the community-care setting, where ICM was compared to <u>standard care and non-intensive case management.</u>)		Update Document: Targeted Update team Peer Review: Schizophrenia Group	first draft: 28 weeks Time taken to complete peer review: 4 weeks	
Skin	Oral propranolol for infantile haemangioma in infants and children. (Original Cochrane review title: 'Interventions for infantile haemangiomas (strawberry birthmarks) of the skin')	2011	All RCTs of <u>oral propranolol</u> compared to placebo for infantile haemangiomas in infants and children. (Original Cochrane Review: All RCTs of <u>all interventions</u> compared to placebo for infantile haemangiomas in infants and children.)	June 2015	Search Update: Skin Group Screening, Extraction, Data Synthesis: Targeted Update team Drafting the Targeted Update Document: Targeted Update team Peer Review: Skin Group	Time taken to complete planning of TU: 4 weeks and 4 days Time taken to complete first draft: 22 weeks and 6 days Time taken to complete peer review: 9 weeks and 6 days	Question identified in partnership with a Guideline Developer

						Time taken to finalise TU post peer review: 2 weeks and 2 days	
Skin	Topical timolol (beta blocker) for infantile haemangioma in infants and children. (Original Cochrane review title: 'Interventions for infantile haemangiomas (strawberry birthmarks) of the skin')	2011	All RCTs of <u>topical timolol (beta-blocker)</u> compared to placebo for superficial infantile haemangiomas in infants and children. (Original Cochrane Review: All RCTs of <u>all interventions</u> compared to placebo for infantile haemangiomas in infants and children.)	June 2015	Search Update: Skin Group Screening, Extraction, Data Synthesis: Targeted Update team Drafting the Targeted Update Document: Targeted Update team Peer Review: Skin Group	Time taken to complete planning of TU: 4 weeks and 4 days Time taken to complete first draft: 22 weeks and 6 days Time taken to complete peer review: 9 weeks and 6 days Time taken to finalise TU post peer	Question identified in partnership with a Guideline Developer

						review: 2 weeks and 2 days	
Skin	Interventions for Cutaneous sporotrichosis (Original Cochrane review title: 'Interventions for the treatment of sporotrichosis (previously titled 'Oral potassium iodide for the treatment of sporotrichosis')	2009	<i>TBC (will be wider than original PICO)</i>	October 2015	Search Update: Skin Group Screening, Extraction, Data Synthesis: Skin Group Drafting the Targeted Update Document: Skin Group Peer Review: Skin Group	Ongoing (Empty TU, therefore restarting with broader PICO)	Question identified in partnership with a Guideline Developer
Injuries	In trauma patients with bleeding requiring (or likely to require) red-blood-cell transfusion, what is the effect of tranexamic acid on survival? (Original Cochrane Review title: 'Antifibrinolytic drugs for acute traumatic injury')	2015	All RCTs of <u>tranexamic acid</u> in trauma patients with bleeding requiring (or likely to require) RBC transfusion. (Original Cochrane Review: All RCTs of <u>antifibrinolytic agents</u> in people of any age following acute traumatic injury.)	July 2015	Search Update: Injuries Group and Original Authors Screening, Extraction, Data Synthesis: TU Team and Original Authors Drafting the Targeted Update Document: TU Team	Time taken to complete planning of TU: 16 weeks and 5 days Time taken to complete first draft: 2 weeks Time taken to complete peer	Question identified by a Guideline Developer – National Blood Authority

					Peer Review: Injuries Group	review: 2 weeks Time taken to finalise TU post peer review: 1 week and 1 day	
Stroke	Intensive speech and language therapy for aphasia following stroke (Original Cochrane Review title: 'Speech and language therapy for aphasia following stroke')	2012	Randomised controlled trials (RCTs) comparing <u>intensive (≥ 5 times/week) Speech and Language Therapy (SLT)</u> with either (1) no SLT or (2) low intensity SLT (<5 times/week). (Original Cochrane Review: Randomised controlled trials (RCTs) comparing <u>SLT</u> with (1) no SLT; (2) social support or stimulation; and (3) another SLT intervention)	Nov 2015	Search Update: Stroke Group and Original Authors Screening, Extraction, Data Synthesis: Targeted Update team Drafting the Targeted Update Document: Targeted Update team Peer Review: Stroke Group and Original Authors	Time taken to complete planning of TU: 3 weeks and 2 days Time taken to complete first draft: 6 weeks and 2 days Time taken to complete peer review: 9 weeks	Question Commissioned by a Guideline Developer – Norwegian Directorate of Health
Common Mental Disorders	Cognitive behavioural therapy compared to any	2009	Randomised controlled trials of <u>CBT</u> (face-to-face) versus <u>other</u>	Feb 2016	Search Update: Common Mental	Time taken to complete	Question Commissioned by a Guideline

	other psychological therapy for binge eating disorder (Original Cochrane Review title: 'Psychological treatments for bulimia nervosa and bingeing')		<u>psychotherapy approaches</u> (face-to-face) for <u>adults with binge eating disorder</u> which applied a standardised outcome methodology and had less than 50% drop-out rate. (Original Cochrane Review: Randomised controlled trials of <u>psychotherapy</u> for adults with <u>bulimia nervosa, binge eating disorder and/or eating disorder not otherwise specified</u> (EDNOS) of a bulimic type which applied a standardised outcome methodology and had less than 50% drop-out rate.)		Disorders Group Screening, Extraction, Data Synthesis: Targeted Update team Drafting the Targeted Update Document: Targeted Update team Peer Review: Common Mental Disorders Group	planning of TU: 14 weeks Time taken to complete first draft: 9 weeks and 2 days Time taken to complete peer review: 4 week Time taken to finalise TU post peer review: ongoing	Developer – Norwegian Directorate of Health
Common Mental Disorders	Cognitive behavioural therapy compared to psychodynamic psychological therapy for binge eating disorder (Original Cochrane Review title:	2009	Randomised controlled trials of <u>CBT</u> (face-to-face) versus <u>psychodynamic psychological therapy</u> for <u>adults with BED</u> which applied a standardised outcome methodology	Feb 2016	Search Update: Common Mental Disorders Group Screening, Extraction, Data Synthesis:	Time taken to complete planning of TU: 14 weeks Time taken to complete	Question Commissioned by a Guideline Developer – Norwegian Directorate of Health

	'Psychological treatments for bulimia nervosa and bingeing')		and had less than 50% drop-out rate. (Original Cochrane Review: Randomised controlled trials of <u>psychotherapy</u> for adults with bulimia nervosa, <u>binge eating disorder</u> and/or <u>eating disorder not otherwise specified</u> (EDNOS) of a bulimic type which applied a standardised outcome methodology and had less than 50% drop-out rate.)		Targeted Update team Drafting the Targeted Update Document: Targeted Update team Peer Review: Common Mental Disorders Group	first draft: 9 weeks and 2 days Time taken to complete peer review: 4 weeks Time taken to finalise TU post peer review: ongoing	
Fertility Regulation	Interventions for preventing unintended pregnancies among adolescents (Original Cochrane Review title: 'Interventions for preventing unintended pregnancies among adolescents')	2016	RCTs evaluating <u>combination of educational interventions with contraceptive-promotion interventions</u> that aimed to increase knowledge and attitudes relating to risk of unintended pregnancies, promote delay in the initiation of sexual intercourse and encourage consistent use of birth control methods to reduce unintended pregnancies in	March 2016	Search Update: Original Review authors Screening, Extraction, Data Synthesis: Targeted Update team Drafting the Targeted Update Document: Targeted Update team	Time taken to complete planning of TU: 18 weeks Time taken to complete first draft: 6 weeks and 1 day Time taken to complete peer	Question Commissioned by a Guideline Developer – Norwegian Directorate of Health

			adolescents aged 10 years to 19 years were included. <u>Setting was Clinic based (school health service) and school-based or a combination.</u> (Original Cochrane Review: (RCTs) evaluating <u>any interventions</u> that aimed to increase knowledge and attitudes relating to risk of unintended pregnancies, promote delay in the initiation of sexual intercourse and encourage consistent use of birth control methods to reduce unintended pregnancies in adolescents aged 10 years to 19 years. <u>Setting was not specified.</u>)		Peer Review: Targeted Update team	review: 7 weeks and 3 days Time taken to finalise TU post peer review: ongoing	
Schizophrenia	Maintenance treatment with antipsychotic drugs for schizophrenia (Original Cochrane Review title: 'Maintenance	2012	All randomised trials comparing maintenance treatment with antipsychotic drugs and placebo for people with schizophrenia or	April 2016	Search Update: Targeted Update team Screening, Extraction, Data Synthesis:	Time taken to complete planning of TU: 1 week and 3 days	Question Commissioned by a Guideline Developer – Norwegian Directorate of Health¹

¹ This review was very complex. In future, it is likely reviews of this complex nature should not be accepted for Targeted Updates.

	treatment with antipsychotic drugs for schizophrenia')		schizophrenia-like psychoses. (Original Cochrane Review: No difference)		Targeted Update team Drafting the Targeted Update Document: Targeted Update team Peer Review: Targeted Update team	Time taken to complete first draft: 8 weeks and 1 day Time taken to complete peer review: 1 day Time taken to finalise TU post peer review: ongoing	
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Appendix 3

Results

Gynaecology and Fertility Group

Question identified in partnership with a Cochrane Review Group

Work on the three Targeted Updates from this CRG began mid-June 2015. The first draft for all three Targeted Updates were produced, and sent to the CRG for peer review within 7 weeks. The peer review process for these documents was completed a further 4 months later. When asked why the process was delayed to such an extent, the CRG were apologetic, and attributed the problem to unexpected delays with authors, referees, and in the editorial office. This further emphasizes how challenging it can be for already overwhelmed CRGs to incorporate new ideas into their workloads.

Schizophrenia Group

Question identified in partnership with a Cochrane Review Group

The production of this Targeted Update was challenging, due to the scope of the original review, and queries regarding the nature of the intervention. The selected Cochrane Review Title was split into two Targeted Updates. These Targeted Updates were more protracted as a result of these issues. Work on the two Targeted Updates began at in July 2015. The first draft for both Targeted Updates were produced, and sent for peer review 7 months later. The peer review process for these documents was completed a further 4 weeks later. Due in part to the tasks completed for this targeted update, the editorial base was successful in obtaining an NIHR incentive award to complete the full review update.

Skin Group

Question identified in partnership with a Guideline Developer

Three Targeted Updates from this CRG were produced in total. Work on the two Targeted Updates being completed by the Targeted Update Team began in June 2015. Due to a number of unexpected issues, including staff changes within the Targeted Update Team, holiday schedules over July and August, and Cochrane Review Group unavailability in September and October due to the Cochrane Colloquium, the work on this Targeted Update took five months to complete. The peer review of both these documents was completed a further 2 months later, in January 2016.

Work on the Targeted Update being completed by the CRG began in mid-October 2015. A final draft was ready to be sent for peer review 4 months later. This process was prolonged in part because when no eligible studies were found in the updated search, the CRG asked that the search be expanded, to include a hand search of additional relevant journals. Although this was not the normal process for a Targeted Update, the team agreed that this was permissible in this instance. Despite the addition of this expanded search, still no eligible studies were identified. As part of the peer review process, the Coordinating editor (CoEd) of the CRG reviewed the Targeted Update document, and decided that an 'empty' review was of no use. The CoEd requested that the authors expand the original PICO to allow a broader range of interventions into the review, and to update the Targeted Update accordingly. Therefore, this Targeted Update is still ongoing.

Injuries Group

Question identified by a Guideline Developer – National Blood Authority

Because the review was recently updated and published, the Targeted Update was completed by the Targeted Update team, with content expertise from the CRG, within 2 weeks and peer reviewed within another 2 weeks. The final output differed slightly from the standard Targeted Update template, as the NBA specifically requested the presentation of relevant forest plots. Feedback from the NBA was very positive, indicating that they would be likely to make this part of their standard process in the future.

Stroke Group

Question Commissioned by a Guideline Developer – Norwegian Directorate of Health

Work on this Targeted Updates began in November 2015. The first draft for the Targeted Updates was produced, and sent for peer review 6 weeks later. The peer review process for these documents was completed a further 8 weeks later. The input from the author team proved to be very valuable for finalizing the Targeted Update.

Common Mental Disorders Group

Question Commissioned by a Guideline Developer – Norwegian Directorate of Health

Work on these two Targeted Updates began in February 2016. The first draft for the Targeted Updates was produced, and sent for peer review 2 months later. The first peer review of these documents was completed a further 4 weeks later. Despite an extensive search, and with the assistance of the Norwegian Health Directorate, a second peer review could not be identified for this document. Every expert contacted was either unresponsive, or unable to complete a peer review within 2 weeks, even with the monetary incentive.

Fertility Regulation Group

Question Commissioned by a Guideline Developer – Norwegian Directorate of Health

Work on this Targeted Update began in March 2016. The first draft for the Targeted Updates was produced, and sent for peer review 6 weeks later. The peer review process for these documents was completed a further 7 weeks later.

Schizophrenia Group

Question Commissioned by a Guideline Developer – Norwegian Directorate of Health

Work on this Targeted Update began in April 2016. The first draft for the Targeted Updates was produced, and sent for peer review 8 weeks later. The first peer review of these documents was completed within one day. Despite an extensive search, and with the assistance of the Norwegian Health Directorate, a second peer review could not be identified for this document. Every expert contacted was either unresponsive, or unable to complete a peer review within 2 weeks, even with the monetary incentive.

Appendix 4

Blog Interview Question and Answer Form

Question 1: Tell me how Targeted Updates? How did it work? What has been your learning?

Points to consider:

What worked well in completing Targeted Updates

What didn't work well in completing Targeted Updates

What were the challenges encountered?

What improvements could be made to the process

Was the process of producing Targeted Updates as you expected? If not, how did the process differ from your expectations

Response:

Question 2: Can you talk me through the final product? How different was it from what you expected and what did this mean for the final Cochrane Review?

Points to consider:

Was the final Targeted Update product, as you expected? If not, how did the final product differ from your expectations?

What happened to the full Cochrane Review after the Targeted Update had been completed?

Response:

Question 3: What impact has this project had on your work, and the CRG, and how would you measure the value of the information?

Points to consider: (TO BE INDIVIDUALLY TAILORED TO EACH CRG)

As part of this project, your CRG received £(XXX) for providing content expertise on the Targeted Update, £(XXX) for running the updated searches, £(XXX) for producing the full TU document, and £(XXX) for completing the Peer Review. To what extent did you feel this amount was adequate/necessary/an incentive?

Did your CRG find it useful/valuable to receive the updated search and screening results?

Did the review authors find it useful/valuable to receive the updated search and screening results?

Response:

Appendix 5

Problems and Solutions

Problems	Solutions
The part time status of all members of the Targeted Update Team, along with the lack of administrative support can cause unnecessary delays in the process.	The process would work best if a formal, full time team is in place. Ideally, this needs to be pushed through by Cochrane Response, as the goal of Cochrane Response is to make this relationship work with the groups.
Delays in the process may occur when initial assessment of the review indicates complex methodology, or out of date methodology requiring amendment.	A more detailed, and precise quality assessment tool must be developed and used as early as possible in the process. Targeted Update team members must reserve the right to decline any Targeted Update of a 'complex' review'.
Nearly all the participating CRGs experienced difficulty engaging in the process over the long term due to their existing, and often overburdened workload.	Duration of time to complete and overall efficiency will continue to improve, as CRGs and authors become more aware of Targeted Updates, their methods and their purpose, and as more formal processes and technology are put in place to deal with requests.
Review author involvement is essential when the Targeted Update is facilitating a full review update. Yet not all review authors are willing or able to contribute to the Targeted Update.	If neither money, nor offer of assistance with updating the search and screening is considering an adequate incentive for review author to become involved in the project, then a more appropriate incentive must be identified and offered.
Contract negotiation with guideline developers can delay the process.	It is likely that if the Targeted Update services were to continue, these processes would be officially set and prepared by Cochrane Response before any formal service was offered.
Different users may have different requirements. It was notable that on more than one occasion, Guideline Developers asked the team to alter the presentation of the document.	One concept that should be considered is to offer guideline developers a 'Menu' of the different features that could be presented in a Targeted Update document, and allow guideline developers to design their own Targeted Update document according to their own requirements and preferences.

<p>Authorship and Ownership of the work is a sensitive issue that can cause disputes.</p>	<p>There must always be a clear statement on the Targeted Update document that outlines who was involved in the production of the Targeted Update, and a reference to the original review. Memorandum of Understanding must be set out from the start of the process, which clearly states who is responsible for the work and who will be cited as an owner/author. All involved must see this document and agree, even authors who are playing no role in the Targeted Update.</p>
<p>Content expertise is essential in this process. Yet there was often a struggle to find Content Experts and Peer Reviewers willing to complete the work within the short time frame, even with the monetary incentive.</p>	<p>Set up network of peer reviewers (using Task Exchange). Ask the commissioners for potential Peer Reviewers earlier in the process.</p>

Cochrane Rehabilitation

An Application for a new Field

[OPEN ACCESS]

Document prepared by:	Mark Wilson
Submitted to Steering Group:	October 2016 (Seoul)
Purpose of the Paper:	To introduce the application for a new Cochrane Rehabilitation Field
Access:	Open Access
Summary of recommendation:	To accept the application to form a new Cochrane Rehabilitation Field
Resource implications:	None, the Field is self-financing.
Contact person for queries:	Professor Stefano Negrini, stefano.negrini@unibs.it



1 Introduction

Over the last year Professor Stefano Negrini, from the University of Brescia, Italy, and colleagues around the world working in the area of physical and rehabilitation medicine, have been engaging with counterparts in Cochrane (including myself) on forming a new Cochrane Rehabilitation Field.

This application has now been received. It is an extensive one, and therefore what is included in the package for Steering Group members to consider initially is:

- The formal application to register the Cochrane Rehabilitation Field from Professor Negrini.
- The Cochrane Rehabilitation Action Business Plan – Short Version

The full set of documents supporting this application are all contained in the Steering Group Dropbox at: (CSG Folder / 2016 Seoul (21 & 22 October) / Individual papers / Cochrane Rehabilitation Field) and includes:

- The Cochrane Rehabilitation Action Business Plan – Final Version
- Letters of Support from:
 - Cochrane Italy
 - Cochrane Neurological Sciences
 - Cochrane Back and Neck
 - Cochrane Multiple Sclerosis
 - Cochrane Neuromuscular
 - Cochrane Insurance Medicine
 - Cochrane Stroke
 - European Society of Physical & Rehabilitation Medicine
 - International Society of Physical & Rehabilitation Medicine
 - International Society for Prosthetics and Orthotics
 - International Spinal Cord Society
 - International Classification of Functioning, Disability and Health (ICF)
 - European Union of Medical Specialists, Section of Physical and Rehabilitation Medicine
 - European Academy of Rehabilitation Medicine
 - European Forum for Research in Rehabilitation
 - Italian Society of Physiotherapy (Società Italiana di Fisioterapia, S.I.F.)
 - Italian Society of Neurological Rehabilitation (SIRN)
- Agreements to host/fund and support the Rehabilitation Field from
 - University of Brescia, Italy
 - Don Carlo Gnocchi Foundation, Italy
- Expressions of interest in becoming part of the Cochrane Rehabilitation Field's active network and providing direct support to its work from:
 - International Classification of Functioning, Disability and Health (ICF)
 - Bharath University, India
 - Hospital Val d'Hebron, Spain
 - Turkish Society of Physical Medicine and Rehabilitation
 - University of Medellin, Columbia
- Conflict of Interest statements for Professor Negrini and the Co-Directors involved in leading the Field.

We are aware of the Steering Group's reluctance to register new Cochrane Groups at a time when structure and function changes are being made. However, the full Cochrane Rehabilitation Action Business Plan has been assessed by the Cochrane Fields Executive, the Editor in Chief David Tovey, Cochrane Italy's Director Roberto D'Amico and the CEO's Office, and we are unanimous in recommending that the CSG accepts the application to form this Field.

This application is actually 'future-proofed' in that it would establish a Field that is very close to the kind of knowledge translation-oriented, organisationally sophisticated, highly de-centralised and widely networked Field that we hope Cochrane can establish in many areas of health and healthcare. The numerous letters of support are testament to the network of supporters that Professor Negrini has already established. I visited a conference in early September to organize the application and representatives from organizations in Europe, North and South America, Asia and the Pacific attended and were enthusiastic supporters of the proposed Field. Details of the conference are also in the Dropbox.

Whilst in Brescia, I signed on behalf of Cochrane a Memorandum of Understanding with the University of Brescia and the Don Gnocchi Foundation guaranteeing the first three years of support to host the Field (subject to the application being approved by the Steering Group).

I am satisfied that the Field is secure in its resources, sustainable and already making the healthy and dynamic working relationships with Cochrane Groups and other stakeholders; and I recommend this application be approved.

2 Recommendation

The Steering Group approves the application to form a new Cochrane Rehabilitation Field.

Cochrane Spokesperson Policy

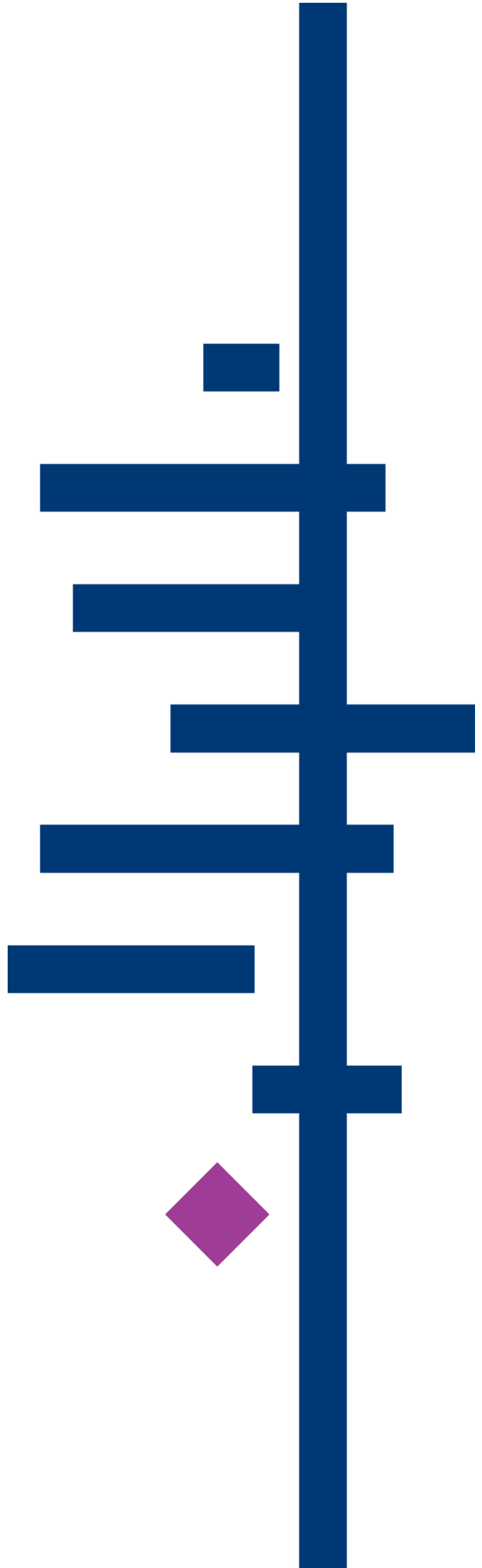
Document prepared by:
Julie Wood

Submitted to Steering Group: October 2016,
Seoul

Purpose of paper: To approve an updated
version of the existing to avoid an ambiguity
and provide examples so contributors are able
to more easily adhere to the Spokesperson
Policy.

Access: OPEN

Resource implications:
None



Official Spokesperson Policy

Approved by the Steering Group: May 2015

Reviewed and Updated: September 2016

Rationale — What is the purpose of this policy?

Cochrane is an international collaboration involving more than 38,000 individuals from many different institutions and organizations. These individuals are our most valuable asset and play an important role in helping Cochrane achieve its *Strategy to 2020*. Because individuals who contribute to Cochrane often have multiple affiliations (both inside and outside of Cochrane), it is important we establish clear guidance about who can speak officially on behalf of Cochrane and the circumstances in which it is appropriate to do so.

This policy clarifies who can represent, write and speak officially on behalf of Cochrane and how they should do it.¹ For the purposes of this policy we define an official spokesperson as an individual who has the authority to speak formally on behalf of Cochrane.

As Cochrane grows and our profile increases, failure to differentiate between official Cochrane policy and individual collaborator's views could cause misunderstandings about our positions, potentially damage our reputation and credibility, and in extreme cases, lead to financial losses and legal action. While there will always be some people who deliberately misconstrue whether someone is speaking officially on behalf of Cochrane, we can protect against this by clarifying when we are speaking on Cochrane's behalf or in a personal capacity. This is particularly relevant if there is reason to believe that what is being said could be misinterpreted as official Cochrane policy.

Cochrane policies and positions

As a registered UK charity, we are governed by laws on what we can and cannot speak about, as it must be based on advancing our mission.² To that end, Cochrane must develop policies to guide who speaks officially for it. In terms of how we develop policies, please refer to our official *Policy Development Framework* as this guides how we formulate policy positions. (To see all Cochrane policies including the one referred to above, go to <http://community.cochrane.org/organizational-info>)

¹While individual conduct is outside of this policy, it is still expected that Cochrane collaborators will follow the principles of the organization and will respect the laws and customs of the country in which they are speaking.

² Speaking out: guidance on campaigning and political activity by charities
<https://www.gov.uk/government/publications/speaking-out-guidance-on-campaigning-and-political-activity-by-charities-cc9/speaking-out-guidance-on-campaigning-and-political-activity-by-charities>

General guidance of meeting our charitable obligations in this area is that as long as our policy positions are grounded in evidence and we can link this back to our mission, we can say it.



The bulk of the responsibilities to be the ‘official’ spokesperson will fall to the Co-Chairs of the Cochrane Steering Group (CSG), Editor in Chief, CEO, Directors of Centres, Associated Centres and Networks, and Coordinating Editors.

Balancing official responsibilities and academic freedom

Many Cochrane contributors are experts in their field and have every right to discuss their work and express their personal views –this may include expressing opinions on Cochrane policies and Cochrane Reviews. This policy is not intended to infringe Cochrane’s long-standing tradition of rigorous academic and scientific debate, but to provide guidance in line with our standing as a charity, on when and how an individual can represent Cochrane as an official spokesperson, and when and how she/he makes clear that the views expressed are their own.

In short, Cochrane contributors have the liberty to say whatever they like within the bounds of the principles the collaboration; you just can’t say whatever you like *on behalf of Cochrane*. Members of the collaboration need to respect Cochrane’s official policies and positions, even when they might individually disagree.

In balancing our obligations to Cochrane with our academic freedom as individuals, the more senior an individual is within Cochrane, the greater their obligation to clarify in what capacity they are speaking – in their Cochrane capacity, in another professional capacity, or in a personal capacity. The best practice is for everyone in Cochrane to clarify which “hat” they are wearing when they speak.

In some instances, due to an individual’s position, whatever that person says could be construed as official policy. Such individuals must be even more diligent in clarifying when they are speaking on behalf of Cochrane.

How to make clear you are speaking in a personal capacity about Cochrane

If you are expressing a view about Cochrane-related issues you should state clearly that you are speaking in a personal (or other professional) capacity unless you have been expressly authorized to represent Cochrane (as outlined below).³

If you have multiple affiliations or positions, you may choose not to use your Cochrane affiliation if this may cause confusion.⁴ If you do use your Cochrane affiliation along with another title, or if Cochrane is the only title or affiliation you have, then it is incumbent upon you to state unequivocally and clearly that the views are your own and not those of Cochrane. This cannot be implied, but must be stated explicitly. This is to avoid any misunderstandings or inaccurate assumptions on the part of the audience.

Examples of how to clarify that you are expressing your personal views and are not representing Cochrane might include (but not limited to the following)⁵:

1. When conducting a media interview, tell the journalist you are speaking in your personal capacity and not speaking on behalf of Cochrane. During the interview use phrases such as, “in my opinion...”

³ This policy does not dictate the exact phrasing to make this distinction clear, it asks that you make an honest attempt to do so to avoid any confusion or misunderstandings.

⁴ That doesn’t mean you need to “hide” your position or affiliation with Cochrane. On the contrary, we should be transparent about associations with Cochrane and other organisations, but if you do mention your official title, it is even more important that you are clear whether you are speaking on behalf of Cochrane.

⁵ Slides below used with permission by Lisa Bero and Hilda Bastian, Se

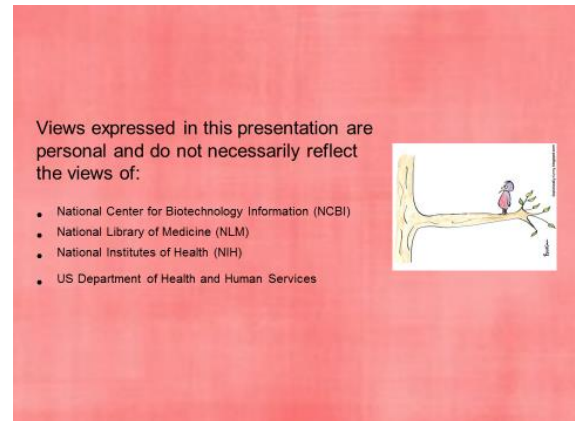
2. In instances where you are presenting a paper, when using your Cochrane title, you should include statements in your slides such as “The views expressed are my opinions and not the expressed views of any organization to which I am affiliated.”

Disclosure of Interests (last 3 years)

Lisa Bero

- Research funding from the California Breast Cancer Research Program, The Cochrane Collaboration Methods Innovation Fund, US Office of Research Integrity, and the US National Institute of Environmental Health Sciences.
- Co-chair of The Cochrane Collaboration since 2013; receive remuneration that is paid to The University of Sydney
- Served on numerous guideline panels and committees to evaluate COI
- Have numerous publications related to conflicts of interest

The views expressed in this talk are my own and not those of Cochrane.



If you did not make it clear at the time of speaking that the views expressed were your personal ones, please do so at the earliest possible opportunity. If the Central Executive is approached for clarification or comes across occasions where the position is unclear, a member of the Communications & External Affairs Department (CEAD) will contact the individual involved and may ask them to clarify.

If you would like assistance on drafting written or spoken communication to clarify your position when speaking publicly, please contact a member of the CEAD team at cead@lists.cochrane.org.

Who “authorizes” an official spokesperson

For Cochrane Reviews at a global level

Authors and members of Cochrane Review Group editorial teams are already free to discuss the findings of their reviews and don’t need to seek permission. However, there are times when other people will also speak about a review’s findings. As a general rule, when officially speaking about the findings of a Cochrane Review at a global level, official spokespersons (in order of preference) will be: the review authors, the respective group’s Coordinating Editors (or nominee), and the Editor in Chief (or nominee). The same principle applies to members of Methods Groups, who also speak on behalf of Cochrane. Authors of any methodology-related papers that have been written for or commissioned by Cochrane are the first official spokesperson, followed by the relevant Methods Group’s convenors (or nominee), and then the Editor in Chief or Methods Co-ordinator (or nominee).

Cochrane contributors may sometimes be asked or wish to comment on published reviews. In doing so they can speak freely, including expressing views that are critical. This is in line with Cochrane’s established tradition of academic and scientific debate, as outlined previously. However, the contributors should make clear that they are expressing personal opinions, and statements should be consistent with Cochrane policies on respect. They should not be libellous or offensive.

Global

The decision about who can speak on behalf of Cochrane globally (on matters other than specific Cochrane Reviews) will be taken by CEAD, in consultation with relevant individuals, such as the Co-Chairs of the CSG



and the Central Executive Team (CET). In many cases, this is likely to be the Co-Chairs or a senior member of the CET, such as the Editor in Chief or CEO. However, depending on the issue, it may also be appropriate to nominate other individuals within Cochrane who have specialist expertise.

Country or regional level

In a specific country or region, the spokesperson will be the Director of the Cochrane Centre, Associate Centre or Network who is the designated leader or co-ordinator of Cochrane activities there, or a designated member of his or her team. CEAD and other members of CET will provide support as needed.

Please note that it is common courtesy and best practice, if you are speaking in a country or have been interviewed by media within a country⁷ with a Cochrane presence - and are referring to Cochrane - to inform the Director responsible for Cochrane activities in that country at the earliest convenience <http://www.cochrane.org/contact/centres>

If you are meeting with funders to support your Cochrane or Cochrane-related work outside of the ones that already fund your Cochrane activities, it is your responsibility to inform the Director responsible for Cochrane activities in that country of your discussions, as well as other Groups that receive funds from that funder. You should make clear to those funders that you are not speaking on behalf of Cochrane, unless you are given express authorization from that Group. CEAD can provide support on ensuring that all relevant people are notified in these situations.

Timing

In a 24/7 news environment, there will be times when Cochrane needs to respond quickly to breaking news or allegations in the media. If you find instances where Cochrane's reputation is called into question, please inform a member of the [CEAD team](#), who will work with other members of the CET, Cochrane groups and CSG Co-Chairs as needed to develop a response. When appropriate, we will publish, sign and date our response on cochrane.org so that Cochrane members can share this information as well.

Channels

All of this guidance applies across communications channels. Specific guidance is listed for social media in Appendix A.

Compliance

The intent of this policy is to establish guidelines for members of Cochrane. Given the complexity, scale, scope, and culture of our work, this is challenging. However, the organization also needs to protect its reputation and ensure clarity and coherence in conveying its official policies, positions, and key messages to the world. Therefore, the Cochrane Steering Group supports compliance with the policy and will, if required, reinforce this with further action.

Where to go for further guidance—

If you are unsure of anything in this policy or have questions about how to apply it, please email the CEAD team at: cead@lists.cochrane.org, and we will be happy to help.

⁷ This may not be practical in all cases, so please do your best.



Appendix A

Social media guidance

Social media is a rapidly growing channel for Cochrane where we can share and react to the latest information quickly. Its constantly changing nature requires broad but clear guidance.

Our working social media policy is adopted from the Mayo Clinic's 12-Word Social Media Policy:

'Don't Lie, Don't Pry,
Don't Cheat, Can't Delete,
Don't Steal, Don't Reveal.'⁸

Our policies will be applicable to anyone working in social media on behalf of Cochrane.

'Official' Cochrane accounts

If you manage an 'official' Cochrane account, on behalf of a specific Cochrane Group, your content should focus on information pertaining to Cochrane's mission. It is the nature of social media to be more informal, so as long as there is at least a tangential link to our mission and evidence-based discussion, this is acceptable. Similarly, personal touches and a relaxed style are good practice in social media communication, but please refrain from posting personal information (e.g., what you cooked for dinner).

CEAD will maintain a list of Cochrane social media accounts and will liaise with individuals who manage them to provide further guidance and support as social media evolves.

Personal accounts

If you are using a personal account to distribute Cochrane information, please make your association with Cochrane clear in your profile section (i.e., if you are an employee or Cochrane author), and state explicitly that your opinions are personal and don't necessarily represent Cochrane's views or policies.

(Sample text: "Cochrane author [employee]. All views expressed are my own unless RTs⁹ [shares].")

If you have questions about using social media for any aspect of Cochrane work, please contact the [CEAD team](#) and we will be happy to provide advice and support.

⁸ <http://network.socialmedia.mayoclinic.org/discussion/a-12-word-social-media-policy/>

⁹ RTs mean retweets in Twitter.

Cochrane Membership

Update for the Cochrane Steering Group, October 2016.

Document prepared by:	Chris Champion.
Submitted to Steering Group:	October 2016
Purpose of paper:	To provide the CSG with an update on the implementation of Cochrane Membership, including a planned timeline.
Access:	Open
Summary of Recommendations:	There is no recommendation for the CSG. This is an update for information only.
Resource implications:	There are no resource implications presented in this paper.
Contact person for any queries:	Chris Champion, cchampion@cochrane.org or Julie Wood, jwood@cochrane.org

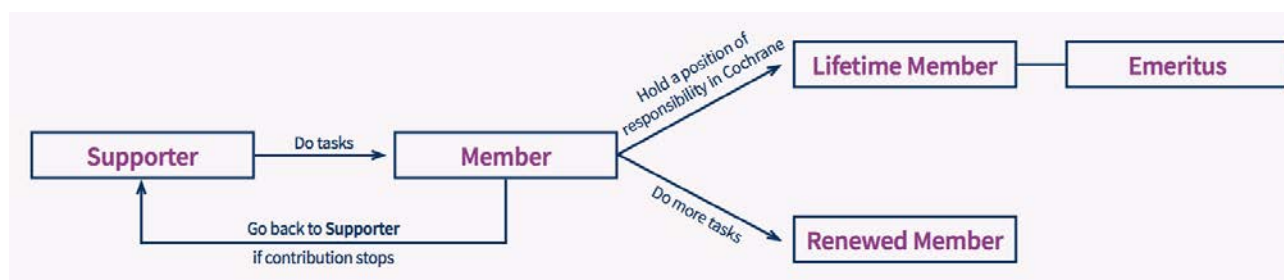
What is Cochrane Membership

Cochrane Membership is an initiative that seeks to reward those who contribute to Cochrane and also open up Cochrane to newcomers. We are trying to make it easier to get involved with Cochrane in a way that helps the organization, creates new pathways for involvement and better captures all the ways that people contribute to our work. Whilst the status of Members is only attributed to those who have made a substantive contribution, we will be opening up Cochrane to anyone who wishes to become part of the organisation through a 'Supporter' status.

Newcomers will initially be supporters, but as they contribute to Cochrane they will reach the threshold for membership and will be given a certain period of membership commensurate with their contribution. (Please note that all these thresholds for different contributions will be discussed with each Cochrane Executive and will need CSG approval before implementation.)

Certain people will qualify for additional types of membership, such as lifetime membership or emeritus membership. These types of membership will be more discretionary and will reflect a long term commitment to Cochrane's work and, in many cases, will be linked to service in a position of responsibility within Cochrane.

Our current active contributors, about 6,000 in 2015, will automatically receive membership status for an initial period.



Why is membership important

Cochrane is not taking advantage of the people all over the world who want to contribute to our organization. We need to make it easier for them to contribute to activities that best meet the skills and time that they are offering. This is what the membership scheme will provide. This is critical to Cochrane's future as we need to constantly attract new talent, and if we are not providing a good experience to newcomers we will not have a strong human foundation for the future.

Gaining a better understanding of Cochrane Supporters and Members will offer significant benefits, for example a comprehensive profile of potential authors will help assess whether they have the skills required to take on a review; or Groups wishing to target certain audiences with special communications will benefit from the detailed records we will be able to store regarding people's interests and experience. Groups will also receive better reporting on who is doing what in their area on a regular basis.

From the member's perspective, he/she will be able to track his/her contribution and there will be public recognition for what he/she has contributed as part of a members' page on our website.

Project update

The first phase of the project focuses on understanding, documenting and tracking people's contributions. This is essential to allow us to set thresholds for membership based on contributions made.

We have done a lot of the foundational work now, which involved assessing different types of contribution and what sort of information needs to be captured to allow for meaningful data to be collected for use in establishing membership.

We have also identified the IT system and partner that will provide the system we need to run the membership scheme. This system is a critical part of membership, as it will pull together all the disparate sources of information on people's contributions to provide a single view on each person who contributes to Cochrane. Most importantly, it will collate data on what tasks and training each person has undertaken.

One of our guiding principles has been to minimize change for the community in terms of ways of working whilst providing better, more robust data on who is doing what. The main change that will affect the community is that all data on people must go into the central database to comply with data protection; and we will provide support in this transition. In return, the community will be able to take advantage of having better information about the people in Cochrane and we will manage all data compliance issues centrally.

We are currently in the process of establishing a firm project plan for the implementation of the system. We estimate that, contingent on technical resources being available, we will be launching the live system in April 2017.

Further information

For more information on membership see the community page where there is a project overview and links to the CSG papers we prepared as we developed the membership concept.¹

You may also contact Chris Champion (cchampion@cochrane.org) or Julie Wood (jwood@cochrane.org) who are co-leading this project.

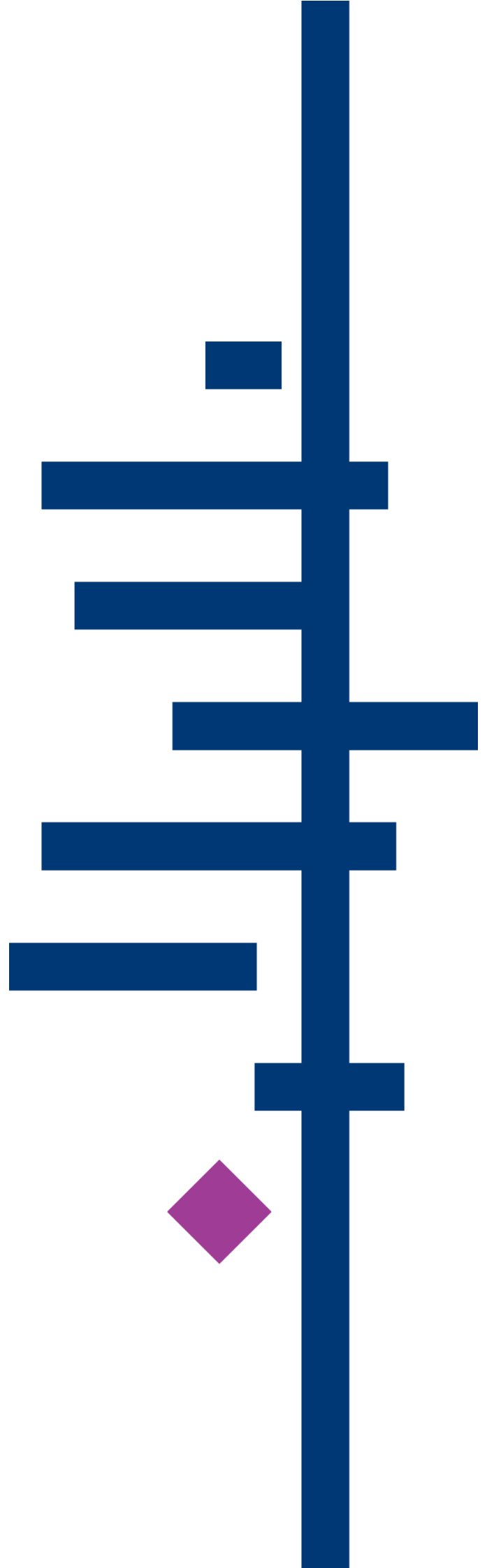
¹ <http://community.cochrane.org/organizational-info/resources/membership/>

Establishing a new Cochrane Events Network - Replacing the Cochrane Policy Advisory Committee (CPAC)

Document prepared by:
Julie Wood

Submitted to Steering Group: October 2016, Seoul

Access: OPEN



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- 1 Rationale / Background**
- 2 Proposal**
- 3 Proposed Terms of Reference for the new group:**
 - 3.1 Purpose
 - 3.2 What are the aims and responsibilities of the Cochrane Events Network?
 - 3.3 Membership
 - 3.4 Working Agreement/Ways of working
- 4 Sharing of information and resources**
- 5 Accountability**

1 Rationale / Background

The main role of Cochrane's Policy Advisory Committee (CPAC) has been to advise on Colloquia's policies and best practice, and to support Colloquia hosts more generally. As part of that role, CPAC has been responsible for the development and update of policies and SOPs with input from relevant stakeholders and CSG approval, and for helping ensure the hosts of Colloquia are aware of requirements and expectations. CPAC's role has also been to provide a platform for past and future Colloquium organizers to exchange experiences. CPAC resources are very limited as they rely on members and convenors dedicating their spare time, on a voluntary basis.

With the recruitment from March 2016 of the new Events Support Officer in the Communications & External Affairs Department (CEAD) within the Central Executive Team, there was a need to review the future remit of CPAC. CPAC and CEAD conducted this review and have concluded that CPAC is no longer needed in its current format and role.

2 Proposal

The Events Support Officer has dedicated capacity to assume CPAC's current responsibilities:

- The Events Support Officer will be responsible for developing and updating policies, SOPs, and other resources for Cochrane events, with input and approval from SMT and CSG as required.
- The Events Support Officer will be the first point of contact and provide pro-active support to hosts of Cochrane Events to an extent that CPAC could not assure as a volunteer committee.
- The Events Support Office will run the call for Colloquium and Mid-year proposals, with final decisions made by CSG.
- The Events Support Office will engage with relevant group executives for decisions around business meetings.

In the place of CPAC, we propose to establish an informal events advisory group. Anyone within Cochrane interested or engaged in running Cochrane events would be able to join, whether they have experience in, or plan to host a Cochrane event, or whether they have a particular stakeholder interest in ensuring Cochrane events take certain groups of people appropriately into consideration.

People within this group may change year on year, and there is no formal election or requirement to join or leave this group.

The objective of this events advisory group would be to provide a central point of contact, exchange and pool of expertise around Cochrane events, to share event information, resources, best of practice and offer general events support and advice as needed. The group would also constitute a source of expertise and advice for Cochrane's Event Support Officer to draw from.

Updates and developments around Cochrane events, including policy and SOP development would be shared with the group for information and/or input as required. Strategy and policy decisions would be made by the Cochrane Steering Group, (CSG).

The CSG would continue to offer strategic direction, scientific programme recommendations, policy advice and decisions, while the Cochrane Senior Management Team would make operational decisions. All other detail will be in agreement with the Memorandum of Understanding agreed between Cochrane and each host, the newly updated 2016 Standard Operating Procedures for Cochrane Colloquia and Cochrane's Mid-Year international business meetings.

3 Proposed Terms of Reference for the new group:

Title: Cochrane Events Network

3.1 Purpose:

In the spirit of Cochrane's collaboration and sharing 'best of practice', we propose to establish a Cochrane Events Network from August 2016. Anyone within Cochrane interested or engaged in running Cochrane events would be able to join, whether they have experience in, or plan to host a Cochrane event, or whether they have a particular stakeholder interest in ensuring Cochrane events take certain groups of people appropriately into consideration.

3.2 What are the aims and responsibilities of the Cochrane Events Network?

- The objective of this group would be to provide a central point of contact, exchange and pool of "expertise" for Cochrane events, to share event information, resources, best of practice and offer general events support and advice as needed. The group would also constitute a source of expertise and advice for Cochrane's Event Support Officer to draw from and pass on that knowledge and learning to other Cochrane groups.
- Updates and developments around Cochrane events, including policy and SOP development would be shared with the Cochrane Events Network for information and/or input as required. Strategy and policy decisions would be made by the Cochrane Steering Group (CSG). When relevant, Group Executives will be consulted.
- If members are attending some of Cochrane's annual events, they may wish to represent Cochrane at our Community exhibition stand.
- Members may wish to contribute to ideas and future plans representing Cochrane in the wider Evidence-based Medicine annual events calendar.

3.3 Membership:

- Anyone within Cochrane who has can demonstrate events experience and a passion for innovative and progressive ideas, spanning multi-media and digital platforms.
- Members of current CPAC would be invited to join the Cochrane Events Network.
- The period of membership is entirely voluntary and informal.
- In order to achieve maximum productivity and performance from this group, we
- recommend there is a minimum membership of 6 within the Cochrane Events Network. However, there is no maximum time limit on membership.

3.4 Working Agreement/Ways of working:

- The Cochrane Events Network will be a remote group that meets regularly to share lessons learned from past experiences and ‘best of practice’ examples, provide feedback on new ideas and suggest ways to avoid or address concerns or problems identified.
- The Events Support Officer will give the group an ongoing update on the global Cochrane Events and the Evidence-based Medicine community events and relevant attendance.
- Meetings will take place video/teleconference.
- The Events Support Officer will organise and chair these group meetings.
- The Events Support Officer will be responsible for the agenda, action points and generating topics for future discussion.
- The Events Support Officer might set up working groups from the members of the Cochrane Events Network to address specific issues or to operationalize suggestions.

In addition:

- The Events Support Officer will have dedicated capacity to assume CPAC’s current and past responsibilities.
- The Events Support Officer would be responsible for developing and updating policies, SOPs, and other resources for Cochrane events, with input and approval from the Cochrane Senior Management Team, (SMT), CSG as required, and relevant group executives as required.
- The Events Support Officer would be the first point of contact and provide pro-active support to hosts of Cochrane Events to an extent that CPAC could not assure as a volunteer committee.
- The Events Support Officer, together with CEAD and the SMT would organise and chair meetings for Colloquia and Cochrane’s Mid-Year proposals, with final decisions made by the CSG.
- The Events Support Officer will be responsible to request a report from the organizers of Colloquia and to compile, and manage, details of issues to maintain and evolve the improvement of Cochrane’s future events.
- The Events Support Officer will be responsible for ensuring that appropriate key indicators of success are recorded, measured and shared to inform future events.

4 Sharing of Information and resources

- Group members will share information and resources virtually.
- Materials and ‘best of practice’ events examples can be shared by the Events Support Officer electronically, for instance via Dropbox, email, or through the Cochrane Community website.

5 Accountability:

- The Cochrane Steering Group will continue to offer strategic direction, scientific programme advice, policy advice and decisions.
- The Cochrane Senior Management Team will make operational decisions.
- All other details will be in agreement with the Memorandum of Understanding agreed between Cochrane and each host, the newly updated 2016 Standard Operating Procedures for Cochrane Colloquia and Cochrane's Mid-Year international business meetings.

Collaboration Trading Company Limited

Registered number: 03657122

Directors' report and financial statements

For the year ended 31 December 2015

COLLABORATION TRADING COMPANY LIMITED

COMPANY INFORMATION

Directors	Dr MW Davies Dr DM Gillies Dr I Shrier
COMPANY SECRETARY	S Watson
REGISTERED NUMBER	03657122
REGISTERED OFFICE	St Albans House 57-59 Haymarket London SW1Y 4QX
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BANKERS	National Westminster Bank plc 249 Banbury Road Summertown Oxford OX2 7HR
SOLICITORS	Penningtons Manches LLP 9400 Garsington Road Oxford Business Park Oxford OX4 2HN

COLLABORATION TRADING COMPANY LIMITED

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COLLABORATION TRADING COMPANY LIMITED

DIRECTORS' REPORT FOR THE YEAR ENDED 31 DECEMBER 2015

The directors present their report and the audited financial statements for the year ended 31 December 2015.

Directors' responsibilities statement

The directors are responsible for preparing the Directors' report and the financial statements in accordance with applicable law and regulations.

Company law requires the directors to prepare financial statements for each financial year. Under that law the directors have elected to prepare the financial statements in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards and applicable law). Under company law the directors must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the company and of the profit or loss of the company for that period. In preparing these financial statements, the directors are required to:

- select suitable accounting policies and then apply them consistently;
- make judgments and accounting estimates that are reasonable and prudent;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the company will continue in business.

The directors are responsible for keeping adequate accounting records that are sufficient to show and explain the company's transactions and disclose with reasonable accuracy at any time the financial position of the company and enable them to ensure that the financial statements comply with the Companies Act 2006. They are also responsible for safeguarding the assets of the company and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Principal activities

The principal activity of the company continued to be the collection of royalties from the sale of subscriptions to The Cochrane Library.

Directors

The directors who served during the year were:

Dr MW Davies
Dr DM Gillies
Dr I Shrier

Distributions

During the year the company distributed £4,808,003 (Period ending 31 December 2014: £4,143,581) to its parent charitable company arising from profits of the previous financial year. A distribution of £3,608,778 is proposed, but not recognised, in relation to profits arising from the current year.

Disclosure of information to auditor

Each of the persons who are directors at the time when this Directors' report is approved has confirmed that:

- so far as that director is aware, there is no relevant audit information of which the company's auditor is unaware, and
- that director has taken all the steps that ought to have been taken as a director in order to be aware of any relevant audit information and to establish that the company's auditor is aware of that information.

COLLABORATION TRADING COMPANY LIMITED

DIRECTORS' REPORT FOR THE YEAR ENDED 31 DECEMBER 2015

Auditor

The auditor, Mazars LLP, will be proposed for reappointment in accordance with section 485 of the Companies Act 2006.

This report has been prepared in accordance with the provisions applicable to companies subject to the small companies regime.

This report was approved by the board and signed on its behalf.

Dr DM Gillies
Director



19/9/16

Date:

COLLABORATION TRADING COMPANY LIMITED

INDEPENDENT AUDITOR'S REPORT TO THE SHAREHOLDERS OF COLLABORATION TRADING COMPANY LIMITED

We have audited the financial statements of Collaboration Trading Company Limited for the year ended 31 December 2015 which comprise the Profit and Loss Account, the Balance Sheet and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the Financial Reporting Standard for Smaller Entities (effective January 2015) (United Kingdom Generally Accepted Accounting Practice applicable to Smaller Entities).

Respective responsibilities of directors and auditor

As explained more fully in the Directors' responsibilities statement set out on page 1, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. This report is made solely to the company's members as a body in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the company's members those matters we are required to state to them in an Auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the company and the company's members as a body for our audit work, for this report, or for the opinions we have formed.

Scope of the audit of the financial statements

A description of the scope of an audit of financial statements is provided on the Financial Reporting Council's website at www.frc.org.uk/auditscopeukprivate.

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the company's affairs as at 31 December 2015 and of its profit for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice applicable to Smaller Entities; and
- have been prepared in accordance with the requirements of the Companies Act 2006.

Opinion on the other matter prescribed by the Companies Act 2006

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

COLLABORATION TRADING COMPANY LIMITED

INDEPENDENT AUDITOR'S REPORT TO THE SHAREHOLDERS OF COLLABORATION TRADING COMPANY LIMITED

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Companies Act 2006 requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of directors' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit; or
- the directors were not entitled to prepare the financial statements and the Directors' report in accordance with the small companies' regime.

Stephen Brown (Senior Statutory Auditor)

for and on behalf of Mazars LLP

Chartered Accountants and Statutory Auditor

The Pinnacle
160 Midsummer Boulevard
Milton Keynes
MK9 1FF

Date:

COLLABORATION TRADING COMPANY LIMITED

PROFIT AND LOSS ACCOUNT FOR THE YEAR ENDED 31 DECEMBER 2015

	Note	Year ended 31 December 2015 £	9 months ended 31 December 2014 £
Royalty income		4,916,765	3,164,706
Non-royalty income		224,662	317,302
		<u>5,141,427</u>	<u>3,482,008</u>
Administrative expenses	1	(608)	(11,204)
		<u>5,140,819</u>	<u>3,470,804</u>
Operating profit	2	5,140,819	3,470,804
Interest receivable and similar income		-	5,168
		<u>5,140,819</u>	<u>3,475,972</u>
Profit on ordinary activities before taxation		5,140,819	3,475,972
Tax on profit on ordinary activities	3	-	-
		<u>5,140,819</u>	<u>3,475,972</u>
Profit for the financial year	9	<u>5,140,819</u>	<u>3,475,972</u>

There are no material differences between the profit on ordinary activities before taxation and the retained profit for the financial year stated above and their historical cost equivalents.

The notes on pages 7 to 10 form part of these financial statements.

COLLABORATION TRADING COMPANY LIMITED

Registered number: 03657122

BALANCE SHEET**AS AT 31 DECEMBER 2015**

	Note	£	2015 £	£	2014 £
Current assets					
Debtors	5	4,191,101		3,588,118	
Cash at bank		610,310		924,454	
		<u>4,801,411</u>		<u>4,512,572</u>	
Creditors: amounts falling due within one year	6	(589,081)		(433,058)	
Net current assets			4,212,330		4,079,514
Total assets less current liabilities			4,212,330		4,079,514
Creditors: amounts falling due after more than one year	7	(400,000)		(600,000)	
Net assets			<u>3,812,330</u>		<u>3,479,514</u>
Capital and reserves					
Called up share capital	8		100		100
Profit and loss account	9		3,812,230		3,479,414
Shareholders' funds	10		<u>3,812,330</u>		<u>3,479,514</u>

The financial statements have been prepared in accordance with the special provisions applicable to small companies within Part 15 of the Companies Act 2006 and in accordance with the Financial Reporting Standard for Smaller Entities (effective January 2015).

The financial statements were approved and authorised for issue by the board and were signed on its behalf by:

Dr DM Gillies

Director

Date:

19/9/16

The notes on pages 7 to 10 form part of these financial statements.

COLLABORATION TRADING COMPANY LIMITED

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER 2015

1. Accounting policies

1.1 Basis of preparation of financial statements

The financial statements have been prepared under the historical cost convention and in accordance with the Financial Reporting Standard for Smaller Entities (effective January 2015).

1.2 Going concern

The accounts have been prepared on a going concern basis as the directors have not identified any material uncertainties or events that may cast doubt about the company's ability to continue as a going concern.

1.3 Turnover

Turnover comprises revenue recognised by the company in respect of royalties and other related income receivable during the year, exclusive of Value Added Tax .

1.4 Tangible fixed assets and depreciation

Tangible fixed assets are stated at cost less depreciation. Depreciation is provided at rates calculated to write off the cost of fixed assets, less their estimated residual value, over their expected useful lives on the following bases:

Fixtures & fittings	-	25% straight line
Computer equipment	-	25% straight line

1.5 Operating leases

Rentals under operating leases are charged to the Profit and loss account on a straight line basis over the lease term.

Benefits received and receivable as an incentive to sign an operating lease are recognised on a straight line basis over the period until the date the rent is expected to be adjusted to the prevailing market rate.

2. Operating profit

The operating profit is stated after charging:

	Year ended 31 December 2015 £	9 months ended 31 December 2014 £
Depreciation of tangible fixed assets:		
- owned by the company	-	2,087
Auditor's remuneration	500	1,500
Auditor's remuneration - non-audit	-	750
	<u> </u>	<u> </u>

During the year, no director received any emoluments (2014 - £NIL).

COLLABORATION TRADING COMPANY LIMITED

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER 2015

3. Taxation

	Year ended 31 December 2015 £	9 months ended 31 December 2014 £
Adjustments in respect of prior year UK corporation tax charge	-	-

4. Taxation

Factors affecting tax charge for the period

The profits of the company are gift aided to its parent charity in full and there is no tax arising from its activities in the year.

5. Debtors

	2015 £	2014 £
Due after more than one year		
Trade debtors	400,000	400,000
Prepayments and accrued income	321,271	321,271
Due within one year		
Trade debtors	5,331	-
Amounts owed by group undertakings	2,330,912	1,820,120
Prepayments and accrued income	1,133,587	1,046,727
	<u>4,191,101</u>	<u>3,588,118</u>

6. Creditors: Amounts falling due within one year

	2015 £	2014 £
Other taxation and social security	372,231	228,558
Accruals and deferred income	216,850	204,500
	<u>589,081</u>	<u>433,058</u>

COLLABORATION TRADING COMPANY LIMITED

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER 2015

7. Creditors:		
Amounts falling due after more than one year		
	2015	2014
	£	£
Accruals and deferred income	400,000	600,000
	<u> </u>	<u> </u>
8. Share capital		
	2015	2014
	£	£
Allotted, called up and fully paid		
100 Ordinary shares of £1 each	100	100
	<u> </u>	<u> </u>
9. Reserves		Profit and loss account
		£
At 1 January 2015		3,479,414
Profit for the year		5,140,819
Dividends: Non-equity capital		(4,808,003)
		<u> </u>
At 31 December 2015		<u>3,812,230</u>
10. Reconciliation of movement in shareholders' funds		
	2015	2014
	£	£
Opening shareholders' funds	3,479,514	4,147,393
Profit for the financial year/period	5,140,819	3,475,972
Dividends (Note 11)	(4,808,003)	(4,143,851)
	<u> </u>	<u> </u>
Closing shareholders' funds	<u>3,812,330</u>	<u>3,479,514</u>
11. Distributions		9 months ended
	Year ended	31 December
	31 December	2014
	2015	2014
	£	£
Donation paid to parent charity	4,808,003	4,143,851
	<u> </u>	<u> </u>

COLLABORATION TRADING COMPANY LIMITED

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER 2015

12. Related party transactions

The company has taken advantage of the exemption in Financial Reporting Standard Number 8 from the requirement to disclose transactions with group companies on the grounds that consolidated financial statements of the Cochrane Collaboration are publicly available.

13. Ultimate parent undertaking and controlling party

The ultimate controlling party is The Cochrane Collaboration, a charitable company registered in England.

Collaboration Trading Company Limited

Management information

For the year ended 31 December 2015

COLLABORATION TRADING COMPANY LIMITED**DETAILED TRADING AND PROFIT AND LOSS ACCOUNT
FOR THE YEAR ENDED 31 DECEMBER 2015**

	Year ended 31 December 2015 £	9 months ended 31 December 2014 £
Turnover	5,141,427	3,482,008
Less: Overheads		
Administration expenses	(608)	(11,204)
Operating profit	<u>5,140,819</u>	<u>3,470,804</u>
Interest receivable	-	5,168
Profit for the year	<u><u>5,140,819</u></u>	<u><u>3,475,972</u></u>

COLLABORATION TRADING COMPANY LIMITED

SCHEDULE TO THE DETAILED ACCOUNTS
FOR THE YEAR ENDED 31 DECEMBER 2015

	Year ended 31 December 2015 £	9 months ended 31 December 2014 £
Turnover		
Royalty Income	4,916,765	3,164,706
Non-Royalty Income	224,662	317,302
	<u>5,141,427</u>	<u>3,482,008</u>
	year ended 31 December 2015 £	9 months ended 31 December 2014 £
Administration expenses		
Auditors' remuneration	500	1,500
Auditors' remuneration - non-audit	-	750
Bank charges	108	127
Rent and Rates	-	1,379
Depreciation - computer equipment	-	2,087
Profit/loss on sale of tangible assets	-	4,633
Sundry expenses	-	728
	<u>608</u>	<u>11,204</u>
	year ended 31 December 2015 £	9 months ended 31 December 2014 £
Interest receivable		
Bank interest receivable	-	5,168

Appointment of Cochrane Auditors

Consideration of the
recommendation from the
Finance, Investment & Audit
Committee

Document prepared by:
Sarah Watson

Submitted to Steering Group: October 2016, Seoul

Access: OPEN



Audit tender run at request of trustees in September 2016

We selected four firms as part of the tender process. These were: Sayer Vincent, Kingston Smith, Buzzacott and Mazars (our current auditors). All four firms submitted tender documents and attended face-to-face meetings with Mark, Martin and Sarah, in London.

The panel felt that each of the four firms would offer a satisfactory audit process and service, however, the added value came from the audit firm's advisory role for both trustees and management, and access to other services such as training seminars.

After considering all the proposals and presentations, the panel recommended to the Finance, Investment and Audit committee, that Sayer Vincent be appointed as auditors.

References were taken up from two of their existing clients: Anti-Slavery and Alcohol Research UK, both of which were excellent.



The Cochrane Collaboration

Proposal for audit services

August 2016



Contact details

Engagement partner

Noelia Serrano

Noelia.serrano@sayervincent.co.uk

Audit manager

Vivien Ma

Vivien.ma@sayervincent.co.uk

Sayer Vincent LLP

Chartered accountants and statutory auditors

Limited liability partnership registered in England and Wales OC390403

Registered office

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[@sayervincent](https://twitter.com/sayervincent)



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Note This proposal has been prepared for the trustees and staff of The Cochrane Collaboration and should be treated as confidential.

Summary of our proposal

We are pleased to be invited to tender for the audit of The Cochrane Collaboration and its subsidiaries.

When Sayer Vincent works with your organisation, you will feel that you have extra people on your team. We make a positive contribution helping you to achieve your strategic objectives. We are a friendly but professional team offering challenge from an informed position, sharing your goal to make your charity more effective. All the individuals at Sayer Vincent are committed to making a difference for charities and helping them to be more effective.

We audit over 300 charities and train or advise many more, for example, the Academy of Medical Royal Colleges, the British Cardiovascular Society and the Eastern Academic Health Science Network.

As well as being commercial accountants, Sayer Vincent people have an in-depth knowledge of the governance and management of charities and social enterprises. We can advise on a range of business activities to achieve the best financial outcomes, keeping in mind the context of your organisation's objectives.

We incorporate simple calls and emails into our annual audit, so you can contact us without worrying about building up large fees. We'll tell you if we think your query is more complex and needs advice outside the scope of the audit. Our people are accessible and easy to talk to – so all you have to do is call us. You can also access advice and help through our seminars and training courses, or made simple guides – free to download from our website.

We suggest an annual audit fee of £8,500 excluding VAT, which will be invoiced in instalments.

As a result of working with Sayer Vincent, your team will be able to improve many areas of your finance operation. Clients are able to undertake more finance tasks themselves and we provide training and development to support staff and trustees so that you are in control of your finances.

In all our work with clients, we set high standards to ensure we provide a service tailored to our clients' needs. We aim to:

- Work in partnership with our clients, providing a professional and supportive working environment
- Provide an added value service, which is a positive benefit to our clients across a range of services
- Deliver a service that is prompt, technically sound and enables our clients to fulfil their objectives.

Background to Sayer Vincent

Sayer Vincent was set up in 1983 to work with charities, community organisations, co-operatives and other social purpose organisations. Today all our clients are in this sector, which now encompasses social enterprises, academies, free schools, campaigning organisations, international development charities and professional bodies.

Size and geography

We are a six-partner firm with headquarters in London operating across the whole of the UK. We have satellite offices in Bristol and Birmingham for meetings and seminars. We are a practice based on audit but extending to highly specialised commercial tax advice and consultancy services. We are growing organically as we are able to recruit and train people with the right skills, aptitudes and values.



Our strengths and adding value

Our key strength lies in our values as this affects how we work as a firm. Our sights are set on the beneficiaries of each charity we work with – we give their interests priority. This helps us to take a long-term strategic view of the issues facing each client and it prevents us from focussing on our own short-term self-interest.

We provide 360° business advice looking at your situation from all angles. You do not have to go from one advisor to another for VAT, tax or legal views. Our teams are knowledgeable

about the structure and needs of charities and we have individuals who lead on highly technical subjects, such as pensions, international aspects of taxation and accounting.

Audit philosophy

The word 'audit' comes from the Latin word meaning 'listen'. We think it is important to listen to our clients, consider the implications of what we hear and then discuss with them any issues arising. So our audits reflect a strong emphasis on engagement, going beyond the finance department. For example, we will speak to staff in other departments as well as your leadership team.

We have our own audit programme and documentation and the audit is not run by checklists or computers. Auditing is a people-orientated activity and we still work on that basis. Communication is a key component to a smooth audit.

We think it is important that we have a good working relationship with your trustees and staff. Our partners and staff are friendly but professional. At times we need to offer challenge, but equally we are open to feedback about how we operate, pro-actively seeking regular feedback.

Once you become a client, you have our commitment. Your audit partner and audit manager will be available for ad hoc advisory calls as well as the regular audit tasks.

A Sayer Vincent audit is rigorous and looks at your finances from all angles. Our risk-based approach starts from understanding your business, the operating model and the risks inherent in it. With extensive experience of commercial and charity models, we offer rapid insights into strategic issues for your organisation. Our audit provides trustees and managers with assurance on the systems and the year end accounts. But we go further – a Sayer Vincent audit is more like a consultancy service. We are there all year and offer advice and support as your organisation grows and changes. Our post-audit report is relevant to both managers and trustees and aims to provide feedback on the audit, the financial statements and provide practical recommendations that your team can implement. Audit meetings provide the opportunity to share our perspectives on the wider charity world and to give context to your organisation's performance.

Our approach to your audit

We appreciate that you have a wide network of stakeholders and interested parties who wish to understand your financial position. The report and accounts are more than just a compliance document. The annual report should also communicate the key achievements, funds flow and your future plans.

We help charities to both achieve their goal of communicating through their annual report and complying with the various regulations.

Planning the audit

Our audit work is based on an assessment of the risks – both the inherent risks in the activities you undertake and the audit risk, being the risk that the financial statements may be materially wrong in some respect. We discuss your risk assessment and the controls you have in place to manage those risks. Starting from an understanding of your business and the associated risks, we assess the quality and effectiveness of the controls you have in place. We then also ensure that the financial impact is reflected accurately in the financial statements.

We start our planning before the year end, and in the first year, we'll also spend a day with your team to make sure we understand your organisation, systems and controls. That way you'll get to know your audit team. We'll provide you with template accounts, audit preparation checklists, a detailed timetable and contact points in case you have queries during the year end preparation phase. You can also send your staff on a free one-day training course on how to prepare charity accounts.

Audit scope and materiality

We review management accounts, plans, your risk register, financial procedures and other background material. From this we draw up the key audit areas and the methods of auditing we plan to use. We prepare detailed audit plans, calculate materiality and agree timetables for the work. We expect to carry out the majority of our audit work in February after you have had an opportunity to prepare all the draft reports and financial statements.

Reporting

The audit manager will come to you at the end of the audit week to review the audit work and meet with you. Any key findings or outstanding audit issues will be flagged up at this point.

After we have reviewed our working papers, we meet with your team to discuss the draft financial statements and our draft post-audit report. We agree the actions needed to address

any of our recommendations and send the agreed version to you. We welcome your comments and we are happy to include your management responses to recommendations. We expect to hold this clearance meeting at the end of February, issuing agreed reports and papers after that meeting.

You would then have time to circulate papers to the Audit and Risk Committee in advance and we attend a meeting with them to go through all the documents. These can then be finalised and issued to the Steering Group for final approval at their meeting.

Post-audit report

Our post-audit report replaces the traditional management letter. We aim to provide a report for the trustees with issues relevant to them and provide assurance on the effectiveness of internal controls. A typical report would cover:

- A review of the audit process itself, with suggestions for future years
- An explanation of any amendments to the financial statements
- Significant audit findings, including important control weaknesses. These are issues which may be critical your organisation, either because of the impact on the financial statements, reputational risk, fraud risk or impact on your ability to operate and fulfil your objectives.
- Other audit findings. These include aspects of governance and the control environment which need to be brought to the attention of trustees and management. It covers systems and controls recommendations for management, looking more closely at operational aspects
- Emerging issues and good practice, flagging up issues on the horizon. Examples of these points might be legislative changes which will affect your charity in the near future, requiring a decision or action.

Fees

We estimate our fees (excluding VAT) for the audit of The Cochrane Collaboration and its subsidiaries to be as follows:

	Annual fee £
The Cochrane Collaboration and the group	5,500
Collaboration Trading Co Ltd	1,500
Cochrane Innovations Limited	1,500
Total	8,500

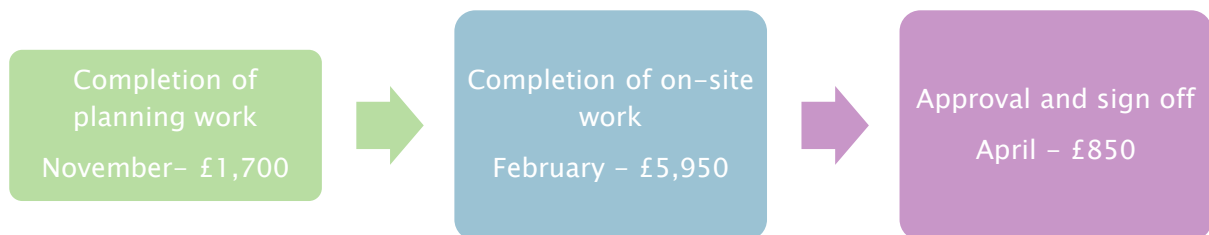
We assume the Danish subsidiary will be audited in Denmark or will not require audit. Its results will be consolidated with those of the Cochrane Collaboration.

Fees are estimated on the basis that the accounts are prepared according to the timetable and in the correct format for the Companies Act and charity SORP. Your team will be responsible for making corrections to the accounts within the agreed timetable.

Expenses are only charged for travel and accommodation outside London.

Our billing schedule

We invoice fees on the following schedule:



Our investment in the first year

We need to get to know you and so we do anticipate spending additional time in the first year, learning about your business and systems. At no additional charge, we will spend an extra day with you documenting your systems prior to the year end.

Basis of fees

The estimated hours to complete the audit by staff grade with the 2016 charge rates are set out in the table below. Fees exclude VAT and expenses. A copy of our standard terms and conditions are provided in Appendix B.

	Hours	Rate	£
Audit partner	8	212	1,696
Audit manager	12	138	1,656
Audit senior	35	91	3,185
Auditor	35	59	2,056
Total			8,593

Included in our audit service

- Documentation of systems and controls
- Templates of accounts in Excel with comparative figures ready for new year entries
- Comprehensive post-audit report with recommendations for improvements and emerging issues relevant to your organisation
- Attendance at a meeting of the Finance and Audit Committee meeting to discuss the accounts and our audit findings

Other elements of our all-round service included in the fee:

- Planning meeting to flag up issues early
- Audit preparation checklists to help staff get ready for the year end
- Review of the presentation and layout of accounts at the planning stage and suggest changes
- Access to advice and support during the preparatory period
- Free monthly newsletters to keep you abreast of news and developments
- Free training in charity accounting

Fees in future years

If your activities and income level remain consistent, we estimate the audit fees will increase only by inflation. However, if The Cochrane Collaboration expands in terms of turnover and activities, we will agree with you the change in fees to reflect the increase of audit work.

Advice and support

We provide a full range of advice and support services to our clients which do not jeopardise our independence as auditors. Fees are quoted in advance.

- VAT advice and reviews to improve VAT position
- International aspects of VAT
- Corporation tax compliance and filing
- Employee taxation issues
- Governance reviews
- Risk management

We provide a full range of tax services including planning, working with you to help you understand the tax issues, advice on handling HMRC inspection visits, assistance with the completion of forms and preparation of returns.

Corporation tax filing

You will need to file corporation tax returns for the two UK subsidiaries. We anticipate these two returns will be simple and so would charge an annual fee of £750 for each one to include preparation of accounts in iXBRL format.

If the charity is requested to file a corporation tax return (which may happen every few years) then it will need to complete a CT600E in addition to the normal return. This can take longer and our average fee for the filing is £1,500.

Corporate structure and trading issues

The Cochrane Collaboration receives the majority of its income from royalties generated from the publication of the Cochrane Library. This contract is currently held in the trading subsidiary Collaboration Trading Co Ltd. This is treated as charitable income in the group accounts and we do not see any legal or fiscal reason why the contract and the royalties could not be held in the main charity.

We would be able to help you review the corporate structure to simplify this where appropriate. The main reason we see for a separate legal entity would be a joint venture where profits are being shared and ownership is not 100% by Cochrane.

Advice fees

Additional services will be charged separately. For example, we charge £950 per day (excluding VAT) for assistance with accounts preparation. We charge an appropriate hourly rate for advice services. The rates range from £100 to £350 per hour depending on the complexity of the matter and the level of the person dealing with the matter.

Our experience

Since 1983, Sayer Vincent has been providing audit, internal audit and consultancy services as well as advice, support and training to charities. We have over 300 charity audit clients and many more clients using us for advice, training and consultancy. Examples of clients we work with:

- Academy of Medical Royal Colleges
- Alcohol Research UK
- BOND
- Brain Tumour Research
- British Cardiovascular Society
- British Lung Foundation
- British Institute of Radiology
- British Small Animal Veterinary Association
- British Thoracic Society
- The College of Optometrists
- Chartered Institution of Highways and Transportation
- Chartered Institute of Public Relations
- Eastern Academic Health Science Network
- European Academy of Optometry and Optics
- Faculty of Medical Leadership and Management
- Faculty of Pharmaceutical Medicine of the Royal Colleges of Physicians of the UK
- International Network for the Availability of Scientific Publications
- National Cancer Research Institute
- Royal College of Obstetricians and Gynaecologists
- Royal College of Ophthalmologists
- Royal College of Radiologists
- Royal Statistical Society
- Royal Institute of British Architects (RIBA)
- University College of Estate Management
- World Council of Optometry

Case studies

The Royal College of Ophthalmologists and the Royal College of Radiologists have been our clients since 1999. We provide external audit services and also other support and advice including facilitating strategy away days, IT issues, VAT and other tax advice, including on membership subscriptions, property matters and partial exemption, and assistance with recruitment.

Testimonials

Royal Institute of British Architects

The Royal Institute of British Architects (“The RIBA”) is the UK body for architecture and the architectural profession, providing support to over 40,000 members worldwide in the form of training, technical services, publications and events, and setting standards for the education of architects, both in the UK and overseas. It works to improve the design quality of public buildings, new homes and new communities. It also lets out meeting rooms at its prestigious building at 66, Portland Place. The RIBA has a group structure consisting of the Charter Body which could be compared to the Charity. It has a significant trading subsidiary RIBA Enterprises; as well as two other subsidiaries, a charitable trust and not for profit company. The annual income for the group is just approximately £38m. RIBA Enterprises runs significant commercial activities. As well as undertaking the statutory audit, Sayer Vincent has advised on tax issues, the acquisition of another company in the commercial arm and has carried out a review of the group legal structure with a view to simplifying it.

“I enjoy working with Sayer Vincent and value their pragmatic, to the point advice. I always feel that their output has been written for me, and is not padded out unnecessarily with material cut and paste from other documents. It is also important to be able to talk directly and quickly to a partner when the need arises, and to be confident of getting a quick response.”

Andy Munro, Chief Financial Officer, RIBA

British Thoracic Society

British Thoracic Society are the official membership body of respiratory specialists, including medical practitioners, nurses and scientists. The Society is committed to working in partnership with a range of organisations to achieve our objectives and provides a range of information and tools to improve respiratory care across the UK.

When Sayer Vincent were appointed auditors in 2007, we spent one day reviewing and documenting their internal audit systems and controls to ensure that they were in line with best practice. Our post-audit report recommended that they consider registering for VAT and have followed up subsequently. British Thoracic Society were previously audited by a Big Four firm but chose Sayer Vincent for its specialism in the sector and personable approach.

“British Thoracic Society felt that the time was right for a change and, following the first audit with Sayer Vincent, knew we had made a great choice. Trustees and senior staff valued the advice received, the professional and considered approach to the work in hand, and also in understanding the bigger picture. They look forward to the audit next year which is a pretty good state of affairs!”

Sheila Edwards, Chief Executive, The British Thoracic Society

Our team

Our partners and staff are at Sayer Vincent because we want to make a difference. Your team will get to know you and your issues. We are:

- Professional but approachable
- Expert but not arrogant
- Technically competent and good communicators

Your team will be:

Audit partner	Noelia Serrano
Audit manager	Vivien Ma

Detailed profiles for the partner and manager are included at Appendix A.

Partner and manager time

We have devised an audit approach and fee estimate based on the following commitment:

- The audit partner approves the audit plan, joins the audit team briefing, reviews the completed audit work and attends your audit committee meeting
- The audit manager meets with your staff at the planning stage, prepares the audit strategy, comes to your office during the audit to review our team's work and meet with you, drafts the post-audit report, attends a clearance meeting with you to discuss drafts and attends the audit committee meeting.

Audit staff

All our audit staff are trained and experienced in charity audit. They are fully briefed before the commencement of each audit. All audit staff participate in our specialist in-house charity accounting and audit training sessions to ensure that they are up to date with legal and accounting issues relevant to the sector. These cover VAT, tax, risk assessment and PAYE. Our audit staff have a good knowledge of relevant technical issues, and topic specialists are available to assist with more complex issues. All qualified staff attend regular external update courses in accounting and auditing developments, and maintain Continuing Professional Development as part of membership of the ICAEW.

Succession planning and continuity

Staff join the team at a junior level and return at progressively higher levels – this is good for their development, as well as ensuring that your staff do not have to go over the same ground every audit visit. The partner and manager will not change for several years.

Adding value to the audit

Sayer Vincent leads initiatives that support and improve the effectiveness of all charities. We are passionate about our clients and the work they do.

Seminars and training

Our clients can attend seminars and training in London, Bristol and Birmingham free of charge. As well as our own programme of open access training, we run training courses for Charity Finance Group and other organisations.

Charity Accountants' Conference

Since 1991 we have organised the annual residential Charity Accountants' Conference with the Directory of Social Change. This is an effective way to develop your staff by training, networking and informal interaction with a range of experts.

Financial Leadership

We support the training course "[Inspiring Financial Leadership](#)" run in collaboration with Charity Finance Group and Cass Centre for Charity Effectiveness.

Newsletters

Our monthly [newsletter](#) keeps clients informed of the latest sector news and developments. As well as technical updates, the newsletter gives the latest training and event details to assist in the preparation of your internal development programmes.

Made simple guides

We cover a wide range of accounting and tax topics in guides you can download for free from our [website](#).

Publications

We also write important reference books such as 'The Complete Charity VAT Handbook' and research studies such as '[Rethinking Risk: Beyond the tick box](#)'.

Appendix A – Team profiles

Noelia Serrano – Audit partner



“It gives me great joy to be able to support not for profit organisations with the many challenges they face. And when you share the same values as the organisations you work with, the job is so much easier and the satisfaction is second to none. As a partner with Sayer Vincent I am driven by helping clients to achieve their goals by tackling inefficiencies and making the most of the resources available to them.”

Noelia is one of our engagement partners for charity audits. As well as an audit partner she is also an advisor, trainer and facilitator. She qualified as a chartered accountant with Sayer Vincent and has a Diploma in Charity Accounting awarded by the ICAEW and Cass Business School.

Noelia works with a variety of audit clients who have wide-ranging activities including ActionAid UK, UNICEF UK, Medical Aid for Palestinians, Movember, Arvon Foundation, Community Housing & Therapy, Whizz-Kidz, Voluntary Action Camden, Cardboard Citizens, the Edge Foundation, Baker Dearing Educational Trust, and Water and Sanitation for the Urban Poor (WSUP)

Noelia is a member of our specialist tax and VAT group, which keeps our staff and clients up to date on the latest developments in the areas of VAT and direct tax. She delivers training in the areas of VAT, grants and contracts made simple and gift aid.

Noelia leads our special interest group which coordinates research and activities for international charities. The group runs regular external events with the aim of providing a forum to share learning, the exchange of ideas, past successes and implementation experiences.

Noelia is a trustee of Womankind Worldwide, an international women's rights organisation where she has taken on the Treasurer role. In her time with the charity she has supported Womankind in completing the new organisational strategy. She is currently leading a review of their finance strategy and reserves policy.

“Noelia and the team have always been friendly, helpful and diligent in completing their work on time, and in making themselves available to suit our timetable. We have also had the opportunity to avail of some of their free training sessions and made simple guides, fantastic resources for a charity like ours!”

Mary Daly, Director of Finance & Administration, Medical Aid for Palestinians

Vivien Ma – Audit manager



“What I enjoy most about working in the charities and not-for-profit sector is that I am amazed and humbled by the people I work with every day – both clients and my colleagues. We are motivated by beliefs and ideas that are bigger than ourselves and we believe that by working together we can make a real difference. It is for this reason that I re-joined Sayer Vincent.”

Vivien re-joined Sayer Vincent in April 2016 as a senior audit manager, having previously worked for the firm for seven years until 2011. In the intervening period, she worked as part of the charities teams at BDO and Grant Thornton and gained experience auditing a wide range of charity clients including the Victoria and Albert Museum, The Institute of Cancer Research, The Woodard Corporation, and the West London Free School Group.

More recently, Vivien was the Interim Deputy Director of Finance at Prostate Cancer UK for six months while the charity was undergoing a period of change. She led a team of 10 to deliver efficient day-to-day finance functions, including banking, transaction processing, payroll, VAT, gift aid, and produced monthly management accounts and quarterly reforecasts. Moreover, she was part of the senior management team, contributing to strategic decision-making including budgeting and attending the Leadership Team and the Finance and Audit Committee meetings.

In her new role, Vivien will manage a portfolio of audit clients and provide strong technical support to the firm’s team, working closely with the partners to deliver exceptional levels of client service and advice. Charities which she works with include Anti-Slavery International, the Institute of Contemporary Arts, Keech Hospice Care, and Landscape Institute, to name just a few.

With a particular interest in training and development, Vivien leads the firm’s Learning and Development group as well training clients in preparing charity accounts, improving their annual reports and managing year-end.

Vivien qualified as a Chartered Accountant as a member of the Institute of Chartered Accountants in England and Wales in 2004, and obtained the Diploma in Charity Accounting in 2008.

Appendix B – Terms and conditions of business

These terms apply unless we specifically agree different terms for a particular assignment. Please contact a partner if you have any queries. We are bound by the ethical guidelines of our professional institute and accept instructions to act for you on the basis that we will act in accordance with those ethical guidelines.

It is our normal practice to set out in advance the scope of work and the basis of fees to be charged. You may accept our proposal in writing or simply ask us to commence work, when we will consider that you have accepted our terms and conditions. All audit work is covered by an engagement letter.

Engagement partner For all work, a partner will be identified as the engagement partner and you will be told who this is before the work commences. The engagement partner is responsible for maintaining the quality standards of the firm and may be contacted if you have any queries on any matter. A manager will also be assigned and will be a key contact for you.

Confidentiality We will not disclose information, nor send accounts, reports, post-audit reports or other information to third parties without your express permission. Should an external body contact us, we will ask your permission to discuss your affairs with them. All information you give us is treated as confidential.

Fees Our fees are based on the time spent on your affairs (including telephone calls, letter writing and meetings) by the partners and staff and on the level of skill and responsibility involved. We will agree the scope of our work and provide you with an estimate of the likely fees before we commence our work. Additional fees may be incurred if the scope of our work is changed or if there are unforeseen difficulties or delays.

Travel and accommodation expenses The costs of travel will be charged unless we have agreed an inclusive fee. We use the most economic and efficient means of travel. This will be standard class rail fare and necessary taxis to travel from the rail station, or mileage at 45p per mile. Accommodation and subsistence will be charged where the work takes place outside London. We are happy to provide an estimate of the costs in advance and agree a fixed amount.

Invoices are issued at appropriate intervals or in accordance with the stage payments agreed at the commencement of an assignment. All fees are subject to VAT and are payable within 30 days of issue. Any queries concerning invoices should be raised with us within 14 days of the date of issue of the invoice.

Delayed payment increases our costs and we feel that it is unfair to pass on these costs to other clients. We therefore reserve the right to charge interest on late payment in accordance with the Late Payment of Commercial Debts (Interest) Act 1998, which is simple interest at 8% above the Bank of England base rate. If you are having difficulty paying our invoices, then please discuss the matter with your engagement partner at an early stage, when we will do everything we can to help. We are happy to accept payment by regular standing order, but this should be set up at the beginning of an assignment. We reserve the right to discontinue services if we have not received payment. We may also ask for advance payment.

Data Protection Act 1998 We may obtain, use, process and disclose personal data about you in order that we may discharge the services agreed under the engagement and for other related purposes including updating and enhancing client records, analysis for management purposes and statutory returns, crime prevention and legal and regulatory compliance. You have a right of access, under data protection legislation, to the personal data that we hold about you. For the purposes of the Data Protection Act 1998, the Data Controller in relation to personal data supplied about you is Joanna Pittman.

Audit registration, audit regulations and ethical standards Sayer Vincent LLP (company registration number OC390403) is registered to carry on audit work in the UK and Ireland by the Institute of Chartered Accountants in England and Wales. Details about our audit registration can be viewed at www.auditregister.org.uk, under reference number C003773061. Audit regulations can be viewed at www.icaew.com/regulations. The APB Ethical Standards for auditors can be viewed at www.frc.org.uk/apb.

Professional indemnity insurance In accordance with the disclosure requirements of the Provision of Services Regulations 2009, our professional indemnity insurer is AIG, The AIG Building, 58 Fenchurch Street, London, EC3M 4AB. The territorial coverage is worldwide excluding professional business carried out from an office in the United States of America or Canada and excludes any action for a claim brought in any court in the United States of America or Canada.

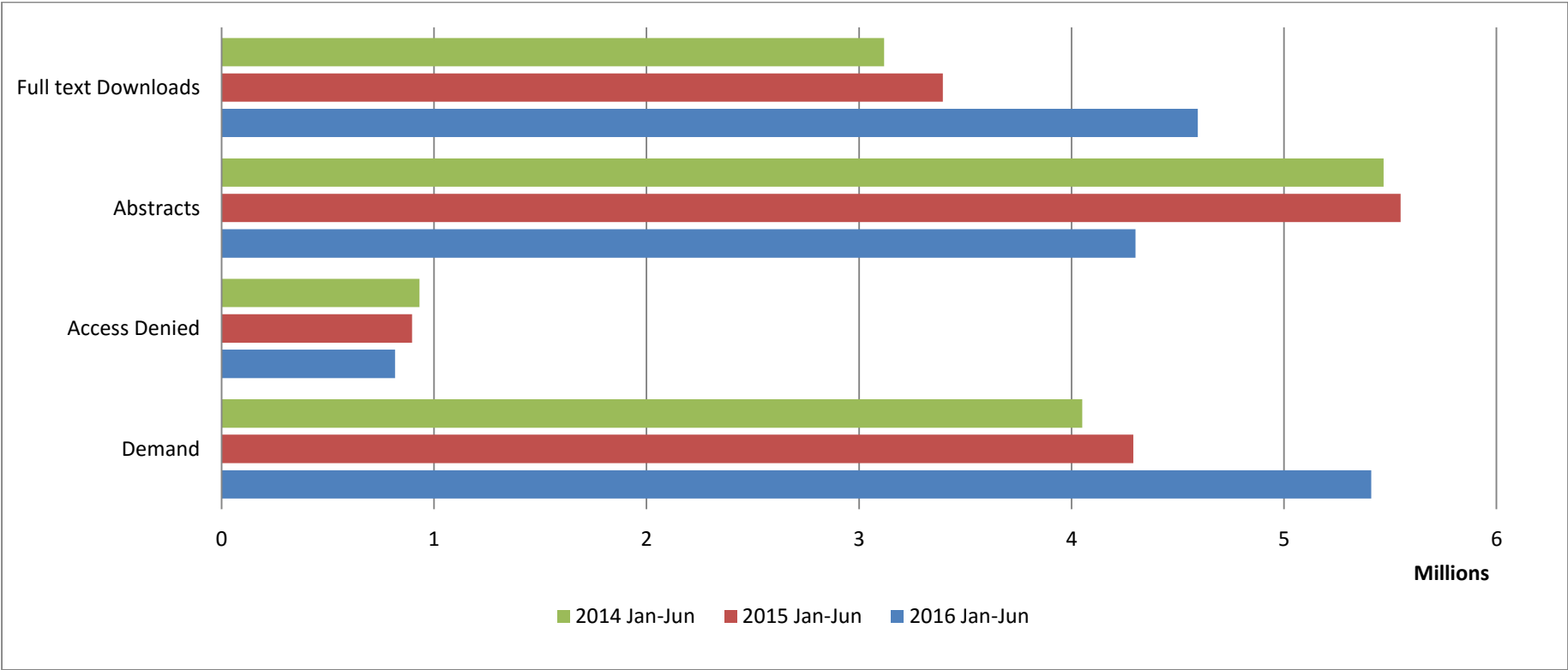
Our service If at any time you would like to discuss with us how our service to you could be improved or if you are dissatisfied with the service you are receiving, please contact your engagement partner or one of the other partners. A copy of our complaints procedure is available on request. We undertake to look into any complaint carefully and promptly. If we have given you a less than satisfactory service we undertake to do everything reasonable to put it right. If we do not answer your complaint to your satisfaction you may of course take up the matter with the Institute of Chartered Accountants in England and Wales.

If you have any questions regarding these terms and conditions, then do please contact a partner.

Publishing Management Team Dashboard for Steering Group at Seoul Colloquium

Reporting Period: 2011 – 2016 (to June)

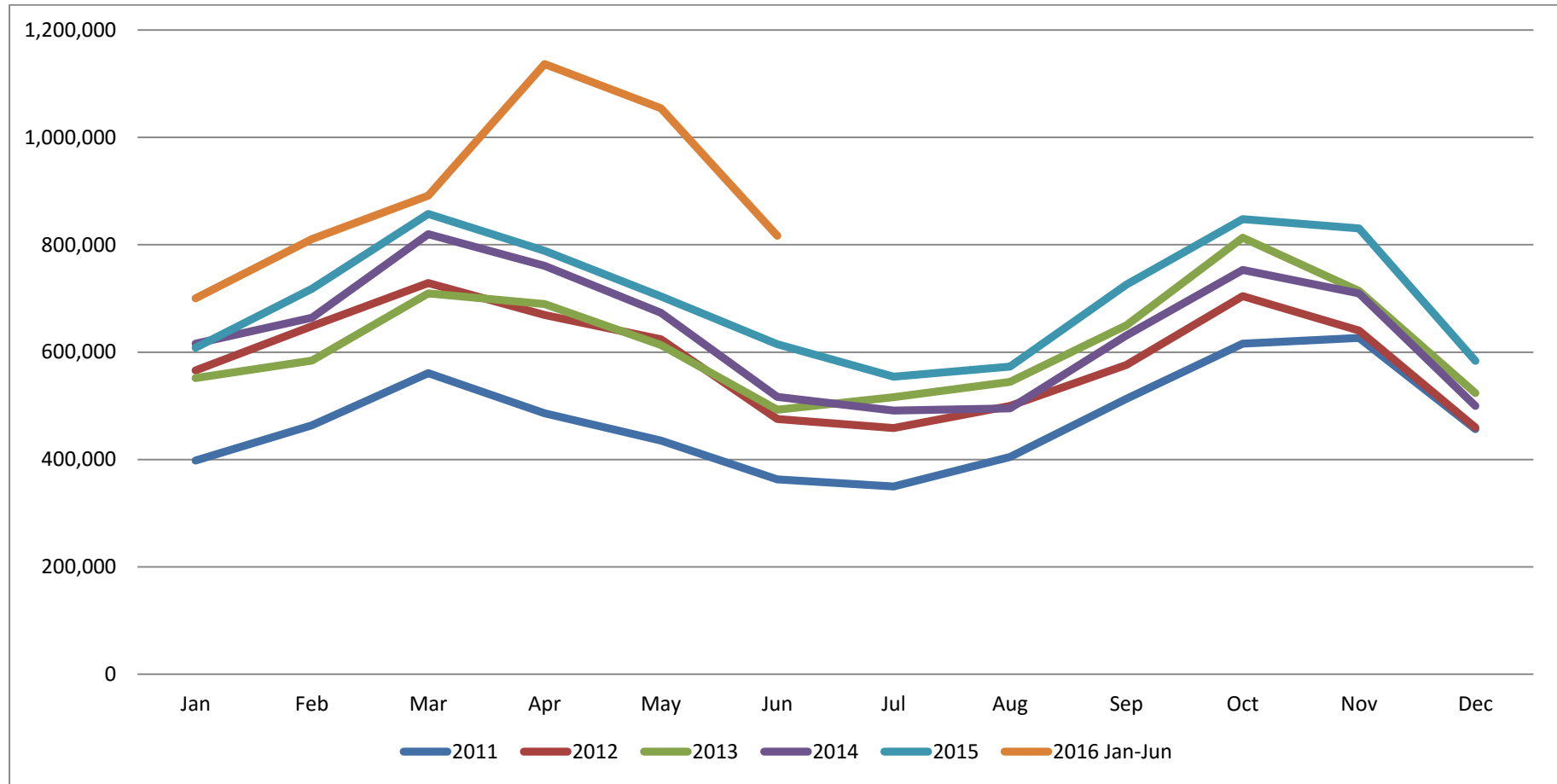
WILEY ONLINE LIBRARY OVERVIEW OF KEY METRICS



The above graph compares key metrics for usage of the Cochrane Library on the Wiley Online Library platform. On March 31st 2016, the default destination for users searching for Cochrane Systematic Reviews was changed from the Abstract View to the full text option, the Anywhere Systematic Review (ASR). This means that full text download usage was significantly higher and abstract usage was considerably lower in 2016 from April to June. The number of recorded full text downloads increased by 9% in 2015 and by 35% in 2016.

OPEN ACCESS

DEMAND (Full text downloads + Access denied)



The rate of demand for the Cochrane Library is calculated by adding the total number of full text downloads to the total number of times that attempts to gain access have been denied. The table above shows a clear pattern of increased demand for Cochrane content since 2011. Demand for content from the Cochrane Library has increased by 100% percent since 2011.

FULL TEXT DOWNLOADS - TOP 20 COUNTRIES

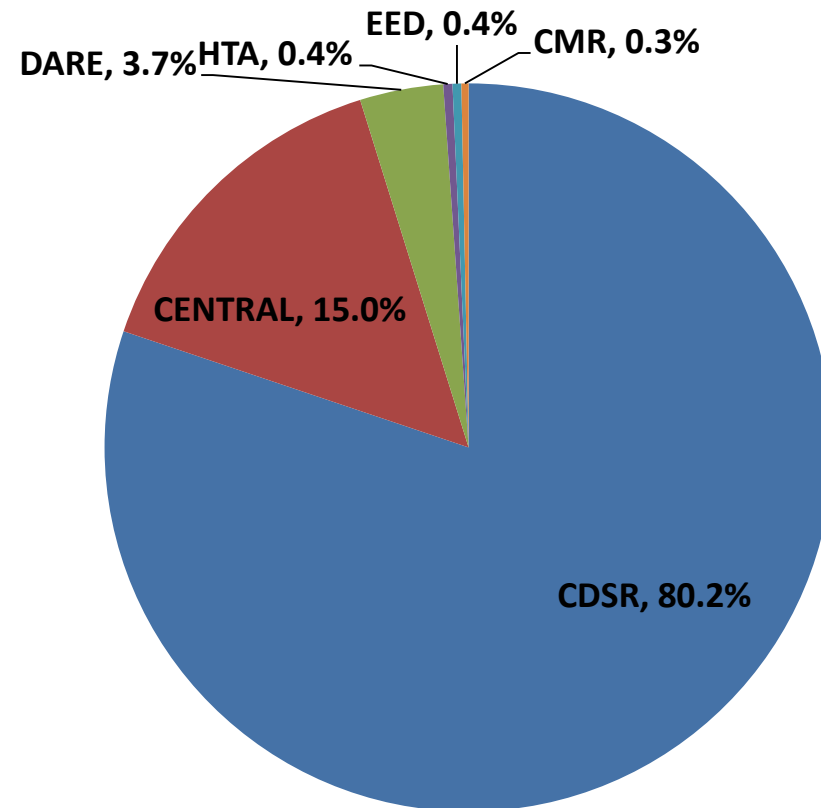
Rank	COUNTRY	2011	2012	2013	2014	2015	2016 (Jan-Jun)	Variance (2011-2015)
1	United Kingdom	972,496	1,230,441	1,312,603	1,369,612	1,504,577	972,446	35%
2	United States	897,469	1,093,907	1,079,639	1,392,623	1,297,318	846,717	31%
3	Australia	495,203	621,922	654,673	648,680	750,490	503,295	34%
4	Canada	190,164	248,121	263,217	167,300	235,388	158,833	19%
5	Netherlands	144,826	159,798	160,989	164,238	193,797	140,542	25%
6	India	113,514	170,627	180,692	162,588	201,346	89,930	44%
7	Taiwan	118,283	129,506	123,410	134,612	150,953	115,278	22%
8	China	31,512	67,783	282,926	87,031	134,620	97,887	77%
9	Germany	97,294	106,315	106,866	116,043	154,377	117,343	37%
10	Italy	96,511	102,040	100,932	109,460	122,751	96,988	21%
11	Norway	94,383	96,068	87,407	88,341	104,451	68,234	10%
12	Sweden	89,579	96,886	96,572	75,682	108,222	55,097	17%
13	New Zealand	62,262	93,302	113,105	82,365	99,411	67,475	37%
14	Ireland	71,769	86,444	83,667	91,687	104,159	67,125	31%
15	France	51,491	61,429	72,564	84,730	93,497	77,924	45%
16	Japan	89,162	59,044	54,386	75,023	87,252	66,577	-2%
17	Switzerland	59,844	68,202	69,856	52,909	74,715	85,173	20%
18	Denmark	48,118	57,441	63,070	61,957	73,957	52,137	35%
19	South Korea	47,115	46,740	51,222	67,457	65,476	46,510	28%
20	Belgium	36,664	43,481	58,447	41,907	60,144	41,529	39%

The above table shows the top 20 countries that have recorded the highest number of full text downloads from 2011 to 2015. The countries in bold (in the table above) either have or have had a national provision for access to the Cochrane Library between 2011 and 2015.

The number of full text downloads for all countries can be provided upon request.

OPEN ACCESS

USAGE BY DATABASE



The chart above shows that on average from 2011-2015, 80.2% of recorded full text downloads of content in the Cochrane Library were from the Cochrane Database of Systematic Reviews.

Four of the six databases of the Cochrane Library have experienced a decline in usage since 2011. Usage of the DARE database has decreased by 12% since 2011, HTA has decreased by 31%, NHS EED by 40% and the CMR by 55%.

CITES AND IMPACT FACTOR

Year	Rank	Impact Factor	In-Window Cites	Citable items	Total Cites	Self-citation rate	5-Year Impact Factor
2015	12	6.103	11,522	1,888	TBC	TBC	6.665
2014	13	6.035	11932	1977	43,592	6%	6.539
2013	10	5.939	9859	1660	39,856	8%	6.706
2012	12	5.785	8087	1398	34,230	8%	6.553
2011	10	5.912	7721	1306	29,593	5%	6.309

The 2015 Impact Factor for the Cochrane Database of Systematic Reviews was released in June. The Impact Factor for the CDSR is 6.103, an improvement on the previous year's release.

Cites	Review Title	Date Published
516	Antenatal corticosteroids for accelerating fetal lung maturation for women at risk of preterm birth	Jul, 2006
499	Interventions for preventing falls in older people living in the community	Feb ,2009
484	Cholinesterase inhibitors for Alzheimer's disease	Jan, 2006
467	Interventions for preventing falls in older people living in the community	Sep, 2012
426	Interventions for enhancing medication adherence	Apr, 2008
301	Decision aids for people facing health treatment or screening decisions	Jul, 2009







The Cochrane Reviews in the table above are the five highest cited Cochrane Reviews of all time. Cochrane Reviews have been indexed in the Web of Science since 2005.

OPEN ACCESS





ALTMETRIC

The table below shows the top 10 Cochrane reviews with the highest Altmetric Attention scores of all time. Altmetric began tracking research outputs in October 2011.

B=Bloggers T=Twitterers N=News outlets FB=Facebook walls M=Mendeley Readers

		B	T	N	FB	M
	Portion, package or tableware size for changing selection and consumption of food, alcohol and tobacco	13	569	75	11	106
	Workplace interventions for reducing sitting at work	12	297	83	11	162
	General health checks in adults for reducing morbidity and mortality from disease	14	816	6	37	189
	Vitamin D for the management of asthma	7	113	64	31	14
	Vaccines for preventing influenza in healthy adults	5	604	3	248	319
	Vitamin C for preventing and treating the common cold	10	231	34	54	52

OPEN ACCESS

	Electronic cigarettes for smoking cessation and reduction	11	318	25	16	156
	Motor control exercise for chronic non-specific low-back pain.	3	344	19	34	69
	Exercise for depression	16	188	20	16	5
	Midwife-led continuity models versus other models of care for childbearing women	6	332	10	91	21

RUNNING TOTAL OF PUBLISHED OPEN ACCESS ARTICLES

	2013	2014	2015	Jun 16
Green Reviews (Running Total)	0	930	1,815	2,265
Gold Reviews (Running Total)	4	19	40	49
Number of Open Access articles available (Cumulative)	4	949	1,855	2,314
% of Cochrane Reviews Open Access	0.1%	16%	29%	35%

The table above shows the percentage of Cochrane Reviews that are available via Cochrane's Open Access policy.

OPEN ACCESS

NATIONAL AND REGIONAL PROVISIONS

Country or Region	Funder
AUSTRALIA - Includes Cocos (Keeling) Islands	National Health and Medical Research Council (NHMRC) Australia
DENMARK - Includes Faroe Islands & Greenland	Ministry of Health - DEFF - Danish Consortium Parent
EGYPT	Egypt National Science & Technology Information Network (ENSTINET)
ENGLAND - Includes Isle of Man	National Library for Health - England Cochrane National Provision (NICE)
FINLAND	Duodecim Medical Publications Ltd
IRELAND & NORTHERN IRELAND	The Health Research Board in Dublin & Research and Development Office in Belfast
NEW BRUNSWICK	New Brunswick Public Libraries
NEW ZEALAND	District Health Boards Ministry of Health (NZ)
NORWAY	Norwegian Knowledge Centre for Health Services
NOVA SCOTIA	Atlantic Health Knowledge Partnership
SCOTLAND	NHS Education for Scotland
SWITZERLAND	Swiss Academy of Medical Sciences (SAMS)
WALES	NHS Wales (Informing Healthcare)

The table above shows the countries and regions that have a national provision access arrangement for the Cochrane Library.



Governance Reform

Final policies and next steps

Document prepared by: **Miranda Cumpston on behalf of the Governance Reform Working Group**

Submitted to Steering Group: **October 2016**

Purpose of paper: **To present final policy documentation to support changes to Cochrane's Governance structures, and outline next steps.**

Access: **Open**

Summary of Recommendations: **That the CSG approves the final policies to implement the new Board and Council, for implementation should the AGM approve the proposed changes to the Articles of Association, and approves the next steps for implementation and for the Governance Reform Working Group.**

Resource implications: **No new resource implications (resources for establishing the Council previously approved).**

Governance reform supporting policies

Following consultation in July and August, and discussion at the Steering Group teleconference on 31 August/1 September, documentation for the proposed reforms to Cochrane governance have been finalised.

The final Articles of Association will be presented for adoption by the Cochrane membership at the Annual General Meeting (AGM) in Seoul on 25 October 2016, and the document has been circulated with the AGM agenda and papers (see documentation at <http://community.cochrane.org/organizational-info/people/steering-group/minutes-agm-meetings>).

Should the Articles be adopted, a set of final policies should be in place to support their implementation. For this purpose, final versions of the Cochrane Board policy and electoral procedure (Appendix 1) and the Cochrane Council Terms of Reference (Appendix 2) have been finalised. These documents, along with an updated plain language explanation of the changes and a Frequently Asked Questions document have also been made available via the Cochrane Community website at <http://community.cochrane.org/organizational-info/people/steering-group/governance-restructure-project>.

Recommendation 1: That the Steering Group approve the Cochrane Board policy and electoral procedure, and the Cochrane Council Terms of Reference, for implementation of the revised Articles of Association (as adopted at the 2016 AGM).

Implementing Governance reform

Should the proposed Governance reform measures receive approval at the AGM, implementation can begin. The next steps in implementing the reforms are as follows:

- The first Board election of internal candidates under the new electoral system will be conducted immediately, before the end of 2016, with four positions to be elected. The CET will coordinate the election process as usual.
- Action will begin to establish the Council. In acknowledgement of the importance of their face-to-face meetings in Seoul, the Governance Reform Working Group has written to the Group Executives to ask them to consider their preferred processes to identify representatives on the Council. Should the proposed changes be adopted, the Executives will be asked to identify their representatives by the end of 2016. Separate arrangements for the Author representatives will be discussed with Mona Nasser given the different nature of the Author Forum. Reviewing these selection processes and the overall membership of the Council will be items for its initial agenda. Logistical preparations have begun to host the first meeting of the Council at the Mid-Year Meeting in Geneva, including a 90-minute joint meeting with the Board.
- All members of the CSG stepping down from their positions in 2016 will be eligible to sit on the initial Council, as a transitional measure. All relevant individuals will be invited to decide whether or not to take up this role.

- The CET will also move to further develop and implement other elements of the reforms, including an individually based electronic voting system for the 2017 AGM, a diversity policy for the CSG, and an email channel for direct communication from Cochrane members to the Board.

Recommendation 2: That the Steering Group note the proposed next steps to implement the Governance reforms.

Governance Reform Working Group

The Governance Reform Working Group, chaired by Denise Thomson, will continue to act as the Board's focal point for collaborating in the establishment of the Council. Although reviewing the role and structure of the Board has been a substantial piece of work, some aspects of Cochrane's Governance structures have not been addressed by the reform proposals to date.

Some of the Working Group's members are stepping down, and so new members will be invited to join.

The Governance Reform Working Group will monitor the work by the Executives in selecting members of the Council, including the processes used, and will convene informal meetings of contact persons from each Exec if it appears that additional communication would be helpful.

Once its membership is revised, the Working Group will review its program of work for 2017. This is likely to include a review of the role and accountability of the Group Executives. This review is likely to require close collaboration with the Execs, and so one or two members of the Execs of the Council may be invited to join the Working Group for this project (in the same manner that Rachel Churchill and Jeremy Grimshaw assisted with the review of the Board). A detailed terms of reference for the review would be developed and shared with the Board before commencing work in detail.

Recommendation 3: That the Steering Group approve the ongoing role of the Governance Working Group and the proposed focus of activities in 2017.

Appendix 1: Cochrane Board policy and electoral procedure

Beginning in 2016, a new Cochrane Board will be introduced to replace the Cochrane Steering Group, to be phased in from 2016 to 2018. The membership of the new Board will comprise up to 13 members:

- 2 Co-Chairs
- 6 internal elected members
- up to 5 external members

The number of external members may be adjusted depending on coverage of key areas of expertise within the Board membership. Where all key areas are considered to be met, fewer external members may be recruited. A draft position description for all members of the Cochrane Board is in Attachment 1. Both internal and external members may serve up to two consecutive terms of three years, as is the case for current Board members. Members who have served the maximum term must take a break of three years, and are then eligible to serve again if elected.

Neither external nor internal members of the Board will be remunerated for their role on the Board, with the exception of the expenses and costs of attending meetings. Co-Chairs may be remunerated under the Articles of Association for their higher workload.

Co-Chairs

The position description of the Co-Chairs was updated in 2015 and is provided at Attachment 2. Anyone who holds or has held a leadership position within Cochrane is eligible to apply for the position of Co-Chair. Each Co-Chair holds the position for a term of two years, and can hold the position for a maximum of two terms.

A call for nominations for one of the two Co-Chair positions is held annually. Responsibility for selection of the most appropriate person from amongst the nominated candidates rests with the Board. If a Co-Chair is selected who is not a current member of the Board, the Board will appoint them as a member. This appointment to the Board must be ratified at the next AGM.

From 2016, Co-Chairs are required to meet the current eligibility criteria and the definition of 'internal' to Cochrane. From 2018, 'external' members of the Board who have completed at least one full term will be eligible to stand for the position of Co-Chair. Only one of the two Co-Chair positions may be held at any time by an 'external' Board member.

Internal Board positions

All internal Board members for election compete in a single field, and are voted on by the entire electorate. There are no separate categories of internal Board members, or representation of specific constituencies.

A detailed electoral procedure is provided in Attachment 3.

As part of the call for nominations for internal Board members, prior to each election the Board will identify key areas of skills and experience considered to be essential to the effective operation of the Board, and to strengthen the practice of governance for Cochrane.

While no individual candidate is expected to cover all areas, the Board will seek to ensure a balance and that each area is covered by at least one Board member. In order to target essential skills and experience, the Board may revise the list of key areas sought for each election. A list of key areas could include:

- Evidence-informed health care or policy
- Editorial policy and publishing
- Consumer engagement
- Systematic review conduct
- Systematic review methodology
- Knowledge translation and communication
- Financial management in the not-for-profit sector
- Organisational governance

Candidates may be elected with any combination of the required areas of expertise. Where the elected internal members of the Board do not collectively provide experience against each area, the published expertise requirements for the next internal election and the selection of external members may be targeted to ensure each area is covered.

The Board will actively seek diversity of gender, geographic location, language and other considerations of equity. In order to encourage and support participation from underrepresented groups, the Board will publish a diversity policy that includes leadership development training and/or mentoring for new members, practical support for members whose first language is not English, reporting and review against diversity criteria and other measures.

From 2016, membership of Cochrane, including eligibility to stand and vote for internal Board positions and vote at the AGM, is defined as all contributors to a registered Cochrane Group with an Active role in Archie, excluding those whose only roles are Other, Mailing list, Possible Contributor, Super User, Web Contributor and Web Publisher.

Every member has one vote. Members who are eligible to vote with more than one Group are permitted to vote only once.

In 2017, the definition of membership will be reviewed after the introduction of the Cochrane membership scheme.

Members of the Central Executive Team (CET) staff are not eligible to stand for the Board, but are eligible to vote. This includes employees, contractors or seconded staff working at least 0.2 FTE for the CET.

External Board positions

External candidates are identified following external advertisement. Successful candidates are selected by the current members of the Board, in the same manner as selection of Co-Chairs. Appointments must be ratified by the members at the next AGM.

As part of the call for nominations for external Board members, prior to each election the Board will identify key areas of skills and experience considered to be essential to the effective operation of the Board, and to strengthen the practice of governance for Cochrane. The key areas may overlap with those identified for internal candidates, but may also reflect skills and perspectives likely not to be found among internal members. They may include:

- Board membership or other leadership of a large not-for-profit organisation

- Financial management and business development in the not-for-profit sector
- Healthcare or other publishing
- Patient/consumer perspective and advocacy
- Evidence-informed health care
- Evidence-informed guidelines and policy
- Organizational operations across an international network
- Technology and data analytics
- Marketing
- Health economics
- Primary research
- Design
- Legal expertise
- Education and learning
- Fundraising
- Communication and knowledge translation

External candidates will be asked to submit a letter outlining their reasons for interest in the position, experience relevant to the position, a CV and a declaration of conflicts of interest.

Eligibility to stand as an external member is defined as individuals who do not currently hold a staff, editorial or leadership position in any Cochrane Group (including positions such as deputy or executive directorships or membership of a Group Executive). They may hold other roles with Cochrane Groups such as author or consumer roles, and may have held Cochrane leadership roles in the past.

Attachment 1: Board Member position description

General description

The Cochrane Board is the Board of Directors and Trustees of The Cochrane Collaboration, a registered charity in the U.K. The Cochrane Board sets policy for Cochrane, and is responsible for setting the charity's strategic direction and ensuring good organisational governance.

Responsibilities

Board members are expected to:

- Exercise their legal duties as the Board of Trustees of the Cochrane Collaboration.
- Act at all times in the best interests of Cochrane as a whole organisation, and in accordance with its vision, mission and values.
- Set organizational strategic direction and policy, and review these on a regular basis to continue to be responsive to the changing environment in which the organization operates.
- Act at all times with integrity and uphold high standards of governance.
- Work constructively as a team while providing creative challenge and independent judgement.
- Delegate to the CEO and the Editor in Chief the authority to determine how best to achieve the strategic objectives and to manage the charity's day-to-day business.
- Monitor the achievement of the strategic objectives and compliance with the policies established.
- Oversee the charity's financial reporting and disclosure.
- Represent Cochrane at meetings with current and potential funders, and other agencies as required.
- Respond to issues raised by members of the organization, outside the remits of the CEO and the Editor in Chief.

Members are expected to attend at least two face-to-face Board meetings each year, and additional meetings by teleconference as set by the Board (approximately every two months). They should also attend the Annual General Meetings (AGMs) of the charity. The AGM is generally held alongside one of the face-to-face meetings of the Board and does not require additional travel. Throughout the year, members should contribute actively to the business of the Board, staying up-to-date with current issues within and affecting the organisation, contributing to such working groups as may be established on particular issues, and responding appropriately to requests for input by email.

It is anticipated that the workload associated with this role is equivalent to approximately 1-2 days per month over the course of each year.

Remuneration

In accordance with charity law, Board members cannot receive payment for fulfilling their role as members of the Board. All reasonable travel and accommodation costs of attending meetings and fulfilling the responsibilities of Board members will be reimbursed.

Accountability

Board members are accountable to the Board, and to the registered Cochrane Groups who are the members of the organisation.

Qualifications

All Board members should bring experience that enables them to fulfil the responsibilities of the Board, and expertise relevant to the operation of an organisation such as Cochrane, operating as a not-for-profit charity in the research and publishing sectors. Members should have experience and expertise in key areas of skills and knowledge, such as:

- Board membership or other leadership of a large not-for-profit organisation
- Financial management and business development in the not-for-profit sector
- Healthcare or other publishing
- Patient/consumer perspective and advocacy
- Evidence-informed health care or policy
- Organizational operations across an international network.

In addition to these areas of expertise, members should be able to work with:

- Sensitivity, openness and awareness of non-verbal communication.
- Display critical thinking, creativity and strategic awareness.
- An ability to identify potential problems and deal with risk.
- Cross-cultural sensitivity and an awareness of issues of equity

Candidates must not have current conflicts of interest with commercial companies with a direct interest in the findings of Cochrane reviews, such as pharmaceutical companies or device manufacturers, including funding, holding paid or honorary positions, or other major conflicts. Candidates are required to step down from those positions before being eligible to take up a Board position.

In addition, members of the Board must make a declaration of all financial and other potential conflicts of interest for the past three years at the time of nomination and annually after their appointment. Declarations of Council members are published on the Cochrane Community website.

Term of office

Board members serve for a period of three years. At the end of three years, they are eligible to stand for re-election for one further term of three years. With the exception of the Co-Chairs, no-one may be a member of the Board for more than two consecutive terms (i.e., six years), but may stand for re-election after a subsequent gap of three years.

Recruitment process

Approximately one third of the positions on the Board fall vacant each year, as terms of office come to an end. Nominations and elections to fill these positions, and any casual vacancies, are held each year, and new members generally take up their positions with effect from the first AGM after their selection.

'External' members of the Board, defined as those who have had no previous staff, editorial or leadership role with Cochrane, are identified through a public call for nominations, and selected by the current Board members. The selections made by the Board must be ratified by the subsequent AGM.

'Internal' members of the Board, defined as anyone with a current active role with a Cochrane Group, are elected from among the membership. Full details of the eligibility and procedures for and election of internal members are outlined in detail in the Cochrane Electoral Procedure.

Attachment 2: Board Co-Chair position description

Date Approved: June 2015

General description

Cochrane's Board has two Co-Chairs, to share workload, utilize complementary skills and experience, and permit continuity through the Co-Chairs stepping down in alternate years.

Anyone who holds or has held a leadership position within Cochrane is eligible to apply for the position of Co-Chair.

An election for Co-Chair is held annually from amongst the members of the organization. Responsibility for selection of the most appropriate person from amongst the nominated candidates rests with the Board.

Responsibilities

Co-Chairs agree upon an appropriate division of responsibilities, which include:

- Chair meetings of the Board.
- Chair Cochrane's Annual General Meeting.
- Ensure and facilitate strategic planning by the Board.
- Advise and guide the CEO, the Editor in Chief and CET staff in working towards delivery of the Cochrane's *Strategy to 2020*.
- Serve as official spokesperson(s) for Cochrane and the Board, with the authority to delegate this responsibility to others.
- Represent Cochrane at meetings with current and potential funders, and other agencies as required.
- Respond to issues raised by members of the organization, outside the remits of the CEO and the Editor in Chief.
- Pursue those initiatives and projects agreed by the Cochrane Board to be the responsibility of the Co-Chairs.
- Conduct performance appraisal for the CEO.

Accountability

The Co-Chairs are accountable to the Board, and to the members of the organization.

Attributes

The Co-Chairs are expected to have leadership skills, to be fully consultative, to have vision, to be adept at dealing with people, to be able to solve problems and resolve conflicts effectively, to communicate well, and to be able to represent Cochrane in a variety of different settings. Experience of membership of the Board is advantageous but not essential.

Recruitment process

Candidates should be nominated by three active members of the organization, including a current member of the Board. Nominations should describe the capacity in which they know the nominee, why they consider the nominee to be an appropriate candidate in the light of this job description, and the extent to which they think the nominee has the necessary attributes. Board members may only nominate one candidate each.

Remuneration

Cochrane's Articles of Association allow the organization to remunerate its Co-Chairs, where necessary, for work conducted on behalf of the organization, up to a maximum of two days per week, pro rata. This cap is set by the organization and reviewed as necessary.

Documentation

In response to the call for nominations, the following documentation is required to be sent to the CEO's Office by the specified deadline, in time for the nominations to be considered by the Board, and for the selected nominee to be ratified at the Annual General Meeting during the Colloquium:

- A written response to a set of prearranged questions with regard to suitability for the position; this should have been shared beforehand with the three nominators.
- Written acceptance of the nomination, and commitment of sufficient time.
- Statements from the three nominators (see previous paragraph).

Time commitment

There is a need for an absolute minimum of eight hours per week for the Co-Chairs combined, but with an expectation that a combined total of up to thirty hours per week might sometimes be needed (not including the full-time requirements at the times of the two face-to-face Board meetings per year).

Term of office

The Co-Chairs hold office for two years. They may continue to hold office for a further two-year term with the majority approval of the Board. However, an invitation for alternate nominees to the Co-Chair position would still be issued and, if other candidates are proposed, an election by the Board would be held.

Information for prospective candidates in the election for the position of Co-Chair of the Cochrane Board

1. Members of the Board constitute the board of trustees and, as such, have legal responsibilities to Cochrane, a registered charity.
2. There is no limit to the number of candidates, who should hold or have held a leadership position within the organization.
3. Co-Chairs are elected for a period of two years. They may stand for election for a second two-year term, but no longer.
4. Board members are eligible for reimbursement of travel and accommodation expenses incurred in attending Board meetings.
5. People considering standing for election are strongly encouraged to find out what is involved, before they stand, from a member(s) of the Board, and also by speaking to the Chief Executive Officer.
6. Members of the Board are expected to attend its meetings and teleconferences, and to participate in the work of its sub/advisory committees as required.
7. Nominations should be e-mailed to the CEO's Office by midnight UK time on [date to be agreed].
8. The Board's recommended choice of Co-Chair will be put to those attending the Annual General Meeting during the annual Colloquium for ratification.

Questions to be completed by candidates for election to position of Co-Chair of the Cochrane Board

Statement from: [Name]

[Date]

1. Please describe how you first became involved in Cochrane and your subsequent contribution to its work.
2. Have you helped to prepare or bring into practice a Cochrane Review? If so, what was your involvement?
3. Please describe leadership roles that you have held within Cochrane and in other relevant contexts, with examples of successful leadership.
4. What experience do you have of committee work, both within Cochrane and nationally and internationally (particularly at the policy-setting level)?
5. What do you think would make you an effective Co-Chair of the Board?
6. Acting as Co-Chair of the Board requires a consultative approach to decision-making. Please illustrate how you would do this.
7. How do you see Cochrane and/or the Board developing or changing in the future (i.e. what is your 'vision'), and why?
8. As Co-Chair, you would be expected to solve problems and resolve conflicts. How would you approach this aspect of the role?
9. In the role of Co-Chair, you would be expected to represent Cochrane in a variety of settings; have you any experience of this or similar representation? In this context, please illustrate your ability to communicate successfully with a range of audiences.
10. For individuals seeking re-election as Co-Chair: What do you think you have contributed to the work of the Board during your previous two-year term of office?

I confirm that I wish to stand for election to the position of Co-Chair of the Cochrane Board and that, if elected, I would be able and willing to commit the necessary time and attention to the role.

Signed:

Attachment 3: Electoral procedure

Background

The Cochrane Board comprises 13 representatives, including two Co-Chairs, six 'internal' members, and up to five 'external' members.

Timetable

The timetable for the electoral process is set by Cochrane's Central Executive Team (CET), and should be conducted once each year.

Steps to be factored into the timetable include:

- Call for nominations.
- Deadline for nominations.
- Announcement of names of candidates.
- Distribution of a URL for the web page where voting takes place (or preparation for a meeting of the Board to consider external candidates).
- Deadline for receipt of votes.
- Count of the votes, and independent double-check.
- Announcement of election results.

External Board members

Eligibility to stand as an external member will be defined as individuals who do not currently hold a staff, editorial or leadership position in any Cochrane Group (including positions of deputy or executive directorship or membership of a Group Executive). They may hold other roles with Cochrane Groups such as author or consumer roles.

Members of the Board may stand for a maximum of two consecutive three-year terms as internal or external members. Once they have completed two terms, following a gap of at least three years, they become eligible to stand again.

A call for nominations will be published through appropriate public channels with at least three weeks' notice before the deadline for nominations. External members may nominate themselves by submitting a completed nomination document, addressing the published criteria, by the published deadline. They must also provide a declaration of conflicts of interest (including direct and indirect conflicts, professional relationships to other members of the Board, other Boards they may sit on, and any employment or other financial relationships with pharmaceutical, device, tobacco or other for-profit companies in the past 10 years).

Nominations will be distributed by the Electoral Officer to the members of the Board, who will select the successful candidate(s) giving consideration to their skills and experience, and the current skills and experience profile of the Board. External members may be specifically chosen to address a prioritised areas of expertise identified by the Board. Where an external member of the Board is standing for re-election, they will not participate in the selection decision-making process.

The decision of the Board in selecting candidate(s) must be ratified by the first Annual General Meeting of Cochrane's members following the selection process, under Articles 44 and 45 of the Articles of Association (September 2013).

Where no nominations are received, or the Board determines that the nominated candidates are not appropriate for selection, the position(s) will be re-advertised within one month of the deadline for nominations or the Board's decision, whichever is later.

Internal Board members

Individuals eligible to stand, nominate or vote for the position of an internal member of the Board must be active members of the organisation.

From 2016, eligible members of Cochrane are defined by inclusion with any Active role with a registered Cochrane Group in Cochrane's Archie database, excluding those whose only roles are Other, Mailing list, Possible contributor, Super User, Web contributor, or Web publisher. It is up to each Group to decide to keep its records up to date. A person must have held this role for at least 60 days prior to the closing date for voting in order to be eligible.

In 2017, a revised definition of membership will be introduced as part of Cochrane's membership scheme.

Members of staff of the Central Executive Team (CET) are eligible to vote in Board elections, but are ineligible to stand for election. A detailed discussion of eligibility is provided in the section below on the eligibility of staff.

Internal members of the Board may stand for a maximum of two consecutive three-year terms. Members of the Board may stand for a maximum of two consecutive three-year terms. Once they have completed two terms, following a gap of at least three years, they become eligible to stand again.

Nominated candidates can vote for themselves.

Elections

A member of the CET will be nominated as the Electoral Officer, and will be responsible for all required business dealing with nominations, elections and advice to candidates.

The call for nominations will be published by the Electoral Officer within internal Cochrane news channels, and all member Groups notified, with at least three weeks' notice before the deadline for nominations.

Candidates for internal election must submit a completed nomination document, addressing the published criteria, by the published deadline. This nomination document must specify the candidate's expertise against the published list of core areas of expertise identified by the Board as critical for its operation. This list may be amended from time to time by the Board, but not during the course of an election. Each candidate must further provide letters of support from two eligible voters nominating them for the position, and a declaration of conflicts of interest (including direct and indirect conflicts, professional relationships to other members of the Board, and other Boards they may sit on).

Nominated candidates' names will be announced on the Cochrane website immediately following the nomination deadline, in alphabetical order (by family name), with the nominators' and seconders' names. There will be a period of one week between the nomination deadline and the opening of voting to allow any disputes about eligibility to be resolved.

The Electoral Officer will disseminate the URL of the online voting system where votes may be cast by e-mail to eligible voters using data generated from the Archie database (or successor membership databases).

Voting will be conducted via a password-protected online system. Each eligible voter must log in using their Archie Cochrane password, identify their primary Group affiliation, and register a vote for one or more of the candidates in preferential order. Login details are used to identify unique voters and prevent the casting of multiple votes, but information on the vote of any individual

voter will be kept confidential by the electoral officer and any IT staff supporting the election process.

As more than one position is likely to be filled at each election, a system of proportional representation will be used. Under this system, the number of first preference votes is first counted. The candidate with the lowest number of first preference votes is eliminated, and the votes distributed at simple full value to the second preference candidates, and so on. A quota for election is calculated based on the number of votes cast divided by the number of positions available. Once a candidate reaches the required quota of votes, they are declared elected, and as counting proceeds, any further votes for them are redistributed to the next candidate in preference order.

Vote counts are double-checked by two members of the CET.

In the event of a tie, the Board as a whole has the deciding vote.

The number of votes that each candidate has received in the election is publicised, together with the announcement of the results.

Co-Chairs

Eligibility for the position of Co-Chair includes anyone who holds or has held a leadership position within Cochrane.

The Board chooses Co-Chairs by a formal process of nominating and seconding. Candidates should be nominated by three active members of Cochrane, including a current member of the Board. Nominators should describe the capacity in which they know the nominee, why they consider the nominee to be an appropriate candidate in the light of this job description, and the extent to which they think the nominee has the necessary attributes. Board members may only nominate one candidate each. All nominated candidates should provide letters of support with their statement from the three people who nominated them, and a declaration of conflicts of interest (including direct and indirect conflicts, and professional relationships to other members of the Board, and other Boards they may sit on).

The Co-Chairs hold office for a maximum of two terms of two years (whereas other Board members hold office for terms of three years). After completing two terms, the individual may not stand again until after a break of three years, after which they are eligible to stand as a member of the Board, but not to stand again as a Co-Chair.

From 2018, external members of the Board may stand for the position of Co-Chair after completing one term of office on the Board. Only one of the two Co-Chair positions may be held at any time by an external Board member.

Where a Board member is selected as Co-Chair, their position on the Board falls vacant and will be filled either by adding a vacancy to any concurrently held election and electing an additional candidate, or if no concurrent election is being held, at the next election.

Where an individual is selected as Co-Chair during the same electoral process in which they are standing as an internal Board member, the candidate will not be elected as a Board member and the next highest ranked candidate will be elected.

Where an individual is selected as Co-Chair but is not a member of the Board, they are considered a co-opted member of the Board under Article 15.2 of the Articles of Association. This appointment must be approved at the next Annual General Meeting.

Non-elected members

Additional members may be co-opted to the Board from time to time under Article 15.2 of the Articles of Association. These additional appointments must be ratified at an Annual General Meeting of the Groups.

Special considerations for staff

Legal context

Cochrane is a charity and jointly-registered Limited Company under UK law (registration number 1045921).

The UK Charity Commission, in its publication, *The Essential Trustee – What you need to know*, states that:

“Generally, a trustee cannot become an employee of their charity nor can an employee become a trustee. The exceptions are where the governing document of the charity explicitly authorises it, or if permission has been given by us or a court of law.”

In noting that there may be exceptions, the Charity Commission makes it very clear that these are unusual. Examples where it might be appropriate include short-term and specific tasks where it may be simpler and cheaper for a trustee to perform the work, rather than engage a third party, for instance, where a Board of Trustees has a solicitor on the Board, and some legal work needs doing, or where some decorating needs doing and a trustee is a decorator. But these are still exceptional circumstances, not usual, and would not include the position where an individual works for the charity on an ongoing basis, for instance, providing ongoing legal services rather than a one-off situation. The primary concern for the Charity Commission is that salaried employees would have clear conflicts of interest should they be on the Board of their employer.

The Charity Commission has approved a specific exemption for Cochrane’s Co-Chairs, who may apply for a specific level of reimbursement for their organisation to compensate for the substantive hours required for their work on the Board (up to two days per week).

Why is Cochrane different?

Many people who provide Cochrane’s core services, whose salaries are paid for fully or in part by the Cochrane, are in fact employed by other organisations. This places them in a difficult position in relation to their directly-employed colleagues, and leaves them open to accusations of conflict of interest should they stand for office. Cochrane also places high regard on transparency, explicitness and avoidance of bias. Cochrane established a policy to clarify this situation.

The following groups are not eligible to stand for election to the Board:

- Directly employed Cochrane staff, such as the CET.
- Core infrastructure teams employed by third party organisations but whose salaries are paid indirectly, in whole or in part (at least 0.2 FTE), by the CET.
- Employees of contracted partners and service providers. These would include, for example, the staff of our publishing partner, John Wiley & Sons Limited, and the employees of our bookkeepers.
- In general, seconded staff employed by third party organisations providing services on behalf of Cochrane, where the CET pays all or some of the salary costs for the secondment (at least 0.2 FTE), and whose secondment will last for a period of more than six months

from the date that they are elected to the Board. At the discretion of the Co-Chairs this category may be over-ridden where the circumstances warrant an exemption.

The following are eligible to stand for election:

- Anyone not listed in the above categories and who is not ineligible for other, non-employment related reasons.
- People undertaking project work as a result of a grant or other similar funding process, such as the Methods Innovation Fund.
- People employed by a Cochrane Group, as distinct from Cochrane's CET.
- People working with, supervising, or being supervised by a person ineligible to stand for election under the list above. (Normal rules for declarations of interest would apply.)

Appendix 2: Cochrane Council Terms of Reference

Status

The Council is an advisory group to the Cochrane Board.

Purpose

The purpose of the Council is to provide:

- a forum for Cochrane Groups to consider high-level matters affecting Cochrane as a whole;
- a mechanism to raise matters and provide input to the Board on behalf of Cochrane Groups; and
- a forum to consider matters at the request of the Board and inform Board deliberations.

Establishment

The Council will be established by Cochrane Groups in November 2016 at the recommendation of the Board, following a review in which directly elected group representatives on the Board were replaced with representatives elected by the full Cochrane membership. The intention of establishing the Council is to ensure that Cochrane Groups retain an effective voice in Cochrane's leadership and strategic decision-making.

Scope/Responsibilities

The Council may consider any matter its members consider to be of importance. Issues may also be referred to the Council for consideration or to request input by:

- the Board;
- Cochrane Groups or Executives;
- the Central Executive Team (CET); or
- individual members of Cochrane.

In order to consider an issue, the Council may consult with its constituent Groups through their Executives or equivalent forums, or form working groups to conduct further development or investigation of an issue. Following consideration of an issue, the Council may:

- provide an opinion or position;
- provide a collated summary of the findings of a consultation; or
- refer an issue to the Board for consideration.

The Council is not a decision-making or policy-setting body, nor is it an operational body. Its role is to complement Cochrane's existing governance and operational structures by ensuring that the perspectives of its members are represented and shared.

Accountability

The Council is accountable to the Board to provide considered and timely viewpoints, and to abide by decisions of the Board.

The Council is accountable to its constituent Groups and their Executives to provide an open forum for the consideration of issues; to provide a fair reflection of the input of members when

providing input to the Board or other stakeholders; and to communicate back to constituents following Council meetings.

Relationship to the Cochrane Board

The Council will act as a valued source of perspectives and input for the Board with specific responsibility for representing the voice of Cochrane's Groups, and the Board will give due consideration to all inputs presented from the Council.

The Council will normally raise issues or provide input to the Board in the form of a paper, submitted in accordance with normal arrangements for submitting papers to the Board. This will allow all members of the Council to have input into papers, and ensure that members of the Board have sufficient time to consider any proposals or perspectives. A standing item in all meetings of the Board will be to consider any papers from the Council. The Council will then receive formal notification of the outcomes of that discussion.

The Board and the Council will hold occasional joint, face-to-face meetings (for example, joint meetings of approximately 90 minutes alongside their individual face-to-face meetings at the annual Mid-Year Meetings) to review developments and allow two-way dialogue between the two groups.

The Board may to invite members of the Council to attend Board meetings for specific items if their expertise would be of assistance.

Disagreements

Should the Council disagree with a decision of the Board, the Council may make a submission in writing to the Board. The Co-Chairs of the Board will determine the appropriate next steps, and will provide a written response to the Council to advise them accordingly.

Any Cochrane member, including members of the Council, may follow Cochrane's procedures for raising any issue, including a decision of the Board, at a General Meeting of the Members, as outlined in Cochrane's Articles of Association.

Membership

The initial Council will include representatives drawn from the Group Executives (note that the Council will not replace the role of the individual Executives). The Council will review and modify its membership over time, adjusting the balance of members, reflecting changes following the Structure and Function review, and bringing in additional members from other sectors of Cochrane's community such as translators, knowledge translation hubs, etc.

- Centre and Branch Directors' Executive (2 members)
- Cochrane Consumer Network Executive (2 members)
- Review Groups:
 - Co-ordinating Editors' Executive (2 members)
 - Managing Editors' Executive (2 members)
 - Author's Forum (2 members)
- Information Specialists Executive (2 members)
- Fields' Executive (2 members)
- Methods Board Executive (2 members)

For the first year of operation, the Council will also include elected members of the Steering Group stepping down from their positions in October 2016, if they are willing to serve in this capacity.

Members of the Board and CET are not eligible to sit as members of the Council.

Executives and other represented Groups are free to determine their representatives however it best suits their constituents, including eligibility (for example, the Co-Eds Exec may also wish to allow other Editors to represent this group). The process for selection should be transparent and publicly available as an Appendix to this document. For example, they may choose to hold an open election from the full constituency, restrict the candidates to those who serve on the Executive, or require the Chair(s) of the Executive to represent them on the Council.

The term of membership will be two years. Members may be re-appointed through the normal process established by their constituency, but may not serve longer than six years in total.

A Chair will be elected by and from among the Council's members. The term of the Chair is one year. The Chair will be responsible for chairing meetings, managing the business of the Council, and assisting in the resolution of any disagreements arising in relation to membership of the Council.

Members of Council must not have any current direct conflict of interest with a pharmaceutical company or other commercial organisation with a financial interest in the findings of Cochrane systematic reviews, including funding, holding paid or honorary positions, or other major conflicts.

In addition, members of Council must make a declaration of all financial and other potential conflicts of interest for the past three years at the time of nomination and annually after their appointment. Declarations of Council members will be published on the Cochrane Community website.

Diversity in leadership groups is strongly valued by Cochrane, and our commitment to diversity in representation will be clearly stated at all stages of recruitment of members of the Council. The Executive Groups from whom members are drawn will also actively seek diversity in membership. Key factors for which diversity will be sought will include, but not be limited to; age, gender, geographical location, languages spoken, areas of expertise and length of experience with Cochrane.

Members of the Council must have sufficient English language skills to participate fully in the business of the Council. Other support will be put in place to encourage participation by a diverse range of candidates, including efforts to ensure clarity and accessibility of meetings conducted in English, mentorship and leadership development training for new members, and other options.

Members and Chairs of the Council will not be paid. The time commitment required for members of the Council is expected to be between 5-10 days per year.

Meetings

Meetings of the Council will be held at least twice each year and may be more frequent if required. This will include one face-to-face meeting to be held in conjunction with the Cochrane Mid-Year Meeting of the Board. The first face-to-face meeting should be held at the Mid-Year Meetings in Geneva in 2017.

Additional meetings will be held by teleconference or videoconference. The Council may find it helpful to meet well in advance of Board meetings to enable the submission of papers to the Board. Discussions may also be conducted by email.

Meetings of the Council will normally be scheduled to allow the largest number of participants to attend, but may be rotated to allow regular participation by members in all time zones. Minutes

of Council meetings and reports of discussions held by email should note the members present or participating.

The Council will aim to reach consensus in its discussions. Where this is not possible, dissenting views should form part of the viewpoints presented to the Board or the Cochrane community.

Minutes and papers considered by the Council meetings will normally be open access and available on the Cochrane Community website, with the exception of confidential papers that may be referred for consideration by the Board.

Support

The activities of the Council will be supported by the CET. The CET will be responsible for administrative arrangements such as organising meetings, circulating papers and managing expenses. The designated CET officer responsible for this work will be in regular communication with the Chair.

Funds will be made approved by the Board to support travel, accommodation and other reasonable expenses to attend face-to-face meetings of the Council. This funding is in addition to any funding provided directly to support Cochrane Executives.

A member of the CET will be available to take minutes and provide other secretariat support for the Council. This additional workload will be accommodated within the existing CET staff. Teleconference or videoconference facilities will be shared with the Council for meetings.

Review

The work of the Council will be reviewed by the Council and the Board 18 months after formation, to assess its performance and the effectiveness of its structures and relationship with the Board in the context of its stated aims. This review will be discussed at the Mid-Year Meetings in Lisbon in 2018. Thereafter, the remit and function of Council should be reviewed at least every five years.

Regular, informal review can be facilitated by direct discussions between the Chair of the Council and the Co-Chairs of the Board.

Open Research Data

Overview of open research data landscape and proposed open data policy by Cochrane.

[OPEN ACCESS]

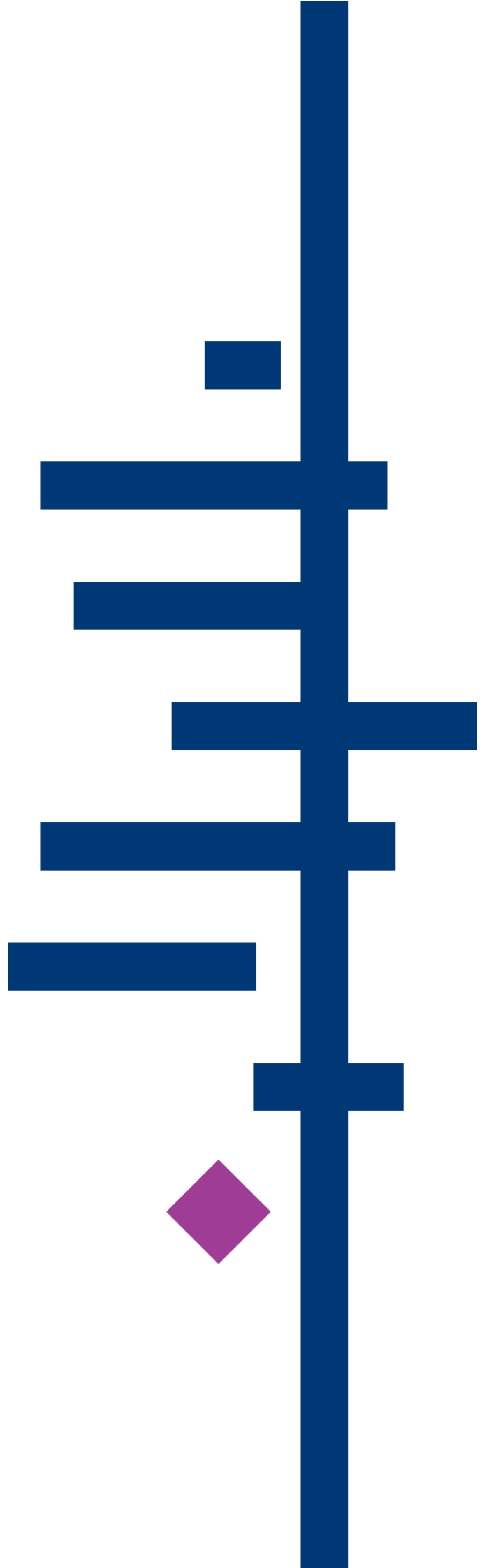
Document prepared by:
Charlotte Pestridge and Julie Wood

Submitted to Steering Group: October 2016, Seoul

Purpose of paper: To provide an overview on the data policy landscape. No decisions are needed at this time.

Access: OPEN

Resource implications:
None.



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1 Background and objectives.

1.1 Background and scope

The report focusses on the issues, concerns and debate happening among stakeholders as the research community tries to move to a sustainable open research data model. Given Cochrane's many discussions on [open access](#), especially in light of potential commercialisation of some of our data, the next frontier is how open we make our underlying data and how we can do that in a way that is sustainable and legal (as we do not own some of the data that we are asked to provide). In the past year, we have faced criticism as to how open we make our data. We have tried hard to listen to those concerns and [respond](#) but as this terrain is ever shifting, we will have to remain nimble and respond to the challenges and opportunities that open data represents.

A good overview of current European open research data mandates and definitions is available at <http://www.dcc.ac.uk/resources/policy-and-legal/overview-funders-data-policies>, and US mandates at <http://datasharing.sparcopen.org/>.

1.2 Objectives

The main objectives of this report are to provide market intelligence to Cochrane and to support the development of Cochrane's future Open Research Data strategy and policy.

Even though the debate on open research healthcare data is mainly focused on primary research we need to position Cochrane strategies and policies within this policy context and debate.

2 Open Research Data landscape.

2.1 Drivers for change

The main driver for change is from current national government economic growth strategies which are based on the understanding that knowledge and innovation will drive economic growth.

In the context of research, fuller and wider access to scientific publications and data helps to:

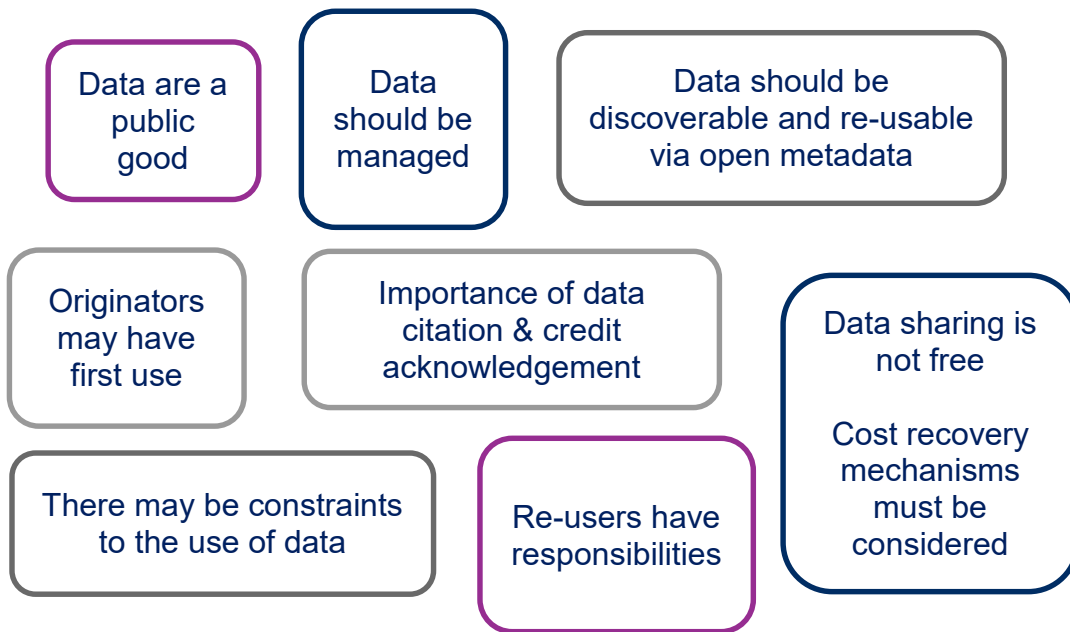
- build on previous research results (improved quality of results)
- encourage collaboration & avoid duplication of effort (greater efficiency)
- speed up innovation (faster progress to market means faster growth)
- involve citizens and society (improved transparency of the scientific process).¹

There is a general call for all publicly funded research to be open access.

2.2 Key principles

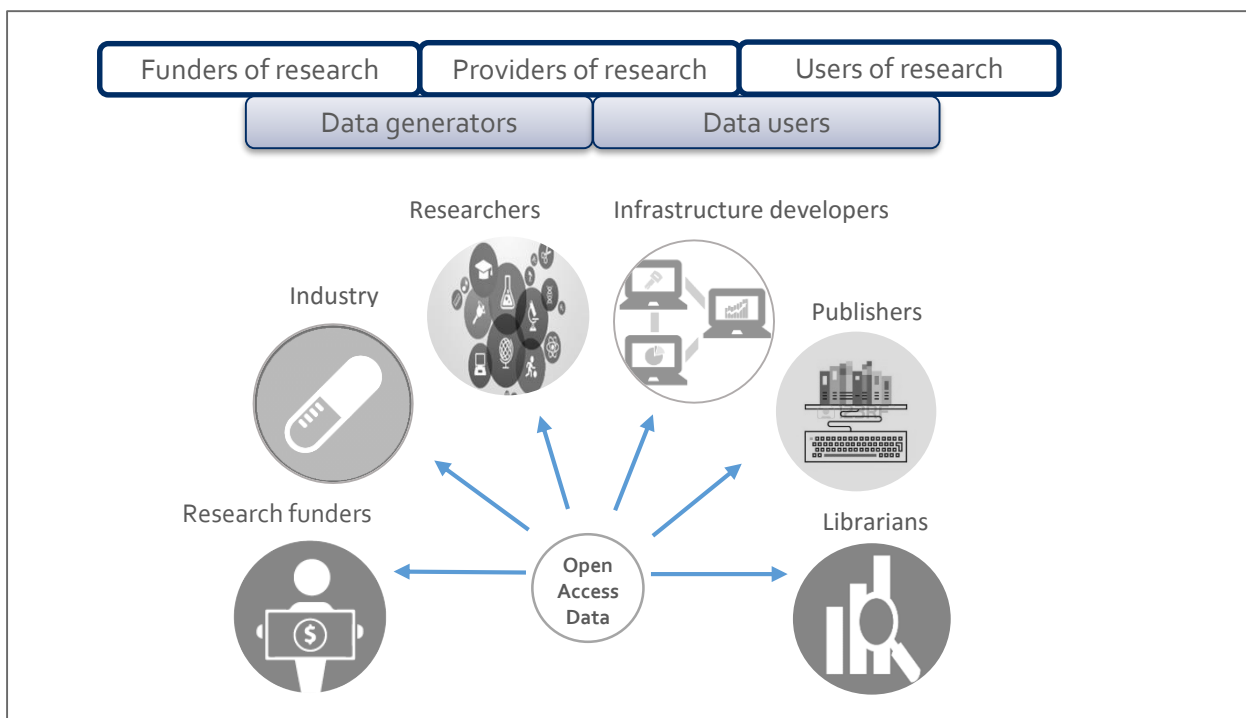
The Research Council UK (RCUK) common principles on data policy from 2013 and 2015 provide a good overview of the current themes and position of open access research data discussions:

¹ [Funding research data management and related infrastructure, Knowledge Exchange and Science Europe briefing paper, May 2016](#)



2.3 Stakeholders

Stakeholders fall into three broad categories – funders of research, providers of research and users of research.



Researchers – want to share, get credit and re-use each other’s data.

Professional data publishers – offering a range of publishing services.

Software and tool-builders - providing data analysis and processing services.

Funding agencies – increasingly concerned with long-term data stewardship.

Data science community – mining, integrating and analysing new and existing data to advance discovery.

2.4 Government and funder mandates

There is an increasing number of government and agency funder mandates related to open research data, and general agreement that publicly funded research data is a public good and should be shared effectively.

In the US they have taken the open research data mandates a step further, confirming that research data infrastructure should be based on open source software and interoperable based on open standards, with data and metadata deposited in machine-readable and open formats (Executive Order May 2013, Making Open and Machine Readable the New Default for Government Information). All US agencies, including AHRQ and NIH must manage information as an asset throughout its lifecycle to promote openness and interoperability in support of these federal mandates.

Specifically, this Memorandum requires agencies to collect or create information in a way that supports downstream information processing and dissemination activities. This includes using machine readable and open formats, data standards, and common core and extensible metadata for all new information creation and collection efforts

EU Commission have an Open Science agenda and are running an open research data pilot within the Horizon 2020 research grant scheme. The Amsterdam conference on 'Open Science – From Vision to Action' hosted by the Netherlands' EU presidency in April 2016, called for the introduction of FAIR data, and data management requirements. Research outputs should be **F**indable, **A**ccessible, **I**nteroperable and **R**eusable.

Research Council UK (RCUK) has an [open data policy](#), and the Royal Society published a report in June 2012 on [Science as an Open Enterprise](#).

NIHR do not have a separate policy on open research data, with data mentioned within their open access publishing policy.

July 2016 publication, [A Concordat on Open Research Data](#), developed by a UK multi-stakeholder group which includes RCUK, Wellcome, Universities UK, and Higher Education Funding Council.

2.5 How are research funders supporting data mandates?

To support the open research data mandates, data archiving and data enrichment activities are now being provided for within research grant funding applications. Data management plans (DMPs) are now submitted for most research projects and grant applications. Where a research funder does not have a mandated data repository, researchers can include the cost of data management, and data ingestion in the research grant proposal.

2.6 Emerging incentives for researchers to share data

Growing calls for universities and research institutions to recognise data communication by their researchers as an important criterion for career progression and reward, rewarding the development of open data on the same scale as journal articles and other publications.

New models are emerging to support the citation and publication of research data to ensure data is identifiable and can be cited. Emerging standards include the integration of [DataCite](#) for data (assigning permanent digital data identifiers to datasets), with CrossRef for articles, and researcher identifiers through ORCID. Publishers are also using FigShare and Dryad for journal data sets, and

Nature Publishing have an open access, peer reviewed data journal [ScientificData](#). The creation of data citation solutions ensures that researchers receive credit for use of their data and that the origin of data remains traceable.

Funders are also supporting the data needs of their researchers, making it easier for researchers to share data by providing access to infrastructure and data standards.

2.7 ScientificData journal

ScientificData is a Nature Publishing open-access journal for descriptions of scientific datasets. The articles, known as Data Descriptors, combine traditional narrative content with curated, structured descriptions (metadata) of the published data to provide a new framework for data-sharing and data-reuse.

- Provides citable, peer reviewed credit for dataset creation.
- Allows publication of datasets that may not be well suited for traditional research journal.
- Provides focused peer review evaluation of the technical quality and completeness of each Data Descriptor and associated data set.
- Fulfils significant part of funders data management requirements, by demonstrating and promoting the re-use potential of research data.
- Machine readable metadata provided with all Data Descriptors.
- Researchers pay APCs which include the cost of developing and managing the metadata.
- Open access publication based on CC BY license, with CC BY NC available on request.
- Metadata files included with each Data Descriptor are made available under the CCO Waiver to promote maximum re-use.
- The article processing charge includes 5GB of storage at figshare and 20GB of data storage at Dryad. Dryad and figshare then charge for additional storage.

2.8 Distinction between accessible and discoverable data, and open data

All stakeholders agree that we need standards, infrastructure and systems in place that enable all research data to be findable, accessible, interoperable and re-usable. The key debate centres on three areas:

- The terms under which data is re-usable,
- How open should open data be, and
- What happens if open data cannot mean free data, because the cost to achieve FAIR data standards are not fully covered by open data funding models.

Stakeholder views from industry, publishers and research funders captured during the 2013 EU Consultation on Open Research Data are summarised below.²

Industry view is that research data should be open on a case-by-case basis, with access controlled by independent review panels. The pharmaceutical industry Clinical Trials Data Repository www.clinicalstudydatarequest.com (CSR) is managed on this basis, and this is the model being proposed by Multi-Regional Clinical Trials (MRCT) for the future of clinical trials data sharing project, Vivli. Researchers submit research proposals and request clinical trial data from

² [Report of the European Commission Public Consultation on Open Research Data](#).

the repository. These proposals are reviewed by an independent review panel. Upon approval, the researcher has to sign a *Data Sharing Agreement*.

Publishers have fully endorsed the accessibility and discoverability of data through the development of journal article datasets and use of author features such as Figshare and Dryad. This is so that they can manage business risk by integrating the dataset publication with the traditional journal publication model, and building a journal data repository through direct linking of the research article with the data repository. In this model they argue that the data set underlies the publication, so some data is part of the publication IP.

In 2013 Elsevier were looking at a catalogue model, promoting open meta-data so that users can find and search data across a data catalogue, but cannot use or access the data without permission.

The large open access publishers such as eLife, PeerJ and Plos have argued that data should not just be stored as supplementary data to a research paper, that is published on a publisher's website – but move towards the housing of data in dedicated repositories – which should be 'ideally specialised for specific data types and domains'.

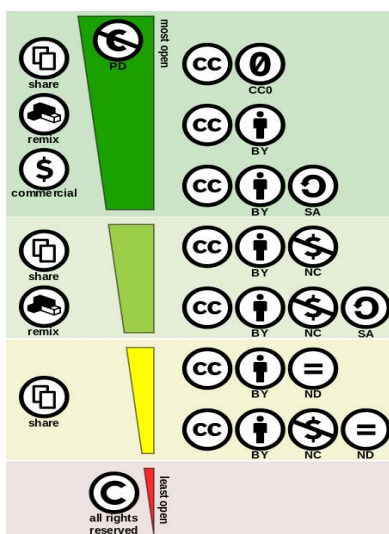
STM publishers are endorsing and promoting the need for actionable data – for understandability of data and for data re-use, it is of great value to present the data in an actionable way – for example via data viewers and analytical tools, and software applications that enable the readers of the publications to investigate the data deeper from their own perspective. Integrate actionable data and new tools into new publications.

Research funders: want to set the default for data sharing to open access, but allow a choice of access regimes: from open and free downloads to application and registration-based access. Restrictions on openness may be needed in relation to commercial interest, personal information, legal (privacy) frameworks, safety and national security.

2.9 Data licensing

Recognition among stakeholders that a simple licensing model is needed and open data is already subject to the same licenses as OA publishing, using the Creative Commons license for use model.

CC0 waiver and CC-BY licenses being seen as the most appropriate licenses for openness.



3 FAIR data management principles.

3.1 Background

The Open Science movement is calling for FAIR data and data management requirements – open data must be Findable, Accessible, Interoperable and Reusable³.

The principles describe the characteristics that contemporary data resources, tools, vocabularies and infrastructures should exhibit to assist discovery and re-use by 3rd parties.

The principles also act as a guide to data publishers to assist them in evaluating whether their implementation choices are rendering their digital research artefacts as findable, accessible, interoperable and re-usable.

The FAIR Guiding Principles

<p>To be Findable</p> <p>F1. (meta)data are assigned a globally unique and persistent identifier</p> <p>F2. data are described with rich metadata (defined by R1 below)</p> <p>F3. (meta)data clearly and explicitly include the identifier of the data it describes</p> <p>F4. (meta)data are registered or indexed in a searchable resource</p>
<p>To be Accessible</p> <p>A1. (meta)data are retrievable by their identifier using a standardized communications protocol</p> <p>A1.1 the protocol is open, free, and universally implementable</p> <p>A1.2 the protocol allows for an authentication and authorization procedure, where necessary</p> <p>A2. metadata are accessible, even when the data are no longer available</p>
<p>To be Interoperable:</p> <p>I1. (meta)data use a formal, accessible, shared, and broadly applicable language for knowledge representation.</p> <p>I2. (meta)data use vocabularies that follow FAIR principles</p> <p>I3. (meta)data include qualified references to other (meta)data</p>
<p>To be Reusable:</p> <p>R1. meta(data) are richly described with a plurality of accurate and relevant attributes</p> <p>R1.1. (meta)data are released with a clear and accessible data usage license</p> <p>R1.2. (meta)data are associated with detailed provenance</p> <p>R1.3. (meta)data meet domain-relevant community standards</p>

(meta)data = metadata and data

Source: Table re-produced from Wilkinson,M.D et al. The FAIR Guiding Principles for scientific data management and stewardship. SciData 3:160018, 2016.

³ [Wilkinson,M.D et al. The FAIR Guiding Principles for scientific data management and stewardship. SciData 3:160018, 2016.](#)

4 Data Repositories

4.1 What is the problem facing data repositories?

National and international funders are increasingly likely to mandate open data and data management policies that call for the long-term storage and accessibility of data. Basic funding of data repositories by research funders is not seen as a long-term solution and may not keep pace with increasing costs; and structural funders are wary of underwriting an ongoing and growing commitment from a central budget.

In view of this stakeholders are starting to explore alternative cost recovery options and diversification of revenue streams.

4.2 Why are data repositories worried about funding?

Data repositories are worried that existing sources of income will not keep pace with growing costs that are emerging due to increase in volumes, deposits and demand for data, the pressure to provide new services, and the need for research and development activities to keep pace with technology and stakeholder expectations.

Repositories need money for feature development and functionality, to investigate feasible business models, introduce better services for dynamic data, improve accessibility to larger data sets, and guarantee data quality and curation.

4.3 What are the current and emerging funding models?

There are 6 broad funding models for data repositories, with structural funding, institutional hosting support and research & development grants being the 3 main existing models. The main emerging model is data deposit fees, and repositories are also starting to experiment with 2 emerging models related to data access fees and added value services. This is part of a revenue diversification strategy to support emerging FAIR data management requirements and minimise risk of reduced funding from current sources.

Table 2: Data repository funding models

Funding model	Description	Use
Structural funding	<ul style="list-style-type: none"> Considered the most appropriate & sustainable Contracts running on 3 to 5 year cycles But leaves little room for innovation or R&D. 	Dominant model
Institutional hosting support	<ul style="list-style-type: none"> Research data management services seen as essential component of the modern research environment which institutions are responsible for making available for their researchers. 	Dominant model
Research & development grants	<ul style="list-style-type: none"> Time limited funding from established research funders. Essential for the repository to progress, to develop its business processes and to enhance its services. 	Ad hoc
Data deposit fees	<ul style="list-style-type: none"> Tends to be required if structural funding or institutional hosting support not available. Research or funding institution pays or author supported via research grant application. Linked 	Emerging

	<p>to data management plans (DMPs) now compulsory for most research grants.</p> <ul style="list-style-type: none"> • Applications can include cost of preparing data for deposit, and cost of ingestion by repository. • This is then driving the ‘pay once store for ever’ price model as easier to support via grant application, as all costs have to be incurred during the research grant period. • Pricing models based on administration costs for ingestion, and data size – cost per Giga Byte for storage. 	
Data access fees	<ul style="list-style-type: none"> • Limited to enhanced data with added value features, not raw data. • Conflicts with the open access principle, so cannot charge for data that is funded by structural funding, without adding considerable value. 	Experimentation phase – lots of talk but limited actual examples.
Value added services	<ul style="list-style-type: none"> • Value added services – enhanced data, visualisation, analysis or interpretive services, access to tools, customised report generation – built on top of data held in the archive – high R&D cost. • Branded repository services for other institutions. • Enhance offer beyond the core data service. • Income diversification requires investment to implement. • Data curation & repository services for research institutions, private sector and NGOs. 	Experimentation – lots of talk but limited actual examples.

5 Next steps

Even though most of the open data policy discussion is related to primary research and trial data, the call for publicly funded research to be open access including open data means that Cochrane needs to have a clear policy on open data. This needs to be in line with our existing open access policy and our commitment to AllTrials as a founding member. This is vital in light of providing a sustainable, open access strategy as well as to deliver our linked data plans.

We also need a clear understanding of how each option is effected by any future mandate or stakeholder pressure for Cochrane Open Research Data.

We would propose that we take the next year to consult with the Cochrane community and other key stakeholders to draft a policy that would then be reviewed annually in line with our open access plans.

APPENDIX: (existing Cochrane Policy)

Cochrane supports prospective registration of clinical trials

The Cochrane Collaboration is committed to providing the most reliable evidence of the [effectiveness](#) of health care through systematic reviews of randomised controlled trials (RCTs), and recognises the importance of prospectively registering trials to ensure that the evidence assessed is complete and unbiased.

The Cochrane Collaboration recommends that:

- all RCTs trials are registered at their inception (at the time of ethical approval and/or funding approval);
- registered information should be potentially accessible to all interested parties;
- registration should be with a register that complies with an appropriate minimum standard of practice;
- prospective registration of trials should be part of ethical guidelines for clinical trials;
- government agencies should ensure that adequate mechanisms and infrastructure are provided so that all RCTs can be registered prospectively;
- government agencies should explore legislative and other strategies to mandate prospective registration as a condition of, for example, funding, ethics or regulatory approval.

In addition, The Cochrane Collaboration supports:

- the principle of a global trials register;
- a unique international numbering system such as the ISRCTN (International Standard Randomised Controlled Trial Number) currently available through the organization Current Controlled Trials (www.controlled-trials.com);
- activities that facilitate the widespread adoption of this unique numbering system:
- If a fee is charged to obtain this unique number, and this fee is a significant barrier to obtaining a number, The Cochrane Collaboration encourages endeavours that would result in a reduction or removal of this fee;
- the comprehensiveness of the global trials register through the incorporation of the [Cochrane Central Register of Controlled Trials](#) (CENTRAL).

The Cochrane Collaboration recognises that the registration of trials at their inception will accomplish the following:

- Help identify health care strategies that require research, and set priorities for research in the light of concurrent studies in progress.
- Avoid unintentional duplication of clinical trials or allow replication of trials when appropriate.
- Foster collaboration between investigators considering similar trials.
- Assist recruitment to trials in progress.
- Allow patients and patient support groups to be kept informed.
- Ensure that all trial results do eventually become publicly available (through publication) and are subsequently used in systematic reviews of the evidence.
- Ensure that more ethical and worthwhile trials are undertaken by better defining the unanswered questions (through systematic reviews of completed trials) and through knowledge of similar trials in progress.

Many clinical trials, especially those with negative or inconclusive results, may fail to be published in medical journals. This risks the unethical use of healthcare resources and participants in trials. To prevent this, ethics committees should promote prospective registration of clinical trials and thus ensure that trial results can subsequently become publicly available.

<http://community-archive.cochrane.org/organisational-policy-manual/appendix-3-cochrane-collaboration-supports-prospective-registration-cli>

Cochrane Knowledge Translation (KT) Strategy

Update for the Cochrane Steering Group, October 2016.

Document prepared by:	Chris Champion, Rachel Churchill, Sally Green and Denise Thomson.
Submitted to Steering Group:	October 2016, Seoul Colloquium meeting.
Purpose of paper:	To provide the CSG with an update on the Knowledge Translation Strategy development and facilitate a discussion around Cochrane's plans for knowledge translation at the CSG meeting.
Access:	Open
Summary of Recommendations:	This is a progress update and discussion paper, therefore, there is no recommendation for the CSG.
Resource implications:	This is a progress update and discussion paper, therefore, there are no resource implications presented in this paper.
Contact person for any queries:	Chris Champion, cchampion@cochrane.org

1 Why Knowledge Translation is important to Cochrane

Cochrane's vision is a **world of improved health where decisions about health and health care are informed by high-quality, relevant and up-to-date synthesized research evidence.**

Our mission is to promote evidence-informed health decision-making by producing high-quality, relevant, accessible systematic reviews and other synthesized research evidence.

Effective Knowledge Translation enables accessibility, understanding and use of evidence, and hence is an essential pathway to meeting our Vision. Cochrane's Knowledge Translation (KT) Strategy aims to enable our mission and vision by ensuring that Cochrane review findings are shared, understood and used to support health and healthcare decisions.

2 The objectives of the KT strategy

The KT Strategy plans to elaborate on the *Strategy to 2020* commitments to Making our Evidence Accessible (Goal 2) and Advocating for Evidence (Goal 3). It will provide a strategy and operational plan describing how Cochrane Groups, and the organisation as a whole, can engage in knowledge translation activities that are appropriate to their context. It will also provide recommendations on how KT can be supported and developed within Cochrane so that it is effective and sustainable.

3 Progress to date

The working group has made significant progress to date and hope to have a draft strategy available for the KT Symposium in Seoul. We have undertaken various data gathering activities and stakeholder interviews to inform the strategy development.

We have decided to adopt an inclusive approach to the strategy, so that it provides flexibility, whilst not overcommitting ourselves in terms of activities. We intend that the strategy will have many options which can be prioritised at the Group level as well as at the organisational level. Ultimately, the degree of KT activity undertaken will be driven by the strategic priority given to KT within Cochrane, as well as the resources that are available, both centrally and at Group level.

At a global level we have agreed that there are four key audiences for Cochrane outputs, and we have identified six thematic areas for consideration and development as part of the strategy.

Audiences

The four key audiences are shown here. It is important to note, however, that these are the target audiences; reaching these audiences will often involve us working with intermediaries.

Intermediaries include, for example, guideline developers and media.

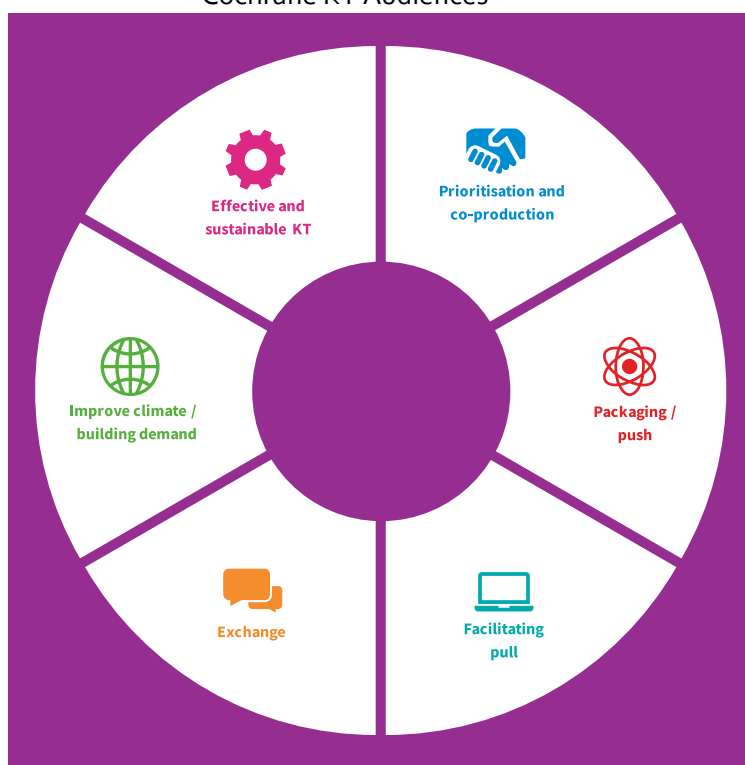


Cochrane KT Audiences

Core themes of the strategy

The six core themes relate to a range of activities that we believe need to be developed as part of Cochrane's KT work. Five themes describe the KT activities Cochrane should engage in, with a focus on our content meeting the needs of our target audiences, channels to stakeholders and engagement practices. The sixth theme addresses the organisational infrastructure that will be required to underpin these activities, ensuring that they are effective and sustainable. It is possible that, as the strategy develops, we will consider this theme separately in relation to the five areas of activity. One important distinction we have made in developing these themes is that for Cochrane, we consider KT to be bi-directional, so it is not just about pushing our evidence out to the world, it is also about listening to what the world has to say to us.

Theme 1: Prioritisation and co-production



Cochrane KT Themes

This theme describes stakeholder engagement to determine and refine Cochrane priority topics and maximize opportunities for KT. These activities focus on considering KT from the outset/through all parts of review production and actively involving target audiences in topic selection, design, execution, interpretation and dissemination of Cochrane content.

Examples of activities

- Involve target audiences in developing KT and/or dissemination plans for priority reviews and/ or reviews likely to be of high impact
- Prioritise reviews of importance to target audiences: organize formal processes and partnerships for prioritizing important reviews
- Facilitate stakeholder involvement in reviews

Theme 2: Packaging, push and support for implementation

Creating 'fit for purpose' reviews and review-derived outputs, disseminating them effectively through appropriate channels for a range of target audiences, and providing resources and tools to support implementation of findings.

Examples of activities

- Develop / scale up a range of dissemination products and approaches such as:
 - Cochrane Corners, tweetchats, journal clubs for **Healthcare Practitioners**
 - Training and resources in how to develop policy relevant summaries, how to contextualize evidence and structured summaries for **Health Policy Makers and Managers**
 - Gap maps and empty review lists for **Researchers and Research Funders**
 - Blogshots, infographics and Wikipedia content for **Consumers**
- Harness new media and other communication channels to disseminate our evidence products and KT outputs
- Establish links with identified intermediaries to make best use of dissemination channels

Theme 3: Facilitating pull: enabling discovery and use of Cochrane reviews to inform decision-making

Facilitating use of Cochrane reviews in health decision making through:

- ensuring our reviews are easy to find, access and understand; and
- developing capacity in target users to use our reviews and products.

Examples of activities

- Improve search, access, search engine optimisation (SEO) on the Cochrane Library

- Develop / extend/ refine / promote - Cochrane Library training materials targeted at a range of users
- Develop training and support materials for all target audiences to support the interpretation and use of Cochrane reviews

Theme 4: Exchange

Facilitating interactions between decision-makers and Cochrane groups and authors to ensure priority topics for decision-makers are addressed and decision makers have opportunity to input into KT approaches.

Examples of activities

- Organize deliberative processes built around needs of target audiences
- Employ/ resource/ facilitate and grow knowledge brokers, both centrally and regionally, to lead/ train others/ broker exchange
- Provide support (training, mentoring, leadership development, resources) on how to build partnerships at local level.

Theme 5: Improve climate and build demand for evidence syntheses

Lay the foundations for use of Cochrane outputs by promoting evidence-informed decision-making and advocating for the use of systematic reviews.

Examples of activities

- Work with, enable and grow opinion leaders in advocating for use of evidence syntheses
- Look for media opportunities for raising awareness about evidence
- Develop/ build libraries of products (e.g., presentations, template publications, videos) about why synthesized evidence is key to decision-making (including stories and images of impact)
- Develop support tools for Cochrane leadership to advocate for synthesized evidence in their jurisdictions

Theme 6: Effective and sustainable KT structures and processes in the organization

Coordinating Cochrane's KT work, monitoring and evaluating strategy, managing and sharing the knowledge generated for and about KT in Cochrane, and acting on the lessons learned.

Examples of activities

- Develop and provide training in KT (generally) and in the use of social media, etc., specifically for Cochrane Groups
- Develop and implement a monitoring and evaluation framework for knowledge translation in Cochrane

- Develop and promote a platform/system to store and share KT outputs, templates, procedures, etc.
- Invest in KT expertise within Central Cochrane team, working with CEU and Communications teams
- Co-ordinate a network of those working with KT within the organisation
- Developing and implementing a KT training program and peer support for current and emerging Cochrane leaders
- Templates for KT plans for reviews

4 Questions for CSG discussion

- Is the strategy developing as the CSG expected?
- Do you agree with the key target audiences identified and are there any that we've missed?
- Are there specific target audiences you feel should be prioritised?
- Do you consider all themes important and central to the work of Cochrane?
- Can you identify any that you think should be prioritised/deferred (must do, should do, could do)?
- Is it likely that resources can be made available to support KT implementation as part of theme 6 (both centrally and at Group level)?
- Are there any other comments/feedback that you would like us to take back to the working group for the next stage of strategy development?

5 Next steps

We have a symposium planned during the Seoul Colloquium where we will be giving participants the chance to comment on our outline strategy. We hope that this open consultation will provide a good opportunity to test parts of the strategy with the community.

After Seoul we will write up a draft strategy that will be put out to the Cochrane community for consultation. We will aim to do this by the end of January so that we have time to collate and incorporate the feedback into a final strategy to be presented to the CSG in Geneva in April 2017.

The final strategy that will be presented will also provide the CSG with a recommendation on the funding required to deliver a sustainable KT strategy.

6 Cochrane Knowledge Translation Working Group Membership

The group is co-chaired by:

- Rachel Churchill (Co-ordinating Editor, Cochrane Common Mental Disorders Group)
- Sally Green (Co-Director, Cochrane Australia)
- Denise Thomson (Co-Director, Cochrane Child Health).

Supported by:

- Chris Champion (Senior Programme Manager, CEO's Office, Cochrane Central Executive)

The working group members include:

- Rebecca Armstrong (Co-ordinating Editor, Cochrane Public Health)
- Martin Burton (Director, Cochrane UK)
- Maureen Dobbins (Scientific Director, National Collaborating Centre for Methods and Tools (NCCMT), McMaster University)
- Sylvia de Haan (Partnerships Co-ordinator, Cochrane CET).
- Sophie Hill (Co-ordinating Editor, Cochrane Consumers and Communication Group)
- John Lavis (Canada Research Chair in Evidence-Informed Health Systems, McMaster University)
- Craig Lockwood (Director Implementation Science, The Joanna Briggs Institute)
- Martin Marshall (Professor of Healthcare Improvement, UCL)
- Pierre Ongolo-Zogo (Associate Professor, University of Yaoundé)
- Sally Redman (CEO, Sax Institute)
- Karla Soares-Weiser (Deputy Editor-in-Chief, Cochrane and Cochrane Innovations, Cochrane CET)
- Julie Wood (Head of Communications and External Affairs, Cochrane CET)
- Taryn Young (Director, Centre for Evidence-based Health Care, Stellenbosch University)

Structure and Function Review Papers

Following the Steering Group's decisions at its meeting in April 2016 in London to proceed with organizational structure and function changes to help Cochrane meet its *Strategy to 2020* objectives and goals, the Central Executive Team have put together a series of papers which set out in more detail the proposed changes to be implemented.

The papers included in this pack are:

Paper One: Creating a more sustainable review production system for the Cochrane Library

Paper Two: Cochrane's Geographic Presence

Paper Three: Cochrane Fields: An update on proposals

The first wave of Structure and Function Reviews conducted in 2014-15 looked at each Cochrane Group type in isolation in relation to the challenges posed by *Strategy to 2020*, and focused on the changes required within each Group type to help them meet those challenges. However, the Steering Group recognized that a 'second wave' of analysis was required that looked holistically at the ways all Groups worked together within an organizational perspective. It concluded that in order to position Cochrane for the future, and to ensure Cochrane was best equipped to meet its mission of promoting evidence-informed health decision-making, deeper level change was required. At its meeting in London in April 2016 the Steering Group set a clear direction of travel and tasked the Central Executive Teams with drawing up proposals aimed at ensuring that Cochrane's structures and ways of working were positioned optimally to meet its *Strategy to 2020* and to promote its longer term sustainability.

An initial set of proposals were developed, then subject to widespread consultation across the Cochrane community between July and September 2016. Following the extensive feedback received the proposals were further adapted and developed in more detail, resulting in the publication of two papers: Paper 1, covering the creation of a more sustainable and efficient review production system for the Cochrane Library; and Paper 2, covering the further development of Cochrane's geographic-oriented Groups, particularly in support of the production process, improved author support and dissemination and knowledge translation of Cochrane evidence.

Paper 3, however, is an Update and presented here to provide context to the other Papers rather than as a firm set of proposals. The reason for this is that the Cochrane Fields Structure and Function Review is highly interrelated with the development of the Cochrane Knowledge Translation Strategy, which is still in progress. The Update provides information on the potential future role of Fields based on what we know so far from the Knowledge Translation Strategy, but the proposals are far from complete and they have not yet been consulted on.

These Papers are now published to the whole Cochrane community and further feedback is invited to be given to the Central Executive (strategy@cochrane.org); to [Cochrane Group Steering Group representatives](#); or to Group Executives by Wednesday 19th October. On Saturday 22nd October the Steering Group will discuss the Papers and make decisions on their recommendations. The next steps in implementing these decisions will then be discussed by Cochrane Group Executives at their meetings in Seoul in the days following.

Structure and Function Review

Paper 1: Creating a more sustainable review production system for the Cochrane Library

[OPEN ACCESS]

Document prepared by: David Tovey
Submitted to Steering Group: October 2016 (Seoul)
Access: Open Access
Contact person for queries: David Tovey, dtovey@cochrane.org



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1 Executive Summary

This paper has been produced as one element of the Cochrane-wide Structure and Function Review, and aims to address aspects of three of four *Strategy to 2020* goals that relate to our review production systems and the impact of Cochrane Reviews.

- Goal 1: the production of high-quality evidence syntheses that inform decision makers in health.
- Goal 2: ensuring access to and use of the syntheses we have produced.
- Goal 4: ensuring a successful and flourishing Cochrane community.

The paper will focus particularly on the review production systems, and therefore the work of Cochrane Review Groups (CRGs), their relationships with one another, and with the Central Executive Teams. However, it is important to note that a Structure and Function project is also ongoing in relation to the Cochrane Methods Groups. Some proposals made in the paper reflect this work. In addition, this paper accompanies additional papers that address the structure and function of 'geographic' groups such as Centres (paper 2) and also Fields (paper 3).

Over the past two decades, Cochrane has achieved success and widespread international recognition, due predominantly to its production of a unique collection of high-quality systematic reviews, the *Cochrane Database of Systematic Reviews (CDSR)*. Through the commitment and expertise of its contributors and teams, the CDSR has grown to over 7,000 reviews, many of which have been updated, and it continues to expand at a rate of 60 to 80 new and updated reviews per month. Cochrane is widely recognized as producing high-quality reviews,⁵ due in large part to its rigorous methodological standards and the efforts of Cochrane Review Groups (CRGs) in support of review development.

Cochrane Reviews have a significant impact on health care across the world. This impact has been generated in multiple ways, and has resulted in individual reviews challenging conventional wisdom, for example on neuraminidase inhibitors,¹ deworming programmes,² and the use of tranexamic acid for reducing mortality in cases of trauma,³ and programmes of reviews around a subject area that change practice and policy through being incorporated into guidelines.

Success, however, brings a number of challenges, many of which are highlighted in our *Strategy to 2020*, and were identified earlier as part of the previous review of Structure and Function,⁴ and the 2013 CRG monitoring report.⁵ These challenges are mainly related to keep producing timely and consistently high quality reviews (see "[Current and future challenges](#)" below), and in this document we build on what we have learned in order to present proposals that address relevant issues that will affect the quality assurance and review production systems.

Compared to the situation in 1993, Cochrane now exists within a much more competitive environment: a growing number of systematic reviews is published every year, and many organizations are competing for

¹ Jefferson T, Jones MA, Doshi P, Del Mar CB, Hama R, Thompson MJ, Spencer EA, Onakpoya IJ, Mahtani KR, Nunan D, Howick J, Heneghan CJ. Neuraminidase inhibitors for preventing and treating influenza in adults and children. *Cochrane Database of Systematic Reviews* 2014, Issue 4. Art. No.: CD008965. DOI: 10.1002/14651858.CD008965.pub4.

² Taylor-Robinson DC, Maayan N, Soares-Weiser K, Donegan S, Garner P. Deworming drugs for soil-transmitted intestinal worms in children: effects on nutritional indicators, haemoglobin, and school performance. *Cochrane Database of Systematic Reviews* 2015, Issue 7. Art. No.: CD000371. DOI: 10.1002/14651858.CD000371.pub6.

³ Ker K, Roberts I, Shakur H, Coats TJ. Antifibrinolytic drugs for acute traumatic injury. *Cochrane Database of Systematic Reviews* 2015, Issue 5. Art. No.: CD004896. DOI: 10.1002/14651858.CD004896.pub4.

⁴ <http://community.cochrane.org/sites/default/files/uploads/inline->

[files/CRG%20Structure%20and%20Function%20consultation%20paper%20DT%20final%205%200_o.pdf](http://community.cochrane.org/sites/default/files/uploads/inline-files/CRG%20Structure%20and%20Function%20consultation%20paper%20DT%20final%205%200_o.pdf)

⁵ <http://editorial-unit.cochrane.org/crg-monitoring>

the same funds to produce these reviews.⁶ Many of these reviews are clearly of lower quality, but some are comparable to the best Cochrane Reviews.

In addition, reviews are becoming increasingly complex, addressing different types of question beyond that of effectiveness, incorporating new data sources (e.g. non randomized studies, data submitted to regulatory bodies) and new methods (network meta-analysis, individual patient data, qualitative or economic analyses). At the same time decision makers are becoming increasingly demanding about the timeliness of high-quality review production.

CRGs currently function with a high degree of independence and examples of intergroup collaboration are relatively infrequent. In addition, for many Groups, the default position is to accept title requests and substandard submissions even when the work required to convert them into publishable reviews is disproportionately high. It is therefore not surprising that many CRGs report that they are overwhelmed and overstretched, whilst author experience and review quality across CRGs are both inconsistent. Furthermore, the editorial process - largely unchanged over two decades - is seen as being inflexible and cumbersome, leading to low levels of retention of trained and experienced review author teams across many CRGs.

Cochrane evolved as a collaboration, and we are actually highly dependent on one another. We are all elevated by the glory reflected by the high performers, and all undermined collectively when we fail to achieve the high standards we have set ourselves. We have the basis on which to further build success: a large, multiprofessional network of researchers, high levels of commitment, and a vibrant community that continues to engage some of the world's foremost experts in the world of evidence synthesis. However, we need to harness our resources more effectively in order to ensure that we remain relevant and influential, and maintain the quality of our outputs. We need to be outwardly focussed so that we understand the knowledge needs of decision makers (health professionals, policy makers, citizens etc), and also to create an environment that attracts new researchers and provides them with professional and career opportunities.

In this paper we outline a transformation programme that aims to create the basis for a Cochrane review production system that is positioned to have maximum impact on clinical care and in health policy. The proposal has four discrete elements:

1. The creation of a new Editorial Board that can shape and develop strategy and provide oversight of the implementation of the transformation programme and the performance of the Cochrane Library.
2. Proposals to improve governance arrangements and mutual accountability between Cochrane and its groups, and increase transparency.
3. A review of the sustainability of current CRGs allied to the needs of our users. This will seek to deliver recommendations that deliver fewer, larger editorial units that bring CRG teams with shared interests closer together within supported networks, and helps them to match the characteristics of the highest performing groups currently.
4. The implementation of the integrated quality strategy and the delivery of the *Strategy to 2020* goal 1 targets: consistently high quality reviews, produced efficiently, that address the needs and priorities of decision makers. This will include the introduction of a Methods Support Team and initiatives aimed at measuring and recording review quality, and increasing the efficiency of the editorial process.

⁶ <http://www.milbank.org/the-milbank-quarterly/current-issue/article/4110/the-mass-production-of-redundant-misleading-and-conflicted-systematic-reviews-and-meta-analyses>

We are grateful to those individuals who have attended the various webinars, and who have made important and substantive contributions to our thinking. We have tried to ensure that those contributions are incorporated into this paper, and believe that they make our proposals stronger and more compelling.

The proposals within this paper are consistent with those developed for the Centres and Fields.⁷ These incorporate the desire to increase effective co-operation between these groups and CRGs in support of the review production process, to benefit both contributors and our end users.

We want to be able to look back in ten years' time and know that we put into place the measures needed on which to build our continuing success. Our current structure and aspects of the way we work now are simply too fragmented and inconsistent in quality to let us achieve our vision. Therefore, we need a process of transformation that will deliver the review production systems we require, built on viable units with the capacity and skills that will be indispensable in the next few years and beyond.

2 Our vision for this project

We want to ensure a transformed review production system Cochrane-wide that delivers high-quality and timely systematic reviews - reliably and consistently - that are identified as important through robust processes, and so prioritise the needs of decision makers across the world.

3 Current and future challenges to achieve the goals of Strategy 2020

This document aims to describe how we can work together as a community to tackle the current and future challenges, focussing on review production, impact, mutual accountability and governance, transparency, and supporting our people to produce excellent work. In this section, we restate some of the main challenges Cochrane faces.

Goal 1: Producing evidence

Quality is our paramount concern

Achieving consistent, high-quality reviews is essential to Cochrane's continuing success.

Cochrane has invested heavily in the management of quality ever since the screening programme, led by Toby Lasserson (the 'screen team'), was introduced in 2013. A paper published in May 2016 by Matthew Page and colleagues,⁸ demonstrated that in terms of reporting standards Cochrane Reviews are superior to non-Cochrane reviews, despite the latter having improved substantially since the last evaluation in 2008. This is consistent with recent audits undertaken by the Cochrane Editorial Unit (CEU) that have demonstrated that there has been a clear improvement in many aspects of quality of Cochrane Reviews. However, our screening programme has identified that review quality challenges are not limited to a small number of high risk CRGs. We now have increasing evidence of reviews being signed off for publication across a substantial group of CRGs that do not consistently meet the high standards we have developed.

In 2015 we initiated changes to the screening process so the quality screening team began to evaluate reviews earlier in the process - including analysis of protocols and review updates - before they were signed

⁷ http://community.cochrane.org/sites/default/files/uploads/inline-files/centres___branches_structure___function_review_-_final_-_june_2016.pdf

⁸ Page MJ, Shamseer L, Altman DG, Tetzlaff J, Sampson M, Tricco AC, et al. Epidemiology and reporting characteristics of systematic reviews of biomedical research: a cross-sectional study. *PLoS Medicine* 2016;**13**(5):e1002028.

off by the CRG. These reviews included those that CRGs designated as being of potentially high impact and worthy of focussed knowledge translation activity, and also those where the CRG requested support from the screening team for other reasons. The CEU has also received referrals from the Copy Edit Support service and the Cochrane UK's *Analysis of Review Group Outputs for decisions on dissemination and promotion* (ARGO) meeting. As the CEU screening programme has expanded, it is becoming increasingly clear that inconsistency in relation to the quality of review production is not limited to a handful of CRGs. Some areas such as adherence to protocols, application of GRADE, unit of analysis decisions, and consistency of writing across different sections of the review, are recurrent problems in the majority of the reviews sent to the CEU for screening.

The screening programme is popular with most CRG teams, and attempts by the CEU to scale it back have been strongly resisted. It also represents a considerable investment on the part of Cochrane into the issue of quality improvement (4.2 FTE currently). However, despite the team's efforts it has not succeeded in achieving its aim of rendering itself redundant; instead it has highlighted deep-seated challenges and inconsistencies in the quality of the review production systems across CRGs. Within the next one to two years, it is important that the CEU role becomes more strategic and less operational and that all editorial teams have the data, skills and capacity to undertake the work of overseeing and managing their review portfolio and production process.

As part of its work, the CEU team has worked closely with a small number of CRGs designated as being at 'high risk', and has supported these Groups in their efforts to implement the changes needed to address specific issues relating to review quality. In addition to screening reviews before signing off, the team has provided regular face-to-face and webinar training sessions, and in some instances a dedicated CEU editor has worked closely with the CRG or provided direct support to editors and other CRG staff. This has led to the implementation of a range of potential solutions, including:

- limiting the number of title submissions being accepted to match resources, and concentrating available resources on the highest priority titles;
- increasing the willingness of CRGs to reject sub-standard submissions at all stages;
- editor training to address knowledge gaps within individual editorial teams.

The recent consultation for the purposes of the Structure and Function project⁹ has demonstrated that those working in high-performing CRGs are not enthusiastic about suggestions that they might be expected to work alongside the lower performers to help improve quality, or to manage their performance, both of which are seen as responsibilities of the CEU and the Editor in Chief. The reluctance to embrace the partially decentralised model set out in the description of 'thematic hubs' is understandable given that many Group leaders have a limited time to devote to Cochrane, receive no direct funding from the organization, and wish to use their available time to produce and develop high-quality reviews in their own discipline.

Efficiency of production

Since April 2013, Professor Dame Sally Davies, Head of the UK National Institute for Health Research (NIHR) added her voice to that of many others across the world on the issue of time to publication. Since then, Cochrane has invested heavily in the implementation of a series of technological changes aimed at addressing the challenge of producing high-quality systematic reviews in a timely and efficient manner. The changes include the introduction of an author support tool (Covidence), and investment in Project Transform, which explicitly aims to facilitate study identification ('pipeline') and the execution of key elements of the editorial process (Cochrane Task Exchange and Crowd). During the next two to three years, once these tools have been fully implemented and are widely used, we believe that they will begin to show an impact on the speed and consistency of review production.

⁹ <https://community.cochrane.org/sites/default/files/uploads/inline-files/CRG%20consultation%20process.pdf>

Currently, however, reducing the time to publication has been challenging. The most recent data taken from Archie shows no overall improvement in the time taken for the production of reviews, which remains an average of 30 months. Whilst it seems to be the case that reviews listed on the prioritisation list are published sooner (average 25 months), an assessment of 'empty' reviews taken to coincide with the Reward / Equator Conference on increasing value and reducing waste in biomedical research suggested that even 'empty' reviews frequently take a similar time to complete.

The causes of delay are certainly multiple, but include:

- review author teams continuing to be predominantly volunteers;
- many CRGs accept more titles than they have the resources or capacity to manage;
- introduction of diagnostic test accuracy (DTA) reviews and newer methods such as network meta-analysis;
- many submissions are of poor quality, but many Cochrane Groups are reluctant to reject work, particularly once a protocol has been published. Cochrane does not have an agreed rejection policy to guide CRGs, and a consequence of these factors is that in many Groups, a large amount of the editorial time is spent on poor quality reviews, leading to lengthy backlogs;
- the CEU screening programme increasing overall time to publication, due mainly to the work undertaken to address issues it has identified.

To address these challenges, Cochrane cannot rely on its technology or 'the crowd' alone. There need to be editorial and process changes also – Cochrane's editorial process has not changed substantially for 20 years, and still assumes that most review author teams require extensive support at all stages of the process. This may have been true in 1993 but is no longer so. Many experienced authors want to continue working with Cochrane, but increasingly publish their highest impact reviews elsewhere. Thus, Cochrane ends up losing important reviews and high-quality teams.

To combat these challenges, we propose to trial and introduce different models of the editorial process. We know from our discussions at the mid-year meeting that there is enthusiasm for this within the CRG community, and we propose to pursue this with urgency over the next year.

In addition, there is increasing interest in the development of 'living systematic reviews' - in essence reviews that are updated in 'real time' when new relevant studies are reported either in published articles in scientific journals or elsewhere. This work is currently at an early stage and being led from within Project Transform. Living systematic reviews will need to be carefully defined, with serious consideration of the methodological and publishing challenges.

Therefore, we propose some radical changes to editorial process that may be applied to specific reviews, alongside an incremental approach that can be applied to all reviews; both strategies aiming to deliver substantial improvement in Cochrane's performance in this area.

Better prioritization and management of scope

Since 2006, many Cochrane Groups have engaged in prioritization activities, some on a regular basis. However, this is inconsistent. To be effective, prioritization requires some external engagement with stakeholders, such as citizens or consumers of health care, health professionals, policy makers and guidelines developers. The Priority Setting Methods Group was set up following the Strategic Session on the topic, but to date, there does not seem to have been substantial engagement with CRGs.

The development in 2015 of the Cochrane-wide prioritization list, and the Review Support Programme have increased the level of engagement by Groups, but what is needed is for all Groups to match the work of the higher performers consistently. In addition, the heterogeneity of CRGs means that maintaining a system-wide perspective is an ever-present challenge that we seek to address within the transformation programme described in this paper.

Implementing new methods that enable Cochrane to meet the needs of decision makers more effectively

Cochrane has consistently implemented changes to its reviews as methods have developed. However, the science of research synthesis is becoming increasingly specialized and sophisticated, with increased review complexity (for example: DTA, mixed methods and prognosis reviews) and enhanced methods (e.g. network meta-analysis, new data sources such as regulatory data). It seems inevitable that the pressure to extend the scope of reviews, and implement innovative new methods will continue.

Recent history demonstrates that whilst Cochrane has introduced many changes to its methods, including introduction of the 'Risk of bias' tool, implementation of GRADE, and DTA reviews, progress has characteristically been slower than predicted and more challenging. This highlights the challenge of introducing change and monitoring progress across 52 units, many of which lack editorial capacity or methodological capability or have fragile funding. The challenges are exacerbated by the current lack of funding support experienced by nearly all methods groups. The Strategic Methods Fund may represent a partial solution by making central Cochrane funds available to support the implementation of newer methods that have been approved by the Scientific Committee and are a priority to end users.

Goal 2: Making our evidence accessible

Creating impact: responsiveness to guidelines producers and Health Technology Assessment (HTA) bodies

Whilst there are many examples of CRG teams and review authors working together to complete programmes of reviews in response to requests by national and international guidelines producers and HTA bodies, there are also consistent reports of opportunities being missed. Not all of the blame for this situation lies at the door of Cochrane, but if our organization wants to remain as the evidence source of choice, we need to ensure that teams are positioned to exploit as many opportunities as possible.

This will require many attributes signalled in the previous sections including:

- improved engagement with policy makers and horizon scanning; and
- creation of 'fast-track' capability and capacity where indicated – perhaps through creating larger multi-disciplinary teams, which already exist in some of the high-performing CRGs.

Cochrane Response (part of Cochrane Innovations) was designed specifically to create the capacity and skills to respond swiftly to stakeholders and to produce high-quality evidence syntheses when CRGs were not able to do that themselves. However, this can only form a part of the picture. What is needed is for Cochrane Response and CRG teams to work in partnership in order to deliver the services and products needed by guidelines producers and HTA agencies internationally, and to generate income for both Cochrane and the Groups. The outputs also need to be flexible, covering the range from targeted updates to fully formed new reviews. Cochrane is well placed to deliver such services, but to do so it needs to find more flexible, efficient and effective ways of working.

Goal 4: Building an effective and sustainable organization

Transparency, governance and accountability

The disseminated structure and funding of the organization, along with a lack of built in formal accountability of CRGs to the Editor in Chief's Office, is a major management challenge. Currently there are very limited mechanisms for accountability of CRGs to the Editor in Chief and ultimately to the Chief Executive Officer (CEO) and Governing Board (currently, the Steering Group or CSG) or vice versa – a consequence of the ad hoc and organic way that Cochrane developed.

During 2015 the CEU team worked with colleagues in the community to develop a Memorandum of Understanding (MoU) between the Editor in Chief, Co-ordinating Editors of CRGs, and the CRG host institutions (where appropriate). Substantial progress has been made. We have consulted with the Co-ordinating Editors' Executive, Cochrane's Senior Management Team, Cochrane's legal advisor, and

circulated a final version to the wider group of Co-ordinating Editors. Alongside the Structure and Function proposals, we now intend to complete this work.

In addition, the UK NIHR has also made it clear that it wishes to see the CEU providing more information relating to the individual performance of NIHR-funded CRGs. Given the critical role of its funding of multiple Cochrane Groups, and the high likelihood that its views would be shared by other funding bodies, we believe that a vital element of these proposals is to address these expectations. As part of this work, we believe that it is now important for metrics related to performance of both CRGs and the central teams to be made available to all within the Cochrane community and to funding bodies.

Developing improved professional opportunities for CRG teams and editors

We recognize from consistent feedback that the current provision of professional and career development opportunities within Cochrane is sometimes limited, and in particular, that there is an unmet need for advanced editorial training and opportunities for staff working in editorial bases. Both of these are central to the strategy developed by the Learning and Support Department within the Central Executive Team (CET).

In our original webinar presentations we envisaged opportunities for creating specialization of roles for Managing Editors (MEs) and Information Specialists (IS). We are aware that there are structural challenges to delivering this, but continue to consider that it is a priority to encourage closer working between groups and also to seek such career development and learning opportunities where possible. Finding such opportunities within networks of CRGs may be easier where they share the same funder, and there is a desire on the part of that funder to promote appropriate skills mix and rationalisation of services.

Creating sustainable teams

There are many highly successful CRGs across the Cochrane community. From our discussions, these Groups appear to incorporate many or all of the following attributes:

- strong leadership allied to a well-functioning editorial board with appropriate methodological expertise and capacity
- sustained and relatively secure funding that is appropriate for the scope of the Group
- additional capacity over and above the ME and IS to provide review support to author teams
- strong commitment to quality
- strong connections to a network of key stakeholders outside Cochrane (e.g. consumer organisations / patient networks, clinicians, researchers, guideline developers, etc.).

Across Cochrane there are also Groups that are currently vulnerable for a variety of different reasons. These include:

- CRGs that lack editorial support and are therefore at higher risk of producing low-quality reviews;
- CRGs whose funding or output is disproportionately low relative to scope and need;
- CRGs with limited capacity or insufficient access to methodological support;
- CRGs that have insufficient or threatened funding;
- CRGs whose leadership is absent or sparse or not sufficiently engaged with the changes Cochrane is making to implement the *Strategy to 2020*;
- CRGs at risk of isolation, with few links to a user community.

To date, the CEU has engaged in different activities aimed at supporting or managing Groups, but these activities alone have not had the impact we need in order to deliver a consistent, efficiently produced and high-quality Cochrane Library. Sustainability is undoubtedly linked to the development of review production systems that match the characteristics of the high achievers. Therefore, the CEU proposes to conduct an analysis of all CRGs over the next 12 months to assess the sustainability of all CRGs against the

attributes of the high-functioning Groups. This will result in proposals that aim to address the challenges identified, and the creation of larger units that are capable of consistently delivering the outputs we seek.

4 Structure and Function Review proposal

This section describes the proposal for the transformation programme that we believe will produce a review production system that can harnesses Cochrane's diverse talents more effectively, and will enable us to achieve our vision.

1. We will create a new **Editorial Board**, comprising a mixture of Co-ordinating Editors and others representing the methods community, knowledge translation and end users from inside and outside Cochrane. This will be the leadership group for overseeing the transformation programme, and the implementation of the *Strategy to 2020*, setting future editorial strategy for the Cochrane Library, and overseeing its implementation.
2. We will improve **transparency, accountability and governance** arrangements between Cochrane and its CRGs, and develop performance metrics for the CEU, CRGs and the Cochrane Library.
3. We will undertake a **sustainability review** of all CRGs and match this to a needs assessment of the Cochrane Library. This will lead to recommendations for ways to achieve the changes needed to create **fewer, larger and more sustainable** editorial teams, including networks of CRGs that have shared interests (e.g. within a clinical discipline). The review will also seek to identify those groups who are most vulnerable and to provide recommendations for achieving greater sustainability.
4. We will introduce changes aimed at improving the functional performance of the review production systems in line with the agreed **Integrated Quality Strategy** that was approved at Cochrane's mid-year meetings in April 2016. This will include measures that seek to assure quality, improve speed to publication, introduce new and more flexible processes, and accelerate methodological innovation.

Enhanced Editorial Board

We propose to retire the current Co-ordinating Editors' Executive and to create an enhanced Editorial Board that will support the Editor in Chief in overseeing and managing the transformation programme, the delivery of our *Strategy to 2020*, and the development of the future strategy for a stronger, more sustainable Cochrane Library.

The main roles of this enhanced Editorial Board will be to:

- oversee implementation of the integrated quality strategy and transformation programme;
- monitor the performance of the Cochrane Library;
- develop and oversee implementation of future strategy in association with the Editor in Chief
- create a collective leadership model in support of the development of editorial and content strategies.

Membership will be determined over the period of the next six months. The Board will include five Co-ordinating Editors, a methods representative, one external member (representing the end users and with relevant experience in the area of evidence synthesis and its application in global decision making) and one representative from the Cochrane community who brings specific expertise in knowledge translation. The Editorial Board will be chaired by the Editor in Chief, supported by the Deputy Editor in Chief and the CEU Senior Editors. The membership will be reviewed after the first 12 months and may be reviewed in the light of experience.

Other Cochrane Central Executive staff (the Communication and External Affairs (CEAD), Informatics and Knowledge Management (IKMD), Learning and Support Departments (LSD) and CEO's team) will be co-opted as necessary in support of the Board.

Internal members of the Editorial Board will be given the title of 'Associate Editor, Cochrane Library'. Each appointment will be for a fixed-term, renewable, dependent on support from the CRG community and Editor in Chief.

Board members will receive funding equivalent to about one day per month, plus one registration for our annual Colloquium. They will therefore be expected to contribute to the work of developing and overseeing strategy for the Cochrane Library, and to work closely with the Editor in Chief, CEU and editorial teams.



Figure 1: Editorial Board

Enhanced governance and transparency

We will finalize and sign Memoranda of Understanding between Cochrane and the CRGs, their Co-ordinating Editors, and host institutions where appropriate. Many CRGs have previously indicated a willingness to sign the MoU as previously drafted, whilst others have indicated a willingness to do so with some minor amendments.

As part of the transformation programme we will increase transparency of quality assessments, and will also consult on and introduce a model whereby we provide an assessment of CRG performance separated by domains such as engagement with external stakeholders and decision makers, review quality, speed to publication, innovation and complexity, coverage related to scope, and impact. Initially this will form part of the sustainability review. It is important that metrics are seen as fair (including with respect for diversity and variable funding), and meaningful, and that they are cost effective to produce for both CRG team and the Central Executive.

We will also develop metrics for CEU performance based on the expectations included in the MOUs and these, including the detail of performance measured against them will be equally transparent.

Sustainability review

We believe that for the long-term sustainability of Cochrane we need fewer, larger, editorial bases, each servicing one or more specialist areas, with strong and committed leadership, increased and stable capacity and resources, and firm links within viable networks (inside and outside Cochrane). The largest funder of CRGs, the UK NIHR has indicated its support for Cochrane moving in this direction.

Over the next 12 months the CEU will work with CRG teams to develop and present a detailed analysis of all current Groups in relation to their future sustainability, matched to a needs assessment process, based on the scope covered by the Group, supported by currently available metrics and data, ongoing assessments of review quality, capacity and resources.

During years one to three of the transformation programme, we aim to create networks of CRGs that have shared interests, working increasingly closely together, and also to identify those groups that are currently vulnerable or unable to achieve the outputs that are needed to maintain the development of the Library and to achieve our vision.

The consultation process has demonstrated that there is no one thematic or network solution that suits all CRGs. Some Groups can be easily form networks around a clinical 'system' e.g. neurology or cancer. However, there are many Groups that do not fit easily into such a structure, either because they do not have a clinical focus, or because their focus sits across many clinical areas or simply does not fit with traditional 'medical' models. The experience of the Cancer Alliance shows that Groups forming a network are able to identify shared interests and aspirations, but that achieving these without additional support or incentive is challenging. Our proposal is to use the sustainability review to identify feasible networks of groups and to work with these networks to identify routes towards achieving shared goals. We will use the review to develop concrete recommendations for the Editorial Board and also the Governing Board where appropriate about the formation of effective networks of CRGs that build on existing relationships and are consistent with external perceptions and expectations. We propose that discretionary funds will be made available from Cochrane to the networks in order to fulfil specific projects that support the achievement of *Strategy to 2020* goals.

CRGs that are currently seen as vulnerable, whether they are under-funded, lacking leadership presence or capacity, or producing outputs that are inconsistent in quality or insufficient in volume to address their scope, will be identified during the first nine months of this review, and the CEU will work with each of these Groups to determine the appropriate path forwards, leading to the development of specific recommendations to be presented to the Editorial Board and Cochrane's Governing Board as appropriate. The recommendations will aim to improve sustainability and may include proposals to enhance leadership, mergers of Groups, changes of scope, recruitment of new experienced editors, editor training, satellites, or more radical solutions where needed. We will develop and present more detailed plans in the first three to four months of the transformation programme.

Case examples (illustrative)

CRG A is a high performing Group with committed leadership, stable funding through infrastructure and programme grants, high-volume output that meets quality expectations and with robust prioritization processes in place, meaning that it can be confident that it is covering its scope adequately. It has a strong editorial board and active networks outside Cochrane. It has been quite restrictive in the type of reviews

it undertakes, in order to concentrate its resources but now wishes to broaden to incorporate network meta-analysis.

It is judged to be a strong and sustainable Group. It agrees a limited engagement in support of another CRG with a related topic area in return for an agreed level of support from Cochrane. The CEU agrees to allocate a named editor in support of quality assurance, and provides active support for developing a new satellite aimed at increasing editorial capacity.

CRGs B, C, D and E have scopes that all are closely linked. All have stable funding but in one case it is relatively limited. Groups B and C are high performers, but Group D has had problems with quality, due to volume of work exceeding capacity, and insufficient methods skills amongst its editors. Leadership is generally strong although in Groups B and E, the Co-ordinating Editors have taken on key roles outside Cochrane that will inevitably mean they have less time to commit to the collaboration.

The Groups are judged to be sustainable, but with the potential to develop further. The Groups are provided with a named CEU based editor, who will focus on working with Group D to help improve review quality and offer methodological support as needed. All editors are offered tailored training through a series of regular webinars. A shared editorial base is created, on which managing editors and information specialists work closely together.

CRG F has unstable, threatened funding and has a very low output. Its editorial board lacks methodological skills, and it has struggled to find methodological input. It does not have sufficient funding to appoint editors to support the core team of Co-ordinating Editors, ME and IS.

The Group is judged to be potentially unsustainable, and it is therefore helped to merge with another CRG that covers a related discipline. This move is supported by the CRG's host institution and the current funding is maintained.

Implementing the integrated quality strategy

Improving quality

We have previously identified a small number of CRGs that were at high risk of producing reviews with methodological and reporting problems, and have been monitoring these Groups and providing support in some cases. We believe that most of these CRGs have introduced changes that should bring about improvement, and have seen examples of this in reviews submitted to the CEU for screening. However, at the beginning of 2016, the CEU initiated a weekly meeting at which Cochrane Reviews from a wider selection of CRGs are presented and assessed. Some of these reviews have been submitted for 'on demand' screening because the CRG team has identified problems. In others, the review has come to the CEU team's attention via a referral from the Copy Edit Support service or because a CRG has requested support for media dissemination. The weekly meeting has demonstrated that many of the reviews referred for screening, irrespective of the context or the CRG involved fall short of the standards of quality set by Cochrane. This is described in more detail in the Quality Report prepared in parallel with this paper.

The current work on supporting quality assurance of reviews will continue, including:

- on demand screening;
- screening of reviews that are being considered for media release;
- dissemination of a screening guide; and
- bespoke support to 'high risk' groups.

Alongside these measures, we will develop and implement a rapid screening tool to evaluate Abstracts and 'Summary of Findings' tables of reviews that have been signed off for publication. The tool will provide a score (out of 10) for each review, and we intend to make this information available across Cochrane, so that review author teams and CRGs can compare their reviews with the average for that CRG, and Cochrane-wide. The checklist will also identify examples of good practice, and, additionally may be used to influence more detailed screening of reviews. Over the first three months we will consult with groups and agree the criteria to be assessed, and will also determine threshold measures for publication and identify those measures that will be considered essential for all reviews. A [draft](#) of the publication audit tool is included in the Appendix of this paper.

We will also improve transparency of reporting – all reports on progress will be fully transparent within the Cochrane community and to funding bodies.

Methods Support Unit

We aim to create better mechanisms of supporting and improving the review production system. This will involve the creation of a Methods Support Unit that will work closely with the CEU and provide 'on demand' input to those CRGs that do not currently have sufficient access to methodological support. We envisage that the team will be funded from central resources, but that researchers will also have non-financial incentives to participate, including the designation of a role of Cochrane Research Fellow (as previously outlined in the quality strategy document), and also through an expectation that where substantial input is provided, this may be recognized by including the individuals concerned into the author teams. The Methods Support Unit will also help identify specific learning needs across the CRG community and will liaise with Central Executive teams to address these.

It is important that the Methods Support team is distributed internationally, perhaps linked to Centres, Associate Centres (formerly Branches) or Affiliates but reporting to the Deputy Editor in Chief and Methods representative on the Editorial Board. Ideally at least some members of the Methods Support Unit would be native speakers in languages other than English, or would be attached to Centres that provide such multi-lingual input. We propose that each member should be available for at least one to two days per week. We would anticipate that the team would expect to provide input on between 60 to 100 systematic reviews per year – an equivalent of one full-time appointment.

Changes aimed at improving efficient production

As agreed in the Integrated Quality Strategy, we will work with volunteer CRGs to pilot and introduce different and new models aiming to create more efficient editorial processes that do not compromise review quality.

These will include:

- a 'journal like' process for selected reviews - dependent on the prior existence of a protocol;
- separation of the author support and editorial functions;
- new approaches to empty or 'near-empty' reviews whose primary purpose is not to determine benefit or harm but to promote primary research;
- experiments with merging title registration and protocol development in selected, volunteer CRGs;
- development of the 'living systematic review' concept.

We will also work with CRGs to implement changes that will lead to incremental gains in efficiency. These will include, but not be limited to:

- changes to the management of titles – establishing a lower threshold for rejection on capacity, priority and quality grounds based on an agreed rejection policy (to be developed), setting standards

- for editorial turnaround of submissions, supporting efficient peer review, on demand 'in time' screening, and accelerated peer review for selected reviews;
- improved access to methodology support;
- increased adoption and use of technology solutions – Covidence, Project Transform, enhancements to existing technology e.g. RevMan web.

Introduction of newer methods

The CEU and methods community will work with Groups of interested CRGs to ensure that agreed innovations, including those supported by the Strategic Methods Fund are implemented more effectively and efficiently. This work will form part of a content strategy to be initiated in either late 2017 or 2018.

For each major innovation approved by the Scientific Committee or supported by the Strategic Methods Fund (SMF), the CEU will work with the Editorial Board and CRG community to develop a project plan. This will address the following:

- those CRGs primarily affected and committed to pursue the change (where non compulsory);
- key responsibilities of the Central Executive Teams and others
- vision and rationale for the project and desired outcomes that denote success;
- requirements for additional funding or support required;
- responsibilities, milestones, dependencies, risks and issues;
- timelines;
- engagement and communications plan.

Methods Network

The methods community will be represented on the Editorial Board, and we envisage that this role will include responsibility for providing leadership within a Methods Network, a role previously taken by the Methods representative on the CSG. We propose that this individual will be funded by Cochrane up to about one day per week, and will work closely with the Editor and Deputy Editor in Chief, and the Methods Co-ordinator.

We recognize that some of the implications for the methods community of the changes to review production, and the alignment of these changes with the Methods Structure and Function review have not yet been fully developed. In addition, the next 12 months will see the introduction of the Scientific Committee and the first wave of developments as a result of the Strategic Methods Fund. We also aim to introduce a Methods Support Team as part of this proposal. We would like to see these developments successfully introduced before initiating consultations on future changes.

5 Relationship between the Editor in Chief, Editorial Board and Methods committees

In order to face the challenges of improving and maintaining timeliness and high quality review production model we plan to establish a support network that will advise the Editor in Chief and play a strategic role in the decision making regarding changes in the editorial process and methods implementation. Editorial process decisions, including the future implementation of the proposed pilots, will be taken by the Editor in Chief and the Editorial Board, and methods decisions by the Editor in Chief in conjunction with the Scientific Committee.

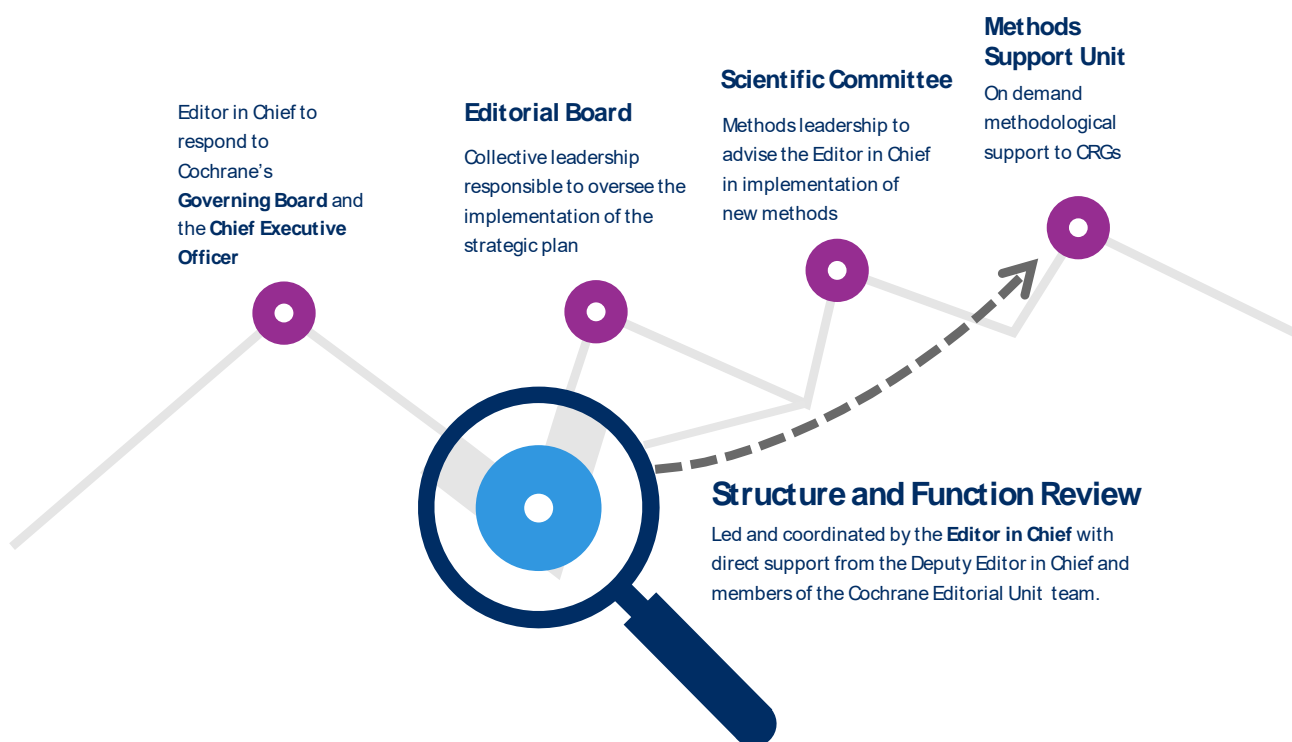


Figure 2: Relationship between Board and committees with the Editor in Chief

The **Scientific Committee** is being set up to advise the Editor in Chief on appropriate methods to be used in Cochrane Reviews. In recent years it has become clear that there is variability across Cochrane in relation to the adoption of new methods (e.g. trial sequential analysis), and no appropriate over-arching body to rule on appropriateness. The Scientific Committee will be made up of a mixture of methodologists and CRG leaders, and will also be able to co-opt expertise in methodological fields where needed. It will be required to consider how individual methods can be implemented but will not have primary responsibility for this.

The **Editorial Board** will develop and oversee strategy of the Cochrane Library alongside the Editor in Chief, as described above. It will ensure that appropriate measures are taken to ensure smooth implementation of methodological decisions made by the Scientific Committee. The Editorial Board will have a majority of Coordinating Editors.

The **Methods Support Unit** will support CRG teams by providing core methodological support to editorial teams who do not have sufficient access currently. The team will comprise methodologists, and will report to the Deputy Editor in Chief.

The **Governing Board** will represent the ultimate authority within Cochrane and will oversee the performance of the Editor in Chief and those under her or him in the context of editorial or content matters.

6 Proposed timelines and project plans

Please see Appendix A for timelines and milestones.

1 to 8 months:

- Formation of the Editorial Board
- Assessment of CRGs' sustainability and identification of sustainable editorial networks and vulnerable groups
- Development and approval of rejection policy
- Quality and transparency: initiation of Abstract/'Summary of findings' assessment of all new reviews and updates
- MoUs signed for at least 30 CRGs
- Initiation of at least three different process pilots across a larger number of CRGs(including 'journal style process')

6 to 15 months:

- Introduction of Methods Support team
- Sustainability review: presentation of conclusions and recommendations to the Governing Board and Editorial Board aimed at developing larger, more sustainable units
- Completion of initial process pilots and implementation of changes for 1) separation of functions, and 2) journal-like style
- Audits demonstrate substantial improvement in consistency of quality across Cochrane
- Demonstration of substantial improvement in speed to publication for high priority standard intervention reviews published after the beginning of 2018 (mean < 20 months from protocol publication)
- MOU signed with all editorial units

18-24 months:

- Evaluation of progress

7 Impact and resources required

Budget and timeline

Budget justification

We describe the timelines and milestones aligned with the objectives of the plan below. Most of the work will be performed by the current CEU team; Table 1 details the additional budget requested.

The transformation programme outlined in this document is far reaching and addresses key challenges for Cochrane and the sustainability of the Cochrane Library. For this reason, we are proposing an evaluation at 18-24 months to check that the intended progress is being made before investing further.

Enhanced Editorial Board

We propose that members of the Editorial Board should receive one complementary registration for the Cochrane Colloquium, and the equivalent of re-imburement of one day per month. They will also be accorded the title of Associate Editor.

Sustainability review and ongoing management of vulnerable Groups

Throughout the year the CEU team will manage directly those CRGs identified as being at high risk of producing reviews that fall short of our standards. We will need additional resources because this work cannot be accommodated by the current team. We require an additional full-time, fixed-term, editorial support person.

In addition, we propose the development of discretionary funding from central resources that will be open for “networks” to apply for, in order to support strategically important projects.

Editorial process pilots

In order to ensure success, we require at least one full-time equivalent editor to provide support for CRGs. She/he will work with CRG teams to develop and monitor project plans, and will provide editorial support as appropriate.

We plan to work closely with the Project Transform team in support of the Living Systematic Reviews project. We are keen to ensure that the project is informed by methodological and publishing input, in addition to the technology function that is required. It is currently impossible to calculate what, if any, additional funding will be required.

Methods Support

We propose a centrally funded Methods Support Unit to work with the CRGs and the CEU to ensure that access to methods support for current methods is available, in addition to the editorial screening support.

Policy development

The Editorial and Publishing Policy team has initiated work to develop and update Cochrane’s policies, and these activities are a key part of delivering the supportive environment that we wish to create in order to facilitate the efficient production of high-quality reviews. This will include development of a ‘rejection’ policy and policies on the initiation and maintenance of satellites.

Expected savings from existing budget:

We are proposing to end the existing CRG support project totaling £200,000/year¹⁰, minus £72,000 already allocated in 2016/7.

Rollover of unused funds for integrated quality strategy budget in first year: ± £30,000

¹⁰ Includes a pre-agreed assignment of £72,000

Table 1: Requested budget 2017-2020

Project / workstream	Costs of new tasks (FTE / £)	Additional CEU costs (FTE / £)	2017	2018	2019	2020
Editorial Advisory Board	8 members /@£4,000 ea	0	£32,000	£32,000	£32,000	£32,000
Methods support team	1.5 FTE methodologists @ £50,000 each Plus methods lead @£15,000	0	£90,000	£90,000	£90,000	£90,000
Pilots		Additional editorial support 0.25 FTE @£45,000 each	£11,250	£11,250	0	0
Sustainability review		1.0 FTE editor @£45,000	£45,000	0	0	0
Discretionary payments for networks	@ £35,000 each	0	£70,000	£70,000	£70,000	£70,000
Quality and policies		0.25 FTE @£45,000	£11,250	£11,250	0	0
Admin support	@£32,000	0	£32,000	£32,000	£32,000	£32,000
YEARLY TOTAL			£291,500	£246,500	£224,000	£224,000
ADDITIONAL COST OVER CURRENT BUDGET¹¹			£91,500	£46,500	£24,000	£24,000

8 Evaluation

We propose an independent assessment of the activities in progress after the initial 18 to 24 months. We will also prepare a report to the Governing Board for each face-to-face meeting that describes progress against these measures.

We will create a number of metrics by which we can monitor performance. These include measures of:

- review quality;

¹¹ Taking into consideration savings from CRG support funds and underspend on integrated quality strategy in 2016

- speed to publication;
- innovation and complexity;
- impact;
- CRG team and author satisfaction;
- cost and value for money.

We also recognise the potential challenges and limitations of the current plan, and they have been summarized in Figure 3.



Figure 3: Potential challenges and benefits of the current Structure and Function Review proposal

9 Recommendations to CSG

We recommend that the Cochrane Steering Group approves the transformation programme in its entirety, including the four discrete areas and provides funding in support of this.

Appendix A: Timelines and milestones

Projects and streamwork	2016	2017	2018	2019	2020	Milestones
Enhanced Editorial Board						
Invitation of members to compose the board	█					<ul style="list-style-type: none"> • Editorial Board formed • Project strategy discussed with the Board and approved • Regular feedback reports to Board of Trustees
Selection process	█					
Bi-monthly teleconferences		█	█	█	█	
Face-to-face meetings		█				
Detailed report of activities			█		█	
Enhanced governance and transparency						
MoU between Cochrane and CRGs	█	█	█			<ul style="list-style-type: none"> • MoU signed with at least 30 CRGs by mid-2017 • All MoU signed by January 2018 • Rejection and sign off policies implemented by mid-2017 • New reviews and updates assessed quarterly with results publically available • CRG and CEU metrics finalized by mid-2018
Rejection and sign off policies	█	█				
Abstract/SoF checklist for new reviews and updates	█					
Abstract/SoF checklist quarterly report		█	█			
Reassessment of metrics			█			
CRGs review metrics			█	█		
CEU assessment			█		█	
Sustainability review						
Assessment of CRGs sustainability	█	█				<ul style="list-style-type: none"> • Assessment of CRGs' sustainability and and identification of 'sustainable editorial units' by mid-2017 • Conclusions and recommendations presented to Board of Governors and EAB aimed at developing larger, more sustainable units by end 2017
Report on consultation about less viable CRGs and proposed solutions			█			
Bi-monthly teleconferences with CRGs teams			█	█		
Encourage the creation of "networks" and provide discretionary funds			█	█	█	

Implementing the integrated quality strategy

Projects and streamwork	2016	2017	2018	2019	2020	Milestones
Screening of high priority reviews and updates and press releases						<ul style="list-style-type: none"> • Methods support team introduced and supporting CRGs on regular basis from April 2017 • Pilots 1 and 2 completed by mid-2017 and recommendations for implementation presented to Editorial Board • Pilots 3 to 5 completed by end 2017 and recommendations for implementation presented to Editorial Board • Audits demonstrating 95% adherence to prepublication checklist requirements • Publication for high quality priority standard intervention reviews in ≤ 20 months from protocol publication
Editorial development – editorial training material (LSD)						
Editorial development – periodic teleconferences on demand						
Appointment of Methods Support Unit						
Methods Support Unit (active)						
Pilot 1: Journal-like publication						
Pilot 2: Separation of the author support and editorial functions						
Pilot 3: Editorial changes for “empty” reviews						
Pilot 4: Experimenting with merging title registration and protocol development						
Pilot 5: Development of “living systematic review” concept						
Methods Network in place						
	2016	2017	2018	2019	2020	

Appendix B: Proposed publication checklist for all Abstracts, Plain Language Summaries, and 'Summary of findings' tables

Main questions:

- Is the research question PICO clear and the rationale for the review well described?
- Is the search date less than 6 months from publication and were trials registers searched?
- Is the methodological approach of the review appropriate and has it been followed in terms of conduct and reporting?
- Are the main (and all primary) outcomes for all important comparisons reported?
- Are harms (or the absence of harms) reported?
- Are absolute and relative effect measures reported?
- Are the direction and magnitude of effects of described outcomes clearly described where appropriate?
- Is there some estimation of the certainty (or quality) of the body of evidence using GRADE?
- Do the reported narrative results and conclusions match the GRADE SoF table(s) and are they appropriately described including the description of uncertainty, and the avoidance of reliance on statistical significance to determine presence or absence of an effect?
- Do the authors avoid making recommendations?

Other (positive) characteristics

- The review demonstrates features of complexity (complex question or interventions or analysis).
- The review addresses a different question type (DTA, prognosis, qualitative).
- The review demonstrates non-standard methods appropriately (network meta-analysis, sources of data beyond randomized controlled trials).
- The Abstract demonstrates excellent clarity of written English, and provides a valid and accessible summary of the review.
- Unit of analysis issues are appropriately addressed.

Structure and Function Review

Paper 2: Cochrane's Geographic Presence

[OPEN ACCESS]

Document prepared by:	Chris Champion and Mark Wilson
Submitted to Steering Group:	October 2016 (Seoul)
Purpose of the Paper:	In addition to the implementation of the adopted recommendations of the 2016 Centre, Branches & Networks Structure and Function Review (http://tinyurl.com/hzy9zrs), to propose further changes to the Centres model as a result of the organizational Structure & Function Review.
Access:	Open Access
Summary of recommendation:	To adopt the additional recommendations affecting Cochrane's geographic-oriented Groups (Networks, Centres, Associate Centres and Affiliates) arising out of the organizational Structure & Function Review; so that these can be implemented in future.
Resource implications:	No additional resources required in 2017. Small additional funds may be required from 2018.
Contact person for queries:	Chris Champion, cchampion@cochrane.org

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1 Executive Summary

Cochrane has already adopted and begun implementing the recommendations of its Structure and Function Review of Cochrane Centres, Branches and Networks¹ to meet the needs of its *Strategy to 2020*, expand its geographic profile and activities, and increase its impact on health decision-making in more countries and regions over the next decade.

However, in this paper – a companion piece to *Paper 1: Creating a more sustainable review production system for the Cochrane Library* - we consider the work of Cochrane’s geographic-oriented Groups within an organisational perspective. Cochrane needs to ensure that it establishes a united system of Groups (including Review and Methods Groups, and Fields) which work more effectively together to achieve Cochrane’s mission. We have a wealth of expertise in the organisation, but too often Cochrane’s Groups work in silos which do not maximize their potential collaboration and impact.

This paper therefore recommends a series of changes which will allow Cochrane’s geographic-oriented Groups to work less rigidly; integrate their activities more effectively with other Cochrane Groups; and offer authors and other collaborators and external stakeholders who interact with multiple Groups a more consistent and ‘joined up’ experience. In achieving this we hope to maximise the benefit from the contribution of all contributors and avoid duplication of effort.

2 Background

2.1 The role of geographic-oriented Groups in Cochrane

Cochrane ‘Centres’, ‘Networks’, ‘Associate Centres’ (formerly called ‘Branches’) and ‘Affiliates’ are Cochrane Groups that act with a country or regional focus for the organization. Their primary roles are to represent Cochrane, to support contributors to the collaboration’s work and to facilitate uptake of Cochrane’s outputs within a defined geographical or linguistic area. These Cochrane Groups are resourced by national governments or agencies and/or their host institutions and other funders; through the efforts of their Director(s) and other Group staff who attract core and project funding for Cochrane activities.

2.2 Structure & Function Review Changes

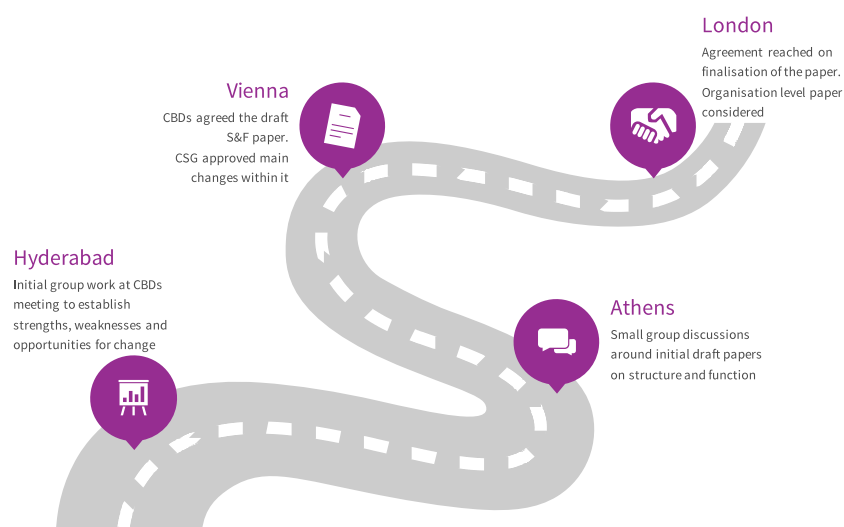
The review of Centres, Branches and Networks’ functions and ways of working, and the structures required to deliver them most effectively, started in Hyderabad, India in September 2014. Since then Cochrane’s Central Executive has worked with the Centre Directors’ Executive and the community of Centre and Branch Directors to develop a series of recommendations which were approved by Cochrane’s Steering Group in late 2015; and in the form of a final paper (*Implementing Strategy to 2020: Cochrane Centres, Branches and Networks Structure & Function Review*²) endorsed by the geographic-oriented Cochrane Groups themselves in July 2016. These revised functions, structures and accountability mechanisms will now be implemented in 2016-17. The main changes now being implemented are as follows:

¹ See <http://tinyurl.com/h7y9zrs> and Appendix 1 for more details.

2.2.1 Structural changes

We have introduced an additional geographic-oriented Cochrane Group type called ‘Affiliates’, which are smaller than the existing Branches structure. This allows for more individuals and institutions to be involved in Cochrane’s work; as well as establishing a more flexible, staged approach to developing a Cochrane presence in a country. It also allows Cochrane to develop multiple groups operating in a country, and for those Groups to offer specialized activities as well as expanding the capacity and opportunities for Cochrane evidence to be promoted and publicized in different parts of a country, and for collaborators to receive more localized support.

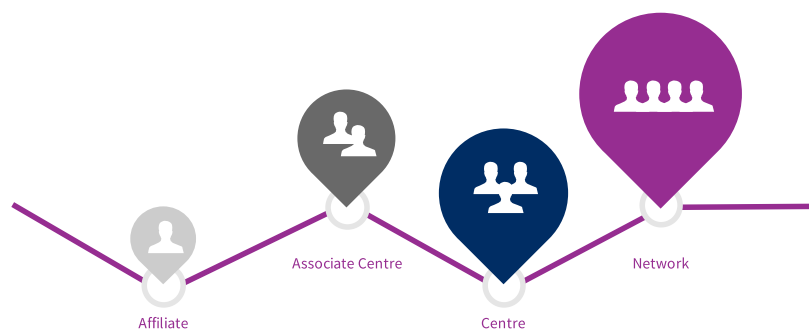
We have changed the name of ‘Branches’ to ‘Associate Centres’ and their outward naming conventions so that we no longer have Groups with names such as the ‘Japanese Branch of the Australasian Cochrane Centre’, which was problematic for Groups for a variety of reasons.



The final structural change is the formalisation of the Cochrane ‘Network’ concept which has been piloted so effectively by the Iberoamerican Network (see page 9).

2.2.2 Functional changes

The functions of Cochrane’s geographic-oriented Groups have been divided into four tiers to reflect the incremental increase in functional output of Groups as they progress from Affiliate to Associate Centre to Centre (and possibly, to Network). Tier One covers functions to be delivered by an Affiliate; Tiers One and Two by an Associate Centre; and Tiers One, Two and Three by a Centre or Network. Tier Four is a level of additional optional functions that can be delivered by any of the Groups. Centres need to undertake one additional ‘Tier Four’ function but other Groups need only undertake additional functions if they have the resources and appetite to do so. For instance, an Affiliate may take on the additional function of translation and support or run a country’s translation-related activities.



The key focus of the functions is around managing Cochrane’s presence in the country or region: including building partnerships and other stakeholder relationships, and undertaking associated knowledge translation activities to ensure that Cochrane evidence is used in that country or region. The strong emphasis on work that facilitates uptake of Cochrane’s outputs within a defined geographical or linguistic area, such as knowledge translation activities, is a significant change for some Groups, but it is critical to achieving Cochrane’s mission.

2.2.3 Accountability changes

Networks, Centres, Associate Centres and Affiliates are ultimately accountable to the CEO and through him/her to Cochrane’s Governing Board. However, direct accountability is established between the CEO and the Networks and Centres; with the Directors of those Cochrane Groups responsible for the support to and management of the Associate Centres and Affiliates who report to them. The reference Centre

concept that over the last 20 years governed the relationships between a Centre and Branch (now Associate Centre) has been changed and instead accountability, mentorship and support relationships between an Associate Centre or an Affiliate and a Centre will be defined on a case by case basis. This means that the Centre which supports and manages a smaller Group can be determined flexibly, to respond better to the range of factors that affect which Centre is best able and most willing to perform that role (for instance: language, location, common functional priorities, and common healthcare system characteristics). It is expected that most Associate Centres will continue to be accountable to a Centre; and Affiliates will be accountable to their local Centre or Associate Centre.

2.2.4 Core priorities for Geographic Groups

The Structure and Function Review of Cochrane Centres, Branches and Networks revealed several priority areas for geographic Groups. These key priorities are – and must remain - the main focus of their work:

- To ensure that Cochrane reviews inform decision making in health care it is fundamental that Networks, Centres, Associate Centres and Affiliates focus on the uptake of evidence through knowledge translation and advocacy.
- Only a geographic-oriented Cochrane Group can build the links and relationships needed and have the nuanced understanding of context required to work effectively on translating knowledge into practice and policy in their country or region.
- It is important that Centres involved in methodological research and support roles in review production continue in these roles, but we anticipate that many new country presences will need to be outward looking and focus on the exchange of knowledge.

For some Centres and Associate Centres there will be a challenge here, because of the disconnect between their own funding priorities and those of Cochrane. The Central Executive will work with each Centre/Network to discuss and agree how to deal with this tension and adapt accordingly.

Nevertheless, the organization-wide review has identified new opportunities and roles that geographic-oriented Groups, if they choose to, may want to take on.

3 New opportunities for Cochrane’s geographic-oriented Groups

The Organizational Structure & Function Review conducted, at the request of the Steering Group, since the Colloquium in Vienna in October 2015, concluded that in order for Cochrane to make most effective and efficient use of its available resources for the production and dissemination of health and healthcare evidence it is important that we break down the ‘silo’ approach in which Cochrane Groups overwhelmingly work within their own sphere of functional activities, and develop more active collaboration across Groups of different types. In relation to Cochrane’s geographic-oriented Groups this means:

- Playing a pivotal role in ensuring Cochrane evidence informs health decisions in policy and practice in their national and regional environments; and
- Having the option of playing a more active and integrated role in the production of Cochrane Reviews.

It must be stressed that these new possibilities and potential activities are optional, and in no way mandatory for any geographic-oriented Cochrane Group to take up. Funding support for some of these activities may be easier for the Group to obtain, and this new flexibility will allow them both to work on activities that interest them and to attract resource support that otherwise would have been closed to them.

For those Groups that are able to take a more involved role in the review production process there will be benefits with regard to knowledge translation, as this could be a form of co-production which can lead to more effective knowledge translation by having more influence earlier in the process and through being more informed about the work being produced. More generally the work of knowledge translation necessitates a high degree of collaboration between all Groups as there may be many Cochrane Groups involved in the knowledge translation of any given review, so the following proposals aimed at improving integration between Groups are important for facilitating knowledge translation work.

3.1 Greater integration with review production process

We want to create a system of Groups in Cochrane that allow us to produce and disseminate reviews more efficiently, taking advantage of all the skills and expertise that are dispersed throughout the organisation without duplicating effort. To do this we need to allow greater flexibility in Group types, and encourage greater integration between Groups where it leads to meaningful collaboration.

The most obvious framework for closer integration between Cochrane Groups is around the Review production workflow. In particular, we believe that closer involvement and collaboration in the process of producing the reviews will allow for an easier transition to the knowledge translation stage post publication.

Successful change would see Cochrane’s geographic-oriented Groups more closely integrated with the new ‘Health Systems’ that frame the outputs of Cochrane Review Groups (CRGs). These ‘Health Systems, as proposed in the *Structure and Function Review Paper 1: Creating a more sustainable review production system for the Cochrane Library*² are:

Potential Clinical Systems and Themes

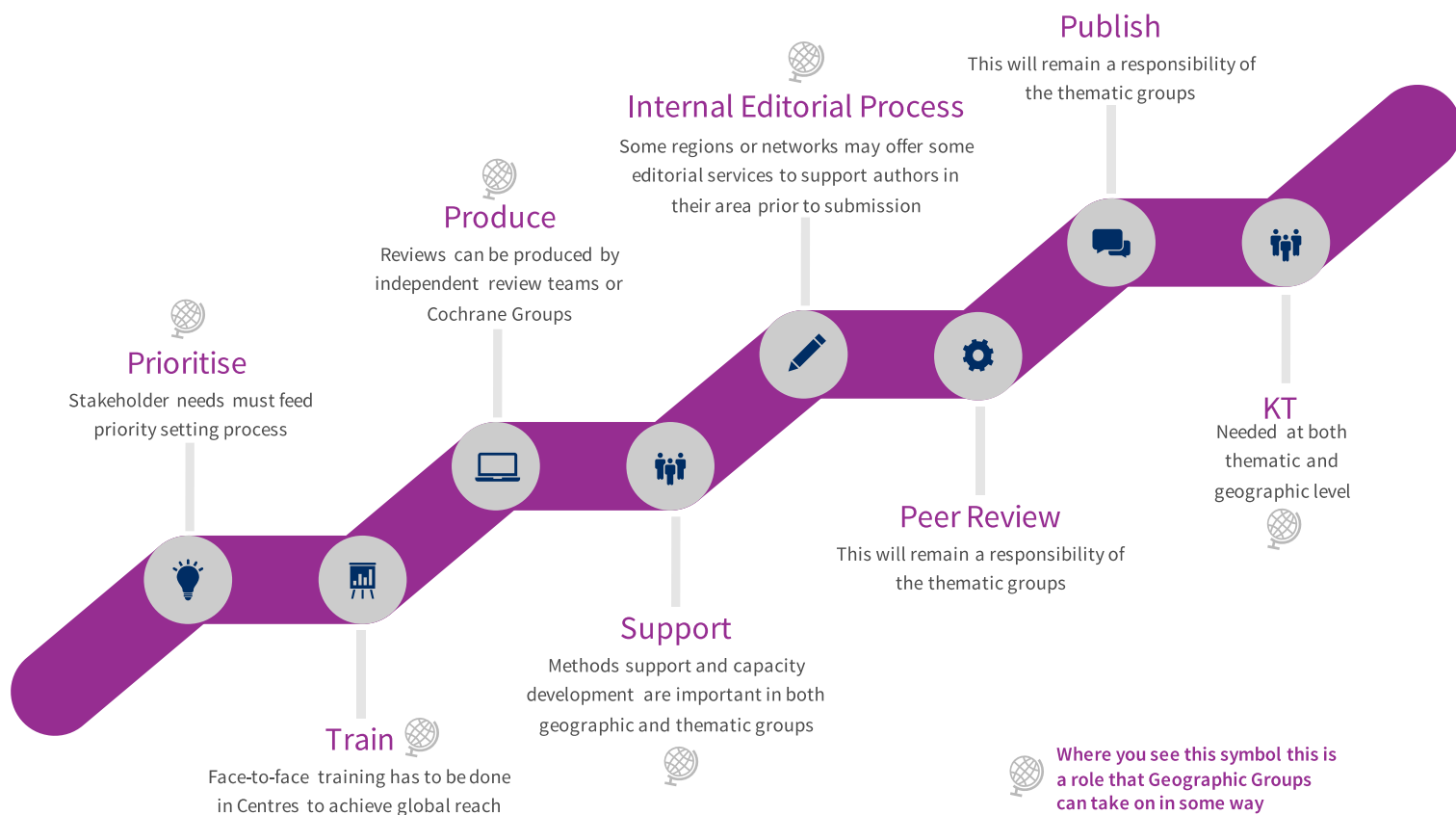
- | | |
|---|---|
| <ul style="list-style-type: none"> • Acute and Critical Care • Cancer • Cardiovascular • Gastrointestinal and Hepatobiliary • Metabolic, Renal and Genitourinary • Health Systems | <ul style="list-style-type: none"> • Mental Health • Musculoskeletal • Neuroscience & Sensory • Public Health • Reproductive and Child Health • Respiratory and Allergy |
|---|---|

3.1.1 Prioritisation

Producing the right Reviews that answer the most pressing, topical and important health questions is critical if Cochrane is to maximize the impact of its evidence on health decision-making worldwide. It is a key objective of *Strategy to 2020* and it is a core issue in the *Structure and Function Review Paper 1: Creating a more sustainable review production system for the Cochrane Library*. Good prioritisation requires extensive, high-quality input from external stakeholders, so that we know what they need in their decision-making. Geographic-oriented Cochrane Groups are ideally placed to contribute to this given their key role in building relationships with stakeholders locally.

² Available at: <http://community.cochrane.org/organizational-info/resources/organizational-structure-and-function/resources>

The sharing of this knowledge and insights to Review Groups so that they make the best decisions on prioritisation is complex, and will require a coordinated system to support such broad engagement in the process within Cochrane.



3.1.2 Training

Training is already one of the key areas of work for Centres and the function most commonly undertaken by them. However, training programmes are not always linked to need, so people are trained who cannot then register titles with CRGs. We need to work with Centres to create a system whereby training is more closely linked to review production needs, and create a system approach that allows authors to access the training support they need at different points in their Cochrane journey on a local level.

Training that falls outside of this Cochrane need should be capitalised on as a commercial opportunity for Centres. Many Centres already offer paid-for training courses to non-Cochrane authors, and we want to encourage this as a way of helping Centres to be sustainable. However, training is not all about review production. It is important that we are training people in the use of evidence, and other skills relating to dissemination, knowledge translation and advocacy.

3.1.3 Producing Reviews

Reviews are often produced in Centres by in-house systematic reviewers or Centre staff who have an interest in authoring reviews. Where this is leading to highly capable repeat author teams this is to be promoted. However, some author teams do not necessarily need to use the full support of the Cochrane CRG process, which may slow them down. As an alternative approach we intend to pilot and implement a 'journal style' fast track editorial process which allows for final submissions of reviews from such Groups, assuming a protocol has been registered (e.g., on Prospero). This will allow Centres to author and provide support for more Cochrane Reviews, as currently a lot of their work is not published within Cochrane when they have to produce reviews rapidly, e.g. for national guidelines.

3.1.4 Supporting Review Production

Methods Support Service

The Methods Groups’ Structure and Function Review identified the need for a Methods Support Service so that authors and CRGs can access methodological support more easily and quickly. It appears to make sense to structure this support geographically, and have a small number of units based in Cochrane’s geographic-oriented Groups. We expect that this would involve some funded time for a coordinator who helps to triage the incoming requests. Ultimately, though, the unit would be reliant on methodologists working locally (i.e., in a country or region) who are willing to be part of the Support Service. We envisage that these units are most likely to be based in a regional structure, which would allow, for instance, for a Methods Support unit serving the Spanish speaking community to be set up as part of the Iberoamerican Network.

The methods elements are covered in more detail in *Structure and Function Review Paper 1*.

Review production support

Many Centres have a vested interest in developing the contributor base in their country. In many cases this will be part of the reason why they are funded and results in local training programmes and sometimes more bespoke support to author teams.

We think that this role in Centres could, where desired, be expanded to become more comprehensive in creating a positive and supportive environment for review production. The aim would be to assist in the support and nurturing of authors in order to increase the standard of quality of submissions to CRGs and the ‘Health Systems’. Authors in different countries will face different challenges, so all of the ideas here will not be relevant in all situations. It is also essential that where support is given, those providing that support must be adequately trained to do so, but it could include:

- English language support;
- Methods support/training in the authors’ own language;
- Support for writing reviews in the authors’ own language;
- Local review screening prior to submission (based on the screening guide being developed by the CEU screening team);
- Mentorship/guarantorship;
- Learning and support for the whole journey of producing a review;
- Intensive remedial work for authors who have had submissions rejected.

Some of these are support activities that existing Centres and Branches may already provide as part of their work for Cochrane. There will need to be some standardisation of approaches and tools to ensure that the materials being used are appropriate and those delivering the support are adequately trained.

Some of these possibilities, however, represent significant shifts. For example, supporting authors to write reviews in their own language is a major departure. This would need to be tested before rolling out to more than one language, but the basic premise would be that the authors could produce the review in their own language and receive support in that language throughout the process from their local Group. The review would be translated into English at a point in the process when it needs to be considered for peer review. This may help to address quality issues where language is a barrier to otherwise highly capable researchers producing high quality reviews.

Geographic-oriented Groups wishing to take on additional work around review support will need, in turn, to be confident of support from their funders. This expanded review production, training, mentoring and author support would be regarded as additional Tier Four functions, where the local context requires such a level of service and where a funder is interested in supporting it.

3.2 Further development of Networks

Cochrane’s Steering Group in April 2016 highlighted that the organization should aim to consolidate its Group structure, where possible, into fewer, larger Groups where this could lead to a more integrated and efficient production and dissemination system.

Merging Centres together to make fewer, larger Centres does not make sense; as their work is explicitly focused at a country level. However, this does not preclude some improvements to the way we organise the overarching structure of Centres. We believe that some form of networked approach whereby Groups collaborate in certain areas could lead to more effective and easier collaboration, not just between Centres but also between Centres and other Groups. The Central Executive investigated whether Cochrane should establish regional groupings to help support, administer and manage geographic-oriented Groups within them, possibly following the WHO regional structure.

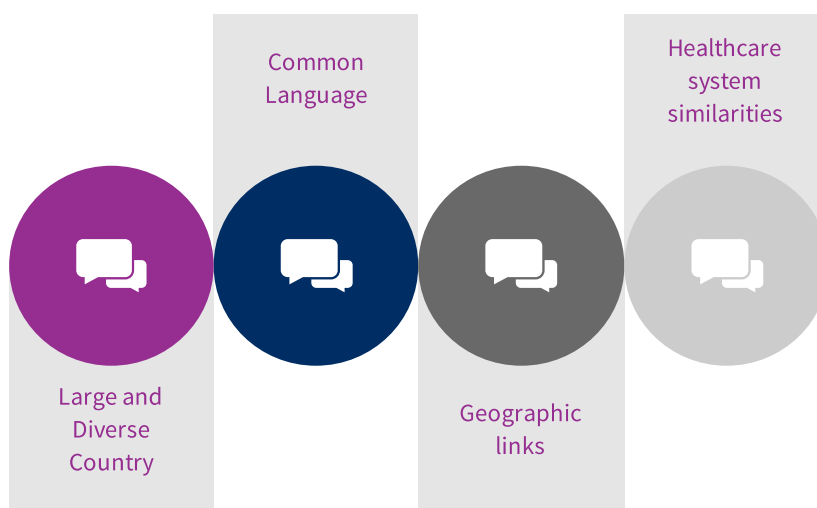
We are only interested in consolidation that maximises benefit and minimises cost and unnecessary bureaucracy. Working together in a given area of activities has to offer clear benefits to the Groups involved. The Central Executive’s conclusion was that regional consolidation along the lines of the WHO structure was not worthwhile, as the benefits were not greater than the likely costs of implementation. However, we think that several large countries will benefit from a Network approach (as set out in the *Centres, Branches & Networks Structure & Function Review*) as would certain cross-country regions, so we will work with those countries to develop these networks over the coming years.

In the next decade, if Cochrane continues to grow at the pace of the last five years, we will need to adopt a more regional approach to effectively manage the growth³, so this situation will be monitored and periodically reconsidered.

3.2.1 Network development factors

Cochrane Networks will be useful in countries that are geographically large or where there is significant diversity within a country. We also think that they will be useful in regions where there is either a common bond (such as a common language as in the Iberoamerican Network) or where Groups are small and could benefit from working together collectively in a region. There may also be instances where common approaches to healthcare drive relationships between Groups, but this may be more applicable to informal, additional relationships that are established between Groups.

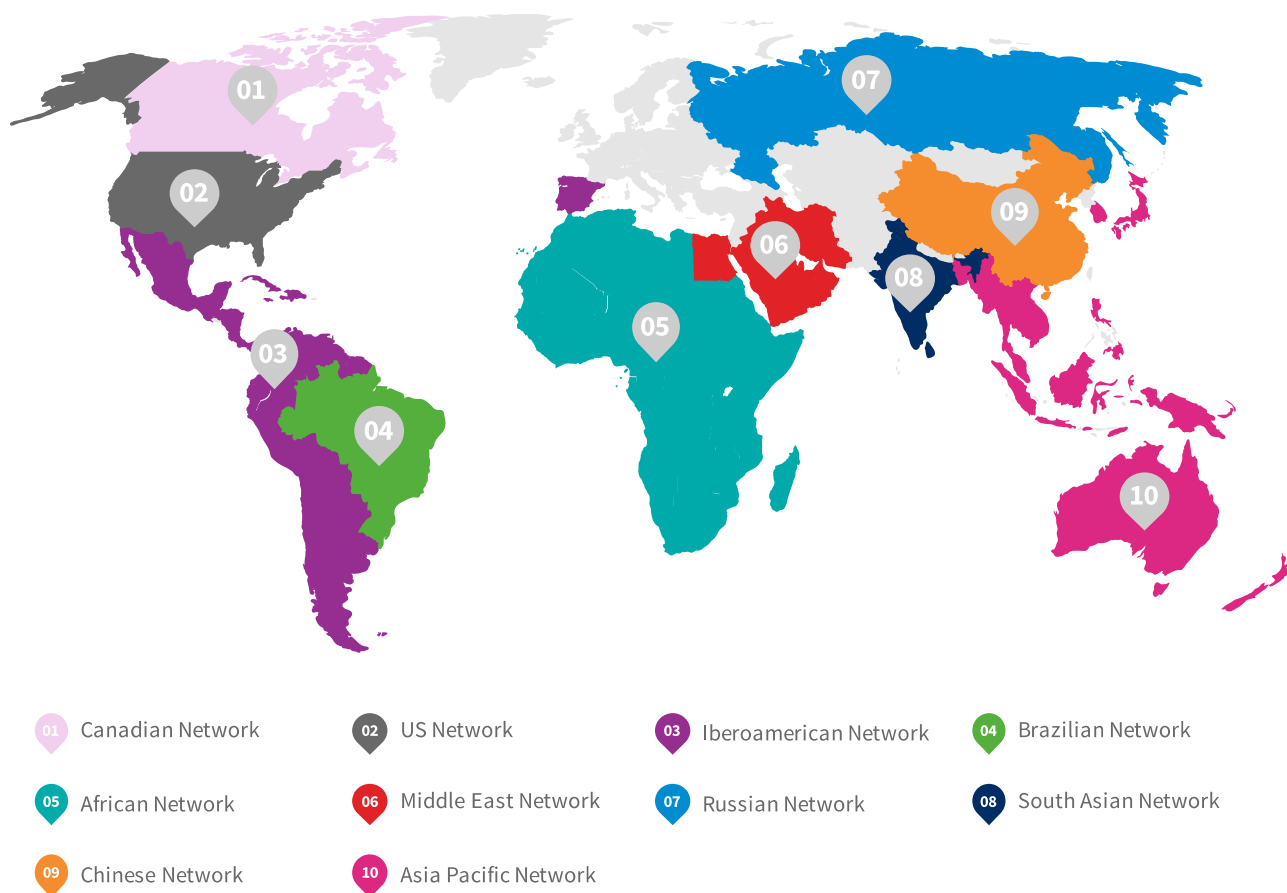
Potential factors to consider in developing Networks



³ Whilst there have been no new Centres registered in the last five years, there have been a large number of new Cochrane Branches registered leading to an increase of over 50% in the total number of Centres and Branches.

3.2.2 Areas where networks are already under consideration or will be considered

The below is not an exhaustive view of where networks may be of use to Cochrane, and we would welcome other suggestions, but it gives a starting point for where we might seek to establish networks in the short term.



4 Cochrane’s Knowledge Translation Strategy

Cochrane’s Knowledge Translation strategy will set out the key themes and approaches of knowledge translation work for all Groups. It will also drill down into each theme and provide examples of activities that can be undertaken. This will help geographic-oriented Groups to prioritise the knowledge translation work that they engage in; but it will also set out priorities for collaboration with other Groups as common ground is established in terms of areas of mutual interest in knowledge translation.

In particular, we expect more collaboration between Fields and Centres as the Knowledge Translation strategy comes into effect. The future of Fields will be closely linked to the KT strategy, given their role in stakeholder engagement and KT, but to achieve as broad an impact as possible they will need to work in collaboration with geographic-oriented Groups to tailor KT products, services and approaches to local contexts. Fields’ KT expertise can also usefully be taken advantage of by Centres and other geographic-oriented Groups.

Much more detail about the collaborative ways of working to increase the influence and impact of Cochrane’s KT work across all its Groups will be provided by the KT strategy when it is finalized for the Mid-year meeting in April 2017 in Geneva.

5 Proposed timelines and project plans

The Central Executive’s priority in 2017 will be to focus on implementing the core function changes already approved in the *Centres, Branches & Networks Structure & Function Review*; and supporting new or existing Cochrane Networks. Following agreement with each Cochrane Centre on the new mutual accountability documents (Collaboration Agreement), the Central Executive will work with each Centre to discuss and agree its annual/multi-year plan of action based on its available resources and local priorities. As part of this we will identify challenges or barriers to the Centres developing in this way (e.g., its funder priorities are not aligned to Cochrane’s functions) and we will support Centres to deal with this.

Embedding the strengthened focus on knowledge translation by geographic-oriented Groups as part of the Knowledge Translation strategy will also be an important area of work in 2017.

If approved, Cochrane’s Central Executive will support Groups who show an interest in diversifying their functions as set out in this paper. However, the Central Executive is not yet budgeting for the resources to support the implementation of the full range of changes or the creation of many Networks, so we will prioritise and phase the changes according to expected benefit and local appetite.

Whilst the objective of breaking down silos and improving and increasing collaboration and greater integration between Cochrane Groups of different types is essential, these changes will have to be carefully managed to complement those involving Cochrane Review Groups and the review production process⁴, as well as other critically important initiatives such as the launch of Cochrane’s membership scheme and finalization of its Knowledge Translation strategy in 2017, and the further development of collaboration and support platforms like Task Exchange and Cochrane Crowd.



A number of Cochrane’s Associate Centres are already preparing applications to become full Centres; and we expect many new applications in the coming years for Affiliate status both in countries where a Cochrane presence already exists, and those in which no recognised Group has been established yet.

6 Impact and resources required

⁴ See *Structure & Function Review Paper 1: Creating a more sustainable review production system for the Cochrane Library*

Oversight, management and support for the changes already under way from the *Centres, Branches & Networks Structure & Function Review* will be provided from existing Central Executive resources (principally in the Chief Executive’s Office).

The need for additional resources to support geographic-oriented Groups develop as recommended in this paper will emerge in 2017-18 as the changes to Cochrane Review Groups and the review production process are implemented. It is expected that – given the optional nature of many of these activities – the extra costs will be small. Specific funds for some initiatives (such as the Methods Support Service units) will be made available. In addition, there may be a need to create a small fund to encourage change and innovation in the work of Networks, Centres and other geographic-oriented Groups from 2018.

7 Evaluation

To understand the success of the changes outlined here we need to think about what success might look like and then identify key measures we might want to evaluate. From the organisational perspective, we think success would be:

- Improved, efficient inter-Group collaboration; with Cochrane Groups operating as a single system and providing more coherent and integrated support to authors.
- Cochrane evidence is flowing through to decision-makers everywhere, driven locally by Networks, Centres, Associate Centres & Affiliates; and Cochrane is increasingly recognised and valued as a key evidence provider.
- High quality methods support and training are available for authors on a geographical basis.
- Networks, Centres, Associate Centres and Affiliates operate under a clear, manageable and meaningful accountability structure.

7.1 Evaluating this success

These are complex outputs to measure, but there are various avenues we can explore to get an understanding of success in these areas:

- Stakeholder satisfaction surveys to assess how well Cochrane evidence and knowledge translation products and services are meeting their needs.
- Cochrane’s internal monitoring and reporting mechanisms: where each Network and Centre will provide an annual report on their activities based on their own strategic/annual plans.
- Author experience surveys to show whether we are meeting our authors’ needs; and an increase in the number of authors returning to do second or subsequent Cochrane Reviews will provide a key metric on improved author retention.

8 Recommendation to Cochrane’s Steering Group

8.1 Approve Changes to structure and function laid out in the paper

To adopt the additional recommendations affecting Cochrane’s geographic-oriented Groups (Networks, Centres, Associate Centres and Affiliates) arising out of the organizational Structure & Function Review; so that these can be implemented in future.

8.2 Approve the associated budget in principle

The Central Executive expects to meet the 2017 costs of oversight, management and support for the changes set out in this paper within existing resources budgeted for 2017. There may be requirement for a small additional resources in 2018 to facilitate and support Cochrane’s Networks, Centres, Associate Centres and Affiliates adapt to these changes in 2018 and beyond.

Appendix 1: Centre and Branch structure and function review paper

As outlined in sections 1 and 2 above, Cochrane has already adopted and begun implementing the recommendations of its Structure and Function Review of Cochrane Centres, Branches and Networks to meet the needs of its *Strategy to 2020*, expand its geographic profile and activities, and increase its impact on health decision-making in more countries and regions over the next decade.

The approved paper is available online and can be accessed from this page:

<http://community.cochrane.org/organizational-info/resources/organizational-structure-and-function/resources>

Alternatively, you can navigate directly to the document here: <http://tinyurl.com/h7y9zrs>

Appendix 2: Consultation with the Cochrane Community

The proposals contained in this document were presented to the Cochrane community in four webinars held in July and August 2016. The feedback was very positive. Below we summarise some of the key areas of discussion in the consultation webinars.

Practical details of implementation

There were some questions on how the potential integrations with review production will work in practice. This level of detail has not been developed yet, as we need to wait until the future structure and improved ways of working of CRGs are clearer before establishing more definitive proposals.

There were also specific questions about the integration with priority setting, which is an area that many collaborators and Groups were interested in contributing to. Priority setting is largely driven by the CRGs and that is appropriate; but geographic-oriented Groups should be encouraged to undertake priority setting exercises and feed the results into Cochrane review and other evidence planning. We need to build a more robust system for tracking ongoing priority setting exercises so that people can easily contribute in this way.

Knowledge translation emphasis

There were various questions around KT structures and support. The KT strategy will determine this, but it is not yet complete.

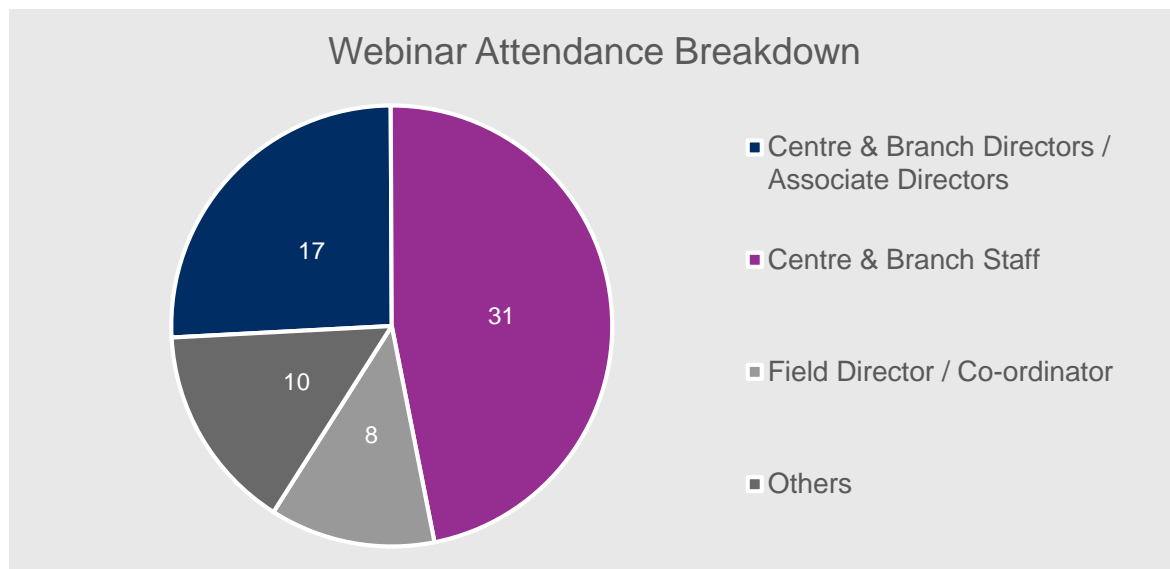
There was also acknowledgement that whilst some Centres are heavily engaged in KT activities, for others KT is not currently a priority (or an activity at all). This will take a big change and will need the backing of funders. The CEO’s office is willing to support Centre Directors in those conversations with funders; and the KT strategy will help guide Centres who are establishing new KT programmes of work for their Centre (as mentioned in sections 2.2.4 and 5 above).

It was highlighted that Fields have a lot of experience in KT that needs to be leveraged by Centres. In many cases Fields may work on KT activities which are then delivered locally in different countries through the geographic-oriented Groups. This is covered above in section 4.

The final area of enquiry around knowledge translation was about the evidence available. Cochrane doesn’t always have all the evidence to respond to stakeholder needs. When undertaking KT this could be an issue and it may be wise to use non-Cochrane evidence in addition to the Cochrane Evidence in such work. This may be true for some KT activities. Where there is an identified gap in Cochrane this needs to be fed back into the priority setting framework. The knowledge translation strategy is focussing primarily on the knowledge translation relating to Cochrane outputs, so this is where the main focus for the organisation will be. This challenge is more relevant to the Knowledge Translation strategy development and so is not covered in this paper.

Quality and management of smaller Groups

Some questions concerned how the quality and performance of Affiliates will be managed. We have set a clear accountability framework such that Affiliates will report to their local Associate Centre or Centre, who will be expected to monitor the quality and performance of their work. The CEO’s Office will always be available to the Centre/Associate Centre to support them where there are concerns. These issues are covered in the approved structure and function review paper relating to Centres, Branches & Networks (see appendix 1 for details).



Of those who attended, the following locations were represented:

Andes	China	Netherlands	Switzerland
Australia	Denmark	New Zealand	Taiwan
Austria	Finland	Nigeria	UK
Belgium	France	Nordic	USA
Bosnia and Herzegovina	Germany	Norway	
Canada	Hungary	Portugal	
Canada Francophone	Iberoamerica	Singapore	
Central America and Spanish-speaking Caribbean	Italy	South Africa	
	Japan	South America	
	Malaysia	South Asia	

Structure and Function Review

Paper 3: Cochrane Fields: An Update on proposals

[OPEN ACCESS]

Document prepared by:	Chris Champion and Mark Wilson
Submitted to Steering Group:	October 2016 (Seoul)
Purpose of the Paper:	To provide an update on the Fields Structure and Function proposals in light of the developments in the Cochrane Knowledge Translation Strategy.
Access:	Open Access
Summary of recommendation:	This update paper is for information. A full proposal with recommendations will be submitted to the Geneva CSG meeting, April 2017.
Resource implications:	No resource implications are considered in this paper. The final proposals to be submitted in Geneva, April 2017, will detail any required resources.
Contact person for queries:	Chris Champion, cchampion@cochrane.org



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1 Introduction

The Fields structure and Function review was put on hold last year, following initial proposals tabled in Vienna, as it became apparent that Cochrane needed to make progress with its Knowledge Translation (KT) Strategy before we could further consider the role of Fields. We have now made significant progress with the KT Strategy and so, for the purposes of providing context to the other structure and function discussions in Seoul, the Central Executive (CET) is providing this update on how it thinks the Fields structure and function proposals could develop given what we now know from the KT strategy work.

This paper sets out some updated proposals, based on those developed for the Cochrane Colloquium in October 2015. The proposals will need to be developed further with Fields and other Groups over the coming months. The CET anticipates that final proposals on the future of Fields will be considered by the Cochrane Steering Group (CSG) alongside the final draft of the Knowledge Translation Strategy at the Geneva mid-year meeting in April 2016.

Fields Structure and Function review timeline



2 The KT strategy

The Cochrane Knowledge Translation Strategy is a critical piece of work that will elaborate on our *Strategy to 2020* commitments to knowledge translation (KT) by providing clarity around Cochrane's role in KT and what activities should be considered as priorities both at Group and organisation level.

We have made good progress on the Cochrane Knowledge Translation Strategy throughout 2016. In particular, work so far has highlighted some key areas of focus for Cochrane's KT work and the major audiences we should be serving. This helps us draw some boundaries around what Cochrane's KT role should be and, importantly, allows us to think again about the role that Fields could play in Cochrane with regard to KT.

Within the strategy there will be six key theme areas for our KT work and under each there will be a menu of options for Cochrane Groups of all types to consider so that they can apply their own prioritisation based on their context.

Whilst the strategy does not explicitly define KT, it does give clarity on what we consider to be the KT activities relevant to Cochrane; so that when a Group is undertaking KT activities as part of its functions there is clarity regarding what that means. One point that is particularly important to emphasize is that we want KT in Cochrane to be a bi-directional process. We have lots to learn from our stakeholders and we can prioritise our review production more effectively if we listen to our users.

For more information on the progress of the Cochrane KT strategy, see the document: *Cochrane Knowledge Translation (KT) Strategy update for the CSG, October 2016*, which is also being submitted to the Steering Group for the Seoul meeting.

The Strategy outlines six key themes:

Theme 1: Prioritisation and co-production

Stakeholder engagement to determine and refine Cochrane priority topics for reviews and maximize opportunities for KT, in order actively to involve target audiences throughout the whole process (e.g., in topic selection, design, execution, interpretation, dissemination of Cochrane content).

Theme 2: Packaging, push and support for implementation

Creating fit for purpose reviews and review derived outputs, disseminating them effectively through appropriate channels for a range of target audiences, and providing resources and tools to support implementation of findings.

Theme 3: Facilitating pull: enabling discovery and use of Cochrane reviews to inform decision-making

Facilitating use of Cochrane reviews in health decision making through ensuring our reviews are easy to find, access and understand; and developing capacity in target users to use our reviews and products.

Theme 4: Exchange

Facilitating interactions between decision-makers and Cochrane Groups and authors to ensure priority topics for decision-makers are addressed and decision makers have the opportunity to input into KT approaches.

Theme 5: Improve climate and build demand for evidence syntheses

Laying the foundations for use of Cochrane outputs by promoting evidence-informed decision-making and advocating for the use of systematic reviews.

Theme 6: Effective and sustainable KT structures and processes in the organization

Coordinating Cochrane's KT work, monitoring and evaluating strategy, managing and sharing the knowledge generated for and about KT in Cochrane, and acting on the lessons learned.

3 What is the need for Fields?

One size doesn't fit all. A Cochrane Review is perfect for some stakeholders and it is certainly a good primary or basic/foundational publication, but for many stakeholders it is long, complex and insufficiently tailored to their needs. As a result, we need to translate this knowledge and re-organise or re-package content so that it is meaningful to our many external audiences. We need a degree of fluidity in this, as our external stakeholders will have different ways of organising health topics, too. Therefore, there is a role in Cochrane for Groups which focus on the needs of particular audiences in an appropriate manner, which may well differ from our internal categorisations used to organise Cochrane Review Groups (CRGs). This role of responding to the needs of particular audiences belongs to Fields.

To be effective, Fields need absolute clarity about who their audience is. They should be a stakeholder-driven, outward facing layer of Cochrane that can make sense of Cochrane for others by re-organising or re-packaging content and undertaking knowledge translation so that Cochrane evidence meets stakeholder needs. Fields should represent a bridge between Cochrane and their external stakeholder communities to help people easily access, engage and communicate with us. The role is not just about pushing information out to stakeholders, it is bi-directional, we need to listen to and learn from our stakeholders and feed that learning and insight into Cochrane. Functionally, all of this work is very closely tied to the Cochrane Knowledge Translation Strategy and - to a large extent - the functional elements of the Fields' role need to be written in the terms of that strategy.

CRGs have and will perform some of these functions, increasingly as part of larger thematic groupings covering specific areas (see Structure & Function Paper 1 for details). But this focus on topic areas may not always be the way in which Cochrane wants to communicate the reviews or engage with external stakeholders, or be sufficiently fluid to meet the diverse range of perspectives required by our stakeholders. When engaging externally we may need to present Cochrane evidence according to categorisations in use by others or in ways that healthcare is organised in healthcare systems. A good example of this is the Global Ageing Field, which is working closely with and responding to the WHO Global Ageing Agenda. For the outside world it is irrelevant that reviews relevant to this subject are produced by Cochrane in different CRGs; what matters is that Cochrane is able to engage in shaping and responding to the WHO agenda through a single Cochrane presence providing much-needed evidence to inform policy.

Fields must also promote their areas of interest internally within Cochrane so that, for instance, high priority reviews which their stakeholders need are identified and taken on by Cochrane. There may also a role in standardising the way various Cochrane Groups approach methodological challenges of a given topic area relevant to the Field (e.g., standardising outcomes, sub-group analysis guidance or managing trial design issues relevant to the interests of the Field's stakeholders). Like the knowledge translation work that Fields do, this internal advocacy and engagement needs to be driven by the effective engagement they have with key external stakeholders and in many cases where this input is received in the production process the subsequent KT is easier more effective.

4 Four primary dimensions of Fields activities

Network Building

01

Connect stakeholders in a given area to create a global network, including those involved in:

- Production;
- Dissemination; and
- Implementation of evidence-based practice.

This should be integrated with and facilitated by Cochrane Membership.

Building Demand / Advocacy

02

- Advocate for Cochrane or other EBM to be used in decision making in the field
- Promote evidence-based practice
- Promote Cochrane Evidence
- Provide education and training on the methods and application of Cochrane Evidence for stakeholders
- Linked to this is a role in internal promotion/advocacy to emphasise the external stakeholder needs to those within Cochrane.

This maps to the knowledge translation strategy Themes 3 and 5

Knowledge Translation Outputs

03

This is the outward communication of Cochrane evidence through activities such as:

- Re-packaging content;
- Producing summaries; and
- Disseminating to targeted stakeholders

Precise activities will be recommended in the Cochrane Knowledge Translation Strategy and a Field will then prioritise based on the needs of their stakeholders.

This maps to the knowledge translation strategy Theme 2

Stakeholder Engagement

04

The KT strategy will emphasise the bidirectional nature of KT in Cochrane. Stakeholder feedback can inform:

- Outcome priorities
- Review topic priorities
- Cochrane methodological research

Opportunities for collaboration and commissioned work will also flow through these channels as we understand the needs of our stakeholders.

This maps to the knowledge translation strategy Themes 1 and 4

5 Organising Models for Fields

Fields don't need to be and shouldn't be fixed entities rooted in one location. The most appropriate organising model for Fields is a 'dispersed network' model, in which the activity of people in different places around the world is managed from one or several sites. Examples include (but are not limited to):

- Child Health and Insurance Medicine, where Fields have multiple Directors in different countries, each managing some activity at their base;
- Nursing Care, with a "node" model where specific activity is managed by nodes located around the world.

These models are examples of generating maximum reach at lower cost, and, if the Field is successful in building a large network of people it will have high impact.

New Field Groups should be prioritised based on external factors. In fact, a new Field does not necessarily have to be permanent. For example, if there was a WHO initiative running for three years and it was important Cochrane had a cohesive team responding directly to that initiative, then a Field could be set up for the duration of the initiative and disbanded once the specific external need was met. As with any Cochrane Group, good, proactive leadership in such Fields would be critical to ensure that they are effective and worthwhile.

This approach will also be able to take advantage of the new Cochrane Membership scheme, which is in the process of being introduced, as it will allow newcomers to be more effectively signposted to the work of the Field and it will also allow the Field to target particular individuals who might be interested in participating in their network.

A structure of subgroups within the network would be a useful approach, whereby leadership for certain areas of work of the Field is delegated to small Groups. This takes the pressure off the Field Director, and allows for deeper engagement from a broader range of interested parties.

Recent applications to form Fields have come from Groups who have taken a dispersed Network approach and tried to approach the tasks in a low cost manner through leveraging the network. Historically, many Fields have struggled to attract and retain funding; and there still needs to be some limited funding to hold the Field together and provide a level of coordination, but it is clear that we need to think creatively about how to resource the work and not expect to have a full-time, paid team for each Field.

Having said this, it is important to acknowledge that knowledge translation work is a serious undertaking that requires dedicated effort from those involved. Groups who have had paid staff have been more productive, as would be expected, and so whilst we want to promote models of organising Fields that are low cost, but functional, we acknowledge that Cochrane must secure sufficient funding in different ways to adequately resource its KT ambitions and objectives. This could be through seeking project funding for discreet initiatives within Fields. This has the disadvantage of being short term and requires a lot of effort to secure for each project, but it is an area where some Fields have had success.

6 Scope of Fields

To avoid duplication of effort it has always been important for Cochrane Groups to have a defined scope for their work. Each Group has a scope defined by their unit of interest. For Centres, the unit of interest is their country or geographical region; for CRGs it is reviews in a specific health area, and for Fields it is a particular stakeholder community.

Some Fields may serve a single stakeholder group, whilst others may be equipped to serve multiple stakeholder groups in their area. As long as there is clarity over who is interacting with which stakeholders and we are operating in a collaborative and integrated fashion then this is not a problem.

7 Interactions with Centres

Collaboration between Fields and Centres is vital. Whilst Fields will have many direct contacts with their stakeholders, working in partnership with Centres can help Fields to extend the reach of their work and, where relevant, contextualise the outputs for each country.

Where a Field operates within a country where there is a country (or a regional) network the Field may choose to be part of that Network as an Affiliate group. The Field would still retain its autonomy and would continue to be accountable to Cochrane through the mechanisms in place for a Field, but it would be able to integrate more with the Cochrane work in its country to develop stronger country and/or regional collaboration. In some cases, a Field may have multiple sites: e.g., with different Field directors operating in several countries. In these instances, assuming there is sufficient local Field activity, the Field could have Affiliate status in multiple country or regional networks.

Having an additional link and status with a regional or country Network should not be seen as limiting the scope of a Field. Fields are intended to be international, and this should be seen as promoting strong local ties in addition to their international relationships.

8 Interactions with CRGs and their thematic groups

The focus of a Field's work (see section 4, above) is driven by external stakeholder groups and their evidence needs. The nature of the work is firmly based around engaging stakeholders so that KT is embedded within Cochrane. As such, Fields could be considered to be a layer around Cochrane's review production infrastructure that facilitates stakeholders to engage with Cochrane throughout the production process (e.g., from question prioritisation, outcome choices, and co-production through to dissemination).

As a result of this Fields can overlap their area of topic interest with that of a CRG and still work effectively. However, there needs to be proactive communication and collaboration between Groups to allow this to work well. The changes to CRGs proposed in Structure & Function Paper 1 offer opportunities for better, simpler communication channels which could be useful.

In some, if not many, cases the CRG will have good working relationships with key stakeholder groups related to their scope, or in the new model set out, with key stakeholders in their thematic groupings. Where this is the case the CRGs (individually or collectively) can perform a Fields-style role in KT and external engagement. Given that Fields are not alone in building relationships with external stakeholders it is important that there is clarity about who is engaging with which stakeholder groups so that we do not overburden or confuse them.

9 Addressing practical barriers to collaboration

Fields in the past have highlighted the internal barriers to collaboration within Cochrane, leading to unsuccessful working relationships between Groups. The barriers highlighted by Fields include communication issues between Fields and CRGs; lack of interest from CRGs in participating in Fields' KT initiatives; the inability of a Field to track reviews they are interested in effectively; no exposure of the produced KT outputs leading to duplication of effort; inability to share resources and good practice; and conflict over the content of KT outputs.

There is a need for easy and effective collaboration between those producing the reviews and the potentially diverse range of people involved in knowledge translation and dissemination of those reviews or associated products to our many external stakeholders.

In the previous paper on Fields presented in Vienna, there was a proposal to create a forum approach to bring people in different Groups together to discuss the KT work relating to reviews as they are produced. There were issues around the practicality of that approach, but it is noteworthy that Cochrane UK already has a similar process in place to assess all Reviews as they reach a certain milestone. This is an interesting approach to the challenge of monitoring the publication output to assess and prepare for the KT needs, but it is not a straight-forward idea to scale up as, ideally, each output needs KT consideration by all Centres (to understand local relevance) as well as many different Fields (to understand its relevance to their stakeholders). The Cochrane UK process is explained below as a case study.

We need a way of recording KT activities undertaken on any given review so that others undertaking KT on the review can take advantage and not duplicate effort, and so the CRG and authors can be aware of the dissemination of the review. This would involve sharing details of the KT undertaken and links to outputs and materials that can be shared or reused. It would also help if we developed workflow tools that allowed those interested in undertaking KT on a review to create a workflow around this which could then alert those involved when it is time to initiate the KT work. This support system could lead to improved transparency and communication, better collaboration and the opportunity to have a more integrated approach to KT.

Case study: Assessment of Review Group Output – Cochrane UK

One of the ways that Cochrane UK seeks to increase the impact of Cochrane Reviews is through targeted dissemination activities using a range of media, including via the Cochrane UK *Evidently Cochrane* blog, Twitter, Facebook, Instagram, newsletters and traditional media. One of the initial steps in this process is to identify newly published and prepublication reviews that have reached Milestone E in the Cochrane editorial process. The abstracts and summaries of these reviews are discussed in a multidisciplinary meeting to assess the potential for wider dissemination for each Review, identify audiences that could be interested and suggest channels for dissemination that might be appropriate. The multidisciplinary team currently consists of general practitioners, a public health consultant, a consultant surgeon, medical trainees, communications professionals, information professionals, a nurse and an allied health professional. Another small team of clinical practitioners (including an anaesthetist, a rehabilitation consultant, a physiotherapist, a cardiologist, a gynaecologist, a neurologist, an ophthalmologist and a consultant vascular surgeon) available to contact via email with specific queries concerning the importance and relevance of any reviews of interest in their clinical area. Clinical input into decision-making for dissemination is vital in the process.

The group meets on a weekly basis, for a round-table discussion about each of the reviews at this stage in Cochrane's production process. To maximise editorial impact, reviews are usually highlighted that:

- have identified definite benefits or harms
- reveal gaps in the evidence
- are of importance to the NHS priority topic areas
- are of topical interest in the media
- can contribute to national or international Awareness Days
- complete a collection of reviews to give an overview of evidence on a condition
- or come as a request for dissemination from a Cochrane Review Group or by the Cochrane Editorial Unit.

Cochrane UK works closely with the Central Executive Communications and External Affairs Department and Cochrane Editorial Unit to support its communications plans, as well as identifying Reviews for targeted dissemination to specific professional groups or to fit with its dissemination campaigns.

10 Fields and review production

Generally speaking, review production is not a key role for Fields. They are, as described above, focused on knowledge exchange and stakeholder engagement. However, there may be times when a Field, through its stakeholder engagement work, identifies priority topics for Cochrane reviews that no CRG is willing or able to support. Furthermore, there may be times where the Field has an interest in authoring reviews of importance to the Field's stakeholders, but there is little appetite to prioritise the review within the relevant CRG.

In line with the Centres' [Structure and Function Review paper on organisational level changes](#), we think that there should be more flexibility in the role of Fields and, in particular, that Fields should be able to take advantage of the introduction of new editorial process options, most notably the journal style submission channel.

Where a Field is keen to author a review that is not being prioritised by a CRG, they will in future be able to use the journal style model that we are seeking to introduce. This will allow authors to register a protocol externally, such as on PROSPERO, and then submit a high quality, complete Cochrane Review for peer review, thus not burdening the Review Group with the Review support and management tasks.

If a Field wishes to take on the author support for a title that has not been prioritised by a CRG then this should be allowed as long as certain criteria are met. Firstly, there must be a clear need for the Review. This would naturally be a need based on the stakeholder engagement work of Fields that has identified that a particular Review is of use to or required by their stakeholders. Secondly, the opportunity to register and support such a title should be offered to relevant CRGs first, with the Field taking forward the Review once these CRGs have declined to take it on.

If no CRG is willing to support an author team to undertake the Review and there is clear evidence that the topic is high priority, then the Field may proceed with offering support for the Review. In such circumstances there are two suggested approaches that could be followed. A lot more work needs to be done on the feasibility of these approaches, but in principle there would be two options:

1. A Field establishes a partnership with a relevant CRG for the production of that Review. The Field agrees to take on all responsibility for author support and initial checking of MECIR standards. All

the CRG would commit to doing would be to manage the peer review process, sign off, and publication of the Protocol and Review.

2. A Field is unable to find a partner CRG which is interested in the Review, so they proceed with the Review, but publish the protocol externally, in PROSPERO for example. Once the review is complete they use the newly proposed journal style final submission channel to submit the completed, high quality Review.

If Fields wish to undertake this role they must be able to demonstrate to the Editor in Chief that they have the resources and skills available to provide author support which leads to consistent, high quality submissions to the CRGs. The above process is indicative only and needs to be worked up in more detail with the CEU.

11 Is 'Field' the right name?

The name of the Group type is important to make it easily understandable outside of Cochrane, but it should not be a major focus of our efforts in this process. However, we know that the term 'Fields' is not overly helpful as it has little external validity. Recent branding changes have helped overcome this challenge to some degree: for example, the Child Health Field has become 'Cochrane Child Health'.

Having said this, it might be worth considering whether a name change to the Cochrane Group type would highlight the fact that the work of Fields is clearly around Knowledge Translation. Knowledge Translation Groups or Networks or perhaps Knowledge Exchange Groups / Networks could be suitable terms that would have external and internal meaning.

12 Next steps

The Fields Structure and Function Review needs to continue alongside the development of the Knowledge Translation Strategy over the next six months. Creating a sustainable KT infrastructure in Cochrane will have a major impact on the work of Fields, and so the Central Executive plans to provide final proposals for the future role of Fields alongside the Knowledge Translation Strategy for the CSG and Cochrane community Mid-Year Business meetings in Geneva in April 2017.