Cochrane Steering Group Minutes

London: 7th & 8th April 2016

Approved 29 June 2016

Present:

Cindy Farquhar (Co-Chair), Martin Burton, Karin Dearness, Marguerite Koster, Anne Lyddiatt, Catherine Marshall, Joerg Meerpohl, Mona Nasser, Holger Schünemann, Liz Stovold, Denise Thomson and Mingming Zhang. Lisa Bero (Co-Chair, participating remotely for items 1,2.1,2.2, part of 2.3,9)

Mark Wilson (Chief Executive Officer), David Tovey (Editor in Chief), Miranda Cumpston (Head of Learning & Support), Lucie Binder (Senior Advisor to the CEO, items 1,2.1,2.2, part of 2.3,2.4,2.5,2.6,2.7,3,4,5,6,7), Chris Champion (Senior Programme Manager Adviser, Items 7,10), Deborah Pentesco-Gilbert (Wiley, Item 5), Charlotte Pestridge (CEO, Cochrane Innovations – item 6), Sarah Watson (Head of Finance & Core Services, items 1,2.2, part of 2.3,2.4,2.5,2.6,2.7,3,4,5,7), Julie Wood (Head of Communications & External Affairs, items 2.4, 2.6, 2.7, 3, 4, 5,8).

Apologies:

Alvaro Atallah

1.   Welcome, Apologies, Declarations of interest, approval of the agenda, correspondence

Cindy welcomed everyone to the meeting and the agenda was approved.

2.   Central Executive Team Report

2.1. 2015 Targets Report

David confirmed that multi-language search and presentation is within scope for the Wiley platform redevelopment in 2016. Joerg noted that information on how Cochrane users can access EPPI-Reviewer could be easier to find.

Action: Miranda to provide feedback to EPPI-Reviewer about prominence of information for Cochrane authors.

2.2. Draft 2015 Trustees Report & Financial Statements

The CSG considered the narrative report, which was supplemented with draft headline financial statements for 2015. Mark noted that the auditors had reviewed the accounts in the week preceding the CSG meeting, and the full financial report was not yet available for approval.

Decision: CET noted the Draft 2015 Trustees Report.
Action: CET to bring an indicative 2017 budget to CSG for approval at the Seoul Colloquium in October.

2.3. Cochrane Group funding

Cochrane Canada

Holger updated the CSG on the funding situation for Cochrane Groups in Canada; and presented a proposal from them for bridge funding from Cochrane to April 2017, pending a final decision by CIHR and SPOR on the longer-term future of funding for Cochrane Canada.

- Catherine sought clarification of the term 'bridge funding' for Cochrane Canada and it was explained that the funding would be an effectively a grant that would not be repaid.

The CSG Canadian representatives (Holger, Karin, Denise, Anne) left the room. The other members of the CSG then considered the Canadian Cochrane Centre proposal.

Decision: The CSG approved up to CAD $500,000 (£267,000) in strategic support funding to support Cochrane Canada for 12 months from 1 April 2016.
Decision: The CSG Co-Chairs to provide a letter of support to SPOR/CIHR for Cochrane Canada outlining the strategic support funding to be made available.
Action: The Co-Chairs to work with Holger and Mark to draft a letter of support.
Action: The CET to draft a communications strategy for the announcement of the Cochrane Canada funding.

Action: Holger to develop a detailed project plan outlining the allocation of funds across the Canadian Groups and deliverables consistent with Cochrane's overall strategic directions with the support of Mark and David.

Action: The CET to review the documentation for the Strategic Support Fund to provide further clarity for future applicants.

The CSG also asked the Senior Management Team to look at Cochrane's approved budget for 2016 and see whether some cuts could be made to save money elsewhere. Mark, David and Sarah agreed to do this.

Action: The CET to review the 2016 Budget to see if cuts from spending on core and other projects could be made.

NIHR
David noted that the NIHR review has been completed but the final report has not yet been released. Martin confirmed that the current funding is approved until 2020 with an optional break clause occurring in 2018.

2.4. Update on 2016 Targets
Mark provided a brief verbal update on progress since the CSG meeting in January 2016. Overall, all projects are on track as planned. He highlighted only key developments, including:

- *Wiley redevelopment*: The final contract for the redevelopment of the platform has now been signed. The CSG thanked the CET staff involved in bringing the project to this point for their efforts and the project is now proceeding.
- *Translation project*: The Cochrane translation teams met during the Mid-Year Meetings to discuss proposed changes to the translation infrastructure and Cochrane Library redevelopment work. MOUs are now in place for most of the translation teams. Joerg acknowledged that current translation efforts rely on a small group of volunteer translators, rather than a large-scale, professional approach. Julie and Mark noted the substantial positive impact of Cochrane's translation efforts on outreach, and access and use figures of Cochrane evidence. Julie noted that funding has been provided to teams working on four of the five WHO languages, and that the CET is reaching out to translating organisations to explore potential partnerships and further funding.
- *PICO annotation of Cochrane Reviews*: A leader of the annotation project has been appointed (Alex Garcia-Castro) who is now recruiting two budgeted annotators to complete the PICO annotation of all existing Cochrane Reviews. The project is proceeding well, and received a positive reception from Information Specialists at the UK Cochrane Symposium in March 2016 and the London Mid-Year meetings.

2.5. Quality Report from CEU
The CSG considered the report, and noted that there may be opportunities for geographic-based groups to provide peer support to Review Groups for quality improvement, although this is not currently required under the draft MOUs for Centres. David confirmed that the title of Senior Cochrane Fellow is honorary, and aims to engage senior methodological experts for referral by the CEU where methodological questions are in doubt.

Decision: The CSG supports the CEU's approach to improving quality with CRGs, and approved the proposal to develop the position of Senior Cochrane Fellows.

2.6. Update on Partnerships
Julie briefed the CSG on the progress of Cochrane's partnerships, including plans to attend the HTAi conference in Japan and World Health Assembly in Geneva in May. She noted that the Wikipedia partnership is now proceeding well with a framework for a new MOU. The position of Wikipedian in Residence will continue (although no longer funded by Cochrane in the same way). Julie noted that the Mid-Year Meetings in 2017 will be held in the week of 3 April 2017 in Geneva, hosted by Cochrane Switzerland. Although the Cochrane meeting will not be directly supported by the WHO, a reception and several meetings will be held jointly by Cochrane and the WHO. Mark reported that in-principle agreement had been reached with Epistemonikos on a strategic partnership with Cochrane; and David reported that dialogue is in progress with IBM Watson (who currently subscribe to the Cochrane Library) about possible future collaborations.

ACTION: Julie to advise Marguerite on activities proposed for the HTAi conference and the World Health Assembly.
ACTION: CET to provide a paper to support a strategic discussion by the CSG about technological strategic issues in Seoul.

2.7. Cochrane Organisational Dashboard 2015
Mark circulated an updated 2015 Dashboard document at the meeting. Most of the key indicators were very positive, including delivery against 2015 targets, sales and revenue growth, demand for the Library, use of Cochrane evidence by WHO and the

increase in translations. David noted that the time to publication is not yet decreasing, and this may be in part due to additional time required to implement CEU screening.

Action: CSG to dedicate time at their meeting in Seoul to consider relative priorities amongst the *Strategy to 2020* Objectives and the resources allocated to support the rate of progress of existing and new projects.

Action: CET to consider presenting the proportion of funding allocated by Cochrane to each strategic area (currently and over time) in future dashboards.

3.   Risk Management Report

The CSG considered the 2016 Quarter 2 Risk Management Report and welcomed the continuing progress on reducing risk in a number of areas.

Decision: The CSG approved the Risk Management Report for Q2 2016.
Action: Mark to note the risk of deficits arising from the 2017 and future Colloquia in the reports.

3.1. Data Protection Policy

Julie briefed the CSG on the new Data Protection Policy, which had been identified as a risk in 2015 and the policy developed in order to ensure Cochrane was legally compliant with data protection issues. She informed the CSG that implementation of the proposed new policy will proceed over 2016 and 2017 across all Cochrane Groups and the data they hold, which will involve consideration of compliance frameworks in other countries.

Decision: The CSG approved adoption of the Data Protection Policy.

4.   Funding Arbiter Panel report

The CSG considered the report of the Funding Arbiters. David acknowledged the investment of time and resources by them and welcomed their plans with the CEU to introduce improvements to the Funding Arbiter system.

5.   Cochrane-Wiley Publishing Update
5.1. 2016 Workplan
5.2. 2015 Workplan Report
5.3. Publishing Management Team Dashboard – 2015

The CSG noted the reports published by the Cochrane-Wiley Publishing Management team. Deborah clarified that service level standards would be maintained at the 2015 level for 2016, and noted the addition of a standard for publication freeze periods during which the Library is functioning but no new publications are processed. Deborah and Julie noted that page views of abstracts and summaries have been relatively stable, and that summaries on Cochrane.org are likely to increase as they rank higher on search engines such as Google. Following the decision to end our contract with BIREME, free access was made available in South America at the end of 2015 for a trial period that saw an enormous increase in use, showing the latent demand in the region for the Library. Free access to HINARI A and B listed countries continues, with significant markets like Argentina now included in the list. Wiley is pursuing country-level agreements including an agreement signed recently with Cuba. Deborah clarified that the Cochrane Library is not bundled with other subscription products. A national licence for Switzerland began in January 2016, but the state licence for Wyoming in the USA has ended. Deborah confirmed that in 2017 Wiley is aiming for a 5% growth in revenue alongside the move towards more open access, and a new Library platform. The start of automatic deposition of Cochrane Reviews in PubMed Central under our recently expanded Open Access policy is being held up by PubMed's continued technology testing to ensure they can receive and present the feed correctly. The Cochrane Library and Cochrane.org are both currently optimised for use on mobile platforms; but CSG members pointed out that the Cochrane Library app remained very basic and under-developed.

Action: The CET to continue to provide a detailed breakdown of Wiley royalties as part of the Dashboard report.

6.   Cochrane Innovations Update Report

Charlotte briefed CSG members on Cochrane Innovations' work, outlining progress in three areas: existing products, current areas of investment in activity, and new areas of work that could be developed. Cochrane Clinical Answers continue to show limited sales, but the product is now beginning to be included as additional value in renegotiating subscriptions to the Cochrane Library. Cochrane Learning will be closed down this year as planned. Recruitment has begun to support Cochrane Response; the first candidates have been appointed and the first bids for work are in progress. All proposals prioritise the role of Cochrane Groups leading the work, with Cochrane Response providing additional capacity where needed. Initial pilots include a grant to PAHO, which will engage a number of Review Groups depending on the priority topics identified, and Cochrane Australia in their relationships with guideline developers.

ACTION: Cochrane Innovations to engage in detail with Cochrane China in relation to any work around training in China.

7.   Environmental Sustainability Policy

Chris Champion presented the draft policy to the CSG and clarified that it covers the work of the CET as well as the two major annual Cochrane events, the Colloquium and the Mid-Year Meeting. The policy is intended to enable annual monitoring and reporting to support future decision-making.

DECISION: The CSG approved adoption of the new Environmental Sustainability Policy.

8.   Plain-Language Summaries

Julie presented a revised version of the Plain-Language Summaries project that had been previously presented as part of the Plan & Budget presented to the CSG in Vancouver. At the request of the CSG the research components of the original proposal were removed, as sufficient research was available to begin an active pilot. Several Cochrane Groups are already engaged in the project, and the aim is to improve substantially the quality of our Plain Language Summaries as a key communication and dissemination content for Cochrane. Mingming emphasized the importance of PLS as a base for translation work. Joerg noted that for longer term sustainability the project is likely to require full time staff, and Julie agreed, pointing out that the pilot will establish the level of resourcing required to sustain central production of PLS. Julie confirmed that the funds to be allocated to the project are rolled over from 2015, and no new funds are required.

Decision: The CSG approved the pilot with four to five Cochrane Review Groups for centralisation of the production of Plain Language Summaries (PLS) based on updated guidance.

9.   Governance Reform

Denise summarised progress to date on the Governance reform process, and emphasised how important it is that governance reform proceeds in a collaborative and inclusive way to meet the needs of all Cochrane contributors. Earlier in the week Cindy and Miranda Cumpston had attended all the Group Executives at the Mid-Year Meetings to explain and discuss the proposed reforms, and a Strategic Session was held on the following day to allow discussion and development of the proposals across all participants. Denise and Cindy summarised the feedback received and members discussed the following issues:

- Overall the feedback from Groups received was positive and constructive.
- Support was clear for the addition of external members of the Board.
- Loss of representation and lack of diversity within the Board and the Council were clearly felt as issues of concern for the membership. The CSG is committed to ensuring these governance reforms are done well and meet these concerns.
- The CSG had deliberately not been prescriptive about the structure of the proposed Council in order to allow the Groups to lead this. Feedback was clear that the Groups would prefer to receive a draft structure in detail for further comments and development. Groups agreed that the relationship between the Board and the Council will be critical to ensure meaningful communication and compensate for the loss of direct representation. A process should be in place to handle disagreements between the Council and the Board, ensuring roles and responsibilities are clear.
- A clear position should be outlined as to how diversity in the Board will be addressed. Options include calling for diversity in elections, targeting diversity in external appointments, having a formal stated policy, support and leadership development to encourage participation from underrepresented or less experience groups, quotas for a small number of key parameters, and others. It was noted that diversity does not imply representation, and that requiring representation from every possible contributor type would not be feasible.
- The issue of English language proficiency was considered and CSG members whose first language is not English advised that a reasonable standard of English proficiency is required in order to participate in meetings, in informal discussions, and CSG business outside meetings, and that formal translation of documents or during meetings would not provide a sufficient alternative.
- Clear communication is needed around who is eligible to vote, currently and after the change, as this is not well understood.
- A final decision should be made as to the voting rights of CET staff. This issue was queried by some participants but was not an overly strong concern. If CET staff can vote, communication should include examples of comparable arrangements in other organisations.
- A formal review of the process should be planned.

Decision: The CSG's Governance Reform Working Group should further consider and recommend the best model for Council inputs onto the Board.
Decision: Board documentation should include a statement on diversity.

Decision: Proficiency in English sufficient to enable effective participation in the Board should be a requirement for Board membership.

Action: The Governance Reform Working Group should draft an initial proposal for the structure of the Council incorporating the feedback received from the community at the Mid-Year Meetings.

Action: The CET should draft amendments to Cochrane's Articles of Association based on the current proposal.

Action: Miranda to provide data on precise numbers of people eligible to vote, and a history of who has voted in past elections.

Action: The CET to offer leadership development training to new Board members to ensure underrepresented Groups with less leadership experience are not discouraged from standing.

Action: The CET and CSG to explore additional support options to improve the experience of Board participants whose first language is not English, in consultation with individual members: such as translation services, formatting papers for translation, providing microphones to improve acoustics, and routinely pausing discussions and actively supporting participants to ask for clarification where discussions are not clear.

Action: The CET induction process for new Board members to include a pre-Board meeting discussion with an experienced Board member to review the agenda and papers and clarify questions.

Action: The CET induction for new members whose first language is not English to include a review of options to support translation and understanding ahead of the first Board meeting, and a review afterwards.

10. Structure & Function Review

The CSG welcomed the Structure & Function Review paper prepared by the CET and the detailed options for change that it contained. CSG members agreed with the rationale for change, including major challenges around Cochrane's coverage and quality of reviews; insufficient focus on knowledge translation; and the capacity of existing teams to support the work needed. Stresses within the current editorial processing model are creating significant problems for both authors and editorial teams, and there are clear issues in terms of quality, timeliness and prioritisation as a result.

Having agreed with the rationale for change, the CSG then discussed in detail the options for change proposed in the Structure & Function Review paper, including considering whether each of the proposals met a series of key criteria (suggested by the CSG):

- Does it improve the author experience?
- Does it build capacity?
- Does it improve group processes/functions?
- Does it improve quality?
- Does it impact beyond Cochrane Groups?
- Are other stakeholders likely to support the change?
- How likely is it to succeed?
- Can we measure success?
- Does it build sustainability for the organisation?

Following these discussions, the CSG approved all three of the major change proposals put forward in the Structure & Function Review. The CSG specifically addressed the issue of whether the changes should be 'piloted' in order to test them on a small part of the organisation before rolling out to the wider Cochrane organisation; or whether they should be approved and implementation plans developed with the organisation so that future amendments would be 'course corrections' to meet the overall objectives of the changes. CSG members voted and agreed on the second approach. The Structure & Function changes approved by the CSG therefore set the destination points for Cochrane, but left open for development with collaborators and Groups the best means of reaching those points.

Steering Group members recognised there may be concerns about the proposed changes from some of those affected within Cochrane, but were convinced that the changes will alleviate the existing stresses and move Cochrane forward. The changes proposed should also align with the priorities of funders and other external stakeholders. The CSG stressed that it will be important to be clear on the measures of success as we proceed; ensure that new processes are more efficient than existing ones; and that additional management layers are not added unnecessarily. Effectively structured, de-centralised functioning Groups would remain at the core of Cochrane's structure, and centralised support processes would not imply the centralisation of all areas of work within the CET. The CSG also stressed that clarity of communication throughout the change process will be important for authors and other contributors to understand and navigate our new structures.

The CSG called on the CET to lead a substantive project of work to develop an operational plan to implement the Structure & Function changes; and to continue to build a coalition for change across the Cochrane community.

Decision: That Cochrane should proceed with centralised review registration.
Decision: That Cochrane should proceed with a centralised editorial service.
Decision: That Cochrane should proceed with implementing consolidation among thematic Groups. All Review Groups will be required to participate in this direction of change, although Groups will be actively involved in the final decisions on the clusters to be implemented. Central funding will be allocated as required to compensate Groups taking on the work of leadership in clusters.
Decision: That Cochrane should proceed with implementing consolidation among geographic Groups.
Decision: That Cochrane should proceed with implementing a new system allowing flexibility of modular functions across geographic and thematic groups.
Action: The CET to convene Advisory Groups made up of senior collaborators from across a full cross-section of Cochrane, to plan the operation and implementation of these decisions in much greater detail. These operational plans would then be open for wide consultation by all collaborators across Cochrane.

11. Reports from the Executives
Representatives reported back from the London Mid-Year Meetings.

Fields
Denise reported that an application had been received to establish a new Cochrane Nutrition Field. The importance of the KT Strategy was noted for the future role of Fields alongside the implications of the Structure and Function Review.

Centre & Branch Directors
Joerg reported that the Centres and Branch Directors had discussed the Cochrane investment policy, and noted that the CCLA ethical investment option selected for Cochrane investment does not exclude investment in pharmaceutical and medical device companies as part of the overall ethical fund portfolio. He recognised that the CSG had considered this issue in its earlier meetings, but asked members to reconsider their decision. Mark noted that Cochrane's investment policy allows for 'no significant investment' in pharmaceutical companies; but that no major investment of funds had yet been made by Cochrane in CCLA's Ethical Fund. Sarah informed the CSG that CCLA has advised that its Ethical Fund currently includes around 5-6% investment in the pharmaceutical industry and that these investments were fluid and changed over time. Cochrane did not and could not influence the choices made by CCLA's Ethical Fund managers. As Treasurer, Martin noted that it would be difficult to identify an ethical investment fund that excludes the pharmaceutical, medical device and all other industries (such as tobacco, alcohol, arms and other defence-related manufacturers) that was not a bespoke – and therefore expensive – investment option for Cochrane; and reminded CSG members that UK trustees have a financial responsibility to obtain an adequate return on the organisation's funds. The CSG recognised the difficulties, but asked its Investment Sub-Committee to investigate further.

Action: The CSG agreed to delay investment in the CCLA fund, and asked the CSG Investment Subcommittee to review the availability of ethical investment funds that exclude pharmaceutical and medical device industries, and make a further recommendation to the CSG.
Action: Cindy to discuss this matter with Lisa and convey her input to the Subcommittee.
Action: Sarah to share more detailed figures on the level of income to be foregone by delayed investment in a fund of this kind.

Co-ordinating Editors
Martin reported that the Board meeting had generally been positive.

Managing Editors
Karin reported that the MEs had requested a workshop on conflict of interest at the Seoul Colloquium. Policy implementation groups have been set up to work on key issues, and the MEs are working with IKMD on Archie development.

Information Specialists
Liz reported that the group has been working closely with IKMD on the PICO annotation 'Linked Data' project, and the 'HarmoniSR' project to standardise records in the CRS.

Methods

Holger reported that the Methods Group Executive discussed governance reform and the establishment of a Scientific Committee. The Executive were interested in being directly involved in designing the Terms of Reference for the Council, and that membership of the Scientific Committee and the Council should overlap.

Consumer Network

Anne reported that the Executive had discussed prioritisation of 21 items arising from their Structure and Function Review, and its own electoral procedures. The Executive thanked Richard Morley, CET Consumer Coordinator, for his support in this work.

12. Any Other Business

Approval of Minutes of the last meeting

Action: Miranda to record under Item 10 of the Minutes of the Vancouver meeting that a clear description of who is eligible to vote was requested.

Decision: The CSG approved the minutes of its last meeting, in Vancouver in January 2016.

Review of 2016 Budget

The CSG acknowledged the impact of the funding decisions made during this meeting and the large projects arising out of the review of structure and function.

Action: The CET to review the 2016 Plan & Budget in light of current and new commitments, and consider any appropriate adjustments that should be de-prioritized or would reduce overall expenditures.

Action: The CET to add a standing item to each face-to-face meeting agenda for consideration of whether course corrections in the annual Plan & Budget are required, and to ensure the papers provided include relevant information to enable this discussion.

Post hoc note: Lisa noted her thanks to Cindy for acting as Chair for this meeting in Lisa's absence, and congratulated her on the successful outcomes.

Cochrane

CSG Agenda & Background Papers

Thursday 7th (08:15 – 18:00)
& Friday 8th (09:00 – 17:00)
April 2016

Venue: Cochrane's London Offices
St Alban's House
57 – 59 Haymarket
London
SW1Y 4QX

**Please Note: The CSG Board Only Day on Wednesday 6th April (09:00 – 18:00)
will be held at The Marlborough Room, The King's Fund,
11 Cavendish Square, London, W1G 0AN.**

**A CSG dinner will be held on Thursday 7th, from 19:00
Venue: 108 Brasserie, Located at The Marylebone Hotel
57-59 Welbeck Street, London, W1G 9BL.**

**Trusted evidence.
Informed decisions.
Better health.**

Agenda

Thursday 7th (08:15 – 18:00)

08:15 – 10:15 Steering Group only

1. Welcomes, Apologies, Declarations of Interest and Approval of the Agenda, correspondence

2. Central Executive Team Report:
   2.1 2015 Targets Report; (I) [RESTRICTED ACCESS]
   2.2 Draft 2015 Trustees' Report & Financial Statements; (D) [RESTRICTED ACCESS]
   2.3 Cochrane Group funding (CIHR, NIHR update); (D) [RESTRICTED ACCESS]
   2.4 Update on 2016 Targets;
   2.5 Quality Report from CEU; (D) [RESTRICTED ACCESS]
   2.6 Update on Partnerships; (I) [RESTRICTED ACCESS]
   2.7 Cochrane Organisational Dashboard 2015 (I) [OPEN ACCESS]

3. Risk Management Report (D) [RESTRICTED ACCESS]
   3.1 Data Protection Policy (D) [RESTRICTED ACCESS]

4. Funding Arbiter Report (I) [OPEN ACCESS]

5. Cochrane-Wiley Publishing Update:
   5.1 2016 Workplan (I) [OPEN ACCESS]
   5.2 2015 Workplan Report (I) [RESTRICTED ACCESS]
   5.3 Publishing Management Team Dashboard - 2015 (I) [RESTRICTED ACCESS]

6. Cochrane Innovations Update Report (I) [RESTRICTED ACCESS]

7. Environmental Sustainability Policy (D) [OPEN ACCESS]

Friday 8th April (09:00 – 17:00)

8. **Plain Language Summaries (D) [OPEN ACCESS]**

9. **Governance Reform:**
   9.1 **Update and review of documentation**
   9.2 **Feedback from Strategic Session & Group Executives**
   9.3 **Next Steps**

10. **Structure & Function Review (D) [RESTRICTED ACCESS]**

11. **Any Other Business / Steering Group only**
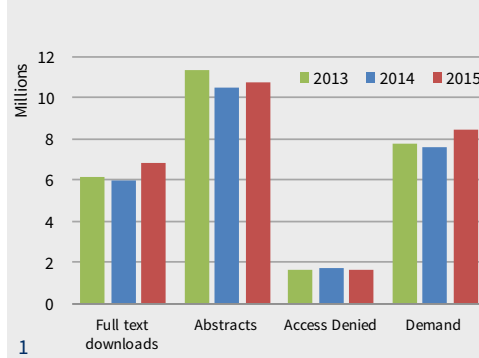

(I) - Agenda Items for Information/report

(D) - Agenda Items for Decision or Strategic Discussion

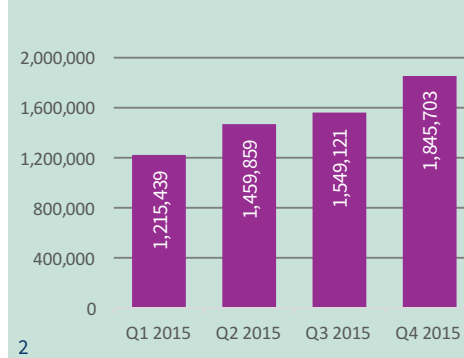# Cochrane Organisational Dashboard 2015 - OPEN ACCESS

Commentary

- 17 of 18 of the 2015 *Strategy to 2020* Targets will be achieved.
- Demand on the Cochrane Library up 10%.
- Publication of new Reviews increased 14% compared with 2014.
- Very strong growth in usage of cochrane.org following launch of new Cochrane brand.
- Record Cochrane revenues fuelled by strong Cochrane Library sales.
- Spending under budget & £6.5m reserves at year end. Reserves to be drawn down in 2016-2017.
- Impact factor increased for 2014. A record 87 Cochrane Reviews used in 2015 WHO Guidelines; 75% of WHO Guidelines using Cochrane Reviews
- Publication of Cochrane's first high priority reviews list completed.
- Covidence author support tool launched to Cochrane authors in Vienna.
- Linked Data PICO Annotator and PICO Finder tool demonstrated in Vienna.
- Project Transform: Task Exchange prototype launched in Vienna.
- Structure & Function Review recommendations considered by groups in Vienna. Next stage will tackle organisation wide view.

Cochrane Library Usage

Bar chart: Millions, categories Full text downloads, Abstracts, Access Denied, Demand. Series 2013, 2014, 2015.

Cochrane.org Usage

Q1 2015: 1,215,439
Q2 2015: 1,459,859
Q3 2015: 1,549,121
Q4 2015: 1,845,703

Impact Factor

Impact factor (IF) — 5 Year IF

6.536 - 5 Year Impact factor
6.035 - 2014 Impact factor
43,592 - Total citations 2014

2013 Impact Factor: 5.939
2013 Total Citations: 39,856

Publishing Output

2014: Reviews 426, Updates 449, Protocols 538
2015: Reviews 485, Updates 455, Protocols 553

- Reviews - Updates - Protocols

Key Finance Indicators
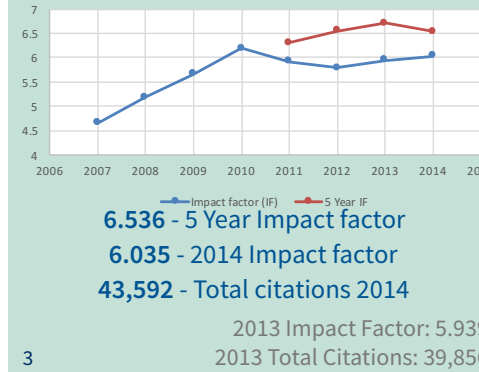
9.5% Sales increase compared with 2014

11% Annual Royalties increase compared with 2014
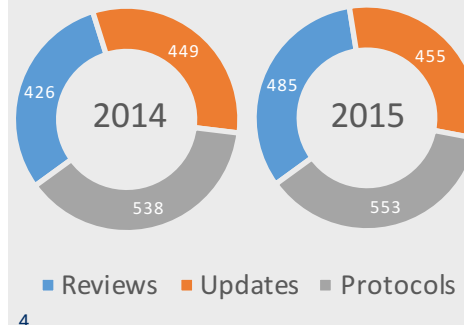
£6.5 million Forecast reserves at end of 2015

£771,889 under budget (forecast)

- Actual expenditure - Budgeted expenditure

Millions
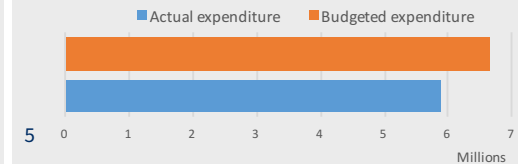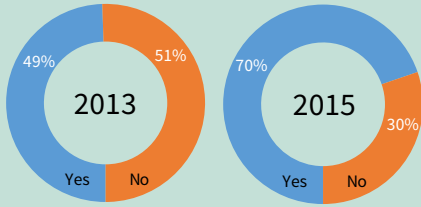
Media Coverage

22% increase in overall media coverage

Strategy to 2020 targets for 2015 – progress (PR) and spend (SP) *(PURPLE: not started or N/A; RED: serious concerns; AMBER: some delays; GREEN: on target)*
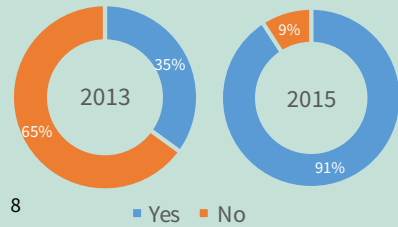
PR	SP		PR	SP		PR	SP		PR	SP	
🟢	🟢	1.1 High priority reviews	🟠	🟢	2.1 User experience review and framework	🟢	🟢	3.1 Cochrane Re-brand	🟠	🟢	4.1 Membership scheme
🟢	🟢	1.2 Quality Assurance Strategy	🟢	🟢	2.2 Open Access Strategy	🟢	🟢	3.2 Partnership Strategy	🟢	🟢	4.2 Governance and Structure and Function Reviews
🟢	🟢	1.3 Grade and SOF implementation	🔴	🟢	2.3 Non-English Access to Cochrane Content	🟢	🟢	3.3 Communicating our Impact	🟢	🟢	4.3 Generating income for a sustainable future
🟠	🟢	1.4 Updating Classification Framework	🟠	🟢	2.4 Simplified and Standardised Language				🟢	🟢	4.4 Capacity Building through Regional Initiatives
🟢	🟢	1.5 Future of Review Production.							🟠	🟢	4.5 Training for Cochrane Editors
									🟠	🟢	4.6 Environmental Impact Review

Goal One

Quality

New Reviews with Summary of Findings Tables

2013: Yes 49%, No 51%

2015: Yes 70%, No 30%

No. protocols referencing GRADE*

2013: Yes 35%, No 65%

2015: Yes 91%, No 9%

- Yes
- No

8

Output

	Q1	Q2	Q3	Q4
Protocols 2015	155	164	110	124
Protocols 2014	145	129	141	123
Updates 2015	101	111	131	112
Updates 2014	111	109	108	121
Reviews 2015	124	109	122	130
Reviews 2014	109	97	96	124

■ Q1 ■ Q2 ■ Q3 ■ Q4
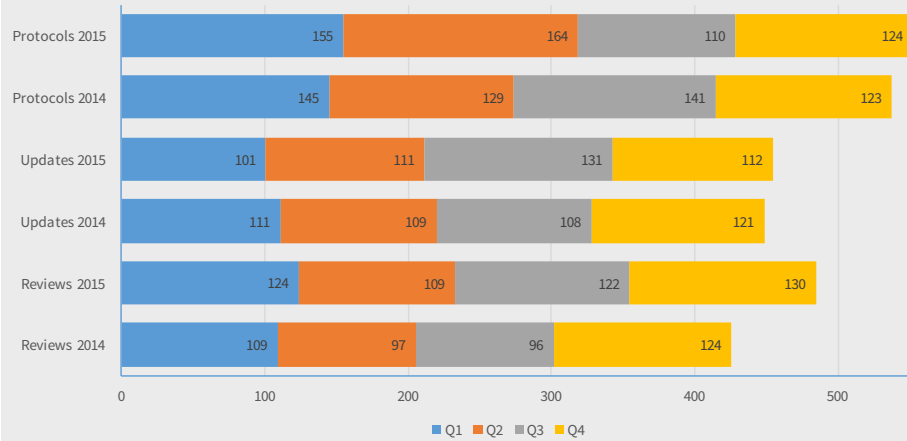
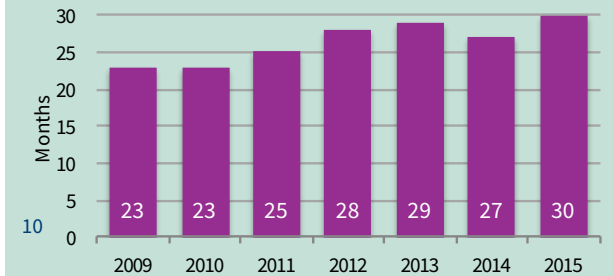|	End Q4 2013	End Q4 2014	End Q4 2015
Total Reviews in CDSR	5,819	6,226	6,713

9

Relevance

345 Reviews on the Cochrane Priority Reviews list. **25** New Reviews and **36** Review Updates from the list published in 2015.

The median time from protocol to full review in 2015 was 30 months. **28%** of New Reviews in 2015 took 18 months or less.
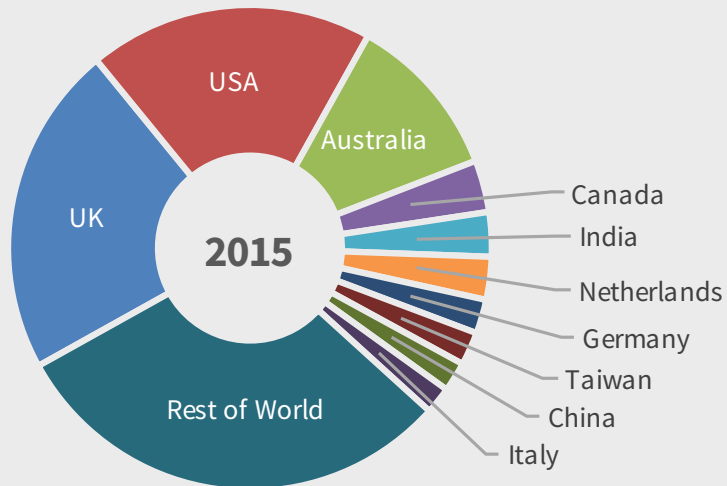
The 25 New Reviews published from the priority list took a median of **23.5** weeks.

Median Time from Protocol to Review

Year	Months
2009	23
2010	23
2011	25
2012	28
2013	29
2014	27
2015	30

Goal Two

Geographic Reach
Full text downloads by location

2015

USA, Australia, UK, Rest of World, Canada, India, Netherlands, Germany, Taiwan, China, Italy

11

Access

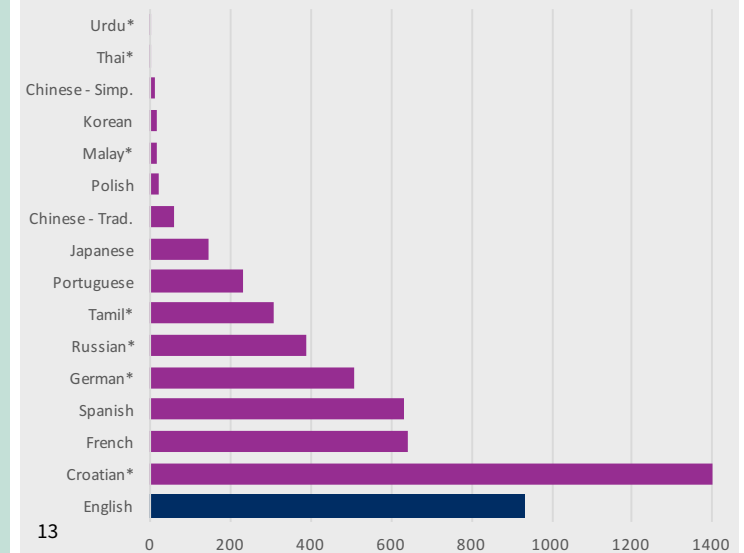**846** Reviews became available under Green Open Access in 2015

25 Reviews were published as Gold Open Access in 2015

3.66 Billion people have free at point of use access to Cochrane Reviews
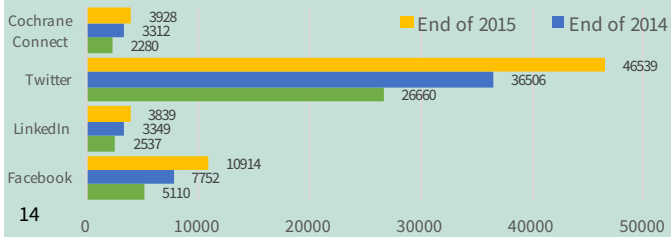
12

2015 Translation Output

Urdu*
Thai*
Chinese - Simp.
Korean
Malay*
Polish
Chinese - Trad.
Japanese
Portuguese
Tamil*
Russian*
German*
Spanish
French
Croatian*
English

(x-axis: 0, 200, 400, 600, 800, 1000, 1200, 1400)
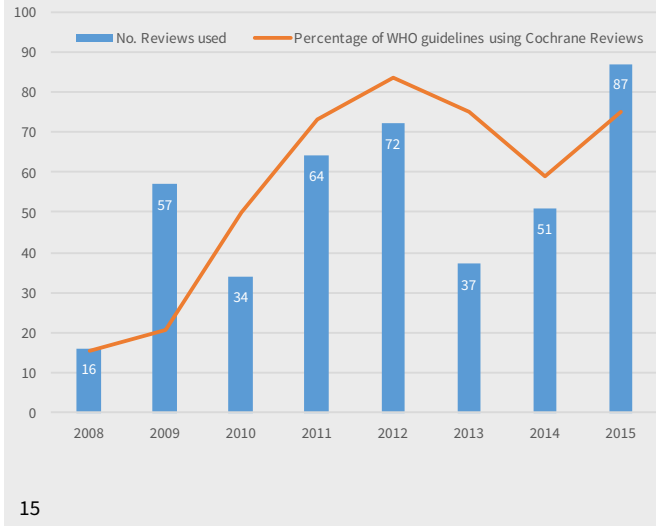
13

Media and Social Media

Traditional media channels

4,571 coverage hits, with 69 of these appearing in International titles. There were 3,885 online hits and 43 regional pieces of coverage. In addition, there were 36 coverage hits in consumer magazines, and 444 coverage hits in business magazines.
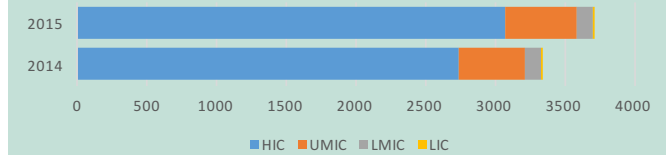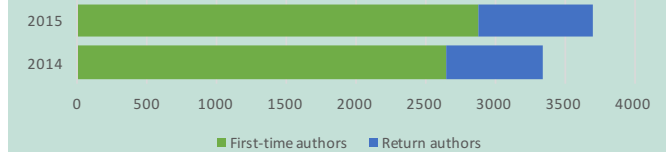
Social media channels

Legend: End of 2015, End of 2014

- Cochrane Connect: 3928, 3312, 2280
- Twitter: 46539, 36506, 26660
- LinkedIn: 3839, 3349, 2537
- Facebook: 10914, 7752, 5110

(axis: 0, 10000, 20000, 30000, 40000, 50000)

14

Impact on WHO guidelines

Legend: No. Reviews used (bars), Percentage of WHO guidelines using Cochrane Reviews (line)

- 2008: 16
- 2009: 57
- 2010: 34
- 2011: 64
- 2012: 72
- 2013: 37
- 2014: 51
- 2015: 87

(axis: 0–100)

15

Author distribution

Authors by country income level

- 2015
- 2014

(axis: 0, 500, 1000, 1500, 2000, 2500, 3000, 3500, 4000)

Legend: HIC, UMIC, LMIC, LIC

First time versus return authors

- 2015
- 2014

(axis: 0, 500, 1000, 1500, 2000, 2500, 3000, 3500, 4000)

Legend: First-time authors, Return authors

Countries represented on author teams

- All years
- 2015
- 2014

(axis: 0, 20, 40, 60, 80, 100, 120, 140, 160)

16
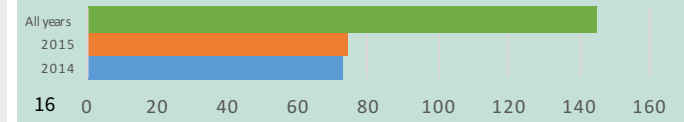
Notes on the data

1. Access denied means a user tried to download a full text, but did not have a subscription to the Cochrane Library. Demand is the combination of successful full text downloads and attempted full text downloads (access denied).
2. The Cochrane website was completely redesigned in Q1 2015 as part of the Cochrane rebranding exercise and has since seen a significant growth in usage.
3. Full details are available on the Cochrane Library: http://www.cochranelibrary.com/cochrane-database-of-systematic-reviews/
4. In 2015 there was a 14% increase in New Reviews; a 1% increase in Updated Reviews; and a 3% increase in New Protocols.
5. Reserves and budget spend are only forecast figures until the accounts are audited and made available in the 2015 Cochrane Annual Report.
6. 22% increase compared with 2014 media coverage.
7. A fuller report on the 2015 targets will appear in the 2015 Cochrane Annual Report
8. The data for "No. protocols referencing GRADE*" is based on a sample of protocols used in an audit undertaken by the CEU. There were 40 protocols in the 2013 sample and 33 in the 2015 sample.
   The data on new reviews with SOF tables relates to all reviews published in 2013/2015 that include one or more SOF table. However, it should be noted that of those that did not have SOF tables 53 were empty reviews (containing no studies) in 2015 and 65 were empty in 2013.
9. See note 4 above.

10. The time period measured for these metrics is the time from publication of the first Protocol version to the time of publication for the first full Review version.
    Whilst reviews on the priority list were completed in a median of only 23.5 weeks, this should be interpreted with caution as the sample size was low.
11. Total full text downloads in 2015 were 6.8 million. Major increases in 2015 include 33% increase in usage in Germany; 41-43% increase in Canada, Switzerland, Sweden, & Spain; 55% increase in China.
12. Free at point of use means a user either has access through our free access to low income countries scheme or they live in a country with a nation provision. More details on access are available here: http://www.cochranelibrary.com/help/access-options-for-cochrane-library.html
13. PLS only for languages marked with an asterisk. PLS and abstract for other languages. English is included as a reference point, there were 931 new or updated reviews in 2015.
14. A media hit is an item of media coverage.
    The graph shows Cochrane Connect subscribers; Twitter followers; members of our LinkedIn group; and members of our Facebook group.
    On average 34% of subscribers opened the monthly Cochrane Connect newsletter in 2015.
15. In 2015 87 reviews (from 10 Cochrane Review Groups) were used in 9 of 12 (75%) guidelines.
16. The country status e.g. LMIC are based on the World Bank categorisations: http://data.worldbank.org/about/country-and-lending-groups

Funding Arbiter report to CSG

Authors: Fergus Macbeth, Angela Webster, 18 March 2016

Activity:

We took over responsibility on December 1st 2015.

Since taking over and up to 29 February 2016 we have had 20 new referrals of which we have given final opinions on 12. Of the remaining eight, most we are awaiting either more information or clarification of case details. Of these three were historic (already referred but not solved before December 1st). There are also other cases still open from the funding audit, that are not counted in the tally above, involving multiple reviews from two review groups, which have been the focus of some time and energy. One set of 70 audit cases is very near resolution.

Panel:

Current panel members are: Fergus Macbeth, Angela Webster, Dorie Apolonnio, Andreas Lundh, Richard Wormald, and Joaquin Barnoya. Tim Lancaster has resigned from the panel but we have not, as yet, replaced him

We have contacted all the current members of the Funding Arbiter panel and discussed the issues and processes with them. We have so far made the majority of decisions ourselves without reference to them. We feel that that the remaining members of the panel are happy to help but we think that the way in which they are used could be changed to increase their involvement and experience of the breadth of issues that arise (see below).

We have identified a number of areas where we think that the process could be changed to increase efficiency and make things easier for the review groups. Our priorities are:

- Modifying the referral form to ensure that all the necessary information is available at the beginning and reduce the need to go back with queries.
- Modifying the online declaration of interest form for authors to ensure that complete and explicit declarations are made not only of relevant financial interests, their timing and the destination of any payment, but also of intellectual/ academic interests.
- Developing a new way of sharing information between panel members to increase efficiency in arbiter decisions
- Adding a section to the reviews in which the review group can explain why specific interests which the authors may have declared and might be perceived as being problematic are considered not to be an issue.
- Involving the panel more directly by delegating responsibility for the initial decision on individual cases to panel members in rotation.
- Developing a searchable database of cases and the decisions for the panel to use to ensure consistency in decision-making over time.
- In tandem, developing and anonymised searchable database of past cases and decisions to aid review groups and others to use as a learning resource for implementing the existing funding policy.

We also intend to engage as best we can directly with the review groups to increase their understanding of the CoI issues by the use of training resources, and to seek their feedback on the way the process operates. We hope to have a workshop/ surgery for cases at the Seoul Colloquium.

Acknowledgement

2016 Cochrane-Wiley Workplan

A series of annual targets are set against these overarching contractual objectives and managed by the Cochrane-Wiley Publishing Management Team*. These targets are not open access as they contain commercially sensitive and financial information.

Overarching contractual objectives to December 2018:

1. Achieve universal 'one-click' access to the Cochrane Library, ensuring that it is free at the point of use.

2. Increase the global awareness and impact of the Cochrane brand and reputation and the Trade Marks, taking particular advantage of innovative technologies and marketing and communication methods.

3. Identify the different ways and circumstances in which users access and use Cochrane content, and respond to these findings by using them as the basis for publishing and delivery developments, improvements and innovations.

4. Customise Cochrane content to meet the different needs and priorities of users, including (without limitation) making available in languages other than English those elements identified by the Collaboration as appropriate for translation.

5. Engage positively with all users and stakeholders.

6. Provide efficient and effective subscription management and support services for users.

7. Develop strategic partnerships with news providers, policy-makers, healthcare organizations, technology providers and others who can disseminate, promote and use Cochrane content in effective and appropriate ways.

8. Prioritise environmental and economic sustainability; and socio-cultural, linguistic, and gender diversity.

9. Promote professional, friendly and supportive relations, and provide clear points of contact with role-based staff, including those in high-level business and management roles.

10. Recognise and respond to the culture and unique organizational structure of the Collaboration.

11. Develop future Cochrane-Wiley publishing strategy.

12. Deliver the *Cochrane Strategy to 2020* 2016 targets with Wiley dependencies.

13. Support the business case development and subsequent development and commercialisation of relevant Cochrane derivative products and services.

*Publishing Management Team as of March 2016:

Cochrane:
CHAIR: Mark Wilson (Cochrane CEO)
Lucie Binder (Senior Advisor – non-voting)
Harriet MacLehose (Senior Editor)
Chris Mavergames (Head, Informatics and Knowledge Management)
Charlotte Pestridge (CEO, Cochrane Innovations)
David Tovey (Editor in Chief)
Julie Wood (Head, Communications and External Affairs - non-voting)

Wiley:
Deborah Pentesco-Gilbert (Editorial Director)
Todd Toler (Vice President, Digital Product Management),
Jay Neill (VP, Digital Product & Platform Development)
Richard Cook (Director Content Delivery Applications)
Ben Townsend (EMEA Sales Director)

Guests: Gavin Stewart (Wiley), Tony Aburrow (Wiley),
Alice Noakes (Wiley), Laura Simmonds (Wiley)

Environmental Sustainability Policy

[Open Access]

Document prepared by:	Graham Webb and Chris Champion
Submitted to Steering Group:	March 2016
Purpose of paper:	To present the findings of the environmental review and to propose a new environmental sustainability policy for Cochrane
Access:	Open
Summary of Recommendations:	The Steering Group approves the adoption of the new Policy
Resource implications:	No additional resourcing required. Any implementation of this will be undertaken using core staff time.
Contact person for any queries:	Chris Champion, cchampion@cochrane.org

Contents

1. Introduction

Cochrane aims to put in place an environmental sustainability policy as part of its *Strategy to 2020*. The first step on this journey was to identify the organisation's main environmental impacts and to measure its carbon footprint. Based on this analysis, we have developed a draft Environmental Sustainability Policy, which sets out how Cochrane proposes to take forward its overall approach in this area and which is presented here for sign off by the Steering Group. It focuses on the key elements of what we believe is achievable over the remainder of this *Strategy* period to reduce Cochrane's environmental impact.

2. Methodology

Organisations wishing to reduce their impact must first understand in detail what those impacts are. They can then design interventions which are in keeping with the scale and nature of the problem. Cochrane therefore commissioned an independent consultant to deliver a review of its operations, including measurement of the organisation's carbon footprint and the development of an environmental sustainability policy. To support this the Senior Management Team was asked to make a number of definitional decisions: e.g., What is the boundary of the organisation? Does it include flights, events, publications, etc? The decisions made are all in line with best practice and were signed off, along with the draft policy, at the SMT meeting on 18th February – this is all summarised alongside the methodology which is set out in Appendix 1. It also refers to the 'Cochrane Carbon Footprint Report (Final)', which is a data file that sets out the detailed calculations used to establish the footprint. This file is available upon request.[1]

The methodology used for the footprint assessment is based on the latest Defra guidance[2] which is both consistent with the Greenhouse Gas/GHG Protocol and the Carbon Trust Standard methodology. Calculations use the latest set of emissions factors published by Defra in 2015[3]. The policy is in keeping with some of the high level principles of the ISO14001 Environmental Management System but it is not proposed to put in place such a system at this time.

3. What is being measured

Cochrane is a large and complex organisation with many 'staff' members working in Groups around the world. For the purposes of this review we are considering the legal entity of Cochrane to be the area of interest (or the 'organisational boundary' in carbon footprint terms) and so are measuring its environmental impacts. In this context 'Staff' covers those employed by the Central Executive and so we look at their travel activities and the usage of the buildings they work in as the organisation's key areas of impact. We also include governance-related travel, i.e., Cochrane Steering Group travel. However, given how much travel is undertaken to attend our major we feel it is appropriate to additionally report on this, so we have provided data on the environmental impact of travel to our two major events: the Mid-Year Meeting and the Colloquium.

The additional environmental impact of Cochrane Group operations around the world, e.g., other travel, buildings emissions, etc., is not captured here as it cannot be measured in any meaningful way and those Groups are part of host institutions who will have their own environmental policies and footprints.

---

1 If you wish to access the detailed data file, please contact Chris Champion for information (cchampion@cochrane.org).
[2] Defra (2009) 'Guidance on how to measure and report your greenhouse gas emissions'
[3] http://www.ukconversionfactorscarbonsmart.co.uk

4.   Assessment and Analysis

The main result of the assessment is that the organisation's annual carbon footprint for 2015 is estimated at 372 tonnes of CO_2 equivalent[4] or approximately 9 tonnes per FTE (based on the average number of FTEs across the year). This covers all significant activities which Cochrane can measure (or reasonably estimate) and over which it can exert a reasonable degree of control. There was a 4% decrease on 2014's absolute footprint, which when also taking into account the growth in the number of staff resulted in a per FTE decrease of well over a third. The footprint report summary is provided in the series of graphs and commentary on the next page.

There are no specific benchmarks in this area, particularly where air travel is involved given the wide range of locations and frequencies people may have to fly due to the nature of their business. However, 9 tonnes per FTE is almost identical to a comparator research institute we have used which is a similar size and has a similar travel footprint. Its last reported per FTE footprint was 8.9 tonnes per FTE for 2014/15.

To give a sense of scale, Cochrane's travel footprint is equivalent to each FTE member of staff flying from London to Panama and back twice. All in all, Cochrane staff and Board members have flown 1.75 million km over the last two years or approximately 4 times the distance from the Earth to the Moon.

---

[4] Tonnes of CO_2e is a universal unit of measurement used to indicate the global warming potential of a wide range of greenhouse gases, expressed in terms of the global warming potential of one unit of carbon dioxide.

COCHRANE CARBON FOOTPRINT REPORT

SUMMARY

| A. Gross emissions by type excluding events (tCO2e)	2014	2015	% Total / diff
Buildings: Electricity	32	49	13%
Buildings: Gas	8	13	3%
Buildings: Water	0	0	0%
Buildings: Waste	0	0	0%
Travel: Commuting	12	19	5%
Travel: Other	1	1	0%
Travel: Flights	333	289	78%
Total	387	372	-4%

The total organisation footprint in 2015 is estimated at 372 tonnes of CO2e. Staff and Board flights make up over 3/4 of the total with just over 15% coming from building emissions and the remainder from staff commuting. Staff and Board flight emissions reduced by 13% between 2014 and 2015. This reduction in emissions from staff flights accounts for the 4% reduction in overall emissions. Waste and water usage account for just 0.1% of total emissions.

B. Gross emissions per FTE (tCO2e)	2014	2015	% Total
Average number of FTEs over year (Jan-Dec)	27.0	41.4	53%
Total emissions per FTE	14.3	9.0	-37%

Overall this works out at about 9 tonnes per FTE reducing by nearly 40% from last year. This is due to a mix between (a) shorter flight distances (despite an increasing number of trips), largely due to the European locations of the 2 main Cochrane events; and (b) the growth in FTE numbers.

C. Buildings emissions by site (kgCO2e)	2014	2015	% Total
London (including Oxford for 2014)	20	35	56%
Freiburg	8	8	13%
Copenhagen	9	9	15%
Others	3	10	16%
Total	41	62	100%

The London office accounts for over half of all building emissions with nearly 30% coming from Freiburg and Copenhagen together. Staff dispersed in satellite offices and working from home make up the remainder.
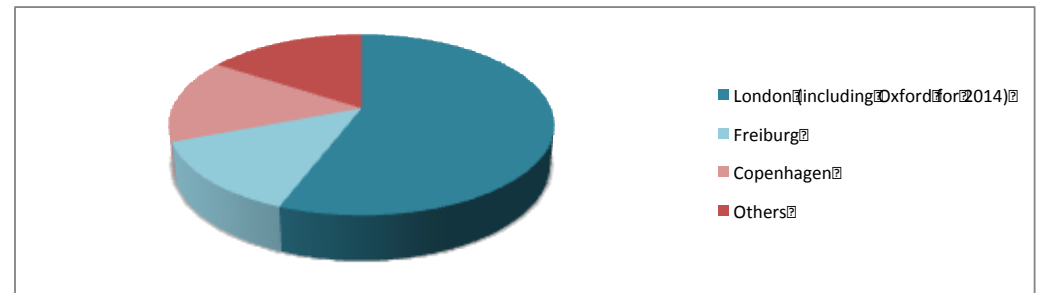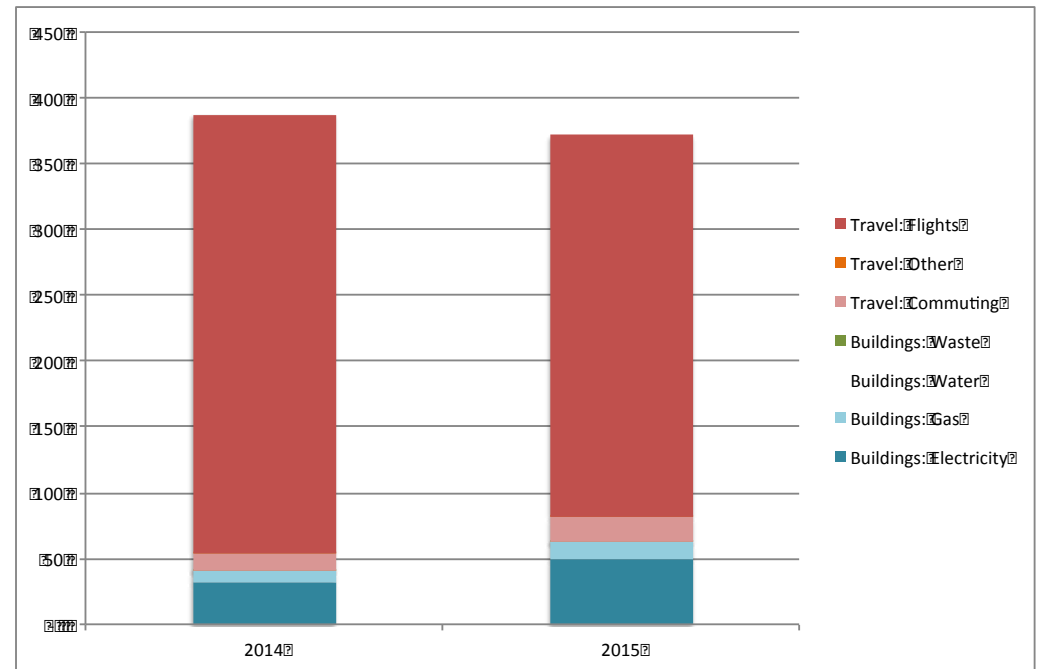
D. Staff and Board flights	2014	2015 (est.)	% change
Total number of flights	382	528	38%
Total km	1,546,535	1,180,539	-24%
Average flight length	4,049	2,236	-45%
Total carbon emissions	333,298	289,414	-13%

While there was a signficant increase in flights (+38%), the average trip length fell even further
(-45%) and this led to an overall reduction in carbon emission from flights by 13%.
This seems to be due to around half the number of long haul flights in 2015 than in 2014.
Much of this can be explained by the number of long haul flights to Hyderabad and
Panama in 2014, compared with the larger number of shorter Vienna and Athens flights in 2015.
So highlights that event location impact is driven by both attendee numbers as well as distance.

E. Commuters	Staff	Emissions	% staff
Tram	3	85	5%
Walking	4		6%
Car	5	1,180	8%
Bus	8	1,806	13%
Tube	13	470	21%
Cycling	18		29%
Train	21	8,868	33%

N.B. 61 FT & PT staff surveyed but some use multiple modes so staff column does not add to 61.

Trains are the most popular method of commuting, with a third of all staff using this
method although cycling is a close second at just under 30% and just over a fifth of
all staff using the tube at some point in their commute. Unsurprisingly, trains therefore
take up the vast majority of the emissions from commuting, with cars and buses together
accounting for a fifth. Over a third of staff incorporate a carbon free option (cycling or walking).

F. Key event attendee travel (not part of footprint)	2014	2015	% diff
Number of attendees	714	1,487	108%
Attendee emissions (tCO2e)	1,915	2,467	29%
Emissions per attendee (tCO2e)	2.7	1.7	-38%

The full impact of events are difficult to assess and, in particular, to control - therefore we have
not included these emissions in our organisation footprint. However, we can and should report
what we can measure - so we will report annually alongside our footprint the travel emissions
of all attendees at our two key annual events (the Colloquium and mid-year meeting).
For 2015 these emissions were estimated at nearly 2,500 tCO2e which is six times higher than the
organisation footprint. This is also an increase of 29% on 2014, mainly due to double the number of
attendees at main events due to their European location so is the reverse of the staff effect above.
This demonstrates that location makes a huge difference to emissions and we have therefore
developed a tool which will help us assess the carbon emissions of future events which we can feed
into the decision making process alongside global accessibility and inclusivity for attendees.
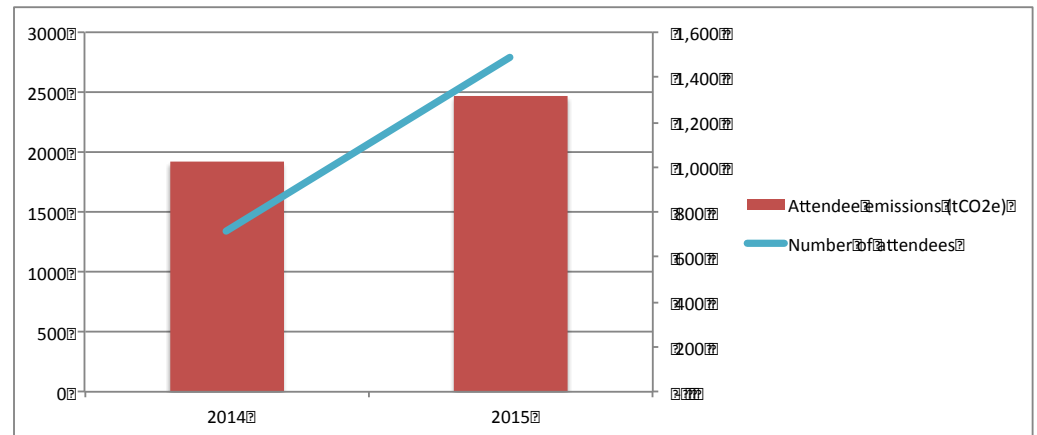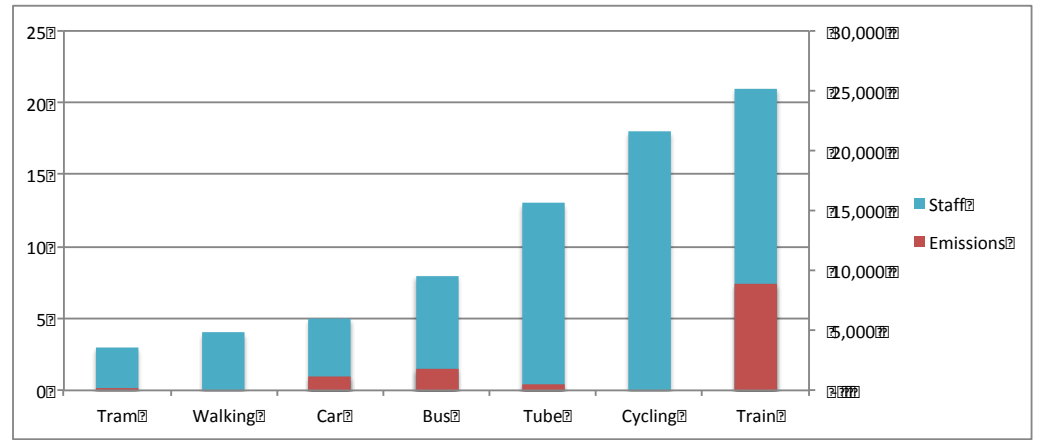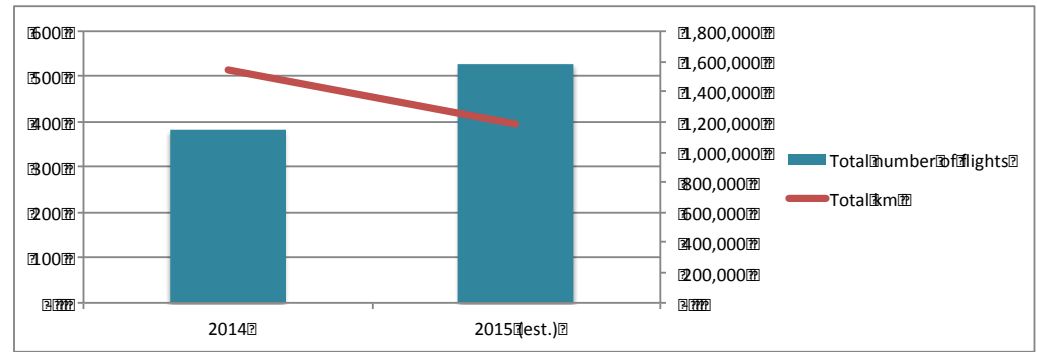
The formal organisation footprint is set out in the table below – this is the format required by the GHG Protocol[5] and other similar standards, with emissions categorised in 'scopes'. A full explanation of this is provided in Appendix 1. This is the format that will be used for the annual report and website, although it will be accompanied by analysis such as in the report section above.

Cochrane carbon footprint*	2014	2015	% change
*GHG emission data in tonnes of CO2e***	*(Base year)*		
Scope 1 (Direct e.g. on-site, owned gas heating)	-	-	0%
Scope 2 (Indirect energy e.g. purchased electricity and heat)***	33	51	+52%
Scope 3 (Other indirect e.g. travel****)	354	321	-9%
Total gross emissions	387	372	-4%
Average number of FTE staff	27.0	41.4	+53%
Per FTE annual emissions	14.3	9.0	-37%

* Based on our sites and the activities of our staff and Board members, this measure excludes our suppliers, partners and attendee travel to our events. Our footprint is measured in accordance with the UK's Department for the Environment's (Defra) 2015 emissions factors and guidelines, which is consistent with the GHG Protocol.

** Tonnes of CO2e is a universal unit of measurement used to indicate the global warming potential of a greenhouse gas, expressed in terms of the global warming potential of one unit of carbon dioxide.

*** Building emissions have to be estimated as there is no actual metered data available so estimates have been made based on the floor area of Cochrane's three sites and using actual data from another central London office.

**** Air travel emissions take into account the effect of radiative forcing (the effect of water vapour and nitrous oxides in the upper atmosphere) and therefore an uplift factor has been used in accordance with Defra guidelines.

Calculating carbon emission related to events

We have developed an innovative new tool that we can now use to calculate the carbon emissions of events due to attendee travel. The tool has several purposes. It can:

- Calculate the emissions of a past event based on the actual profile of attendees from different countries.

- For the same past event, assess what the emissions would have been for any other location across the world based on the same attendee profile (or based on how the profile may have changed due to the new location).

- Compare the emissions for different locations for future events using an estimated profile of attendees in order to support the decision making process over future event locations.

Some interesting outputs from the tool so far are that for the last two years, the following locations would have yielded the lowest footprint assuming the same attendance profile:

- Mid-Year meeting 2014, Panama –UK would have yielded the lowest footprint (20% lower emissions);

- Colloquium 2014, Hyderabad – Poland would have yielded the lowest footprint (15% lower);

- Colloquium 2015, Vienna – Netherlands would have yielded the lowest footprint (5% lower); and

---

[5] For more information on the GHG protocol that governs UK institutions see here: http://www.ghgprotocol.org

- Mid-Year meeting 2015, Athens – UK would have yielded the lowest footprint (29% lower).

However, as we have seen above, a European location may actually increase overall emissions due to increased attendees, so the model needs to be used carefully. In the future we will do some analysis on the potential carbon footprint of various locations to support the decision making process for key events.[6]

5.   Proposed Policy

The text on page 9 and following sets out the proposed Environmental Sustainability Policy which states how Cochrane will attempt to address the environmental impacts identified in the analysis above. The Steering Group is asked to approve the policy for use.

6.   Next steps

Once the policy has been agreed, we will embed it into our management structure. The main objective will be to ensure that the sustainability strategy is itself sustainable. The key activities will be:

- Revising existing (or developing new) policies and guidelines to embed the new policy;

- Developing an annual workplan based on a clear set of SMART actions for the organisation;

- Developing the ongoing carbon measurement and management approach with guidance documents, tools and spreadsheets;

- Establishing responsibilities and ownership with the Head of Finance and Core Services and updating terms of reference and job descriptions (where relevant);

- Ensuring general staff awareness and buy in to the policy; and

- Agreeing the ongoing measuring and monitoring processes to ensure activities are carried out.

---

[6] N.B. The tool only works on capital cities in order to make the dataset small enough for the tool to be usable. In the vast majority of cases an alternative city in a country would have a negligible change in impact except for really large countries e.g. USA, Russia, China, etc.

Environmental Sustainability Policy

(A) Policy statement

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

Cochrane's impacts - Cochrane recognises that in delivering our mission we impact the environment. In particular, this includes:

- Greenhouse gas emissions to the atmosphere from the use of fossil fuels for air travel and other transport necessary to deliver our mission;

- Greenhouse gas emissions to the atmosphere from the use of fossil fuel-based energy and the consumption of electricity in our offices in London, Copenhagen and Freiburg (as well those working in other offices on our behalf);

- Printing, production of waste and the use of water in our offices; and

- Indirectly, the environmental impact of our partners, contractors, suppliers and consultants (including the delivery of events and publications).

Cochrane's commitments - We are committed to continually improve our environmental performance and prevent pollution by:

- Ensuring our compliance with all relevant legislation, regulations and other relevant requirements;

- Estimating our carbon footprint and environmental impacts on annual basis and reporting this publicly on our website and in our annual report;

- Estimating the potential carbon footprint of future major events (e.g. annual Colloquium) as one input into the decision making process about location;

- Where possible improving the measurement of our environmental impacts over time by working with our landlords and suppliers;

- Putting in place a simplified environmental management system that is consistent with the high level principles of ISO14001;

- Setting appropriate and realistic targets and objectives for all of our most significant environmental impacts where we can exert elements of control over them; and

- Ensuring employee awareness of our environmental policy and impacts.

This policy is communicated to all employees, suppliers and sub-contractors and is made available to the public. Cochrane's Senior Management Team oversees and reviews the policy, and our Head of Finance and Core Services coordinates its implementation.

(B) Environmental impacts and approach

Events - Cochrane recognises that our most significant impact on the environment is the emissions from air travel created by attendees flying to the key events we organise for our stakeholders every year, including the annual Colloquium. However, in order to deliver our mission, we cannot look at the environmental impact of these events in isolation – first and foremost we must recognise the huge value created by convening such events and the collaboration they encourage and also ensuring a fair approach to accessibility for our network of global stakeholders. Going forward we will:

- Publicly report the estimated carbon footprint of our major events each year alongside our organisational footprint.

- Always measure the carbon footprint of planned events in advance and look at alternative locations so that we are fully aware of the potential impact on the environment and take this into account in decision making alongside the other factors.

- Continue to review the latest technology to potentially allow remote participation where appropriate and cost effective, although we will still encourage attendance at events.

- Seek to minimise the printed materials provided at such events by offering electronic alternatives.

- Ensure that sustainability is used as a factor in procuring facilities and services at the chosen location.

- Encourage participants to use public transport wherever possible during events.

Cochrane Groups – Cochrane Groups are generally hosted in other institutions across the globe, who will have their own policies and approaches to sustainability. Going forward we will:

- Expect all Cochrane Groups to understand and follow the environmental sustainability policies (or equivalent) of their host institutions.

- Ask that Cochrane Groups are aware of this policy and follow the principles of it whenever they are acting on behalf of Cochrane outside of their host institutions.

Buildings (and their use) - For all its current office sites, Cochrane is a tenant in some form and therefore does not own or control the delivery of energy and other utilities. It generally pays for these services as part of a service charge or desk fee and no metered data is currently available. However, we recognise that our activities still create a significant environmental impact through our water usage and office waste and the greenhouse gas emissions caused by our use of heating, hot water and electricity. Going forward we will:

- Work with our landlords and suppliers to pursue improved measurement data for our utility services (e.g. installing local floor meters, weighing waste, etc.).

- Raise staff awareness by ensuring that they know about the environmental policy and understand the impact of their actions within the office environment and publishing usage statistics where available.

- Encourage staff to power down appliances when not in use (e.g. screens, computers, printers, etc.).

- Reduce paper waste by encouraging staff to print less.

- Where possible, maximise whatever waste can be recycled or composted and work with our suppliers and landlords to ensure best practice disposal/recycling.

- Ensure all obsolete electrical/electronic goods are disposed of using the correct methods minimising environmental impact.

- Ensure that environmental sustainability is a key factor in our future decision making over office buildings and locations.

Travel - In order to deliver our mission, Cochrane recognises that we need our staff and Board members to travel internationally in order to be effective. We also recognise that our offices are a vital part of how we collaborate and therefore we will need the vast majority of our staff to regularly commute to work. However, we commit to doing more to try to reduce the impact of these requirements. Going forward we will:

- Put in place new systems/processes which will monitor staff travel to ensure more effective reporting.

- Put in place staff policies which encourage staff only to travel when there is a clear business need and to monitor.

- Ensure that before booking travel, staff consider whether there are lower carbon alternatives (e.g. train vs. plane, teleconference, Skype, videoconferencing, etc.) or whether another member of staff is currently flying to that location and could cover the trip purpose.

- Put in place a home working policy which is sensitive to work-life balance and also assesses the environmental impacts of home working vs. office working.

- Encourage more staff to cycle to work or to use other lower carbon alternatives (e.g. promoting our cycle-to-work schemes, etc.).

Publications (and other materials) - Cochrane acknowledges that we need to create high quality publications and documents and that the best format for this is sometimes a physical print version. However, we also recognise the impact this has on the environment, in terms of the drain on physical resources, the carbon emissions associated with both production and shipping and the physical waste created. Going forward we will:

- Always assess the alternatives for delivering publications and encourage greater use of electronic versions where appropriate.

- Work with our suppliers to understand better their approach to sustainability and what they are doing to measure the impact of physical publications.

Suppliers - Cochrane acknowledges that we can only exert limited control over our suppliers in their delivery of services to us. However, we will use what influence we have to ensure reduced environmental impact. Going forward we will:

- Ensure that all our major suppliers are aware of and receive a copy of our environmental policy and that we request a copy of theirs.

- Update our procurement policies and procedures to ensure that environmental sustainability is a criteria used in the purchase of all future major assets and services.

Measuring, monitoring and management - Cochrane is committed to estimating its annual environmental impact and reporting this on its website and in its annual report. We will ensure that the most up-to-date methodology and emissions factors are used in accordance with the latest Defra guidance. Should there be a need for a base year recalculation due to structural changes or changes in methodology, we will publish clearly the way we recalculated our emissions. We will maintain an annual workplan that is signed off by our Senior Management Team and progress reviewed by them on a quarterly basis. The Senior Management Team will undertake an annual review of the environmental management system to ensure it is up-to-date and that the assessments of impacts, objectives and measures are all still appropriate. Accountability for delivery of the Environmental Sustainability Strategy will sit with the Head of Finance and Core Services.

(C)   Reducing our impact

Cochrane recognises that it only has limited control over some aspects of its environmental impacts and in some cases can only estimate rather than measure those impacts. Therefore, putting in place any systematic reduction targets would not be appropriate at this time. However, through implementing this environmental sustainability strategy through our workplan we undertake to take steps to reduce our impact even where it is not possible to measure the outcome.

Appendix 1 – Carbon Footprint Methodology

This appendix sets out the detail of the carbon footprinting methodology and the choices that have been made around the measurement of the organisation's carbon footprint. It refers to the 'Cochrane Carbon Footprint Report (Final)' (available on request)[7], which sets out the detailed calculations based on this methodology and also a tool which has been developed to estimate the carbon footprint of events for different locations (the 'Event emissions calculator (Final)').

The methodology is based on the following steps:

A) Organisational boundary
- Which parts of the organisation should be reported on? i.e. What legal entities should be included (subsidiaries, joint ventures, etc.)

B) Operational boundary
- Which activities in the organisation release greenhouse gas emissions?

C) Emission types
- Which greenhouse gases should be measured?

D) Data collection
- What information should be collected to calculate greenhouse gas emissions? i.e. What can be measured? What can be estimated? What can be discounted as minimal? How best to collect data?

E) Emissions assessment
- How to calculate greenhouse gas emissions i.e. applying appropriate emissions factors to convert usage data into tonnes of CO2 equivalent.

F) Reporting
- What should be reported? i.e. how best to set up the assessment and reporting
- How best to track emissions over time?

G) Management
- Whether to get emissions data verified or to implement a management system?
- Whether to set an emissions reduction target?
- Whether to use offsets?

The following section sets out the key information relevant to the methodology framework and where relevant the key decisions made by senior management.

A. Organisational boundary

Which parts of the organisation should be reported on? i.e. What legal entities should be included (subsidiaries, joint ventures, etc.)

Cochrane has a simple legal structure whereby it owns 100% of its own operations. It does not have stakes in other organisations where it owns less than 100% in which case it would have to make decisions about what portion of those businesses to report on. Therefore, we define the organisational boundary as the legal entity of The Cochrane Collaboration.

B. Operational boundary

Which activities in the organisation release greenhouse gas emissions?

In accordance with the Greenhouse Gas Protocol, the way to identify and categorise emissions-releasing activities is in three groups as summarised in Figure 1 below.

---

[7] Please contact Chris Champion if you wish to see the data file (cchampion@cochrane.org)

Figure 1 – Main types of emissions sources under each scope (Defra, 2009)
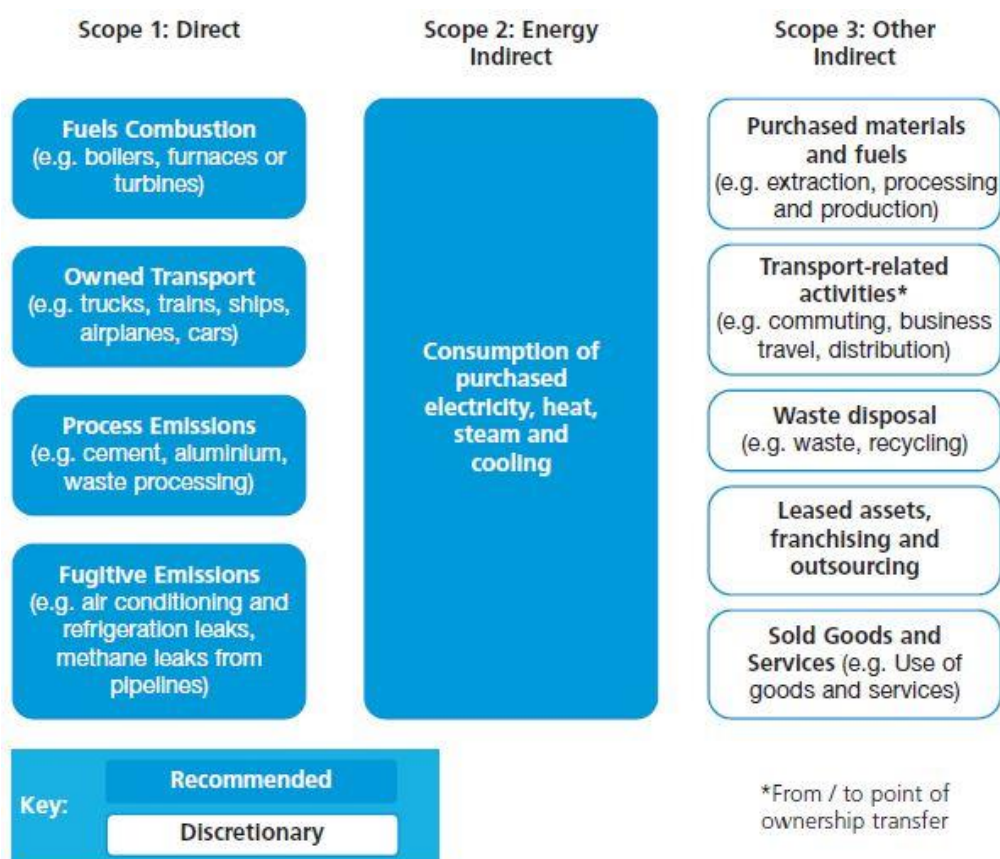
So the minimum that must be measured and reported by an office-based organisation such as Cochrane are the **'Scope 1'** emissions resulting directly from buildings (e.g. emissions from the gas burnt by any onsite boilers controlled by Cochrane) and the **'Scope 2'** indirect energy emissions resulting from energy usage. All other emissions are classed as **'Scope 3'** and are both indirect and discretionary. The organisation must therefore choose the 'boundary' of the organisation which determines what emissions it will measure and report on – the principles to be used are typically whether the levels of emissions are significant, can be measured (or estimated well) and then what level of control the organisation has over them. Further commentary on each of these three areas as relevant to Cochrane is as follows:

- **Scope 1 (Direct emissions):** Activities owned or controlled by the organisation that release emissions straight into the atmosphere (e.g. combustion in owned or controlled boilers, furnaces, vehicles and emissions from chemical production in owned or controlled process equipment). It is recommended that organisations report all of these emissions.

   - Cochrane does not own or control anything which directly emits carbon emissions other than the 'fugitive emissions' from onsite refrigerators which given the size and number owned will be negligible and does not need to be included in the calculation.

   - N.B. In the case of a building where the boiler was owned or controlled by Cochrane, this would include gas emissions for heating and hot water, however for all its sites Cochrane purchases heating and hot water from building owners/managers through service charges or equivalent so they go into Scope 2.

- **Scope 2 (Energy indirect):** These are indirect energy emissions that are a consequence of the organisation's activities but which occur at sources not owned or controlled by the organisation (e.g. consumption of purchased electricity, heat, steam and cooling). It is recommended that organisations report all of these emissions.

   - For Cochrane, this includes the heating, hot water and electricity consumption by Cochrane at all its sites as purchased from the landlords or building managers.

- **Scope 3 (Other indirect):** Emissions that are a consequence of the organisation's actions, which occur at sources which are not owned or controlled by the organisation and which are not classed as scope 2 emissions. (e.g. business travel by means not owned or controlled by your organisation, waste disposal, or purchased materials or fuels). It is discretionary to the organisation which of these emissions are reported.
    - Cochrane's main emissions in this area are from its use of buildings, travel, events and publications:
        - Office buildings:
            - Water supply & treatment
            - Indirect emissions from its gas and electricity use (i.e. emissions in the supply chain) additional to the Scope 2 emissions above
            - Waste and recycling
        - Travel:
            - Business travel (staff and Board)
            - Commuting (staff)
        - Events:
            - Attendee travel
            - Attendee use of hotels, facilities, etc.
            - Use of buildings hosting events
        - Cochrane Groups:
            - Use of buildings
            - Commuting, business travel
        - Publications and materials
            - Production
            - Shipping
        - Website hosting

When considering which elements from Scope 3 above to include (as they are all discretionary), an organisation should consider:

- **Significance** – The materiality of the emissions in relation to its footprint (i.e. would including the activity make a difference to the footprint);

- **Measurability** – The ability to measure the emissions (i.e. would an estimate be meaningful); and

- **Control** – The level of control it has on the emissions (i.e. can it do anything to affect or reduce the emissions).

Figure 2 below sets out Cochrane's assessment of the discretionary elements of the footprint against these criteria and which elements have been included in the footprint.

Figure 2 – Assessment of inclusion of discretionary Scope 3 activities

Category	Type	Significance	Measurability	Control	Included
Buildings	Water supply & treatment	*	**	**	Yes
	Indirect gas and electricity use	**	**	**	Yes
	Waste and recycling	*	***	***	Yes
Travel	Business travel (staff & Board)	***	***	***	Yes
	Commuting (staff)	**	**	**	Yes
Events	Attendee travel	***	**	**	Report
	Attendee use of hotels, etc.	*	*	*	No
	Use of buildings hosting events	*	*	*	No
Cochrane Groups	Use of buildings, travel, etc.	**	*	*	No
Publications	Production	*	*	*	No
	Shipping	*	*	*	No
Websites	Hosting	*	*	*	No

Attendee travel to main events has not been included within the official operational boundary of the organisation. The impact is, of course, highly significant and accounts for six times the total emissions from Cochrane's organisation footprint – so it certainly should not be ignored. The issue is the wide variability this will mean to the footprint year-to-year based on the locations chosen and the resulting number of attendees. For example, the travel footprint for main events in Athens and Vienna in 2015 was 30% higher than for Hyderabad and Panama in 2014. Locations more distant from the majority of attendees mean higher per attendee emissions, but lower overall attendees so the interactions can be quite complex. A tool has been developed (the 'Event emissions calculator (Final)') to help Cochrane in its decision making over future event locations and the reporting of emissions. Different locations can be entered and assumptions made about the number of attendees from each country which will attend and this results in an estimated total footprint. Alternative locations can then be assessed against this provided sensible assumptions are made as to the change the location would mean to the distribution and number of attendees. However, fundamentally, Cochrane has other competing priorities for its events – in order to maximise their impact, it wants to promote both global accessibility to attend these events as well as wanting, within reason, as many people to attend. So Cochrane will report emissions from key events separately but not as part of the official organisational boundary. Importantly, the new tool will be used to help plan future events while understanding the potential environmental impact and to report against actual events.

Emissions from non-travel elements of events and publications are notoriously difficult to estimate. Cochrane will continue to monitor for developments in best practice in this area as well as working with suppliers to measure and reduce impact where possible.

Website emissions are potentially easier to estimate and could be included in the future subject to getting the required information from suppliers although this is still an embryonic area.

Cochrane Groups have to abide by the environmental policies of their host institutions and the actual pattern of usage and therefore emissions would be almost impossible to measure in a meaningful way.

C. Emission types

Which greenhouse gases should be measured?
While there is a general focus on measuring carbon dioxide emissions, guidance states that best practice is to measure all six greenhouse gases covered by the Kyoto protocol: carbon dioxide (CO_2), methane (CH_4), hydrofluorocarbons (HFCs), nitrous oxide (N_2O), perfluorocarbons (PFCs) and sulphur hexafluoride (SF_6). Cochrane will therefore measure the full range of greenhouse gases.

D. Data collection

What information should be collected to calculate greenhouse gas emissions? i.e. What can be measured? What can be estimated? What can be discounted as minimal? How best to collect data?

Guidance states that where possible, actual data should be collected covering the periods being assessed. In the absence of actual data then estimates should be made using the best available data.

i. Buildings

Cochrane leases all of the buildings it uses from landlords who are responsible for the delivery of heat and power and the removal of waste (except for the London office where this is done under direct contract). None of this usage is measured at the organisational level of Cochrane. However, reasonable estimates can be made based on the floor areas of each of the current and past offices (Oxford, London Cavendish Square, London Haymarket, Copenhagen and Freiburg) compared with another actual central London site where real data has been measured. For the other 20 staff where there is no specific floor area data available, then instead a per person estimate can be used.

This approach was verified by looking at the actual gas usage of the whole of the Haymarket building which was made available by the landlord and applying the floor area percentage (7.22%) for Cochrane to give an estimate of Cochrane's actual gas usage. The estimate based on the central London building was just 8% different based on floor area and so this gives some comfort that the estimation technique is reasonable. Actual data for electricity and water has not been made available however so the estimation technique has been applied for all of these utilities.

ii. Travel

A staff survey was undertaken in November 2015 covering business travel (air, rail, etc.) and commuting patterns of staff. Staff were asked to list all trips taken on behalf of Cochrane between January 2014 and October 2015 and to also confirm their main modes and distances of getting to work over that period. In addition, the business travel of Board members was assessed. The use of an online distance calculator then allowed the total distances to be calculated so that business and commuting travel could be estimated. The business travel data was pro rated upwards to cover the missing two months to give a full estimate of 2015. The commuting data was a snapshot in time of current patterns of all staff in November 2015, so calculations were pro rated based on the average number of FTEs for each year.

iii. Events travel

Lists of attendees to past events were analysed and then the 'Event emissions calculator (Final)' was used to estimate the distances travelled to the events.

E. Emissions assessment

How to calculate greenhouse gas emissions i.e. applying appropriate emissions factors to convert usage data into tonnes of CO_2 equivalent.

Defra's latest set of emissions factors have been applied to the estimated usage data set out above to calculate the total emissions from all Kyoto protocol greenhouse gas emissions. In the case of the buildings emissions, full Scope 3 emissions including supply chain emissions have been included (specifically for travel data this includes 'well to tank' emissions). For air travel, the full recommended emissions factors have been used including:

- Radiative forcing – which is a measure of the additional environmental impact of nitrous oxides and water vapour when emitted at high altitude (i.e. contrails); and

- Uplift – which is a distance uplift of 8% to compensate for planes not flying using the most direct route i.e. flying around international airspace, stacking etc.

The approach used provides the highest estimate possible based on best practice and so Cochrane cannot be criticised for under-reporting its carbon emissions.

F. Reporting

What should be reported? i.e. how best to set up the assessment and reporting. How best to track emissions over time?

Defra guidelines state that carbon emissions should be reported as a gross figure in tonnes of CO_2 equivalent. They also allow for an 'intensity ratio' which normalises gross emissions data with an appropriate business metric or financial indicator e.g. staff numbers, full time equivalent staff numbers, turnover, units of production, floor area, etc. Using an intensity ratio allows you to compare your performance over time and with other similar types of organisations - Cochrane will use FTEs for this purpose as it gives the best sense of the size of the organisation as it changes.

Guidance also recommends choosing a 'base year' in order to be able to compare performance in the future and that this should be the earliest year for which verifiable emissions are available for. As a more or less full data set was available for 2014, then this will be used as the base year. This will allow immediate comparison with 2015. Calendar years will be used as reporting periods as these are consistent with the financial year and annual reporting cycles.

G. Management

Whether to get emissions data verified or to implement a management system? Whether to set an emissions reduction target? Whether to introduce offsetting of emissions?

These are strategic operational questions. What will be the organisation's approach to managing emissions going forward? Should external verification or certification be sought for the footprint (e.g. Carbon Trust Standard)? Would an environmental management system such as ISO14001 help? Would a target be appropriate so as to reduce emissions year on year? Should the organisation offset its emissions in some way through the purchase of carbon offsets? For now, Cochrane will focus on embedding the policy and assuring awareness across staff and Groups – we will not seek external verification, put in place an EMS or explore offsets at this time.

Plain Language Summaries—pilot proposal

Document prepared by:
Julie Wood, CEAD
David Tovey, CEU

**Submitted to Steering Group:** March 2016, London

Purpose of paper: For CSG to approve how we plan to use the budget already agreed to pilot with 4-5 Review Groups the centralisation the production of Plain Language Summaries (PLS) based on updated guidance. We aim to make PLS easier for our users to find via online search engines, translate them and understand them.

Access: Open

Resource implications for implementation:
To spend the £40,000 already approved this year on the linguistic input, search engine training and piloting centralising PLS production with 4-5 Review Groups.

Trusted evidence.
Informed decisions.
Better health.
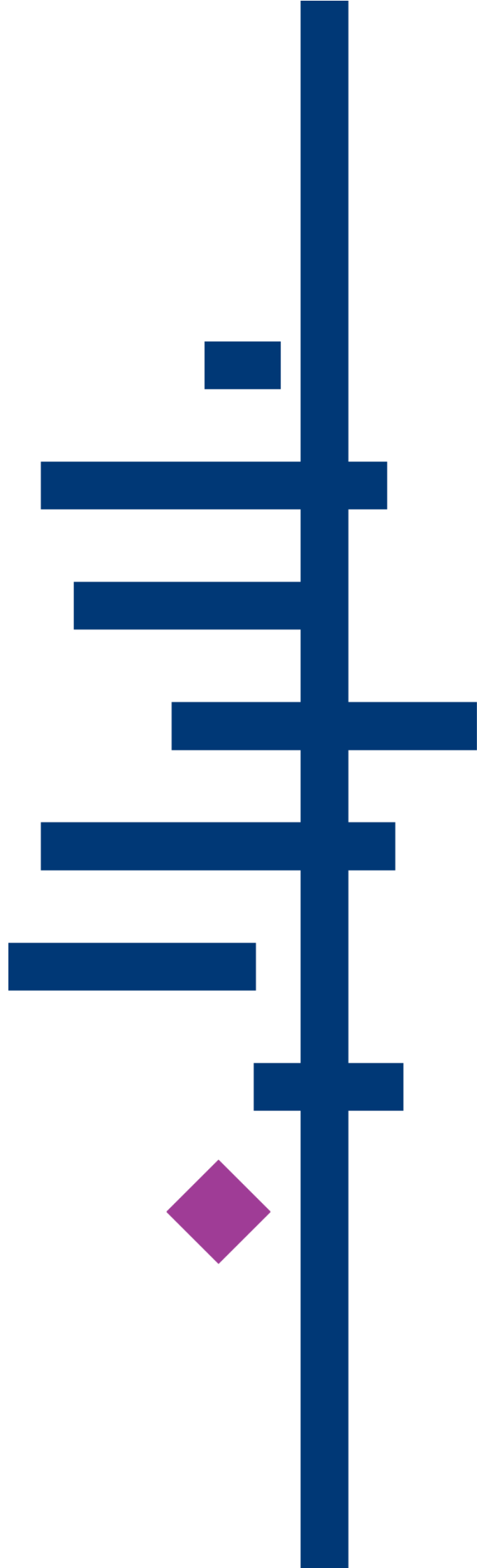
Project brief
Background/problem statement

Plain Language Summaries (PLSs) help people to understand and interpret research findings and are included in all Cochrane Reviews. However, Cochrane PLSs vary in quality and are written in various formats, which can make them more difficult to understand and to translate. Making the PLSs as accessible to as many people as possible is vital to achieving *Strategy to 2020's Goal 2—Making our Evidence Accessible*. In this context, it could be argued that this is the most important project we will undertake to meet our goal of increased access.

The Plain Language Expectations for Authors of Cochrane Summaries (PLEACS) was last updated in February 2013. Since then further needs have been identified:
- To make our PLSs as findable as possible by online search engines
- To have more structure in our PLSs to make them easier to translate
- To provide more guidance to our consumer referees to feedback on PLSs.

Further developments of Cochrane's PLSs in terms of design may be needed in 2017, but this will be considered as part of the standard budgeting process.

The project has been developed as a way to:
- Reduce the workload of Review Groups and editors. The PLS is designed to improve the quality and consistency of reporting. As such, it functions as a way of improving the efficiency of both the review production process and the editorial process.
- Improve the language and content quality of PLSs.
- Reduce the workload on translations.

As the PLS is the key section to disseminate a review, our aim is to identify ways in which other dissemination products can be linked more closely to PLSs and built on PLS content. The advantages of doing so include:
- Reducing the duplication of effort by improving awareness of existing content and improving ways in which people can access and understand this material.
- Ensuring the consistency and accuracy of reporting across different dissemination products.
- Increasing awareness of the value of the PLS as a tool that can:
  - improve public and funder awareness of research findings;
  - improve the accessibility of review content;
  - impact on access and potentially citation rates of reviews.

Project principles:
1. Through this project we are also aiming to improve the standard of Cochrane PLSs by recognizing that PLSs are valuable both as a *quality improvement tool for systematic reviews* and as a *dissemination tool*.
2. Need to use standard language to how we write PLSs to aid comprehension of users, translation needs, and ease of producing PLS.
3. The project will be based on the best available evidence.

Project Plan

To meet these new needs, the project will work with a linguist and SEO experts to make our PLS as easy as possible to translate as well as findable on the internet. We will base this work on updated guidance produced by Cochrane Norway that is based upon the best available evidence. This structure will be reviewed by SEO experts and a linguist to ensure that it will meet our needs. It will then be piloted by the Review Groups. (See Appendix III). Before any phases of this project can begin, further awareness raising and discussion with CRGs will need to occur so we can understand better how this approach differs from existing practices across CRGs.

Project objectives, sub-project and outputs

Objective	Sub-project	Outputs	Duration
To ease production, comprehension, and translation to non-English languages through standardization of content, structure, and language of the PLS, and develop writing guidance.	Working with a linguist ensure PLS structured content works across Cochrane's multilingual content needs.	Input included in the revised PLS template	May/June
To ensure that PLS are written in a way that makes them as findable as possible by search engines and to develop guidance on how to write a PLS that makes this possible.	Working with SEO experts to train PLS writers on the best ways of improving PLSs findability on the internet.	Input included in the revised PLS template, design and guidance and tracked via Google Analytics	May/June
To explore how Review Groups can best implement the PLS template and the iSoF	Pilot implementation of the new PLS as part of the review production process.	Use the pilot to develop a plan for how to operationalize new PLS approach across Cochrane Review Groups.	Late June-train the central team and pilot to run July to Oct. Wrap up meeting held at the Colloquium. 2017 plans and 2016 report of pilot ready for 2017 budget.

Potential projects in 2017

Objective	Outputs
To develop guidance for development of clear and consistent **key messages** in the PLS and the iSoF.	Input included in the revised PLS template, design and guidance.
Improving the design of PLS and test the use of graphics to aid comprehension of the information contained in a PLS.	Input included in the revised PLS template, design and guidance.
To develop a consumer checklist for PLS feedback.	Develop resources and mechanisms to gather consumer feedback about the PLS.

Appendix 1 PLS Pilot

Background:
While the PLS template provides guidance for the writing of PLSs, it is not sufficient in itself. Three core skills are needed for the production of good PLS material and to maximize the potential for user understanding and uptake:

(a) *Review skills,* i.e. methodological expertise which allows the writer to interpret a review and to report its findings consistently;
(b) *Writing skills,* i.e. plain language skills which allow a writer to apply and adapt plain language principles both according to the Cochrane template guidelines *and* the specific needs of particular target groups and campaigns;
(c) *Knowledge translation skills,* i.e. the ability to identify use the most appropriate ways to present evidence to a broad audience.

It is unlikely that review authors, language editors, or people experienced in knowledge translation will have a combination of all three skills. In this sub-project we will therefore explore:

1. The feasibility of centralizing PLS production by training dedicated PLS. The resource burden of this approach is likely to be substantial (potentially 4-5 full-time staff by some estimates). It is therefore important to pilot the feasibility, effectiveness, and sustainability of building PLS capacity in this way.

2. The feasibility of providing additional training to the PLS writers noted above to support them with writing iSoF content. As noted earlier, Cochrane also wishes to include interactive Summary of Findings (iSoFs) in Reviews. The production of iSoF content requires a similar combination of skill sets and will therefore present similar resources challenges to those noted above.

Note: Cochrane's CEU has recently approved a pilot project whereby dedicated staff members in selected Review Groups will receive training and support from the iSoF developers to produce iSoFs for their Group's reviews. It should be noted that the iSoF will include features that are currently not included in a standard SoF table, but which *are* included in the PLS template. One example is the use of standardized qualitative statements and "bottom line" statements. For this reason, skills training for plain language elements related both to the PLS template and to the iSoF are included in this Sub-project.

Aim:
The aim of Sub-project 3 is to pilot an approach whereby Review Groups identify a dedicated PLS/iSoF producer, and to develop and assess training materials and editorial processes which include the use of the PLS template and iSoF guidance.

Activities:
1. We will identify 4-5 Review Groups who are willing to participate in the PLS/iSoF pilot. We will aim to recruit Review Groups that are of different sizes (i.e. Groups that produce large numbers of reviews as well as Groups that produce small numbers of reviews), that are based in English-language and non-English language countries, that cover a range of topics, and that typically deal with complex reviews

with multiple comparisons and narrative syntheses. We are currently in discussion with the following Review Groups: Consumers and Communication Group; EPOC; Pregnancy and Childbirth Group;

2. We will ask the pilot Review Groups to identify 1-2 people to serve as PLS/iSoF producers to form part of the centralised team. These people can be consumers, managing editors, editors, or others working for or connected to the Group, and should be willing to receive training and to develop PLS and iSoFs, as paid staff or volunteers, for the duration of the pilot project (3 months). We will also consider solutions where PLS/iSoF producers are shared across two or more Review Groups.

3. We will develop any additional training materials needed for PLS and iSoF production. The training materials should be developed in collaboration with Cochrane CET's Learning and Support Department

4. We will offer PLS/iSoF producers training and support in two stages.
   - In the first stage, the producers will be offered training, and will then develop PLS/iSoF for 3-5 published reviews according to the PLS template. This will allow them to familiarise themselves with the process without time pressure. We also use this opportunity to gather feedback about the training materials and template instructions. This training will include best practice and where in a review the information for writing a PLS can be found.
   - In the second stage, the producers will develop PLS/iSoF for 3-5 unpublished reviews as part of the normal publication process. This will allow each Group to explore where in the process it is most efficient to produce the PLSs/iSoFs.

5. We will assess the Review Groups' and the PLS/iSoF producers' experiences with the following issues:
   – Selecting PLS/iSoF producers – How easy was it to identify producers? Advice to others?
   – Training and support – Was this sufficient, and how could it be improved? To which extent did they need individual support in addition to the written materials? How helpful was the template and how could it be improved?
   – Editorial processes – Where in the editorial process were the PLS and iSoF produced, and how well did this work? Was the amount of work involved feasible? How were disputes or discrepancies between the Review author and the PLS author resolved?
   – How likely is it that they will continue this work after the pilot period is over, and to which extent. i.e. do they plan to discontinue these efforts, do they plan to continue for all reviews, or do they plan to continue for priority reviews only?
   – What level of resourcing (people, funding) would be required to scale this up to an ongoing programme?

6. We will take a sample of PLSs completed by the CRGs in the pilot and have a linguistic expert review them for ease of translation and update the guidance accordingly and discuss this with the CRGs involved.

Appendix 2 Proposal Input

This proposal has been created based on feedback from a workshop on PLS on 5 Oct. 2015 in Vienna organized by Claire Glenton, Nancy Santesso, Simon Goudie, Shaun Treweek, and Marita Sporstøl Fønhus. The workshop was a working session that outlined the current issues in the production of PLS and brainstormed how to practically address those issues in the context of review production. The following people signed up to this workshop.

NAME	PRIMARY ROLE IN ARCHIE
Elaine Beller	Author and other roles at Kidney and Transplant Group
Sarah Chapman	Knowledge Broker, Cochrane UK
Jane Cracknell	ME at Anaesthesia, Critical and Emergency Care Group
Lyn Charland	Author at Cochrane Skin Group
Patricia Logullo	Translator at Cochrane Brazil
Livia Puljak	Cochrane Croatia
Simone Cocchi	No Archie record
Daniela Goncalves Bradley	Author and works at Effective Practice and Organisation of Care Group
Caroline Struthers	On the exec for Cochrane Consumer Network
Marilyn Halverson Bamford	Consumer Referee at Musculoskeletal Group
Aline Flatz	Cochrane Switzerland
Fiona Stewart	Author and works at Incontinence Group
Carol Rhodes	Member of Cochrane Consumer Network
Jani Ruotsalainen	ME at Work Group
Nancy Fitton	On the exec for Cochrane Consumer Network
Sandy Walsh	Author and Editor at Breast Cancer Group
Rebecca Weida	Work at Cochrane Insurance Medicine
Annhild Mosdøl	Author at Public Health Group
Gill Gyte	Author and Editor (consumer) at Pregnancy and Childbirth Group
Marie-Martine Lefevre-Colau	Author at Musculoskeletal Group
Richard Davis	Videographer and Cochrane Canada
Karianne Hammerstrøm	Author at Developmental, Psychosocial and Learning Problems Group
Heather Ames	Author at Consumers and Communication Group
Elisabeth Couto	No Archie record
Elizabeth Royle	CEU, Copy Editor Support
Miranda Cumpston	Head of Learning and Support
Toby Lasserson	Senior Editor, CEU
Julie Wood	Head of Communications and External Affairs
Nancy Owens	Senior Comms Officer
Deirdre Walshe	Author and works at Infectious Diseases Group

Further consultation was done subsequently in creating this document. Claire Glenton, Simon Goudie, David Tovey, Toby Lasserson, Richard Morley, Chris Watts, Miranda Cumpston, Livia Puljak, Nancy Santesso, Joy Oliver, Gabriel Rada, Sarah Rosenbaum, Angela Morelli, Marita Sporstol Fonhus, Holger Schünemann, Cindy Farquhar and Karin Dearness.

Appendix 3 Pilot PLS Guidance

(See attachment)

How to write a plain language summary of a Cochrane intervention review

8th May 2015

Cochrane
Norway

Plain language summary template

In this document, we describe how to write a plain language summary for a Cochrane Intervention Review. We suggest sub-headings and provide a description of the content required under each sub-heading.

The instructions in this template aim to supplement the Standards for the reporting of Plain Language Summaries in new Cochrane Intervention Reviews (PLEACS).

The recommended length of a Cochrane plain language summary is between 400 and 700 words.

A

In-service training for health professionals to improve care of seriously ill newborns and children in low-income countries

B

What is the aim of this review?

The aim of this Cochrane review was to find out whether additional emergency care training programmes can improve the ability of health workers in poor countries to care for seriously ill newborns and children admitted to hospitals. Researchers in the Cochrane Collaboration collected and analysed all relevant studies to answer this question and found two relevant studies.

C

What does the review conclude?

The review authors suggest that giving health professionals in poor countries additional training in emergency care probably improves their ability to care for seriously ill newborns. But we still need more high quality studies, including studies where health professionals are trained to care for seriously ill older children.

D

What was studied in the review?

In poor countries, many babies and children with serious illnesses die even though they have been cared for in hospitals. One reason for this may be that health workers in these countries are often not properly trained to offer the care that these children need.

In poor countries, children may often become seriously ill because of conditions such as pneumonia, meningitis and diarrhoea, and may need emergency care. For newborn babies, the most common reason for emergency care is when the baby gets too little oxygen while being born. If this goes on for too long, the person delivering the baby has to help the baby breathe, and sometimes has to get the baby's heart rate back to normal. This is called neonatal resuscitation.

Neonatal resuscitation is a skilled task and the health worker needs proper training. As babies need to be resuscitated quickly, the health worker also needs to know how to prepare for this before the baby is born. For instance, he or she needs to know how to prepare the room and the proper equipment. Health workers in poor countries often do not have these skills, and these babies are likely to die. Babies can also be harmed if the health worker does not resuscitate the baby correctly.

There are a number of training programmes that teach health workers how to give emergency care to seriously ill babies and children. But these have mostly been developed and tested in wealthy countries and we don't know if these would work in poor countries.

E

What are the main results of the review?

They review authors found two relevant studies. These studies compared the practices of health professionals who had been given extra training in the care of newborns with the practices of health professionals who did not get extra training.

This example has been written with the help of the plain language summary template and is based on the following review:
Opiyo N, English M. In-service training for health professionals to improve care of the seriously ill newborn or child in low and middle-income countries (Review). Cochrane Database of Systematic Reviews 2015 (In press).

Cochrane
Norway

In the first study, nurses at a maternity hospital in Kenya got a one-day training course in how to resuscitate newborn babies. This course was adapted from the UK Resuscitation Council, and included lectures and practical training. The study suggests that after these training courses:

- Health professionals are probably more likely to resuscitate newborn babies correctly (moderate certainty evidence)
- Newborn babies may be less likely to die while being resuscitated (low certainty evidence)

In the second study, doctors, nurses and midwives in five Sri Lankan hospitals were given a four-day training course in how to prepare for and provide care for newborns. This course was adapted from the WHO Training Modules on Essential Newborn Care and Breastfeeding, and included lectures, demonstrations, hands-on training and small group discussions. This study suggests that after these training courses:

- Health professionals are probably more likely to be well-prepared to resuscitate newborn babies (moderate certainty evidence)

Unfortunately, the two studies only followed up the health professionals for two to three months after they have received training. We therefore don't know if the benefits of the training courses lasted over time.

The review authors did not find any studies that looked at the effect of training programmes for the care of older children.

F

How up-to-date is this review?

The review authors searched for studies that had been published up to February 2015.

Instructions for each part

A Review title

If the review title is difficult to understand, for instance if it includes technical terms or jargon, consider re-writing it in plain language. However, this solution can cause confusion if the plain language summary is used outside of the review and should be avoided if possible.

B Suggested sub-heading: **"What is the aim of this review?"**

People do not always understand that the results of a plain language summary come from a systematic review rather than a single study. Some also wrongly assume that the review authors have carried out the studies themselves. We therefore suggest that you use an introductory sentence like the following:

> *"The aim of this Cochrane Review was to find out if [….]. Researchers in Cochrane collected and analysed all relevant studies to answer this question and found [X#] studies."*

Cochrane
Norway

C Suggested sub-heading: **"What does the review conclude?"**

In this section you should only present a brief summary of the results. This summary should include a reference to the quality or certainty of the evidence, and any important research gaps. NB! Summarising the main results may involve some interpretation and caution is required!

The results for *each* main outcome must be presented in the section called "*What are the main results*".

D Suggested sub-heading: **"What was studied in the review?"**

Give a brief description of the review topic based on the following questions:

- Why is this particular topic important?
- What was the population(s)/health problem(s) addressed in the review?
- What was the intervention(s)? Give enough information for readers to judge whether the intervention is comparable to those available to them
- What was the intervention compared to?
- Are there outcomes in the results section that need to be explained, including adverse effects?

E Suggested sub-heading: **"What are the main results in this review?"**

Describing the included studies

In this section you should briefly describe the included studies. It may be enough to give information about how many studies you included and where they were set. Sometimes, you may also need to give more specific information about the intervention and comparison group and the study population. You may also need to mention the funding sources of the included studies. For instance:

> *"The review authors found [x#] relevant studies. [X#] were from [country/setting] and [x#] were from [country/setting]. These studies compared [intervention] with [comparison] for [population]. [X#] of the studies were funded by the manufacturer while [X#] were funded by government agencies."*

Cochrane
Norway

Presenting the effect of the interventions

Principles when presenting the effects of the intervention

When presenting the main results of the review, always follow these principles:

1. Only present results for the most important outcomes, and try to present no more than seven outcomes. These outcomes are likely to be your pre-defined primary outcomes and should be the same as the outcomes that are presented in the Summary of Findings table
2. If you found no data on an important outcome, you must present the outcome anyway, but explain that no data were found
3. Present the quality or certainty of the evidence for each outcome, as presented in the Summary of Findings table. (Within GRADE, the phrase "quality of the evidence" is increasingly referred to as "certainty of" the evidence. Use the same term that has been used elsewhere in the review)
4. Present the results consistently, using similar words and expressions for similar levels of effect
5. Ensure that the results are reported consistently between the plain language summary and the main text of the review, including the abstract, summary of findings table, results, and summary of main results

Using qualitative statements when presenting the effects of the intervention

You may be able to increase the accessibility of the review by avoiding numbers and using qualitative statements to present the results. By 'qualitative statements' we mean an expression of your results in plain language, using similar words and expressions for similar levels of effect.

Qualitative statements about effect are difficult to get right. It is easy to cause confusion and misinterpretation by using words inconsistently or by using overly complicated statements such as "a high likelihood of somewhat small but possibly important effects".

To help authors formulate clear, consistent statements, we present a set of standardised statements in the Appendix. This shows which qualitative statements you can use for different combinations of the magnitude of effect (or effect size) and the quality or certainty of evidence.

Presenting confidence intervals in qualitative statements:

In most situations, it is not necessary to refer to the confidence intervals. However, there may be situations where this is useful. For instance, in situations where the confidence interval includes the possibility of both an important benefit and no effect or an important benefit and harm, consider the following type of statement:

> *"[Intervention] may lead to [better outcome]. However, the range where the actual effect may be shows that [intervention] may lead to [better outcome] but may also make little or no difference/may worsen/increase [outcome]."*

Cochrane Norway

F Suggested sub-heading: "**How up-to-date is this review?**"

Describe here when the review authors searched for the included studies, for instance as follows:

> *"The review authors searched for studies that had been published up to [date]."*

What are these instructions based on?

These instructions were prepared by Claire Glenton and Marita Sporstøl Fønhus (Cochrane Norway) and Simon Goudie and Eamonn Noonan of the Campbell Collaboration. They build on earlier instructions developed by Claire Glenton and Elin Strømme Nilsen (Cochrane Norway) and Nancy Santesso (Cochrane Applicability and Recommendations Methods Group), and on the following sources:

1. Glenton C, Santesso N, Rosenbaum S, Nilsen ES, Rader, T, Ciapponi A, Dilkes H. Presenting the results of Cochrane systematic reviews to a consumer audience: A qualitative study. Medical Decision Making 2010 Sep-Oct; 30(5):566-77
2. Santesso N, Glenton C, Rosenbaum S, Strømme Nilsen E, Rader T, Pardo J, Ciapponi A, Moja L, Schünemann H. A new format for plain language summaries: does it improve understanding, and is it useful and preferable? A randomised controlled trial. 17th Cochrane Colloquium. Singapore, 2009
3. Glenton C, Kho M, Underland V, Nilsen, ES, Oxman A. Summaries of findings, descriptions of interventions and information about adverse effects would make reviews more informative, Journal of Clinical Epidemiology 2006, 59 (8): 770-778
4. Woloshin S, Schwartz LM. Communicating data about the benefits and harms of treatment: A randomized trial. Annals of Internal Medicine 2011; 155:87-96.

Cochrane Norway

Appendix: Table of standardised statements about effect

This table shows which qualitative statements you can use for different combinations of the magnitude of effect (or effect size) and the quality or certainty of evidence. To use the table:

1. Select an outcome that you are planning to report
2. Determine the quality/certainty of the evidence for that outcome (assessed using GRADE)
3. Decide whether the size of the effect is important, less important or not important. This decision is a judgment call and should focus on importance to the end user (decision makers, health care providers, health service users etc.) rather than "statistical significance"
   Go to the relevant cell in the table below and select the appropriate standard sentence to use in your review. NB! You may need to amend the statements slightly to fit your intervention and / or outcome. However, amendments to the statements should not change the underlying principles of using a standard approach to describing the magnitude and certainty of the evidence.

Table of standardised statements about effect

	Important benefit/harm	Less important benefit/harm	No important benefit/harm
High quality / certainty[1] evidence	[*Intervention*] improves/reduces [*outcome*] (high quality / certainty evidence)	[*Intervention*] slightly improves/reduces [*outcome*] (high quality / certainty evidence)	[*Intervention*] makes little or no difference to [*outcome*] (high quality / certainty evidence)
Moderate quality / certainty[1] evidence	[*Intervention*] probably improves/reduces [*outcome*] (moderate quality / certainty evidence)	[*Intervention*] probably slightly improves/reduces / probably leads to slightly better/worse [*outcome*] (moderate quality / certainty evidence)	[*Intervention*] probably makes little or no difference to [*outcome*] (moderate quality / certainty evidence)
Low quality / certainty[1] evidence	[*Intervention*] may improve/reduce [*outcome*] (moderate quality / certainty evidence)	[*Intervention*] may slightly improve/reduce [*outcome*] (moderate quality / certainty evidence)	[*Intervention*] may make little or no difference to [*outcome*] (moderate quality / certainty evidence
Very low quality / certainty[1] evidence	We are uncertain whether [*intervention*] improves/reduces [*outcome*] as the quality of the evidence has been assessed as very low		
No studies	No studies were found that looked at [*outcome*]		

[1]Within GRADE, the phrase "quality of the evidence" is increasingly referred to as "certainty of" the evidence. Use the same term that has been used elsewhere in the review.

Cochrane Norway