Welcome to EvidenceLive 2017

This is our sixth conference, jointly hosted by the Centre for Evidence-Based Medicine (CEBM) at the Nuffield Department of Primary Care Health Sciences, University of Oxford and The British Medical Journal (BMJ).

This year’s conference will focus on the EBM Manifesto, Better Evidence for Better Healthcare, its development, dissemination and Implementation.

We have a line-up of world leading speakers whose remit is to stimulate, provoke, entertain and inspire.

Evidence Live encourages debate on the current status and future directions of Evidence-Based Medicine.

You are all invited to attend the EBM Manifesto consultation workshop at 18:00 on Wednesday 21st. This session will be facilitated by authors of the manifesto. Our aim is to generate working groups that will take forward and implement solutions for better evidence and healthcare in their respective fields.

Feel free to follow on discussions after the workshop with drinks in the atrium of the Radcliffe Primary Care building in the Radcliffe Observatory Quarter.

EL2017 Conference Committee.

Notice of photography and filming

Evidence live 2017 is being visually documented. By attending you acknowledge that you have been informed that you may be caught on camera during this event. Images taken will be treated as the property of Evidence Live and may be used in the future for promotional purposes. These images may be used without limitation by any organisation approved by CEBM & The BMJ and edited prior to publication as seen fit for purpose. Images will be available on the internet accessible to internet users throughout the world including countries that may have less extensive data protection than partnering countries. All films will be securely stored on University of Oxford servers. Please make yourself known at registration if you wish to remain off camera.

For updates: www.evidencelive.org or follow us on @EvidenceLive #EvidenceLive
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**Breakfast Session**

**Better Value Healthcare**
- Muir Gray

**The REWARD Alliance and the EQUATOR Network:** promoting increased value of research
- Co-organisers: Iain Chalmers and Doug Altman

**Keynote Session 2, Lecture Theatre one**

**Better Data, Reduced Waste in Research and Public Engagement to Transform Patient Care**
- Tessa Richards – Session Chair
- Simon Denegri – Going beyond the patient to add value in research
- Trish Groves – How to improve patient care through publishing research that truly adds value
- James Munro – Care Opinion: people helping health/care get better
### Parallel Sessions

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| Seminar Room 1 | Chair: Annette Pluddemann  
Fay Chinnery – National Institute for Health Research (NIHR) Health Technology Assessment (HTA) Programme research funding and UK burden of disease: a cross-sectional study  
Jamie Falk – Money for Nothing: The Evolution of COPD Treatment in Canada  
Carol Rivas & Sydney Anstee – An automated approach to analysing and visualising patient experience survey freetext comments to drive service improvements – Present Study: Development and Proof of Concept with patients and healthcare professionals  
Joy Ngai – Applied Data Intelligence for Clinicians – Scotland’s unique tools for delivering better healthcare  
Kelsey Chalmers – Measuring low-value care in Australian routinely collected health data  
| Chair: Peter Gill  
Mary Fraser – Shared decision making in veterinary and human medicine – a comparison  
Nicole Capdarest-Arest – Assessing Information Seeking Skills of Medical Students to Improve Evidence-based Practice Curriculum  
Peter Oettgen – Individualized effects for Well Informed Shared Decision Making for Atrial Fibrillation thromboembolic prophylaxis: WISDM for A FIB  
Rachel Thompson – Right For Me: Results of a Cluster Randomised Controlled Trial of Two Interventions for Facilitating Shared Decision-Making about Contraceptive Methods  
Janet Martin – Troubled Evidence? Tracking Excess Significance, Cherry-Picking, and Premature Closure  
Emmanuel Azuike – Clients’ satisfaction with waiting time in HIV treatment centres: An urban rural comparison in Anambra State, Nigeria  
| Chair: Helen Macdonald  
Aislinn Conway – Evidence Rounds: a targeted initiative to disseminate research evidence to health care professionals (HCPs)  
Riaz Agha – Consensus-based surgical case report guidelines: The SCARE Statement  
Denise Goodwin – Understanding drivers of behaviour to support knowledge translation: the example of urinary catheter care management following spinal cord injury  
Amy Price – How to implement Patient Review and navigate The BMJ Patient Involvement Statement  
| Chair: David Nunan  
Kushal Banerje – Homeopathy for Allergic Rhinitis: A Systematic Review  
Rabia Bashir – Do systematic review updates target questions where evidence accumulates faster?  
Junqiao Chen – Prospective Comparison between Rapid and Systematic Reviews on the Same Topics: A Feasibility Study  
Ewelina Rogozinska – Should we be concerned – what does access to Individual Participant Data tells us about the unreported outcomes?  
Eve O‘Toole – The development of “Evidence into Practice – Rapid Reviews”  
Anna Noel-Storr – Cochrane Crowd: using citizen science to meet the challenge of information overload in evidence production  
| Chair: Jeffrey Aronson  
Amy Rogers – Large Streamlined Trials – what works, and what doesn’t  
Penny Reynolds – Why academic clinical trials fail: Trial ‘cemetery demographics’ and a case study  
Heidi Gardner – “Is that it?” – Using ‘Explorachoc’ to engage the public with clinical trials and encourage involvement with health services research  
Patrick van Rheenen – Telemonitoring versus usual care: a multicentre trial among teenagers with inflammatory bowel disease  
Ignacio Atal – Does health research effort match health needs? A large scale comparison between the global conduct of randomized controlled trials and the global burden of diseases  
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<td><strong>Workshops</strong>&lt;br&gt;From population to personal: getting the balance right in evidence based medicine&lt;br&gt;Paul Chrisp&lt;br&gt;Evidence at the Point of Care&lt;br&gt;Caroline Blaine&lt;br&gt;Patient Engagement&lt;br&gt;Paul Hewitson&lt;br&gt;A One Health approach to Evidence-Based Medicine – working across healthcare disciplines to improve evidence and care and contribute to the manifesto EBM 2.0&lt;br&gt;Rachel Dean&lt;br&gt;TRIP – Community rapid reviews&lt;br&gt;Jon Brassey</td>
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<td>Closing Keynote, Lecture Theatre 1&lt;br&gt;Evidence Policy and impacting on Global Health&lt;br&gt;Fiona Godlee – Session Chair&lt;br&gt;Mukesh Kapila – Transforming the humanitarian-health interface&lt;br&gt;Marie Lindquist – Improving policy for a positive impact on global health</td>
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For the latest updates go to: evidencelive.org
Map showing walk from train station

Taxi numbers
001 Taxis: 01865 240000
Royal Cars: 01865 777333
A1 Taxis: 01865 248000

More online info
evidencelive.org/location/
Lack of trust in medicine leads to sub-optimal medical outcomes. It also has serious cost implications for patients, health providers and pharmaceutical companies. Transparency is vital for building such trust, especially transparency as regards the process by which the safety and efficacy of medicines is verified. The European Ombudsman has therefore placed great emphasis on encouraging EMA to strengthen its policies of making public information relating to its procedures for authorising medicines and monitoring their use.

The presentation will seek to give a “state of play” account as regards the transparency of EMA. It will cover the area of pre-authorisations, such as access to clinical study reports submitted by pharmaceutical companies with an application for marketing authorisation and the documentation generated by EMA when evaluating such applications. It will also cover post-authorisation evaluation procedures, such as access to EudraVigilance, the PSUR repository, and access to documents relating to “referral procedures” which aim to resolve concerns over the safety or benefit-risk balance of a medicine or a class of medicines already on the market.

One new area which has attracted the interest of the Ombudsman is the development of pre-submission guidance, and more particularly, the future use of “adaptive pathways”. Transparency in these areas is vital to building public trust in EMA and the medicines it eventually approves.

The difficult issue of how to reconcile transparency with the need to protect the privacy of patients, especially in the context of “big data”, will be examined in relation to the above issues. Transparency also plays a key role in resolving any concerns that may exist as regards conflicts of interests at EMA or its committees, such as the CHMP and PRAC.

Finally, a very brief comment will be made on how Brexit may impact upon the proper functioning of all of the above.

Improving the evidence for improving healthcare
Professor Mary Dixon-Woods
University of Cambridge

Although quality improvement (QI) is frequently advocated as a way of addressing the problems with healthcare, evidence of its effectiveness has remained very mixed. This lecture will identify some of the major challenges and offer suggestions on what needs to be done to get better at getting better. It will stress the need for strengthening of the scientific foundations of QI, for more rigorous evaluation, and for improved fidelity in the application of QI methods. It will also point to structural problems in the way QI is organised at present, including the tendency for pursuing it through time-limited, small-scale projects, led by professionals who may lack the expertise, power or resources to instigate the changes required. There is insufficient attention to rigorous evaluation of improvement and to sharing the lessons of successes and failures. Too many QI interventions are seen as ‘magic bullets’ that will produce improvement in any situation, regardless of context. Too much improvement work is undertaken in isolation at a local level, failing to pool resources and develop collective solutions, and introducing new hazards in the process. Progress will depend on addressing these challenges.
Scandal of poor medical research
Professor Doug Altman
Centre for Statistics in Medicine, University of Oxford

Research has value only if the study methods have validity and the findings are published in a usable form. In 1994, in “The scandal of poor medical research”, I concluded by arguing that we needed “less research, better research, research done for the right reasons.” What progress has been made nearly a quarter of a century later?

My main concern in 1994 was poor methodology. Since then other deficiencies of research publications have become apparent. Notably, it is abundantly clear that questionable research conduct is exacerbated by poor reporting of research, making the methods unclear and non-replicable. CONSORT was published in 1996, and huge numbers of reporting guidelines have appeared since. But reviews of publications generally show painfully slow improvement. Also, misinterpretation of research findings, especially in relation to significance testing, remains rife. And reviews of methods show that bad methods remain common.

Research isn’t just for the present. Researchers leave a legacy of scientific information for the future, so the consequences of bad research practice are very serious. But researchers, funders, and journals have largely failed to stem “questionable research practices”. Bad research and bad publications remain much too common, and it is still a scandal.


Wednesday June 21st 17:00  Lecture theatre 1
Carrots, Sticks, or Stones?
Audit and Accountability to Improve Research Quality.

Dr Ben Goldacre
EBM Data Lab, University of Oxford

Audit and feedback are used extensively throughout clinical medicine to establish whether high standards are being achieved, as part of the “quality improvement cycle”. When shared openly the results of audit can help drive up standards, by identifying sites or individuals that might benefit from additional support, and outstanding performance that others can learn from.

These opportunities have been relatively neglected when addressing problems in research, such as trials transparency and reporting quality. Work on research integrity typically reports summary figures for the overall prevalence of a problem, without identifying the individual research centres, funders, studies or researchers that are found to have breached guidelines or ethical obligations. This deprives the system of important information needed to improve quality and performance, and of contextual knowledge needed to interpret published research.

This talk will explore the opportunities and challenges around using open audit and feedback in the field of research integrity, with examples taken from the COMPare Trials projects, the TrialsTrackers, audits of transparency policies, and other audits outside of medicine. It will discuss how this approach may improve both data quality and impact; but also how, as with all open performance data, open audit can be unpopular, or met with anxiety.
Better data, reduced waste in research, and public engagement to transform patient care

CHAIR: Tessa Richards

Going beyond the patient to add value in research

Simon Denegri
NIHR National Director for Patients and the Public and Chair, INVOLVE

Health researchers are involving patients, carers and the public – ‘the public’ – more and more in the design and delivery of their work. A growing number of research funders are also expecting researchers to demonstrate how they are involving the public. They are recognising that the insights gained through public involvement can lead to better research – more relevant, efficient and with greater reach – and better evidence upon which to base future health care practice. This presentation will look at examples of public involvement in research from a number of countries and the impact this has had on research. It will also consider the deeper partnerships being formed between the public, researchers and health professionals in research and how this might influence the wider health care system.

How to improve patient care through publishing research that truly adds value

Trish Groves
The BMJ

Given estimates that 85% health research is wasted – asking the wrong questions, using poor designs, getting only partly reported – there’s an urgent need to increase value in health research and make it truly able to improve patient care.

Responsible innovation focused on the needs and preferences of patients and wider society depends on changes at every stage of research: priority setting, grant-giving, ethics approval, regulation, reporting and publication, educations, and shared decision making. In this short talk Trish will focus particularly on the reporting of research.

Care Opinion: people helping health/care get better

James Munro
Care Opinion

Care Opinion is a non-profit platform for public feedback about health and care services across the UK. We want people to be able to share their experiences of care in ways which are safe, simple, and lead to learning and change. We aim to provide a service which makes it easy for people to share honest feedback without fear, and for everyone to be able to see how and where services are listening and changing in response. In a sense, this is crowdsourcing patient-centred improvements in care.

Currently about 1850,000 stories are available through the Care Opinion site, of which 75% have received a response from staff. About 7,000 staff and students from 600 organisations use the platform to hear what people are saying about local services, and the stories have been read about 89 million times in all.

I am CEO at Care Opinion and my background is in public health medicine and health services research. In 1994 I learned about evidence-based medicine from David Sacket at McMaster University and now, to my own surprise, I find myself promoting experience-based health care via an online service. Working at Care Opinion has caused me to reappraise my own assumptions about healthcare, to reflect on what matters most to people, and think about the different kinds of evidence we need to ensure that health services are safe, effective and life-enhancing for those who use them and those who work in them.
About a billion people around the world are struggling every day at the frontlines of armed conflicts and so-called natural disasters, not all of which make the headlines. For them, the margin between life and death can be very thin and their access to healthcare can make a vital difference.

In reality, access to such care is an unfairly-skewed lottery of chance and circumstance. It does not have to be that way because even amidst the direst humanitarian crises, we have the knowhow and means to bring healthcare essentials, anywhere and everywhere. Conflicts and disasters will continue to happen but, if you have not been killed by the initial trauma or shock, it should be fully possible to maintain adequate health and well-being among affected people. Keeping people as strong and resilient as possible amidst the depths of misfortune and adversity is an essential investment for finding sustainable solutions to underlying causes, and ultimate crisis recovery.

“Crises” are created in the minds of people and that is where they must be tackled. Thus, the real crisis we face is that of the paucity of vision and ambition in the face of inevitable catastrophes in the world we inhabit. Indeed, we will have more of them in the future as many adverse planetary and people factors collide.

In that mind-set, what does an improved policy for humanitarian work look like? What is the evidence-based package of health essentials that should be part of humanitarian crisis response? What will it take to put this into practice so that, in the words of the United Nations Agenda 2030, “no one is left behind”?
Brian Alper & Peter Oettgen: Determination of the Certainty of Net Benefit when making recommendations for clinical practice guidelines (Sem 1)

**Objective:** An evidence-based approach to clinical practice guidelines includes expressing the confidence that the desirable consequences outweigh the undesirable consequences for a particular recommendation. This is often done by expressing the strength of recommendation and the quality of evidence. The overall quality of evidence rating however is not the same thing as the confidence in the evidence that the summation of beneficial effects outweighs the summation of harmful effects. The objective is to more clearly express this concept and how to do it.

**Methods:** Members of the GRADE Working Group struggling with how to convey the concept of Overall Certainty of Evidence for a concept when fully contextualized in the guideline development process came to realize that directly expressing Certainty of Net Benefit would be clearer and more useful for guideline users. The workshop facilitators have actively developed a protocol for determining the Certainty of Net Benefit and applied it to numerous examples.

**Results:** The 7-step process to determine the Certainty of Net Benefit is:

1. determine the outcomes to be combined for a net effect estimate;
2. determine the relative importance for each outcome to be combined;
3. determine the importance-adjusted effect estimate for each outcome to be combined;
4. determine the net effect estimate upon combining the importance-adjusted effect estimates;
5. consider the precision of the net effect estimate and its influence on the certainty of net benefit or harm;
6. consider which outcomes are potential differentiators for the likelihood of net benefit and the certainty of effect estimates for potentially differentiating outcomes; and
7. consider the range of relative importance for outcomes and if the net effect estimate across the range of relative importance changes the Certainty of Net Benefit rating.

**Conclusion:** The Certainty of Net Benefit is a clearer way of expressing the overall confidence that the benefits outweigh harms for a particular decision or recommendation. The 7-step process allows guideline developers to reproducibly determine and rate the certainty of net benefit. Workshop participants will determine the Certainty of Net Benefit for a recommendation to convey the certainty that the benefits outweigh the harms.

Sharon Mickan: Identifying Barriers and Facilitators to maximise the Implementation of research Evidence in clinical Practice (Sem 2)

**Objective:** This interactive workshop will mix presentations, discussion, and group work to demonstrate how clinicians can systematically and efficiently identify barriers and facilitators in their local context, in order to use research evidence to inform and improve their clinical practice.

**Methods:** The Canadian Institutes of Health Research model of knowledge translation will be reviewed to identify the importance and timing of identifying barriers and facilitators in the sequential knowledge-to-action process. Theories of organisational readiness and behaviour change will be introduced along with practical tools for stakeholder analysis.

**Results:** Practical examples of clear knowledge-practice gaps will be shared as a guide for small group work. Participants
will be facilitated to apply research evidence to their local practice; beginning with a critical appraisal of the research evidence, focussing on comparisons to their local context. In order to identify key barriers and facilitators, participants will be guided to identify and analyse the motivation and power of key stakeholders, within a broader analysis of their local context. **Conclusion:** Key barriers and facilitators will then be identified and mapped against the Knowledge to Action process. Participants will continue to discuss and compare ways they could maximise the potential impact of facilitators, while managing the identified barriers in applying specific research evidence to their own clinical practice. This workshop will highlight that the identification and management of key barriers and facilitators is an important stage in adapting and applying research evidence within local clinical settings.

**Lars Hemkens: Routinely collected health data (RCD) for randomised controlled trials (RCT) (Sem 3)**

**Objectives:** Routinely collected data (RCD e.g. administrative claims data, electronic health records and patient registries) can be useful for the conduct of randomised trials. We will outline the opportunities and challenges for the use of RCD, in particular for recruitment of participants and follow-up.

**Methods:** This interactive workshop invites data scientists, clinical researchers, trial managers, regulators and other interested stakeholders. We will present and discuss empirical research on the validity and reliability of RCD in general and specifically for trial recruitment and follow-up. We will discuss examples from the UK, Switzerland and other countries aiming to interactively outline promises, opportunities and challenges of this way of evidence generation. We aim to develop recommendations for trialists and regulators to make best use of this opportunity.

**Results/Conclusions:** RCD should be used for more than observational data analyses. Their true value for evidence based health care may be their potential to generate more and more useful randomized evidence by facilitating large-scale pragmatic trials at low cost.

**Claudia Ashton: Critical appraisal of the surgical literature: Application of the IDEAL framework (Sem 4)**

**Background:** Evaluation of new surgical procedures is complex. In contrast to pharmaceuticals for which valid evidence of safety and efficacy must be provided via a robust pathway of randomised controlled trials before licensing, surgical innovations frequently gain acceptance following a series of biased observational studies. This relative lack of regulation, together with the unique characteristics of these complex interventions, has resulted in persistent difficulties in obtaining high-quality evidence for surgical innovations. Assessment of new surgical interventions is complicated by a specific set of problems. These include the difficulty in defining surgical procedures precisely, iterative modification of procedures by surgeons during development, lack of agreed standard outcomes in surgery, operator learning curves, variable procedural quality (dependent on training and operative capabilities), as well as strong treatment preferences among patients and clinicians. Recognition of these difficulties led to the development of the Idea, Development, Exploration, Assessment and Long-term follow-up (IDEAL) Framework and Recommendations, in an attempt to establish a more scientifically rigorous and ethical evaluation pathway. [1,2]

The aim of this workshop is to use the IDEAL Framework as a tool to critically appraise the surgical literature to help understand and identify the key features of evaluation needed at each stage of innovation.

**Target audience:** Surgeons and non-clinical professionals involved in planning, conducting and publishing surgical studies as well trainees from all disciplines.

**Learning objectives:**
- Understand the purpose of IDEAL and why it is necessary
- Understand each stage of the Framework and relevant questions at each stage
- Appraise a surgical study by identifying the IDEAL stage of the procedure described in the paper
- Learn how to apply the IDEAL framework and recommendations practically by designing studies to progress through the lifecycle of a surgical innovation
References:

Wednesday 21 June 13:30–15:00

Trish Groves: How to write papers that add value in health research and deserve publication (Sem 1)

Given estimates that 85% health research is wasted – asking the wrong questions, using poor designs, getting only partly reported – there's an urgent need to increase value in health research and make it truly able to improve patient care.

Responsible innovation focused on the needs and preferences of patients and wider society depends on changes at every stage of research: priority setting, grant-giving, ethics approval, regulation, reporting and publication, educations, and shared decision making. In this short talk Trish will focus particularly on the reporting of research.

Caroline Fiennes: Bringing evidence-based practice into charity & philanthropy (Sem 2)

Charities and charitable giving could – like medicine – improve vastly by better use of better quality evidence. Caroline Fiennes recently had an article in Nature calling for 'a science of philanthropy' to enable this.

This workshop will look at the current state-of-play around evidence in charities and charitable giving, and seek input as to how they can most rapidly become more evidence-based.

Anitava Banerjee: Fixing EBM with Data (Sem 3)

Routinely collected clinical data are gaining in importance in the electronic health records era, whether as disease-specific registries, local or national audit data, clinical care records or prescription databases. However, such data are currently sub-optimally used. This wastage of resources leads to inefficient data collection and analysis, as well as inadequate healthcare and research. An example of an increasing use of routine data is in real world evidence for effectiveness when trials have either not answered a clinical question or are unlikely to be done. New methodologies are necessary for such uses of routine data, as well as new considerations including ethical, legal and scientific. In a “learning health system”, all relevant routine data would be used to improve healthcare whether at the individual or the population level continuously. How can routine data be best used in an evidence-based healthcare framework? What are the limitations? How realistic is a learning health system? These questions and more will be tackled in this workshop.

Sietse Wieringa: The Fundamentals of EBHC (Sem 4)

There is a growing interest in the guideline developing community on how to evaluate and integrate other types of knowledge besides randomised controlled trials. Especially with current challenges regarding multi-morbidity, rare conditions, complex interventions and person centred care, there is a call for a consideration of the epistemological concepts that underpin EBHC.

In this workshop we would like to explore with you new insights on the nature of valid knowledge, inferring/reasoning when there is no frequency of events and the processes involved in reaching recommendations. We will discuss several noteworthy developments within the EBHC movement from a philosophy and sociology of science perspective.

We will present recent work from the Appraising and Including Different kinds of knowledge (AID) working group of the Guidelines International Network (GIN) as well as the Knowledge Implementation (KNOWIT) group from the university of Oslo.
Sharon Swain: Introduction to Systematic Reviews on diagnostic Accuracy (LT 2)

The aim of this workshop is to provide guidance on conducting a systematic review of diagnostic accuracy studies. The first part of the session focuses on how to write a clinical review question and protocol. Examples will be taken from National Institute for Health and Care Excellence (NICE) clinical guidelines. In the second half of the session participants will be asked to apply the QUADAS2 risk of bias tool to a study. The workshop concludes with how to write up the results.

Thursday 22 June 14:30–16:00

Paul Chrisp: From population to personal: getting the balance right in evidence based medicine (Sem 1)

- What is the fit between guidelines and shared decision making?
- What is the place of clinical judgement and the patient voice?

Caroline Blaine, BMJ Knowledge Centre: Evidence at the Point of Care (Sem 2)

Health care professionals are increasingly time poor and feel overwhelmed by the sheer amount of information available. As well as the lack of time there is often also the lack of skills to interpret the available evidence and decide if it is applicable to the patient in front of you. Point of care tools are used to guide evidence-based practice (EBP), however recommendations without access to the underlying evidence in an easy to understand format may hinder true EBP. This workshop will explore how evidence can be presented in a meaningful way in the clinical workflow, using the example of BMJ Best Practice’s new evidence layer consisting of Cochrane Clinical Answers and BMJ Rapid Recommendations.

Paul Hewitson: Patient Engagement (Sem 3)

Expanding the role of patients/public in the design and interpretation of research.

Rachel Dean: A One Health approach to Evidence-based Medicine – working across healthcare disciplines to improve care (Sem 4)

The application of evidence-based Medicine (EBM) has impacted healthcare in medicine for a number of years but in other healthcare disciplines e.g. veterinary medicine, dentistry, physiotherapy, midwifery etc., it is not so well developed. The relative novelty of EBM, the diverse healthcare models and delivery systems means in the other professions the EBM principles are being used in many different ways. These professions are in a situation where they can copy the successes of EBM in medicine, potentially sidestep the ‘failures’ and test new ways of delivering evidence-based healthcare in these more novel healthcare settings. Meanwhile the ‘machine’ that is EBM in medical healthcare has been criticised and challenged. EBM can be viewed as a complex intervention that is currently being trialled in a number of different ways in a number of different settings but which is the most efficacious?

If we wish to promote better healthcare across all professions, we need to reflect on our practice and those of other professions. The patients of some professionals are the clients or patients of others and we all provide healthcare information to decision makers so we affect their healthcare choices which influences the quality of care they (or their pets) receive.

To date there has not been a cross disciplinary ‘think tank’ that has explored the successes and failures in applying EBM. During this discussion the panel will present the current status of EBM in their professions, highlight the differences and similarities to other professions, discuss their perspective on the EBM manifesto and propose how a One Health approach EBM can help patients – whatever the species, whatever the discipline.
Jon Brassey: TRIP – Community rapid reviews (LT 2)

Rapid reviews are increasingly being discussed yet there is considerable confusion as to what they are! For supporters, they are a useful tool that compensates for some of the deficiencies of systematic reviews. For detractors they are often dismissed as being ‘quick and dirty’.

The Trip Database (www.tripdatabase.com), an EBM search engine, was created to help support clinical question answering and it’s still the main use of the site. This question answering activity is a form of rapid review and thousands of questions are answered, using Trip, every week. Currently this hard work in answering questions is only seen by the person doing the review.

It is proposed that the community rapid review system will be built with nurturing users at the heart of it. Users will be supported in undertaking their review by a step-by-step rapid review ‘wizard’ and by the latest developments in automation. At every step users can ask for help from the Trip community. When finished the user will post the review and other community members can review and, if needed, improve it. This improvement may be immediate or in the future as new research is published. As such the reviews will never truly be finishing, they will be living documents.

A key mantra underpinning the system will be: coax don’t criticise.

The challenges are substantial but the rewards – a large database of freely available, high quality rapid reviews – seems ultimately worth it. The purpose of the workshop is to explore the proposed system and to help find solutions to the problems (such as quality) and also to look at opportunities for further collaboration and enhancement of the system.

Participants are asked to come along and prepare to be involved at the start of this great initiative.

Aims
1. To share with attendees the background, principles and plans for the development of a community rapid review system to be made available, for free, via the Trip Database.
2. To gain input from the attendees on opportunities and barriers to the approach.

Objectives
- To describe the work the Trip Database is undertaking in the area of rapid reviews.
- To explore the thinking behind providing a rapid review system to users of the Trip Database and to outline the likely features of the system and how it might work.
- To use the experience and knowledge of participants to explore ways of enhancing the usage of such a system and to minimise any possible problems with the approach.

Thursday 22 June 08:15–09:15

The REWARD Alliance and the EQUATOR Network: promoting increased value of research
Co-organisers: Iain Chalmers and Doug Altman

In 2009, a paper published in the Lancet suggested that over 85% of the investment in biomedical research was being avoidably wasted. This led to a Lancet series of five papers on this theme published in January 2014, to which over 40 authors contributed. The series promoted wide interest and, in October 2015, an international conference in Edinburgh was co-convened by some of the authors of the Lancet series working with the EQUATOR (Enhancing the QUAlity and Transparency Of health Research) Network (https://www.equator-network.org/), which promotes improved conduct and reporting of research. The conference led to the initiation of the REWARD (Reduce Waste And Recognise Diligence) Alliance (http://rewardalliance.net/) to promote the many recommendations for action to reduce waste which were made in the Lancet series. Iain Chalmers and Doug Altman will introduce REWARD and EQUATOR, respectively; Ben Goldacre and Carl Heneghan will present initiatives to monitor and reduce under-reporting of research. A minimum of 20 minutes will be allocated to audience comments and questions.
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1. **Bruckner Till**, TranspariMED, Bristol, UK (1)

Trial registration and reporting: Policies, performance and practices of UK universities

2. **Rosati Paola, Cantile Tiziana, Galeotti Angela**

Bambino Gesù Children’s Hospital, Rome, Italy (1)

An argumentative review on the social, clinical and neurodevelopmental benefits outweighing dental and other risks of finger and dummy-sucking habits, supporting infants’ and children’s right to do so

3. **Capittini Cristina, Scudeller Luigia, Scotti Valeria, Manzoni Federica, Rebuffi Chiara, Tinelli Carmine, De Silvestri Annalisa**

Scientific Direction, IRCCS Policlinic San Matteo Foundation, Pavia, Italy

A meta-analytic approach to set up an informatics tool or App that will suggest the most appropriate genotyping in patients affected by HLA-related diseases

4. **Belachew sewunet admasu, Erku Daniel asfaw, Mekuria Abebe Basazn**

University of Gondar, Gondar, Amhara, Ethiopia

Preferred information sources and needs of cancer patients on disease symptoms and management: a cross-sectional study

5. **Welink Lisanne, Bartelink Marie-Louise, Pype Peter, Deveugele Myriam, Damoiseaux Roger, De Groot Esther**

Julius Center for Health Sciences and Primary Care, UMC Utrecht, Utrecht, The Netherlands

Design of the TEE-study: Together for Evident Evidence

6. **Suthi Amandeep**

Sandwell and West Birmingham Hospital, Birmingham, UK

Total parenteral nutrition management in patients with high output stomas secondary to familial adenomatous polyposis

7. **Decullier Evelyne, Maisonneuve Hervé**

HCL, Lyon, France

Retraction notices’ content in 2016

8. **Decullier Evelyne, Maisonneuve Hervé, Besson Jean-Noël**

HCL, Lyon, France

Publication in 6 rehabilitation professions: a five-year bibliometric analysis


REMEDY, Research Ethics in Medicine Study Group, Department of Philosophy and Bioethics, Jagiellonian University Medical College, Krakow, Poland

Risk and Benefit for Pediatric Phase 1 Trials in Oncology: A Systematic Review

10. **Tagami Shinichi**

Mt. Olive Hospital, Naha, Okinawa, Japan

Developing an “evidence-based framework” for whole person care utilizing well-being scales of the four dimensions of human existence: physical, psychological, social, and spiritual.
11. **Nyanchoka Linda**, Porcher Raphaël, Tudur-Smith Catrin
Centre de Recherche Épidémiologie et Statistique
Sorbonne Paris Cité (CRESS-UMR1153) Inserm / Université Paris Descartes, Paris,
Methods of Identifying and Displaying Gaps in Health Research

12. **Seid Mohammed Assen**, Tegegn Henok Getachew, Sema Feser Dula, Bhagavathula Akshaya Srikanth
University of Gondar, Gondar, Amhara, Ethiopia (1)
Potential drug–drug interactions in pediatric wards of Gondar University Hospital: A cross-sectional study

13. Kaleya Ronald, Sobol Gene, Horovitz Joel, Bodenstein Hannah, Samy Sameh, Borgen Patrick
Maimonides Medical Center, Brooklyn, NY, USA
Safety in Surgery: the effect of an early warning system and co-management on surgical mortality.

Queen Mary University of London, London, UK
Relationship between the description of primary outcomes and magnitude and significance of the effect in trials with diet and lifestyle in pregnancy

15. Hasan Uzair³, Jamal Amr¹, Srinivasan Shankar², Haque Syed², Hasan Izhar¹,²,³
¹. Department of Medical Informatics & elearning unit (Mielu) & Family Medicine, KSU, Riyadh, KSA
². Department of Health Informatics, Rutgers University, Newark, NJ, USA
³. Clinical Pearl, Inc., Princeton, NJ, JOURNALCLUB.NET:
Design and Implementation of web based journal club

16. **Capdarest-Arest Nicole**, Lee Henry C., Gray Jamie M
Stanford School of Medicine, Stanford, CA, USA
Growing EBP Curricula to Include Expanded Aspects of Information Seeking

17. **Antequera Alba**, Oliveras Laura, González María, Garrido María, Madrid Olaya
La Princesa Hospital, Madrid, Spain
Gender gap in authorship of articles published in general medicine journals. Preliminary results.

18. **Gebreyohannes Eyob**, Bhagavathula Akshaya, Gebresillassie Begashaw, Tefera Yonas, Belachew Sewunet, Erku Daniel
University of Gondar, Gondar, Ethiopia
Recreational use of Phosphodiesterase 5 Inhibitors and its Associated Factors among Undergraduate Male Students in an Ethiopian University: A cross-sectional study

University of Gondar, Gondar, Ethiopia
Pattern of chemotherapy-related adverse effects among adult cancer patients treated at Gondar university referral hospital, Ethiopia: a cross-sectional study

20. **Ryan-Vig Selena**
Cochrane UK, Oxford, UK
Students 4 Best Evidence: A Network for Students Interested in Evidence-Based Healthcare
21. **Scudeller Luigia**, Capittini Cristina, Tinelli Carmine, Klersy Catherine, Musella Valeria, De Silvestri Annalisa
Scientific Direction, IRCCS Policlinic San Matteo
Foundation, Pavia, Italy

“A guideline of no importance”: knowledge of major reporting
guidelines among junior and experienced personnel involved in
biomedical research

22. **Dziedzic Krysia**, Marshall Laura, Finney Andrew, Paskins Zoe, Stevenson Kay, Duffy Helen, Evans Nicola, Quicke Jonathan, Ashby Sue, Cottrell Elizabeth, Edwards John, Cooper Vince, Warburton Louise, Blackburn Steven, Campbell Laura, Mallen Christian, Boaden Ruth, Currie Graeme
Institute for Primary Care and Health Sciences, Keele
University, Stoke on Trent/Staffordshire, UK

Knowledge Mobilisation in primary care: a new role for PICO?

23. **Abebe Tamrat**, Gebreyohannes Eyob, Tefera Yonas, Abegaz Tadesse
University of Gondar, Gondar, Amhara, Ethiopia

Patients with HFrEF and HFrEF have different clinical
characteristics but similar prognosis: a retrospective cohort study

24. **Elghblawi Ebtisam**
Private practice, TRP, Libya

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Across
01. Investigation to establish facts
02. Doubt
03. Chemical Combining form
04. A basic hemodynamic index often utilized to guide therapeutic interventions, especially in critically ill patients
05. People receiving or registered to receive medical treatment
06. Person responsible for defining a course of action
07. When information is masked from the participant
08. A foil faced insulation board
09. A specialist unit set up with a specific remit to design, conduct, analyse and publish clinical trials. Abbr
10. A substance or treatment with no active therapeutic effect.
11. Body of facts or information indicating whether a proposition is valid
12. A person who takes part in a clinical test of a new product
13. 1st aid without the 1st
14. The process of sharing something out
15. The framework of a clinical question
16. Starting point used for comparisons
17. Associated with tiredness – none of this at EL2017
18. Youth
19. European Medicine Agency
20. 21 across in ____ backwards
21. Master of science. Abbr
22. A published verbal declaration of the intentions
23. Removal of selection bias
24. Evidence Live 2017 co host

Down
01. A detailed set of proposed activities support by other research
02. What you are intent on achieving
03. Pharmaceutical used for the treatment of chronic pain excluding pill
04. An upside down problem affecting the skin
05. The evidence suggest this energy source could cause harm
06. What a funders does to continue with research (plural)
07. This drug has no parents
08. When the outcome of an experiment or research study influences the decision whether to publish
09. A system of methods used in a particular area of study or activity
10. General condition of body and mind – Scrambled
11. Number Needed to Treat
12. The science and practice of the diagnosis, treatment, and prevention of disease
13. Formal assessment
14. Organisation providing money for a particular purpose
15. Collaboration for Leadership in Applied Health Research and Care
16. Moral principles that govern behaviour and conduct
17. Medicines and Healthcare products Regulatory Agency
CROSSWORD ANSWERS

Across
1 Research; 2 Uncertainty; 3 Nitro; 4 ABP; 5 Patients; 6 Policymaker; 7 Blinded; 8 Celotex; 9 CTU; 10 Placebo; 11 Evidence; 12 Trialist; 13 Faid; 14 Allocation; 15 PICO; 16 Baseline; 17 Yawn; 18 Adolescent; 19 EMA; 20 EBHC; 21 MSc; 22 Manifesto; 23 Randomisation; 24 BMJ.

Down
1 Protocol; 2 Aim; 3 m tablet; 4 Acne; 5 Eolian; 6 Reinvests; 7 Orphan; 8 Publication Bias; 9 Methodology; 10 Health; 11 NNT; 12 Medicine; 13 Appraisal; 14 Funder; 15 Clahrc; 16 Ethics; 17 MHRA.