[Guideline 37]

Hysteroscopic Surgery

SIGN Publication No. 37

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The Guideline and Quick Reference Guide are available to download in Acrobat pdf format (info). Quick Reference Guide (127K) Guideline (421K).

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21 March 2002

- Long-term follow-up of survivors of childhood cancer draft available for comment.
- Addition of details of User Involvement: Drawing on Existing Developments in NHS Scotland meeting.

12 March 2002

- Addition of Guideline No. 58 Safe Sedation of Children Undergoing Diagnostic and Therapeutic Procedures.
- Scottish Dentists and Doctors to be Issued with New Guidelines on the Safe Sedation of Children. (Press Release)

5 March 2002

- Cutaneous Malignant Melanoma draft available for comment.

18 February 2002

- Addition of further details of The Management of Alcohol Dependence in Primary Care national meeting.

31 January 2002

- Addition of Guideline No. 56 Prevention and Management of Hip Fracture in Older People and Guideline No. 57 Cardiac Rehabilitation.
- New Initiative aims to Improve Patients' Uptake of Cardiac Rehabilitation Treatment. (Press Release)

29 January 2002

- Doctors, Nurses, Patients & Health Service Managers meet to agree "Life-saving Document". (Press Release)

29 January 2002

- Doctors, Nurses, Patients & Health Service Managers meet to agree "Life-saving Document". (Press Release)

18 January 2002

- Addition of further details of Long Term Follow-Up of Survivors of Childhood Cancer national meeting.

15 January 2002

- New SIGN Chairman Appointed. (Press Release)

13 November 2001

- Addition of Guideline No. 55 Management of Diabetes.
- Scottish Medical Staff to Receive New Guidelines as part of National Drive to Improve Treatment of Diabetes. (Press Release)

25 October 2001

- Addition of Guideline No. 54 Perioperative Blood Transfusion for Elective Surgery.

31 August 2001

- **Statins Update: Withdrawal of *cerivastatin***

Earlier this month the cholesterol-lowering drug *cerivastatin* was withdrawn from use in worldwide markets, except Japan, as a result of being linked with the deaths of 31 adults in the United States. The Food and Drug Administration (FDA) reported that the deaths were attributable to an unusual side effect known as rhabdomyolysis (or the breakdown of muscle).

In recent years SIGN has published two clinical guidelines in which the prescribing of statins was covered (SIGN 40: Lipids and the primary prevention of coronary heart disease and SIGN 41: Secondary prevention of coronary heart disease following myocardial infarction). These guidelines recognised that "there have been no reported long term intervention trials of *atorvastatin*, *cerivastatin* or *fluvastatin* and they do not have as comprehensive long term safety data as the other statins". As has also been stated within these guidelines "drug choice should be made on the balance of trial evidence, safety and cost-effectiveness considerations".

20 August 2001

other statins". As has also been stated within these guidelines "drug choice should be made on the balance of trial evidence, safety and cost-effectiveness considerations".

20 August 2001

- Addition of Guideline No. 53 on Day Case Cataract Surgery

31 July 2001

- National Meeting to Discuss New UK-wide BTS/SIGN Asthma Guideline (Press Release)

1 July 2001

- Addition of Guideline No. 52 on Attention Deficit and Hyperkinetic Disorders in Children and Young People
- New Guideline on Diagnosis and Treatment of ADHD in Children Issued (Press Release)

27 June 2001

- SIGN guide to the AGREE guideline appraisal instrument.

23 May 2001

- Claims that Scots Heart Patients are Excluded Drug Treatment "Misleading and Untrue" (Press Release)

3 May 2001

- New Guideline on Management of Stable Angina (Press Release)

30 April 2001

- Addition of guideline No. 51 on Management of Stable Angina.

27 April 2001

- Addition of Business Plan 2001-2.

19 March 2001

- New Hypertension Guideline could Prevent Stroke, Heart Failure and Death in Older People (Press Release)

9 March 2001

- New Hypertension Guideline could Prevent Stroke, Heart Failure and Death in Older People (Press Release)

9 March 2001

- Addition of guideline No. 49 on Hypertension in Older People.

22 February 2001

- New SIGN Website Launched with 50th SIGN Publication - 'A Guideline Developers Handbook' (press release)

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SIGN Methodology

SIGN guidelines are developed using an explicit methodology based on three key principles:

- Development is carried out by multidisciplinary, nationally representative groups.
- A systematic review is conducted to identify and critically appraise the evidence.
- Recommendations are explicitly linked to the supporting evidence.

These principles have remained consistent since SIGN was first established, but the detailed methology based on them has evolved to take in new developments in the methodology of individual studies, and to take into account new types of evidence. The detailed methodology is described in our 50th guideline, generally referred to as SIGN 50.

SIGN 50 will be updated regularly to take into account any further changes in the methodology.

- SIGN guide to the AGREE guideline appraisal instrument.

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Patient Involvement in Guideline Development

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Patients and carers may have different perspectives on health care processes, priorities, and outcomes from those of health professionals. The involvement of patients, carers or their representatives in guideline development is therefore important to help ensure that guidelines reflect their needs and concerns. Patients also have an important role in promoting guideline implementation and it is important that they should have access to information on the recommendations of published guidelines.

The Scottish Association of Health Councils has represented patients on SIGN Council since 1996. The Patient Focus and Public Involvement paper recently published by the Scottish Executive Health Department (SEHD) gives a national importance to involving people in the design and delivery of NHS care and outlines plans for the development of a national Scottish Health Council. In August 2001, the SEHD provided one year funding to enable SIGN to explore and enhance the ways in which patients and carers are involved in the SIGN guideline development process.

The term patients is used throughout this document as a generic term to describe patients, lay representatives and those that work in the voluntary sector.

The purpose of patient and carer involvement is to ensure that the guideline addresses issues that matter to patients and carers' and that their perspectives are reflected in the guideline. Patients and carers can identify issues that may be overlooked by health professionals, can highlight areas where the patient's perspective differs from the views of health professionals, and can ensure that the guideline addresses patient and carers' key issues of concern.

Patient and carer representatives on guideline development groups are encouraged to remind the group of the limitations of the scientific findings in respect of age, quality of life, gender, ethnicity, and life circumstances such as accessibility. They also help to ensure that the group is aware of patient concerns such

Patient and carer representatives on guideline development groups are encouraged to remind the group of the limitations of the scientific findings in respect of age, quality of life, gender, ethnicity, and life circumstances such as accessibility. They also help to ensure that the group is aware of patient concerns such as informed consent, communication skills, equity of access, adherence to standards, and the patient's right to choose.

How are patients involved in SIGN guideline development?

Patients and carers are involved in SIGN guideline development in three broad ways:

1. Identifying patients' and carers' views
2. Recruitment to guideline development groups
3. Consultation processes

1. Identifying patients' and carers' views

SIGN is extending literature searching coverage to include published studies of patients' and carers' experiences and preferences of relevance to the clinical topic in question. In doing so it is important to ensure that any studies identified are relevant to the Scottish population. The studies identified tend to be observational, surveys, or qualitative in design. Methods of appraising qualitative literature are currently being reviewed (see SIGN 50).

The types of studies sought include patients' and carers' views on:

- positive and negative experiences of the condition, including diagnosis, medication and other treatments, follow-up care and quality of life
- unfulfilled needs
- information needs, preferences and choices
- participation in decision making about treatment choices and preferences
- overall satisfaction with care received.

Where published evidence is lacking, patient and carer views are sought via direct contact with users of the service. Discussion groups with current and previous patients and carers are held across different regions of Scotland to elicit the information required. Views are sought from both men and women, of different age groups, in both rural and urban communities. Special efforts are made to include those who are socially excluded and may be less likely to join a local or national organisation.

The themes that emerge from the above help to establish patients' and carers' concerns that the guideline should address. These issues are fed back to the first meeting of the guideline

socially excluded and may be less likely to join a local or national organisation.

The themes that emerge from the above help to establish patients' and carers' concerns that the guideline should address. These issues are fed back to the first meeting of the guideline development and used to inform some of the key questions underpinning the guideline.

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2. Recruitment to guideline development groups

SIGN recruits a minimum of two patient representatives to guideline development groups by inviting nominations from the relevant "umbrella", national and / or local patient focused organisations in Scotland and, where necessary, from consultation with members of the SIGN Patient Network.

Lastly, where discussion groups have been held to solicit patient and carer views, these may also provide a source of possible future patient and carer representatives.

Details of the role of the patient representatives, the support they will be given, the commitment required and the useful attributes required are provided to allow informed nominations to be made.

SIGN supports patient representatives by:

- inviting new patient representatives to join the SIGN Patient Network
- providing access to other Patient Network members and links to the National Network currently being set up by the SEHD
- providing clear guidance on their roles and responsibilities within the group
- ensuring opportunities to attend the training opportunities open to all guideline development group members are available.

In addition, support from SIGN is provided to all group members with specific identified training needs in relation to guideline development.

Role of patient and carer representatives

Although their areas of expertise will vary, members of the guideline development group have equal status on the group. A key role for patient and carer representatives is to ensure that patient views and experiences inform the group's work. This includes:

Although their areas of expertise will vary, members of the guideline development group have equal status on the group. A key role for patient and carer representatives is to ensure that patient views and experiences inform the group's work. This includes:

- being a full and equal member of the guideline development group
- ensuring that identified patient/carer issues inform the key questions to be answered by the group
- reading research papers from a patient or carer perspective (*e.g. did the researchers address issues that patients consider important; did they take patient views into account when drawing their conclusions*)
- making sure that patient and carer perspectives are taken into account when the guideline group draws up guideline recommendations
- helping to identify other patients and carers who could be invited to the National Open Meeting for the guideline or to be involved in the peer review of the draft guideline
- assist with the identification of patient information needs to help inform the Information to Patients section of the guideline

Where patients' concerns cannot be addressed within the guideline, either due to constraints caused by the scope of the guideline, or where no satisfactory evidence can be identified, this is stated in the guideline.

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4. Consultation processes

Further patient and public participation in guideline development is achieved by involving patients, carers, voluntary organisations and representatives from Health Councils at the National Open Meeting which is held to discuss each draft guideline. Free places are made available at each National Open Meeting and patients' expenses are reimbursed. The National Open Meetings are publicised via the Patient Network and other sources. In addition, patient representatives are involved in the peer review stage of each guideline.

SIGN's processes are likely to develop over time both as a result of the SEHD funded project and from consultation with other clinical effectiveness organisations in both Scotland and the UK that are also working towards a patient-focused agenda, such as HTBS, CSBS and NICE. For further detail on the outcomes of patient and carer discussion groups held so far please contact Joanne Topalian email: j.topalian@rcpe.ac.uk. We would welcome comments on our evolving patient involvement processes.

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National Meetings 2002

For every guideline it develops, SIGN holds a national open meeting to give the to present their preliminary conclusions and draft recommendations to a wider valuable feedback and suggestions for additional evidence they might consider Participants are able to contribute to and influence the form of the final guidelin

The meetings are registered for CPD (Continuing Professional Development) a accreditation.
All meetings are full day meetings and will be held at the Royal College of Phys

Melanoma	Monday 11 March 2002 F
Childhood Cancer	Wednesday 27 March 20
Alcohol Dependence	Monday 29 April 2002
Dysphagia	Thursday 16 May 2002
Ovarian Cancer	Friday June 14 2002
Postoperative Management	Thursday June 27 2002

If you are interested in attending any of these meetings please contact Lesley F Physicians, 9 Queen Street, Edinburgh EH2 1JQ, Scotland. Tel: +44 (0) 131 24 l.forsyth@rcpe.ac.uk for further information.

Critical Appraisal Courses

- Monday 18 April 2002 (Introductory) ***(fully booked)***
- Wednesday 5 June 2002 (Advanced)

If you are interested in attending any of these courses please email Gaynor Ra information. Alternatively you can contact her at the SIGN Executive, Royal Co EH2 1JQ, Scotland. Tel: +44 (0) 131 225 7324 Fax: +44 (0) 131 225 1769.

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The following are a selection of links to other Web sites that users of this site may find useful. This should not be regarded as a complete and exhaustive list of relevant Web sites!

Clinical Governance in Scotland

- Clinical Research and Audit Group (CRAG)
- Clinical Standards Board for Scotland
- Health Technology Board for Scotland

Disease Specific Websites

- British Heart Foundation

Evidence-Based Medicine

- Centre for Evidence Based Medicine
- Centre for Reviews and Dissemination, University of York
- Cochrane Collaboration
- Critical Appraisal Skills Programme

Full Text Journals on the Web

- Freemedicaljournals.com
- Monash University Directory of Electronic Health Science Journals
- WHO List of full text journals

Guidelines (General)

- AGREE
- Agency for Health Care Research and Quality
- Canadian Medical Association
- National Guideline Clearinghouse
- New Zealand Guidelines Group
- National Health and Medical Research Council
- National Institute for Clinical Excellence

- Canadian Medical Association
- National Guideline Clearinghouse
- New Zealand Guidelines Group
- National Health and Medical Research Council
- National Institute for Clinical Excellence

Guidelines (Special areas)

- British Thoracic Society
- SOGAP (The Scottish Obstretric Guidelines & Audit Project)
- Clinical Effectiveness Programme in Practice-Based Primary Care

Health Technology Assessment

- Danish Institute for Health Technology Assessment
- Health Technology Assessment
- Health Technology Board for Scotland
- National Coordinating Centre for Health Technology Assessment
- SBU: The Swedish Council on Technology Assessment in Health care

National Health Service

- Ambulance service
- Information Services Division
- National Electronic Library for Health
- NHS Direct
- Nursing and Midwifery Practice Development Unit (NMPDU)

Useful tools

- Clinical Decision Support System (CDSS) there is also pilot version of the CDSS system (password required).
- Electronic BNF
- National Prescribing Centre
- Weight Management for Children Site

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Hysteroscopic Surgery

Key to evidence statements and grades of recommendations

The definitions of the types of evidence and the grading of recommendations used in this guideline originate from the US Agency for Health Care Policy and Research[1] and are set out in the following tables.

Statements of evidence

Ia	Evidence obtained from meta-analysis of randomised controlled trials.
Ib	Evidence obtained from at least one randomised controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study without randomisation.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study.
III	Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies.
IV	Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities.

Grades of Recommendations

[A] Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation. *(Evidence levels Ia, Ib)*

[B] Requires the availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation. *(Evidence levels IIa, IIb, III)*

[C] Requires evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities. Indicates an absence of directly applicable clinical studies of good quality. *(Evidence level IV)*

Good Practice Points

[tickbox] Recommended best practice based on the clinical experience of the guideline development group

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Hysteroscopic Surgery
Notes for users of the guideline

Development of local guidelines

It is intended that this guideline will be adopted after local discussion involving clinical staff and management. The Area Clinical Audit Committee should be fully involved. Local arrangements may then be made for the derivation of specific local guidelines to implement the national guideline in individual hospitals, units and practices and for securing compliance with them. This may be done by a variety of means including patient-specific reminders, continuing education and training, and clinical audit.

Statement of intent

This report is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve.

These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor in light of the clinical data presented by the patient and the diagnostic and treatment options available.

Significant departures from the national guideline as expressed in the local guideline should be fully documented and the reasons for the differences explained. Significant departures from the local guideline should be fully documented in the patient's case notes at the time the relevant decision is taken.

A background paper on the legal implications of guidelines is available from the SIGN secretariat.

Review of the guideline

This guideline was issued in 1999 and will be reviewed in 2001 or sooner if new

evidence becomes available. Any updates to the guideline in the interim period will be noted on the SIGN web site. Comments are invited to assist the review process. All correspondence and requests for background information regarding the guideline should be sent to:

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Hysteroscopic Surgery
Summary of recommendations

Patient selection for hysteroscopic surgery

[A] **Hysteroscopic surgery - transcervical resection of the endometrium (TCRE) or endometrial laser ablation (ELA) - should be offered as an option to all women needing surgical management of dysfunctional uterine bleeding.**

[A] **The main indication for hysteroscopic surgery is dysfunctional uterine bleeding in a woman who has completed her family in whom surgical treatment is indicated.**

[A] **Pre-menstrual pelvic pain not related to excessive bleeding is a relative contraindication.**

[C] **Counselling is vitally important both to ensure that the patient understands the implications of the procedure and for medico-legal reasons. A patient information leaflet is recommended.**

[B] **The uterus should be less than 12 weeks in size and the endometrium should be histologically normal.**

[B] **Endometrial sampling is essential prior to hysteroscopic surgery.**

[A] **Preoperative hysteroscopy is not needed in the majority of women whose uterus is not enlarged.**

Methods of hysteroscopic surgery

Transcervial endometrial resection (TCRE)

[B] **Loop resection of the cornua should be avoided and endometrial destruction with a rollerball electrode is advised.**

[C] **All methods should be carried out using video camera equipment to maximise the view.**

[C] **Good irrigation will clear blood and debris rapidly from the field of vision and maintain uterine distension.**

[C] **Orientation is essential and is best achieved by identifying both tubal ostia and observing air bubbles on the roof of the cavity.**

Endometrial ablation (ELA)

[B]

The laser power with the neodymium:yttrium-aluminium-garnet (Nd:YAG) laser should be no less than 80 W.

[C] **The laser must not be activated when stationary.**

Endometrial preparation

[B] **Endometrial preparation is recommended.**

[A] **Either a gonadotrophin releasing hormone (GnRH) analogue or danazol may be used: a GnRH analogue may give better results, compliance is more certain and will reduce the size of fibroids.**

[C] **In patients in whom a difficult cervical dilatation is anticipated danazol may be preferred.**

[C] **Obese women pose a problem as GnRH analogues alone give poor thinning, a combination of both agents may be the most effective.**

Minimisation of complications and risks

[C] **The risks associated with hysteroscopic surgery can be minimised by experienced operators and hence training and supervision for those less experienced is imperative.**

[tickbox] Adherence to the Royal College of Obstetricians & Gynaecologists accreditation for level 3 hysteroscopic surgery is essential.

Uterine perforation

[C] **If uterine perforation is suspected while activating the resectoscope or laser, immediate laparoscopy is indicated.**

[C] **If perforation is confirmed and associated with active diathermy, laparotomy may be required if there is any suspicion of bowel or vascular damage.**

Irrigation fluid absorption

[A] **Laser ablation leads to greater fluid absorption than endometrial resection.**

[C] **The operator must be constantly aware of the fluid volume infused and the volume removed. The assisting staff should make a formal report of this balance at five minute intervals.**

[B] **An accurate assessment of the calculated deficit must be made.**

[B]

If the deficit exceeds 1500 ml then the procedure should be abandoned unless it is nearly complete.

[C] **Haemoglobin, haematocrit and serum sodium must be measured serially and the patient observed postoperatively for signs of fluid overload. If a rapid deficit occurs during a procedure, uterine perforation must be suspected.**

[B] **In the rare event that significant bleeding persists, a 30 ml balloon Foley catheter** (14-18 gauge) **can be inserted in to the uterine cavity and inflated to effect tamponade. The catheter should be left in situ for 12 hours before removal.**

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Hysteroscopic Surgery
Section 1: Introduction

1.1 Background

Although the techniques of ablating the endometrium are relatively new, they have been introduced widely into gynaecological practice as more conservative surgical alternatives to hysterectomy in women with menorrhagia. The development of video systems and fibre optics allowed visualisation of the endometrial cavity and so to the invention of these techniques in the 1980s.

1.2 The need for a guideline

The two most widely used methods in Scotland and the rest of the UK are Transcervical Resection of the Endometrium (TCRE) using a diathermy electrode and Endometrial Laser Ablation (ELA) using a neodymium:yttrium-aluminium-garnet (Nd:YAG) laser.

The uptake of these techniques has not been uniform, especially in Scotland; [2] perhaps because of doubts about the efficacy and safety of, and indications for these procedures. Although guidelines have been produced previously [3, 4] these preceded the publication of large randomised trials and other valuable evidence. It was therefore felt to be timely to produce an evidence-based guideline for hysteroscopic surgery.

This guideline should be of particular interest to gynaecologists and their nursing colleagues and to general practitioners who must advise and counsel women about the management of menorrhagia.

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Hysteroscopic Surgery

Section 2: Indications for endometrial resection/ablation

2.1 Definition of menorrhagia

Menorrhagia is defined as periodic blood loss of more than 80 ml, but measuring this is a tedious business for both the woman and the laboratory. In everyday practice, therefore, the clinician must rely on a much simpler and of necessity much less accurate assessment of the woman's blood loss. Flooding and the passing of clots are clearly important symptoms; the numbers of pads and/or tampons used are less reliable indices; and the haemoglobin level indicates the ability to compensate as much as the blood loss itself. The way in which each woman's periods affect her lifestyle and her own perception of their normality or otherwise often become the basis for treatment.

For the purposes of this guideline, dysfunctional uterine bleeding is defined as a patient's perception of excessively heavy periods in the absence of major pathology.

2.2 Management of menorrhagia

Menorrhagia can be managed in various ways: by careful counselling and reassurance; medically with a choice of several different agents; and surgically. Traditionally that has been the order of treatment, reflecting not only increasing cost but also increasing potential morbidity.

Drug therapy has to be used repeatedly to maintain control of menorrhagia. Newer agents such as gonadotrophin releasing hormone (GnRH) analogues, although more effective than older commonly used remedies such as progestins, are much more expensive. The levonorgestrel intrauterine system has been shown to be superior to norethisterone in one randomised controlled trial[5], and as a possible alternative to hysterectomy in a further small randomised study.[6] Satisfaction with medical treatment is less than with endometrial resection (TCRE).[7] This difference is maintained after two years of follow up and patients who are treated medically and then need surgical treatment do not attain the same degree of satisfaction as those treated with initial TCRE.[8] (*For further details of the medical management of menorrhagia, see the Royal College of Obstetricians & Gynaecologists guideline on initial management of menorrhagia.*[9])

Surgical procedures have become less expensive as length of hospital stay shortens and endometrial resection and ablation have been introduced. There is an increasing wealth of literature which clearly demonstrates that endometrial resection

and ablation are effective in reducing menstrual loss in the majority of women, with minimal complications in experienced hands, resulting in high levels of patient satisfaction and offering a safe alternative to hysterectomy to those carefully selected and counselled.[2]

Overall costs would increase if the endometrial resection and ablation were simply intermediate procedures on the way to hysterectomy, or if they were used as a ready alternative to simple, effective, and inexpensive medical treatments. The indications for their use are, therefore, important considerations.

[tickbox]  Whilst effective medical treatment should be offered to patients with menorrhagia, surgery should not be denied to women who do not wish medical treatment.

2.3 Outcome of hysteroscopic surgery

One-year follow up studies have shown hysteroscopic endometrial resection/ablation (TCRE/ELA) to result in patient satisfaction in about 84% of cases, compared with 93% following hysterectomy.[2, 10] Following TCRE/ELA, about 42% of patients had amenorrhoea/brown discharge; 33% had light periods. Sixteen per cent required subsequent hysterectomy and 10% required repeat hysteroscopic surgery.[4] There does not seem to be a difference between TCRE and ELA in terms of outcomes at one year, and both have low morbidity.[11] Hysteroscopy at three and 12 months after TCRE revealed a small fibrotic uterine cavity in the majority of patients.[12]

Following TCRE/ELA there is a shorter time taken to return to work and normal activities, decreased hospital stay and less postoperative morbidity than following hysterectomy. [10, 13, 14, 15] Sixty six per cent of patients had returned to work within two weeks and 88% within four weeks, compared with about eight weeks for hysterectomy.[2, 15] Hospital stays (median times) were one day for hysteroscopic surgery and seven days for hysterectomy.[10, 15] Dysmenorrhoea and pre-menstrual syndrome (PMS) symptoms and scores of anxiety and depression are improved following either TCRE or ELA, and bladder symptoms are unaffected.[15, 16, 17] There is no evidence that hysterectomy results in postoperative psychiatric disorder[18] and ELA and hysterectomy have been shown to have a similar beneficial effect on psychiatric and social outcomes, although the less invasive nature of hysteroscopic surgery may result in a better psychological outcome.[19]

Long term follow up of TCRE has been reported for 525 women followed up for up to five years. [20] The mean duration of follow up was 31 months but only 43 patients were followed to five years. The hysterectomy rate in this uncontrolled study was 9%, with 80% avoiding further surgery. In a review of 746 uncontrolled patients following ELA with follow up of up to six years, only 15% of patients required further surgery, but survival curve analysis predicted a hysterectomy rate of 21% at 6.5

years. [21] The patients in the Pinion et al randomised controlled trial of hysterectomy vs. TCRE/ELA[22] have been followed up for between four and six years.[23] In this controlled trial of women expecting a hysterectomy, hysterectomy was avoided in 76% of the TCRE/ELA group. There was no significant difference in overall satisfaction between the two groups (80% vs. 89% for the hysterectomy arm). Life table analysis showed that the risk of requiring a hysterectomy was low after 36 months, a finding in agreement with the long term follow up of TCRE.[20]

Failure has been found to be more common in women aged under 40, if surgeons had done less than 10 previous hysteroscopic endometrial ablations, if intramural fibroids were present, if performed during the luteal phase of menstrual cycle, or for certain methods of endometrial thinning.[12, 24] Some women develop late onset pain with or without bleeding[12] after 12 months. One study of 61 women who were given medroxyprogesterone acetate after TCRE suggested that this had a beneficial effect reducing the incidence of late onset pain, but further studies are needed.[25] Ovarian function is unaffected two years following TCRE/ELA as compared to hysterectomy.[17, 26]

In summary, endometrial resection/ablation offers patient satisfaction only slightly less than hysterectomy but with significantly less morbidity and faster recovery.

There is no difference in outcome between TCRE and ELA. [2, 10, 11, 22] *Evidence level Ib and III* *

[A] TCRE/ELA should be offered as an option to all women needing surgical management of dysfunctional uterine bleeding.

* *Note that this conclusion is supported by two further randomised controlled trials,*[27, 28] *although these are methodologically inferior to the studies cited above.*

2.4 Cost effectiveness

Although many studies have been carried out comparing hysterectomy with TCRE/ELA, very few have been prospective randomised studies and hardly any have considered the cost implications.

To determine the cost effectiveness of hysteroscopic surgery compared with hysterectomy for dysfunctional uterine bleeding it is necessary to know not only comparative costs of the operation but also the costs and benefits of short and long term follow-up, subsequent hysterectomy rates and patient satisfaction. Two randomised studies from Bristol and Aberdeen meet the required criteria. In Bristol, a prospective economic evaluation running alongside a randomised controlled trial reported that, on the basis of health service resource cost input four months after surgery, TCRE has a cost advantage over abdominal hysterectomy.[29] These results were supported by a further study which reviewed the health related quality of life

and costs two years after surgery.[30] Similar results were found in the economic evaluation of the randomised trial of hysterectomy and TCRE/ELA from Aberdeen. [31]

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Hysteroscopic Surgery

Section 3: Patient selection for hysteroscopic surgery

Women with genuine menorrhagia-i.e. whose measured blood loss is >80 ml-have a better outcome after endometrial ablation than those whose loss is less than 80 ml.[15] Dysmenorrhoea and pre-menstrual tension diminish in most women after TCRE or ELA.[22] Women over the age of 35-40 years do better than younger women.[24], [32], [33] *Evidence level Ib and III*

The best results can be expected in women aged over 45 with proven menorrhagia due to dysfunctional bleeding, which is unresponsive to traditional drug treatment, and who are otherwise faced with hysterectomy. There is no difference in outcome in women with regular or irregular periods.

[A] **The main indication for endometrial resection or ablation is dysfunctional uterine bleeding in a woman who has completed her family in whom surgical treatment is indicated.**

3.1 Contraindications

Excessive uterine size, the presence of active pelvic infection, and evidence of premalignant or malignant disease are all considered to be self-evident absolute contraindications to endometrial resection and ablation.[2], [4], [10], [11], [22] *Evidence level Ib and III*

[A] **Pre-menstrual pelvic pain not related to excessive bleeding is a relative contraindication**

[B] **The uterus should be less than 12 weeks in size and the endometrium should be histologically normal.**

Endometrial sampling is essential prior to resection or ablation: for full discussion of the complications and risks of hysteroscopic surgery, see section 5.

Small submucous fibroids and benign endometrial polyps are not a contraindication to hysteroscopic surgery and can be resected during the procedure. Superficial adenomyosis can be treated definitively with endometrial ablation, but deep

adenomyosis responds poorly.[34] *Evidence level III*

3.2 Preoperative hysteroscopy

In cases in which the uterus is less than the size of a 10 week pregnancy, either TCRE or ELA was shown to be possible in 95% of cases which were not previously assessed with hysteroscopy, suggesting that hysteroscopy is not routinely indicated before endometrial resection or ablation unless the uterus is enlarged.[22] *Evidence level Ib*

[A] Preoperative hysteroscopy is not needed in the majority of women whose uterus is not enlarged.

A checklist of points to consider in selecting patients for hysteroscopic surgery is provided as Figure 1.

Figure 1

Patient selection checklist for hysteroscopic surgery

- 35-50 years old
- Menorrhagia with associated pre-menstrual symptoms
- Absence of:
  - organic disease - malignant or pre-malignant endometrium
  - intra-mural fibroids
  - pelvic infection
  - uterine abnormalities or excessive size
- Benign histology
- Normal cardiac and respiratory function
- Consider medical and obstetric history:
  - allergies
  - anticoagulant therapy
  - previous caesarean section/hysterotomy
- Particularly suitable for obese patients
- Desire to avoid hysterectomy

3.3 Patient counselling

Patients should be adequately counselled prior to any operative procedure. The new endoscopic operations have led to greater explanation of procedures. Although the risk of a major complication after TCRE or ELA is undoubtedly less than for a hysterectomy there are some points that need to be raised specifically.

Patient satisfaction rates are high for endoscopic techniques. Satisfaction overall is between 80% and 90%, with amenorrhoea rates of under 50% (see section 2.3).

There is much interoperator variation and each surgeon must be able to quote his or her own results to patients. There is a small chance the procedure will need to be abandoned temporarily or permanently due to perforation (about 1% risk)[2], fluid overload, problems dilating the cervix, or unexpected fibroids (see section 4). Rarely, a hysterectomy will need to be carried out (reported rates vary widely[2, 35] and local rates should be discussed with the patient). Damage to other organs can occur but is very uncommon.

Pregnancy is both possible and potentially hazardous to both mother and fetus after endometrial ablation, therefore the woman's family must be complete. Continued use of contraception is strongly advised and concurrent sterilisation should be offered at the time of ablation.

[C] Counselling is vitally important both to ensure that the patient understands the implications of the procedure and for medico-legal reasons. Use of a patient information leaflet is recommended.

Patient counselling should include full discussion of the advantages, disadvantages and potential complications of hysteroscopic surgery. These are noted in the key messages for patients at Annex 2.

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Hysteroscopic Surgery

Section 4: Methods of hysteroscopic surgery

4.1 Transcervical endometrial resection

The aim of endometrial resection is to remove or destroy 3 mm of myometrium. This will ensure removal of endometrial glands which extend approximately 2 mm into the myometrium.[36] If less tissue is removed, glandular regeneration may take place and the clinical outcome will be compromised. Deeper resection will increase the risk of uterine perforation, increase fluid absorption and cause excessive bleeding by disturbing larger vessels.

A loop diathermy electrode correctly applied will remove 3 mm of tissue and induce tissue necrosis to a further depth of 2 mm. Assuming that the endometrium has been thinned to 1 mm, the resection should remove safely all active endometrium with minimal risk of perforating the uterine wall, which is usually 2 cm thick.[36] *Evidence level III*

[tickbox] It is imperative that the loop is not activated whilst stationary as excessive tissue destruction results from the time the tissue is in contact with the current and not the absolute level of the current per se. [36]

4.1.1 AVOIDANCE OF CORNUAL AREAS

The uterine wall in the area of the cornua can be only 6 mm thick.[36] Most surgeons would advocate initial use of the rollerball electrode to destroy this area, then to roll the electrode across the fundus between the tubes using a blend of current (75 W cutting and 100 W coagulation).[36] *Evidence level III*

[B] Loop resection of the cornua should be avoided and endometrial destruction with a rollerball electrode is advised.

Some surgeons use a straight 3 mm loop to excise the fundal tissue but this manoeuvre requires considerable experience.

4.1.2 MAINTAINING VISION

Failure to obtain a satisfactory view of the cavity is invariably related to inadequate

fluid flow through the system.[37] *Evidence level IV*

[C] All methods should be carried out using video camera equipment to maximise the view.

[C] Good irrigation will clear blood and debris rapidly from the field of vision and maintain uterine distension.

[C] Orientation is essential and is best achieved by identifying both tubal ostia and observing air bubbles on the roof of the cavity.

4.2 Endometrial ablation

Endometrial ablation can be achieved using electrical energy, through a rollerball electrode, or with laser energy using the Nd:YAG laser. The preparation of the uterus, the patient and the equipment are as for endometrial resection.

4.2.1 ROLLERBALL ABLATION

A rollerball electrode can have either a ball or a cylinder as the moving part. The shape of the electrode does not influence the outcome but affects the power density of the diathermy current. The rollerball causes tissue necrosis to a depth of 3-4 mm depending on the power used, the length of time in contact with tissue and the frequency of applications. Like the loop resector, the electrode must not be activated whilst the rollerball is stationary. Glycine is used for irrigation to facilitate diathermy activity.

There is a very low reported incidence of complications relating to fluid overload in rollerball ablation. Perforation of the uterus with the rollerball is very unlikely to take place, but bowel perforation and fistula formation have been described where the uterus has undergone full thickness coagulative myometrial necrosis but without actual perforation.[38], [39], [40], [41] *Evidence level III*

Rollerball ablation of the endometrium has been more extensively used outside the UK and has not been truly evaluated by randomised trials.

4.2.2 LASER ABLATION (ELA)

The Nd:YAG laser allows endometrial destruction in contact and non-contact mode. The laser fibre is dragged across the tissue or can be fired at the tissue without touching it. The wavelength used is 1060 nm (1.06 µm).

To effect laser ablation, 80 W is the usual power level for the Nd:YAG laser, passed

through an open-ended bare quartz fibre of 600 µm.[22], [37], [42] *Evidence level III and IV*

[B] The laser power with the Nd:YAG laser should be no less than 80W.

The Nd:YAG laser causes tissue vaporisation and necrosis to a depth of 4 mm. Common to all methods of ablation or resection, the laser fibre tip (or roller ball or loop electrode) must not be activated when stationary and should only be activated when the fibre is being dragged towards the optic.[37] *Evidence level IV*

[C] The laser must not be activated when stationary.

Medical lasers can only be operated under the control of the hospital Laser Protection Advisor or Laser Safety Officer who is usually a member of the Medical Physics Department. This person is responsible for ensuring that a series of safety procedures are adhered to and that the surgeon and associated operating team are suitably trained in laser technology. There are significant risks of blindness caused to theatre staff and the patient if the laser rules are not strictly adhered to.

[tickbox]

Laser ablation must only be used in fully equipped laser theatres with local laser safety rules in place.

4.3 Endometrial preparation

All methods of endometrial resection and ablation aim to destroy around 3 mm of myometrium so as to destroy endometrial glands.[36] Endometrial thinning has been proposed to improve the quality of the view within the uterus and to reduce the total amount of tissue to be destroyed or removed so as to treat the endometrial glands.

Danazol and gonadotrophin releasing hormone (GnRH) analogues are the most widely used. Randomised studies have shown that GnRH analogues are superior to the use of no thinning agent [43] and to danazol [44] in respect of providing a thinner endometrium, shorter operating time, less fluid absorption and improved menstrual outcome. However, a further randomised study and a very large audit did not show any difference between GnRH analogue and danazol. [2], [45]

The use of a GnRH analogue does increase cervical resistance making the cervix more difficult to dilate and this effect is not reversed with prostaglandin administration. [46] *Evidence level Ib and III*

[B] **Endometrial preparation is recommended.**

[A] **Either a GnRH analogue or danazol may be used: a GnRH analogue may give better results, compliance is more certain and will reduce the size of fibroids.** [43], [44]

[C] **In patients in whom a difficult cervical dilatation is anticipated danazol may be preferred.**

[C] **Obese women pose a problem as GnRH analogues alone give poor thinning, a combination of both agents may be the most effective.** [37]

Grade C recommendations extrapolated from evidence level Ib and III

4.4 Training

Common sense suggests that complications will be fewer and outcome improved in the hands of trained and experienced surgeons. Though there is no evidence for this in a large audit,[2] retrospective results suggest an improvement in results with increasing experience. [47]

[tickbox] The guideline development group recommends attendance at a hysteroscopic skills course followed by supervised clinical training until competence is reached.

The number of cases needed to be carried out before competence and acceptable results are reached is unknown.

4.5 Postoperative care

[tickbox]

Standard recording should be carried out of the patient's:

- vital signs: colour, respirations, temperature, pulse, blood pressure
- vaginal loss
- pain
- orientation
- analgesia.

4.6 Discharge planning

[tickbox]


Advice should be provided on:

- after-effects of anaesthetic
- anticipated degree of postoperative pain and vaginal loss
- emergency contact telephone number if patient:
  - bleeds heavily
  - has severe pain
  - develops a temperature or feels fevered
  - becomes breathless
- * resumption of sexual activity
- * contraception
- * postoperative follow-up, nursing and social care arrangements.

[tickbox]


A patient information booklet should be provided outlining postoperative advice.

[tickbox]


Should hormone replacement therapy (HRT) be needed in the future, this should be as for patients who have not had a hysterectomy.

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Hysteroscopic Surgery
Section 5: Complications and risks

Two large randomised trials comparing hysteroscopic surgery with abdominal hysterectomy for the management of menstrual dysfunction concluded that postoperative morbidity was significantly less following TCRE/ELA compared with hysterectomy, which was associated with a 3% risk of life threatening complications.[10, 22] The risks with hysteroscopic surgery appeared to be uterine perforation and fluid overload. There were no cases of bowel damage and no cases of significant intraperitoneal bleeding.[10, 22]

A further randomised study comparing TCRE with ELA demonstrated that there were risks of uterine perforation (less than 1%), fluid overload (6%) and uterine tamponade (1%).[11] Fluid overload appeared to be more common with endometrial ablation, uterine perforation with endometrial resection, and tamponade was equal in both groups. The study also mentioned late complications which included pregnancy and two cases of haematometra specifically following resection. Infection has been cited as a complication of hysteroscopic surgery, but its clinical significance is unclear.[48] *Evidence level Ib*

Case reports have indicated that it is imperative to try to exclude endometrial carcinoma by endometrial sampling before hysteroscopic surgery.[49, 50] Endometrial resection was preferred over endometrial ablation, since it provided additional tissue for histological examination and it might be difficult at a later stage if endometrial cancer had been missed preoperatively to make a diagnosis. However, the overall incidence of endometrial cancer following TCRE/ELA is unknown. *Evidence level III*

[B] Endometrial sampling is essential prior to hysteroscopic surgery.

Newer forms of endometrial destruction, including thermal balloon ablation, cryo ablation and microwave ablation, have yet to be evaluated both from the point of view of efficacy and risk. Radio frequency ablation is no longer advocated because of complications.

The main risks associated with hysteroscopic surgery (endometrial resection and laser ablation) appear to be uterine perforation, fluid overload and to a lesser extent haemorrhage and infection. [2, 10, 11, 20, 22, 32] *Evidence level Ib and III*

[C] **The risks can be minimised by experienced operators and hence training and supervision for those less experienced is imperative.**

[tickbox] Adherence to the Royal College of Obstetricians & Gynaecologists accreditation for level 3 hysteroscopic surgery is essential.[51]

5.1 Uterine perforation

Laparotomy is the only way to exclude bowel damage definitively.[37] *Evidence level IV*

[C] **If perforation is suspected while activating the resectoscope or laser, immediate laparoscopy is indicated.**

[C] **If perforation is confirmed and associated with active diathermy, laparotomy may be required if there is any suspicion of bowel or vascular damage.**

5.2 Irrigation fluid absorption

With both TCRE and ELA the endometrial cavity needs to be distended with fluid both to create the space in which to operate and to flush blood and debris from the cavity so as to optimise the view. The irrigating fluid can be absorbed into the circulation via intra uterine vessels or after absorption from the peritoneal cavity secondary to trans tubal passage or uterine perforation.

Endometrial resection has to be done with non ionic solutions, the most common being 0.9% glycine. Excess absorption leads to hyponatremia, hyper ammoniaemia and fluid overload. Laser ablation can be performed with normal saline which does not lead to hyponatremia, but will cause circulatory overload if sufficient is absorbed. It is important to maintain the distension fluid at a pressure high enough to tamponade bleeding and low enough to avoid excessive fluid vasceration.

It is vital to calculate the volume of irrigation fluid absorbed. This can be done by either measuring the volume infused and subtracting the volume recovered giving the presumed volume absorbed by the patient. This can be made easier by the simple use of a spring balance on the fluid bag. [52] Alternatively the glycine or saline can be labelled with ethanol and the volume absorbed estimated using a breathalyser to measure expired ethanol concentration. [53], [54] *Evidence level III*

Intracervical injection of vasopressin was shown in a randomised trial to reduce the

absorption of glycine. [55] *Evidence level Ib*

[A] **Laser ablation leads to greater fluid absorption than endometrial resection.** [2], [11]

[C] **The operator must be constantly aware of the fluid volume infused and the volume removed. The assisting staff should make a formal report of this balance at five minute intervals.**

[B] **An accurate assessment of the calculated deficit must be made.** [2], [32], [37], [56]

The mean volume of glycine absorbed during a routine resection is 432 ml. Electrolyte disturbance is not seen with absorption below 1500 ml.[56] *Evidence level III*

[B] **If the deficit exceeds 1500 ml then the procedure should be abandoned unless it is nearly complete.**

The safe upper limit for normal saline absorption has not been determined.

[C] **Haemoglobin, haematocrit and serum sodium must be measured serially and the patient observed postoperatively for signs of fluid overload. If a rapid deficit occurs during a procedure, uterine perforation must be suspected.**

[tickbox] If a uterine perforation is suspected during cervical dilatation or on introduction of the inactive resectoscope, the procedure should be abandoned. The patient should be observed overnight and arrangements made to repeat the resection in six weeks' time.

5.3 Haemostasis

Haemostasis is best assessed by reducing the fluid inflow to ensure that significant bleeding has not been held back by the irrigation pressure in the uterus. [37] *Evidence level III*

[B] **In the rare event that significant bleeding persists, a 30 ml balloon Foley catheter (14-18 gague) can be inserted in to the uterine cavity and inflated to effect tamponade. The catheter should be left in situ for 12 hours before removal.**

5.4 Antibiotic prophylaxis

The use of antibiotic prophylaxis in hysteroscopic procedures has been recommended [32], [57] and a death due to toxic shock syndrome following endometrial resection has been reported.[58] *Evidence level Ib and III*

Antibiotics with a spectrum covering enterobacteria, anaerobic Gram positive cocci and bacterioides would be expected on theoretical grounds to be the most effective in preventing the most common potential infective sequelae of hysteroscopic surgery.[59] No prospective study has demonstrated that any one antibiotic prophylactic regimen is superior for this purpose in hysteroscopic surgery, although one study has reported that prophylactic antibiotics can significantly decrease the incidence of bacteriaemia.[48] This decrease was mainly in non virulent organisms. *Evidence level Ib and III*

There is insufficient evidence to support a recommendation on antibiotic prophylaxis in hysteroscopic surgery.

5.5 Prophylaxis of thromboembolic disease

Although the risk of thromboembolism for patients undergoing hysteroscopic surgery is small, individual factors may well make prophylactic therapy of benefit to a small number of patients.[10]

No prospective studies of this area have been undertaken. It is recommended that the general guidelines produced by the Scottish Intercollegiate Guidelines Network on Prophylaxis of Venous Thromboembolism should be taken into account by clinicians when presented with a patient of moderate to high risk. [60]

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Hysteroscopic Surgery

Section 6: Recommendations for audit and research

6.1 Key points for audit

- Number of procedures
- Type of procedure
- Initial postoperative outcome:
  - Uterine perforation rate
  - Excess fluid absorption rate
  - Emergency hysterectomy rate
- Outcome at six months:
  - Patient satisfaction
  - Amenorrhoea rate
  - Reoperation (repeat TCRE/ELA and hysterectomy rate) at six months
- Compliance with local guidelines derived from the national guideline
- Specialist nurse or consultant referral rate.

6.2 Recommendations for further research

Any new method of endometrial resection or ablation, e.g. thermal balloon or microwave ablation, must not be introduced into routine clinical practice without proper assessment with randomised clinical trials comparing them to previously validated methods.

Trials are needed comparing hysteroscopic surgery methods with the progestogen-secreting intrauterine contraceptive system (Mirena).

Studies should be carried out to determine why there is geographical variation into the provision and patient demand for hysteroscopic surgery.

Further trials are needed of alternative agents for endometrial thinning.

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Hysteroscopic Surgery
Annex 1

Details of the systematic review undertaken for this guideline

The evidence base for this guideline was synthesised in accordance with SIGN methodology. An initial systematic review of the literature was carried out using an explicit search strategy using the Cochrane Library, Embase (1988-1996), HealthStar (1985-1996), and Medline (1985-1996). Information was also provided by the Scottish Health Purchasing Information Centre (SHPIC) and a hand search of the journal Gynaecological Endoscopy was carried out. This evidence base was updated to incorporate studies published during the course of development of the guideline.

Papers were only included if they adhered to recognisable methodological principles, including adequate sample size, a clearly identified hypothesis and measure of outcome, and accurate reporting of results. Whenever possible randomised trials have been discussed. However, due to the paucity of sound randomised controlled trials work in this area, the literature search was extended to cover all types of study and a number of clinical studies have been included.

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Hysteroscopic Surgery
Annex 2

Key messages for patients

Patient counselling prior to hysteroscopic surgery should include discussion of the advantages, disadvantages and potential complications:

ADVANTAGES

- Reduces menorrhagia in 66-87% women
- Reduces dysmenorrhoea and premenstrual symptoms
- Fewer potential postoperative complications
- Can be performed as a day patient (length of stay in hospital may therefore be only one day as opposed to an average of seven days for hysterectomy)
- Shorter postoperative recovery (average 2-4 weeks) than hysterectomy (average 2-3 months)
- Less likelihood of need for postoperative blood transfusion
- Significantly high patient satisfaction rate (87% patients)

DISADVANTAGES

- Failure rate 10-24%
- Can offer short term improvements but hysterectomy may be required later (within 3-5 years)
- More likely to result in reduced menstruation than amenorrhoea
- Pre-menstrual symptoms reduced, but not completely obliterated
- Cannot be regarded as a sterilising procedure

POTENTIAL COMPLICATIONS

- Injury to cervix, uterus, bowel
- Fluid overload of >1500 ml may lead to adverse side effects
- Haemorrhage
- Failure of procedure

Note that all of the potential complications noted above may be reduced by appropriate patient selection and expert operative techniques.

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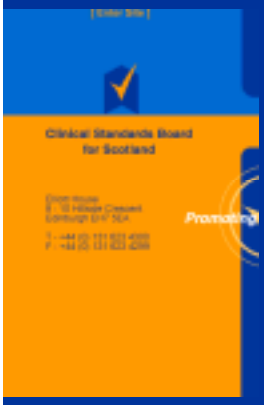

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- We've given up on fixing the FTP site, so it's been replaced with a Downloads page.
- Check out our teaching programme for details of the 2002 workshops in Teaching and Practising EBHC, **both** of which have Spanish and English speaking groups;
- Bob Phillips (with others) has updated the Levels of Evidence table and would like comments. The old one is still there for comparison.
- Oxford University Clinical Students click here for support materials.

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New Zealand Evidence-based Healthcare Bulletin - March 2002
[Last updated on 23 Mar 2002]

From October - December 2001, NZGG was ranked No 3 in the Hitwise New Zealand 'Health and Medical - Primary & Specialist' category.

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The New Zealand Guidelines Group (NZGG) was established by the National Health Committee (NHC) in 1996 as an informal network of expertise and information on guideline development, implementation and evaluation.

The primary purpose in establishing the (NZGG) was to train health and disability professionals and consumers in the development and implementation of best practice guidelines. The long-term aim is to help facilitate a culture change among all stakeholders in health care and disability support to improve the quality, effectiveness and equity of service provision.

The (NZGG) has overseen the training a range of health care professionals from the areas of medicine, psychiatry, surgery, public health medicine, and general practice, as well as nursing and other allied health professionals. There has been active Maori and consumer involvement in the guidelines development and implementation process.

In July 1999, the NZGG became an incorporated society and is now funded through a contract with the Health Funding Authority. The core business will remain guidelines and the scope of activities will broaden to include clinical indicators and other aspects of evidence-based practice.

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An updated code of practice. Sub-committee of the Joint Tuberculosis Committee of the British Thoracic Society: Br Med J 1990; 300: 995-999

Chemotherapy and management of tuberculosis in the United Kingdom:
Recommendations of the Joint Tuberculosis Committee of the British Thoracic Society. LP Ormerod. Thorax 1990; 45:403-408

Guidelines on the management of tuberculosis and HIV infection in the United Kingdom.
Sub-committee of the Joint Tuberculosis Committee of the British Thoracic Society: Br Med J 1992; 304: 1231-1233

Guidelines for the management of asthma.
The British Thoracic Society and others: Supplement to March issue of Thorax 1993; 48: 3

Guidelines for the management of asthma: a summary.
The British Thoracic Soctety and others: Br Med J 1993; 306: 776-782

Guidelines for the management of community-acquired pneumonia in adults admitted to hospital.
The British Thoracic Society: British Journal of Hospital Medicine 1993; 49: 346-350

Guidelines for the management of spontaneous pneumothorax.
AC Miller & JE Harvey on behalf of the Standards of Care Committee of the British Thoracic Society: Br Med J 1993; 307:114-116

Control and prevention of tuberculosis in the United Kingdom:
Code of Practice 1994. Joint Tuberculosis Committee of the British Thoracic Society. Thorax 1994; 49; 12:11993-1200

AC Miller & JE Harvey on behalf of the Standards of Care Committee of the British Thoracic Society: Br Med J 1993; 307:114-116

Control and prevention of tuberculosis in the United Kingdom:
Code of Practice 1994. Joint Tuberculosis Committee of the British Thoracic Society. Thorax 1994; 49; 12:11993-1200

The British guidelines on asthma management:
1995 review and position statement. The British Thoracic Society et al: Supplement to February issue of Thorax 1997; Vol 52; 51
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Current best practice for nebuliser treatment.
The Nebuliser Project Group of the British Thoracic Society Standards of Care Committee.Supplement to April issue of Thorax 1997; Vol 52 Supp 2
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Guidelines on the Management of COPD.
The British Thoracic Society Standards of Care Committee. Supplement to December 1997 issue of Thorax 1997, Vol 52:5.
Download guidelines

Suspected acute Pulmonary Embolism - a Practical Approach.
The British Thoracic Society Standards of Care Committee. Thorax 1997; 52: Supplement 3 S3.
Download guidelines

BTS Recommendation to Respiratory Physicians for Organising the Care of Patients with Lung Cancer.
The Lung Cancer Working Party of the British Thoracic Society Standards of Care Committee: Supplement to June issue of Thorax 1998; 53:1.
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Chemotherapy and management of tuberculosis in the United Kingdom: recommendations 1998.
Joint Tuberculosis Committee of the British Thoracic Society. Thorax 1998, Vol 53, 7: 536-548.
Download guidelines

The Diagnosis, Assessment and Treatment of Diffuse Paranchymal Lung Disease in Adults:
The Diffuse Parenchymal Lung Disease Group of the British Thoracic Society. Thorax April 1999, Vol.54, 1
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Management of opportunist and mycobacterial infections:
Joint Tuberculosis Committee guidelines 1999. Subcommittee of the Joint Tuberculosis Committee of the British Thoracic Society.Thorax 2000. Vol.55 , 3 : 210-218
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Control and prevention of tuberculosis in the United Kingdom: Code of

Tuberculosis Committee of the British Thoracic Society.Thorax 2000. Vol.55 , 3 : 210-218
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Control and prevention of tuberculosis in the United Kingdom: Code of Practice 2000. Joint Tuberculosis Committee of the British Thoracic Society. Thorax 2000. Vol. 55,11: 887-901
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Guidelines on the selection of patients with lung cancer for surgery.
British Thoracic Society and Society of Cardiothoracic Surgeons of Great Britain and Ireland Working Party. Thorax 2001. Vol 56: 89-108
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British Thoracic Society Guidelines on Diagnostic Flexible Bronchoscopy.
Thorax March 2001. Vol 56; Supplement I.
Download guidelines

Guidelines for the Management of Community Acquired Pneumonia in Adults
British Thoracic Society. Thorax 2001. Vol 56; supplement IV.
Download guidelines

BTS Statement on Pulmonary Rehabilitation, 2001.
British Thoracic Society. Thorax 2001. Vol 56; 827–834.
Download guidelines

BTS Statement on Malignant Mesothelioma in the United Kingdom, 2001.
British Thoracic Society. Thorax 2001. Vol 56; 250–265.
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You can obtain re-prints of the above directly from the publishers or by downloading any guidelines produced since 1997 from this website.

Copies of BTS Guidelines can be obtained from the Thorax Subscription Department, British Medical Journal.Telephone 0207 387 4499.

Clinical Effectiveness Programme - Home Page

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These pages have been developed by RCGP Scotland for professionals in Primary Care to provide informatio SIGN guidelines and their implementation in practice. We aim to

- encourage GPs to participate in the development of SIGN guidelines.
- share information on implementing guidelines as well as materials developed to support them.

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Clinical Effectiveness Programme,
Quality Department, RCGP Scotland, 25 Queen Street, Edinburgh, EH2 1JX
Tel: 0131 260 6800
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Welcome

The first of April 2001 the Danish Institute for Health Technology Assessment (DIHTA) and The Danish Hosp Centre merged to form a new Danish Centre for Evaluation and Health Technology Assessment (DACEHTA) situated as a seperate entity within the framework of The National Board of Health and is headed by the direc served by an advisory board and a scientific advisory board

Key aims include carrying out health technology assessments (HTAs) and integrating HTA-priniciples into the planning of the public health service at all levels. DACEHTA also carries out evaluations of public health sevi improving quality, standards and value for money.

Islands Brygge 67 P.O. Box 1881 DK-2300 Copenhagen S 72227400

Danish Centre for Evaluation and
Health Technology Assessment
National Board of Health
Islands Brygge 67
P.O.Box 1881
DK-2300 Copenhagen S, Denmark
Tel. +45 72 22 74 00
Fax +45 72 22 74 13
E-mail cemtv@sst.dk

The centre primarily targets health professionals and decision-makers at all levels as well as related research communities.

DACEHTA is charged with employing those activities and methods that will contribute most effectively to quality, efficiency and standards of care in the danish health service.

A web-site for the new center is under construction. Until then, this site will cover

levels as well as related research communities.

DACEHTA is charged with employing those activities and methods that will contribute most effectively to quality, efficiency and standards of care in the danish health service.

A web-site for the new center is under construction. Until then, this site will cover material relevant to DIHTA. For information relevant to the The Danish Hospital Evaluation Centre see www.ecs.dk. Material published since the first of Ápril 2001 will be accessible from both sites.

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*

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ISD Online - the leading source of health data in Scotland offers a topic based service, providing the latest news and publications as well as a range of other topics and links to related sites.

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12 March 2002

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Information and Statistics Division (ISD)
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Trinity Park House, South Trinity Road. Edinburgh. Scotland. EH5 3SQ
tel :0131 551 8899 **fax**: 0131 551 1392
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The National electronic Library for Health has moved to:

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Please update any bookmarks accordingly.

NHS SCOTLAND

nmpdu
Nursing Midwifery Practice Development Unit

Welcome

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Welcome to the web site of the **Nursing and Midwifery Practice Development Unit (nmpdu)**. The main purpose of the site is to let you know about the work of the Unit, and to keep you in touch with what's happening across Scotland within practice development.

We would like the site to be a forum for exchange of information on work going on in this area. Contributions and suggested topics for inclusion are welcome, and can be emailed to nmpdu.

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nmpdu
Nursing and Midwifery Practice Development Unit
Elliott House
8-10 Hillside Crescent
Edinburgh EH7 5EA

email info@nmpdu.org

tel 0131 623 4287
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Picture 

Treatment of chronic disease in Primary Care and the c
management and poor treatment of compliance constitu
for the NHS.

Merck Sharp & Dohme Limited (MSD) have invested five years in the
clinical informatics initiatives for Primary Care. This commitment has
decision support system, known generically as CDSS, which can be
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This will take you to a public area of the web site, wh
information about CDSS.

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BNF.org
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The BNF provides UK healthcare professionals with authoritative and practical information on the selection and clinical use of medicines in a clear, concise and accessible manner.

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Important

Current internet technology is not sufficiently reliable to deliver information for use in clinically critical situations. Users should **not** therefore rely on the availability of BNF.org to make individual treatment decisions. The following BNF products are specifically designed for use in such circumstances and are available from the British Medical Association and the Pharmaceutical Press:

- BNF printed copy
- eBNF
- WeBNF (Pharmaceutical Press only)

This website is optimised for viewing at a screen resolution of 1024 x 768 with 256 or more colours using Microsoft® Internet Explorer version 5 or above.

Email your comments on this website.

BNF conference

Click here for details of the BNF conference on prescribing excellence

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Scottish Health on the Web (SHOW) is provided by the National Health Service in Scotland and funded by the Scottish Executive Health Department.

SHOW is here to provide a focal point for National Health Service in Scotland websites.

Latest on SHOW

LATEST ON SHOW

- New website - Royal Infirmary of Edinburgh Intensive Care Unit
- Major new website for information about diabetes in Scotland to be launched soon
- Referral Criteria for examinations involving x-rays (radiology) and gamma rays (nuclear medicine), Royal College of Radiologists, 4th Edition Guidelines
- Vacancy - Policy Development Co-ordinator
  Assistant to NHS Spiritual Care Co-ordinator / Healthcare Chaplaincy Training and Development Officer for Scotland (rtf 24K)
- Scottish Executive Health Department Response to Recommendations from Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995 (PDF 19K)
- NHS (Scotland) Summarised Accounts for the Year Ended 31 March 2001 (PDF 168K)
- Advice on Travel Related Deep Vein Thrombosis
- Environmental monitoring and impact - the foot and mouth outbreak in Scotland
- Occupational Health and Safety for General Medical and Dental Practitioners and their staff
- Lanarkshire Health Board now has a new site and a new address at www.show.scot.nhs.uk/nhslanarkshire
- Cancer In Scotland: Action For Change National Implementation/Investment Plan - 2001-2002
- Health in Scotland 2000 - report on the state of Scotland's health
- New website - Scottish Diving Medicine
- Health and Homelessness Guidance
- Coronary Heart Disease/Stroke Task Force Report
- NHSScotland National IM&T Strategy
- The National Health Service (Choice of Medical Practitioner)(Scotland) Regulations 1998 (pdf, 31K)

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Board for Scotland to assess.

NHSScotL

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Scottish Medicines Consortium web
live

Health Technology Board for Scotla
Sharing Scheme for beta-interferons
glatiramer acetate

24th Mar - 1st Apr:
Prostate Cancer Awareness Week

- Implementation/Investment Plan - 2001-2002
- Health in Scotland 2000 - report on the state of Scotland's health
- New website - Scottish Diving Medicine
- Health and Homelessness Guidance
- Coronary Heart Disease/Stroke Task Force Report
- NHSScotland National IM&T Strategy
- The National Health Service (Choice of Medical Practitioner)(Scotland) Regulations 1998 (pdf, 31K)
- New website - Implementation Support Group (Supporting the New Deal for Training Grade Doctors in Scotland)
- Scottish MRSA Reference Laboratory website
- The Confidentiality & Security Advisory Group for Scotland PROTECTING PATIENT CONFIDENTIALITY: A consultation paper (pdf, 305K)
- Guidance on the Implementation of the change programme "Rebuilding our National Health Service"
- Report of the Scottish Medical and Scientific Advisory Committee on Immunology and Allergy Services in Scotland

Older items that were previously listed here are now available in the SHOW homepage archive

24th Mar - 1st Apr:
Prostate Cancer Awareness Week

All decade: International Decade fo Peace and Non-violence for the Chi World

More on current and fortho events

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Further Information

FURTHER INFORMATION

- How to use this site.
- Becoming part of SHOW.
- Resources for those who already have a site.

Scottish Executive Health Department

SHOW is provided under the aegis of the Scottish Executive Health Department

Scottish Executive Health Department website address

www.show.scot.nhs.uk/sehd

We hope you like the new look for SHOW and that you think its an improvement. We welcome your feedback. If you have any problems with accessing the features of the site please let us know. You can still access the previous version here.

AGREE

Breast & Ovarian Cancer Services

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National and Local Reports

Local Reports can be viewed by selecting from the drop down lists below.. The National Overviews can
documents are in Adobe Acrobat format. You will need at least version 4 of the Adobe Acrobat Reader
click on the following link: **Adobe Acrobat 5 Reader**

Breast Cancer

National Overview
Argyll & Clyde
Ayrshire & Arran
Borders
Dumfries & Galloway
Fife
Forth Valley
Grampian
Greater Glasgow (North)
Greater Glasgow (South)
Highland
Lanarkshire
Lothian
Lothian (West)
Orkney
Shetland
Tayside
Western Isles

Ovarian Cancer

National Overview
Argyll & Clyde
Ayrshire & Arran
Borders
Dumfries & Galloway
Fife
Forth Valley
Grampian
Greater Glasgow (North)
Greater Glasgow (South)
Highland
Lanarkshire
Lothian
Lothian (West)
Orkney
Shetland
Tayside
Western Isles

EBH Calendar of events, 2002

Last update 6th March 2002.

If you are running an event which you'd like to publicise here, please email the details to Douglas Badenoch

Month	Date	Title (English language unless stated)	Venue (UK unless stated)	Contact
April	3-5	**6th Workshop on Practising Evidence-Based Mental Health**	Centre for Evidence-Based Mental Health, Oxford	Email: help@cebmh.com Tel: +44 (0)1865 226476 Fax: +44 (0)1865 793101
April	4-6	**2nd Annual Workshop in Teaching Evidence-Based Medicine**	Centre for Evidence-Based Practice, School of Population Health, University of Queensland, Brisbane, Australia	Email: p.fraley@sph.uq.edu.au Tel: +617 3346 4642 Fax: +617 3365 5442
April	8-11	**2002 Oxford Workshop in Evidence-Based Practice**	Centre for Evidence-Based Medicine, Oxford	Bridget Burchell: bridget.burchell@ndm.ox.ac.uk Tel: +44 1865 222941 Fax: +44 1865 222901
July	29 - 3 Aug	**2002 Oxford Workshop in Teaching Evidence-Based Medicine**	Centre for Evidence-Based Medicine, Oxford	Bridget Burchell: bridget.burchell@ndm.ox.ac.uk Tel: +44 (0)1865 222941 Fax: +44 (0)1865 222901
August	11-15	**4th Rocky Mountain Workshop on How to Practice Evidence-Based Health Care**	University of Colorado, Keystone, Colorado, USA	Jennifer McIntyre: jennifer.mcintyre@uchsc.edu Tel: +1 303-724-1174

If you are running an event which you'd like to publicise here, please email the details to Douglas Badenoch

The EBM Toolbox

- About the Toolbox
- List of what's in the Toolbox
- Never mind all that, just take me to the **evidence** on: NNTs, SpPins and SnNouts, Likelihood Ratios, Prognosis, Pre-test Probabilities

We've used the Toolbox metaphor because you will find here an assortment of materials which are very useful for practitioners of EBM. Of course, this is not a completely exhaustive collection, and you may find gaps that need to be filled. So, not only can you retrieve information here, you can also comment and contribute. Use the comment icon (the speech bubble with an exclamation mark) to submit your own ideas. We'll study them and, if they work, we'll add them to the site, giving you the credit.

How to use this information

This information has been carefully gathered, filtered and checked, but should not be regarded as a substitute for finding it out yourself. Here is our three-point guide to how to use the Toolbox:

1. Look up the references!
2. This information is for integration with, not substitution for, your clinical expertise and personal knowledge, so don't blindly apply this stuff or blame bad outcomes on it.
3. Learn to recognise the icons and symbols used here.

Generic Resources:

- Asking Focused Clinical Questions.
- Educational Prescriptions, how to download one and what to do with it.
- Searching for the Best Evidence, some tips for MEDLINE users.
- Glossary of EBM Terms, giving brief definitions.
- Comparison of Study Designs, summarising the advantages and disadvantages of

different types of study.
- All-Purpose 4-fold Table calculator, which (using Shockwave) allows you to do quick calculations.
- Levels of Evidence and Grades of Recommendation which can be applied to show the quality of evidence you have found.
- Quality Filters which we apply to the data appearing on these pages.
- Feedback page so you can comment on the material you see here and even add your own if you want.

Specific Tools and Data:

- **Pre-Test Probabilities**, with definition, how to calculate one, an example and some samples from real life.
- **SpPins and SnNouts**, with definition, how to calculate one, an example and a set of samples from real life.
- **Likelihood Ratios**, with definition, how to calculate one, an example, an interactive calculator and interactive nomogram for LRs (using Shockwave), and a set of samples from real life.
- **NNTs** (Numbers Needed to Treat), with definition, how to calculate one, an example and a set of sample s from real life.
- **Confidence Intervals**: download Dan Tandberg's Excel spreadsheet for calculating the CI around a difference between two proportions. (**PC users**: right-click on the link and choose Save Target from the menu if you want to save the file on your own machine)
- **Prognosis**, featuring an excellent synthesis of risk factors for cardiovascular events.

To comment on the material contained here, click the icon below:

The CATbank

The CATbank is a storage and retrieval facility for a collection of CATs (Critically Appraised Topics).

Our CAT facilities extend to:

- What's a CAT?, a guide to what CATs are and what they're for;
- The CATbank: a collection of CATs and NNTs. **New** Catbank search engine!
- You can download the CATnipper, our demo version of the CATmaker software;
- you can add your own CAT to our collection.

You might also like to check out what's going on at the University of Rochester, NY, USA, where Brett Robbins and his colleagues have a collection of CATs in various topic areas. Of course, not everyone is a CAT lover; some people prefer POEMs (Patient-Oriented Evidence that Matters).

To comment on this material, click the icon below:

Levels of Evidence and Grades of Recommendations

Levels of Evidence Footnotes & References Recent Comments Related material on Stud and Quality Filte

Introduction

What are we to do when the irresistible force of the need to offer clinical advice meets with the immovable object of flawed evidence? All we can do is our best: give the advice, but alert the advisees to the flaws in the evidence on which it is based.

The ancestor of this set of pages was created by Suzanne Fletcher and Dave Sackett 20 years ago when they were working for the Canadian Task Force on the Periodic Health Examination [1]. They generated "levels of evidence" for ranking the validity of evidence about the value of preventive manoeuvres, and then tied them as "grades of recommendations" to the advice given in the report.

The levels have evolved over the ensuing years, most notably as the basis for recommendations about the use of anti-thrombotic agents [2], have grown increasingly sophisticated [3], and have even started to appear in a new generation of evidence-based textbooks that announce, in bold marginal icons, the grade of each recommendation that appears in the texts [4] in bold icons.

However, their orientation remained therapeutic/preventive, and when a group of members of the Centre embarked on creating a new-wave house officers' manual (see the EBOC page), the need for levels and grades for diagnosis, prognosis, and harm became overwhelming and the current version of their efforts appears here. They are the work of Chris Ball, Dave Sackett, Bob Phillips, Brian Haynes, Sharon Straus, and Martin Dawes with lots of encouragement and advice from their colleagues.

Comments to this latest version are available. More are welcome as these continue to develop.

Periodic updates will appear here, and surfers are invited to suggest ways that they might be improved or further developed.

A final, cautionary note: these levels and grades speak only to the validity of evidence about prevention, diagnosis, prognosis, therapy, and harm. Other strategies, described elsewhere in the Centre's pages, must be applied to the evidence in order to generate clinically useful measures of its potential clinical implications and to incorporate vital patient-values into the ultimate decisions.

Oxford Centre for Evidence-based Medicine Levels of Evidence (May 2001)

Level	Therapy/Prevention, Aetiology/Harm	Prognosis	Diagnosis
1a	SR (with homogeneity*) of RCTs	SR (with homogeneity*) of inception cohort studies; CDR† validated in different populations	SR (with homogeneity*) of Level 1 diag studies from different clinical centres
1b	Individual RCT (with narrow Confidence Interval‡)	Individual inception cohort study with ≥ 80% follow-up; CDR† validated in a single population	Validating** cohort study with good††† tested within one clinical centre
1c	All or none§	All or none case-series	Absolute SpPins and SnNouts††
2a	SR (with homogeneity*) of cohort studies	SR (with homogeneity*) of either retrospective cohort studies or untreated control groups in RCTs	SR (with homogeneity*) of Level >2 dia
2b	Individual cohort study (including low quality RCT; e.g., <80% follow-up)	Retrospective cohort study or follow-up of untreated control patients in an RCT; Derivation of CDR† or validated on split-sample§§§ only	Exploratory** cohort study with good†† derivation, or validated only on split-sa
2c	"Outcomes" Research; Ecological studies	"Outcomes" Research	
3a	SR (with homogeneity*) of case-control studies		SR (with homogeneity*) of 3b and bett
3b	Individual Case-Control Study		Non-consecutive study; or without con
4	Case-series (and poor quality cohort and case-control studies§§)	Case-series (and poor quality prognostic cohort studies***)	Case-control study, poor or non-indepe
5	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical a bench research or "first principles"

Produced by Bob Phillips, Chris Ball, Dave Sackett, Doug Badenoch, Sharon Straus, Brian Haynes, Martin Dawes

since November 1998.

Notes

Users can add a minus-sign "-" to denote the level of that fails to provide a conclusive answer because of:

· EITHER a single result with a wide Confidence Interval (such that, for example, an ARR in an RCT is not statistically significant but whose confidence intervals fail to exclude clinically important benefit or harm)

· OR a Systematic Review with troublesome (and statistically significant) heterogeneity.

· Such evidence is inconclusive, and therefore can only generate Grade D recommendations.

*	By homogeneity we mean a systematic review that is free of worrisome variations (heterogeneity) in the directions and degrees of results be and not all worrisome heterogeneity need be statistically significant. As noted above, studies displaying worrisome heterogeneity should be t
†	Clinical Decision Rule. (These are algorithms or scoring systems which lead to a prognostic estimation or a diagnostic category.)
‡	See note #2 for advice on how to understand, rate and use trials or other studies with wide confidence intervals.
§	Met when all patients died before the Rx became available, but some now survive on it; or when some patients died before the Rx became a
§§	By poor quality cohort study we mean one that failed to clearly define comparison groups and/or failed to measure exposures and outcomes identify or appropriately control known confounders and/or failed to carry out a sufficiently long and complete follow-up of patients. By poor q exposures and outcomes in the same (preferably blinded), objective way in both cases and controls and/or failed to identify or appropriately
§§§	Split-sample validation is achieved by collecting all the information in a single tranche, then artificially dividing this into "derivation" and "valid
††	An "Absolute SpPin" is a diagnostic finding whose Specificity is so high that a Positive result rules-in the diagnosis. An "Absolute SnNout" is
‡‡	Good, better, bad and worse refer to the comparisons between treatments in terms of their clinical risks and benefits.
†††	Good reference standards are independent of the test, and applied blindly or objectively to applied to all patients. Poor reference standards a 'test' is included in the 'reference', or where the 'testing' affects the 'reference') implies a level 4 study.

††††	Better-value treatments are clearly as good but cheaper, or better at the same or reduced cost. Worse-value treatments are as good and mo
**	Validating studies test the quality of a specific diagnostic test, based on prior evidence. An exploratory study collects information and trawls t
***	By poor quality prognostic cohort study we mean one in which sampling was biased in favour of patients who already had the target outcom an unblinded, non-objective way, or there was no correction for confounding factors.
****	Good follow-up in a differential diagnosis study is >80%, with adequate time for alternative diagnoses to emerge (eg 1-6 months acute, 1 - 5

Grades of Recommendation

A	consistent level 1 studies
B	consistent level 2 or 3 studies ***or*** extrapolations from level 1 studies
C	level 4 studies ***or*** extrapolations from level 2 or 3 studies
D	level 5 evidence ***or*** troublingly inconsistent or inconclusive studies of any level

"Extrapolations" are where data is used in a situation which has potentially clinically important differences than the original study situation.

"Extrapolations" are where data is used in a situation which has potentially clinically important differences than the original study situation.

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Comment on Levels of Evidence 

Click here to comment on Levels of Evidence

Evidence-Based Medicine Glossary

This glossary is intended to provide guidance as to the meanings of EBM terms. If you would like to comment on any of the entries given, please be encouraged to do so.

Absolute Risk Reduction (ARR) is the difference in the event rate between control group (CER) and treated group (EER): ARR = CER - EER.

Case-control Study involves identifying patients who have the outcome of interest (cases) and control patients without the same outcome, and looking back to see if they had the exposure of interest. See also glossary of study designs.

Case-series is a report on a series of patients with an outcome of interest. No control group is involved.

CER Control Event Rate: see Event Rate.

Clinical Practice Guideline is a systematically developed statement designed to assist practitioner and patient make decisions about appropriate health care for specific clinical circumstances.

Cohort Study involves identification of two groups (cohorts) of patients, one which did receive the exposure of interest, and one which did not, and following these cohorts forward for the outcome of interest. See also glossary of study designs.

Cost-Benefit Analysis converts effects into the same monetary terms as the costs and compares them.

Cost-Effectiveness Analysis converts effects into health terms and describes the costs for some additional health gain (e.g. cost per additional MI prevented).

Cost-Utility Analysis converts effects into personal preferences (or **utilities**) and describes how much it costs for some additional quality gain (e.g. cost per additional

quality-adjusted life-year, or QALY).

Crossover Study Design: the administration of two or more experimental therapies one after the other in a specified or random order to the same group of patients.

Cross-Sectional Study the observation of a defined population at a single point in time or time interval. Exposure and outcome are determined simultaneously. See also glossary of study designs. **Decision Analysis** is the application of explicit, quantitative methods to analyse decisions under conditions of uncertainty.

Ecological Survery: based on aggregated data for some population as it exists at some point or points in time; to investigate the relationship of an exposure to a known or presumed risk factor for a specified outcome.

EER Experimental Event Rate: see Event Rate.

Event Rate is the proportion of patients in a group in whom an the event is observed. Thus, if out of 100 patients, the event is observed in 27, the event rate is 0.27. Control Event Rate (CER) and Experiemental Event Rate (EER) are used to refer to this in control and experimental groups of patients respectively.

Evidence-Based Health Care extends the application of the principles of Evidence-Based Medicine (see below) to all professions associated with health care, including purchasing and management.

Evidence-Based Medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise wi th the best available external clinical evidence from systematic research. See also the article on EBM: What it is and what it isn't

Likelihood Ratio is the likelihood that a given test result would be expected in a patient with the target disorder compared to the likelihood that the same result would be expected in a patient without that disorder. See also Calculating Sensitivity and Specificity and on samples of Likelihood Ratios.

Meta-analysis is an overview which uses quantitative methods to summarise the results.

N-of-1 Trials The patient undergoes pairs of treatment periods organised so that one period involves the use of the epxerimental treatment and one period involves the use of an alternate or placebo therapy. The patients and physician are blinded, if possible, and outcomes are monitored. Treatment periods are replicated until the clinician and patient are convinced htat the treatments are definitely different or definitely not different.

Negative Predictive Value (-PV) is the proportion of people with a negative test who

are free of disease. See also Calculating Sensitivity and Specificity.

Number Needed to Treat (NNT) is the number of patients who need to be treated to prevent one bad outcome. It is the inverse of the ARR:

$$NNT = 1/ARR.$$

See also section on NNTs.

Odds are a ratio of events to non-events. If the event rate for a disease is 0.1 (10 per cent), its nonevent rate is 0.9 and therefore its odds are 1:9, or 0.111. Note that this is not the same expression as the inverse of event rate.

Odds Ratio describes the odds of an experimental patient suffering an adverse event relative to a control patient. See also section on Odds Ratios.

Overview is a systematic review and summary of the medical literature.

Positive Predictive Value (+PV) is the proportion of people with a positive test who have disease. See also Calculating Sensitivity and Specificity.

Randomised Controlled Clinical Trial a group of patients is randomised into an experimental group and a control group. These groups are followed up for the variables / outcomes of interest. See also glossary of study designs.

Relative Risk Reduction (RRR) is the percent reduction in events in the treated group event rate (EER) compared to the control group event rate (CER):

$$RRR = (CER - EER) / CER * 100$$

Risk Ratio is the ratio of risk in the treated group (EER) to the risk in the control group (CER): RR = EER/CER. RR is used in randomised trials and cohort studies.

Sensitivity is the proportion of people with disease who have a positive test. See also Calculating Sensitivity and Specificity.

SnNout when a sign/test has a high **s**e**n**sitivity, a **n**egative result rules **out** the diagnosis; e.g. the sensitivity of a history of ankle swelling for diagnosing ascites is 92 per cent, therefore is a person does not have a history of ankle swelling, it is highly unlikely that the person has ascites. See also section on SpPins and SnNouts.

Specificity is the porportion of people free of a disease who have a negative test. See also Calculating Sensitivity and Specificity.

SpPin when a sign/test has a high **sp**ecificity, a **P**ositive result rules **in** the diagnosis; e.g. the specificity of fluid wave for diagnosing ascites is 92 per cent. Therefore, if a person has a fluid wave, it is highly likely t hat the person has ascites. See also section on SpPins and SnNouts.

 Click here to comment on the glossary. We especially welcome suggestions for new entries and debates about existing ones!

CEBM Downloads

Now, we've got lots of lovely stuff here on our site, just a mouse-click away. Note, however, that we've changed the download format so that it doesn't use FTP. This means that your browser might try to open these files automatically when you download them. We recommend that you:

1. right-click on the link you want (or click-and-hold if you're a Mac user),
2. select **Save Target As**.. from the menu,
3. save the files where you like on your file system and
4. scan 'em with your anti-virus software.

Of course, we've made every effort to ensure that these resources are virus-free, but you can't be too careful.

So anyway, here are the goodies:

Critical Appraisal Tools

- Educational Prescription (RTF)
- Levels of Evidence
- Worksheets (RTF); also available as PDF
- Calculator for Confidence Intervals around the Difference between Two Proportions (Microsoft Excel), by Dan Tandberg

CATmaker:

- CATnipper demo (3MB, PC)
- CATnipper demo (3MB, Mac; pending an update for MacOS 9 and X)
- Instructions (RTF)
- Order form (PDF)

PowerPoint Presentations:

- Introduction to EBM, (1MB) by Martin Dawes
- Critical Appraisal of Therapy, by Bob Phillips
- Critical Appraisal of Systematic Reviews, by Douglas Newberry
- Decision Analysis, by Martin Dawes
- Economic Analysis, by Ken Stein
- David Sackett's collated PowerPoint presentations on The Need for EBM (2MB

Winzip file)

Workshop Application Forms:

- Practising EBM, April 2002 (PDF)
- Teaching EBM, July 2002 (PDF)

If the stuff you're after isn't here, either it doesn't exist or I've forgotten to transfer it from the old FTP site. If the latter, email me with a gentle reminder at badenoch@cebm.jr2.ox.ac.uk

Abbreviations:

MB	Megabytes - or millions of bytes. I've included the file size only where it's so big that those of you connecting via 28k modem might want to go off and make a cup of tea, grow a beard or re-train as a software compression engineer while the file is downloading.
PDF	Page Description Format - you know, the Adobe Acrobat type thing. If your computer can't make sense of the file, you need to go to www.adobe.com and install their (free) Acrobat Reader, which will take ages so we've provided RTFs where possible.
RTF	Rich Text Format - any old word processing program can open these, even some emailers like Outlook

University of York NHS Centre for Reviews and Dissemination

CRD Publications

Publications 

The existence of good research evidence does not ensure that it is used in practice, and an active approach to dissemination is required. The majority of the CRD's dissemination activity involves raising awareness of messages from research and aims to provide important information in an easily accessible form. CRD uses a range of methods in collaboration with relevant health professionals and organisations to promote implementation.

In addition to the CRD databases, the core dissemination products which the Centre uses to raise awareness are printed reports and series which are distributed within the NHS. Findings from research are also published as journal articles etc.

- CRD Reports
- Effectiveness Matters
- Effective Health Care bulletins - Full Text now available from Vol.2(1)

- Alphabetical list of CRD publications

- Other CRD staff publications 2001

For further information on all CRD publications, or to obtain copies of CRD Reports and *Effectiveness Matters* contact:

The Publications Office
NHS Centre for Reviews and Dissemination
University of York
York
YO10 5DD

Tel: 01904 433648/434565
Fax: 01904 433661
E-mail: crdpub@york.ac.uk

To obtain copies of *Effective Health Care* bulletins, contact:

Publications Subscription Department
The Royal Society of Medicine Press Ltd.
PO Box 9002
London
W1A OZA

Tel: +44 (0)171 290 2927/8
Fax: +44 (0)171 290 2929

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Systematic Reviews

reviews image 

- About systematic reviews
- CRD Reviews (Completed) - details of completed systematic reviews carried out or commissioned by CRD
- CRD Reviews (In Progress) - details of ongoing systematic reviews carried out or commissioned by CRD
- Ongoing reviews initiative - CRD initiative to establish a register of ongoing systematic reviews
- CRD guidelines for carrying out or commissioning systematic reviews
- Search strategies to identify systematic reviews and meta-analyses in Medline and CINAHL
- Training and advice on systematic reviews etc.

Information Resources

- **Finding studies for systematic reviews: a basic checklist for researchers**
  Suggests some key sources to search, and advises on information tools which may yield further sources of information when identifying studies for a systematic review.
  Available to download in Word 97 and Word 6.0 for MS-DOS, or view in HTML
- **Health Technology Assessment: databases and research registers**
  List of health technology assessment resources, including information on how to locate completed and ongoing HTA research. View in HTML
- **Information Resources in Health Economics**
  Details of sources of information in health economics. Click here for details of this document in Word and HTML formats.

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Dissemination

dissemination 

The main aim of NHS CRD's dissemination activity is to make NHS staff and service users aware of the results of high quality systematic reviews. The research evidence comes from three sources:

- systematic reviews undertaken or commissioned by NHS CRD
- systematic reviews produced by the Cochrane Collaboration
- high quality reviews undertaken elsewhere, which are of particular clinical or health service significance

Centre staff summarise and disseminate the research findings from good quality systematic reviews in brief and user-friendly formats, such as CRD's Effectiveness Publications *Effective Health Care* and *Effectiveness Matters*. More detailed academic papers are published in journals and as CRD reports.

We use a variety of channels to communicate information including:

- NHS CRD web pages, plus other internet and intranet sites
- the media (radio, TV, newspapers etc)
- professional journals and magazines
- conferences and seminars
- networking in the NHS and associated agencies

In addition, a wide range of activities are undertaken by dissemination staff at NHS CRD, including advising on dissemination, providing a publications service, supporting evidence-into-practice initiatives, developing information materials for patients, publicising the work of the Centre, organising training and conferences and co-ordinating the NeLH 'Hitting the Headlines' series.

Contact the Dissemination Team

Click here for the CRD home page

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University of York NHS Centre for Reviews and Dissemination

Introduction to CRD

About CRD

About CRD

The NHS Centre for Reviews and Dissemination (CRD) was established in January 1994 to provide the NHS with important information on the effectiveness of treatments and the delivery and organisation of health care.

CRD, by offering rigorous and systematic reviews on selected topics, a database of good quality reviews, a dissemination service and an information service, helps to promote research based practice in the NHS.

Within the NHS R&D programme, CRD is a sibling organisation of the UK Cochrane Centre. The UK Cochrane Centre is part of an international network, the Cochrane Collaboration, committed to preparing, maintaining and disseminating systematic reviews of research on the effects of health care. CRD plays an important role in disseminating the contents of Cochrane reviews to the NHS.

CRD is a member of the Alcuin Collaboration a network of academic departments and research centres at the University of York concerned with teaching, research and consultancy in health and public policy.

CRD collaborates with a number of health research and information organisations across the world and is a UK member of the International Network of Agencies for Health Technology Assessment (INAHTA). CRD produces a database of HTA projects and publications.

INAHTA

What does CRD do?

- Undertakes and commissions credible, rigorous reviews of research findings on the effectiveness of health care relevant to the NHS.
- Liaises with NHS decision makers to prioritise reviews and in particular the questions addressed in

reviews.

- Aims to help raise the general standard of reviews carried out for the NHS.
- Collaborates in conducting research into methods of reviewing the literature.
- Disseminates the results of research to NHS decision makers.
- Encourages research-based practice in the NHS by networking with health care professionals.
- Collaborates in conducting research into ways in which research evidence can be better disseminated and implemented.
- Maintains databases of abstracts of good quality reviews of health research, abstracts of economic evaluations of health, and health technology assessments.
- Provides an information and enquiry service on reviews and economic evaluations for health care professionals, purchasers and providers, NHS managers, information providers, health service researchers and consumer organisations.
- Conducts research into providing health service users with research-based information on the effectiveness of health care.

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Information & Enquiry Service

information service 

Enquiry Service

The Information Service provides a **free** enquiry service about systematic reviews and economic evaluations.

Telephone	01904 433707 (9am - 5.15pm, Monday - Friday)
Fax	01904 433661
E-mail	nhscrd-info@york.ac.uk

We can provide information to healthcare professionals, researchers, managers and information workers on the results of systematic reviews of research and economic evaluations, in subjects related to healthcare interventions and the organisation and delivery of health services.

Typical questions you might ask us could include:

- How do I go about searching for systematic reviews on healthcare databases?
- Do you have any data on the cost effectiveness of screening programmes for cancer?
- Is there any research evidence that zidovudine is an effective treatment for HIV/AIDS?
- Is CRD doing a review on diabetes? Is anyone else in the UK reviewing diabetes care?
- What evidence is there to show that health promotion can help prevent illegal drug use in young people?
- What is a systematic review exactly? Can you give any guidance on how to go about doing such a review?
- Do you have any information on methods of applying cost-benefit analysis?
- Does CRD publish the systematic reviews that it produces? If so, how can I get them?

CRD Databases

The Information Service acts as the helpdesk for the CRD databases (DARE, NHS Economic Evaluation Database and the HTA database) and any problems accessing these should be reported to us. If you do not have access to the databases, the Information Service will undertake searches for you.

We will do our best to help enquirers, but if unable to assist we will try to direct you to other possible sources of information or other organisations.

Information Resources

- **Finding studies for systematic reviews: a basic checklist for researchers**
  Suggests some key sources to search, and advises on information tools which may yield further sources of information when identifying studies for a systematic review.
  Available to download in Word 97, Word 6.0 for MS-DOS and Word 6.0/95, or view in HTML
- **Health Technology Assessment: databases and research registers**
  List of health technology assessment resources, including information on how to locate completed and ongoing HTA research. View in HTML
- **Information Resources in Health Economics**
  Details of sources of information in health economics. Click here for details of this document in Word and HTML formats.

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Click here to search the CRD databases

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Cost-effectiveness Information

money 

* **NHS Economic Evaluation Database**

CRD produces the NHS Economic Evaluation Database, which provides access to detailed structured abstracts for economic evaluations of healthcare interventions. The database is available free of charge online via the internet.
Click here for further information or to search the NHS Economic Evaluation Database

* **CRD Report:**

Improving access to cost-effectiveness information for health care decision-making: the NHS Economic Evaluation Database
(CRD Report 6; 2nd Edition 2001)

* **Information Resources in Health Economics**

Details of sources of information in health economics.
Includes health care financing and expenditure in the UK; comparative health care; costs of care; databases; journals; the world wide web; organisations; health economists, e-mail discussion lists and bibliographies.
Available to download in Word 97 and Word 6.0 for MS-DOS, or view in HTML.

* **Distance Learning Course**

Health Economics for Health Care Professionals
Designed for those working in the health care sector who wish to gain an accredited qualification in health economics, but who are unable to study full time at an academic institution. The programme is a collaboration between three centres at the University of York - the Department of Economics and Related Studies, the Centre for Health Economics, and the York Health Economics Consortium.
The programme will be available to residents of the United Kingdom and the European Union in the academic year starting Autumn 2001.

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NHS Centre for Reviews and Dissemination; University of York

CRD and the Cochrane Library

CRD has a responsibility in the UK for disseminating the Cochrane Library and its content. The Information Service at CRD has been providing training to interested groups of health/medical librarians, clinical audit groups and effectiveness leads since the beginning of 1998, and have been involved in establishing the UK branch of the Cochrane Library Users' Group. These web pages support these two activities and provide further information.

* **Cochrane Library Training**

Information on UK training, and support materials for the Cochrane Library

* **Cochrane Library Users' Group**

Information on the aims and activities of the UK Users' Group

Click here for the CRD Homepage

Last updated: February 2002

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Useful Links

links 

This is a collection of links to other organisations involved in systematic reviews, health technology assessment and evidence-based health care. Links to useful NHS Research and Development and other health related internet sites are also provided.

The Cochrane Collaboration
Evidence Based Healthcare
NHS and Department of Health sites
Health Technology Assessment
Internet Resources for Medicine and Health Care

See also:
Finding studies for systematic reviews: a basic checklist for researchers
Information resources in health economics

The Cochrane Collaboration

The Cochrane Library

Online Access to the Cochrane Database of Systematic Reviews. (Subscription Required)

The Cochrane Collaboration. The Cochrane Collaboration facilitates the creation, review, maintenance and dissemination of systematic reviews of the effects of health care. This site provides an extensive overview about the Collaboration including info on the Cochrane Database of Systematic Reviews (CDSR), a full text Cochrane Collaboration Handbook and details of the worldwide Cochrane Centres, including the UK Cochrane Centre.

The Cochrane Library: a self-training guide. The training guide includes an introduction to the definition and value of systematic reviews, the work of the Cochrane Collaboration and NHS Centre for Reviews and Dissemination, a pictorial guide to the databases on the electronic library with simple exercises to encourage the user to explore parts of the system, an explanation of odds-ratios and how to interpret an odds-ratio diagram and sample exercises in interpreting odds-ratios for three specific

reviews. Model answers are provided.

Cochrane Effective Practice and Organisation of Care Group (EPOC). Formerly known as Cochrane Collaboration on Effective Professional Practice

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Evidence-based Healthcare

ARIF (Aggressive Research Intelligence Facility).
A NHS Executive West Midlands funded specialist unit based at the University of Birmingham to help health care workers in the West Midlands access and interpret research evidence in response to particular problems. The WWW pages provide useful information on problems previously submitted to ARIF and their response.

Bandolier. Full text of the evidence-based health care newsletter.

Centre for Evidence-Based Child Health. Based at the Institute of Child Health, the aim of the Centre is to increase the provision of effective and efficient child health care through an educational programme for health professionals.

Centre for Evidence-Based Dentistry. Established at the Institute of Health Sciences in Oxford to promote the teaching, learning, practice, and evaluation of Evidence-Based Dentistry.

Centre for Evidence-Based Medicine. The Centre for Evidence-Based Medicine was established in Oxford to promote the teaching, learning, practice and evaluation of evidence-based health care. This site includes information on courses, research, teaching materials and other EBM resources.

Centre for Evidence-Based Mental Health. Contains a range of resources to promote and support the teaching and practice of evidence-based mental healthcare including OXAMWEB (links to evidence-based mental health web sites), toolkit of teaching resources, details of workshops, conferences etc.

Centre for Evidence-Based Nursing. Based at the University of York, the Centre for Evidence-Based Nursing works with nurses in practice, other researchers, nurse educators and managers to identify evidence-based practice through primary research and systematic reviews. The Centre is also researching factors which promote or impede the implementation of evidence-based practice.

Centre for Evidence-Based Pharmacotherapy. Set up in July 1995 to undertake research in the methodology of medicines assessment, pharmacoepidemiology and pharmacoeconomics, and to undertake such studies.

Evidence-Based Child Health Unit Conducts systematic reviews/literature reviews in areas relevant to the Royal Liverpool Children's NHS Trust and provides training in

evidence-based practice to any health care professional of any discipline involved in research or practice

Evidence-Based Librarianship

Evidence-Based Medicine Education Center of Excellence. Provides collection of resources that support teaching and learning EBM for faculty, librarians, students and other health care professionals.

Health Development Agency (HDA) Evidence Base web site and database. Gateway site which contains high-quality links to public health evidence and evidence-based web-sites, and a growing database of research and resources, aimed at public health professionals. To be developed over 2001.

Health Evidence Bulletins - Wales. Act as signposts to the best current evidence across a broad range of evidence types and subject areas. Bulletins are currently available on: Maternal and early child health; Respiratory diseases; Cardiovascular diseases; Injury prevention; Mental health; Oral health.

Health Information Research Unit. The Health Research Information Unit at McMaster University (including the Canadian Cochrane Centre and the ACP Journal Club) is dedicated to the generation of new knowledge about the nature of health and clinical information problems, the development of new information resources to support evidence-based health care and the evaluation of various innovations in overcoming health care information problems.

Institute for Clinical Evaluative Sciences in Ontario. A non-profit research organization dedicated to conducting research that contributes to the effectiveness, quality and efficiency of health care. Includes information about ICES clinical and medical research plus selected articles from *Informed*, ICES newsletter (similar to Bandolier).

MeReC Publications. Clear, concise and evaluated information on medicines and prescribing related issues based on the best available evidence. The comprehensive literature reviews concentrate mainly on current clinical and therapeutic issues chosen principally to provide support to primary care professionals. Produced by the National Prescribing Centre.

National Information Center on Health Services Research and Health Care Technology (NICHSR). The NICHSR was created at the National Library of Medicine to improve the collection, storage, analysis, retrieval and dissemination of health services research, clinical practice guidelines and health care technology assessment. Includes access to HSTAT (Health Services/Technology Assessment Texts), a fulltext database for clinical practice guidelines including those supported by the AHCPR and DIRLINE, an NLM database of organisations including those involved in technology assessment and practice guidelines development.

Pain Relief Unit at Oxford Radcliffe Hospital.

Includes a listing of 100+ systematic reviews/meta-analyses in pain relief.

PRODIGY
Computerised clinical decision support system for UK general practice. Funded by the NHS Executive.

Scottish Intercollegiate Guidelines Network (SIGN). SIGN develops and publishes evidence-based clinical practice guidelines for use by the health service in Scotland. The site contains the guidelines themselves, plus additional information about SIGN and its activities.

Systematic Reviews Training Unit
Funded by the NHS Executives for North and South Thames and based at the Institute of Child Health, the main aim of the SRTU is to train health professionals in the conduct of systematic reviews

TRIP (Turning Research Into Practice) Searchable database of hypertext links to evidence based material

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NHS and Department of Health sites

Department of Health
R & D in the Department of Health and NHS Executive
Submit your views on the Department of Health website

National Electronic Library for Health (NeLH)
Includes Primary Care NeLH site

National Research Register (NRR).
Register of ongoing and recently completed research projects funded by the NHS

NHS website

NHS Direct

NHS Executive Eastern R&D

NHS Executive North Thames R&D

NHS Executive North West R&D

NHS Executive Northern & Yorkshire R&D

NHS Executive South & West R&D.

NHS Executive Trent R&D

NHS Executive West Midlands R&D

NHS Service Delivery and Organisation (SDO) Programme

NICE - National Institute for Clinical Excellence

Health Technology Assessment

Health Technology Assessment on the Net: a guide to Internet sources of information. A joint publication between AHFMR and the Institute of Health Economics.

L'Agence Nationale pour le Developpement de l'Evaluation Medicale (ANDEM). Information on research projects conducted by ANDEM (in French).

Agency for Health Care Research and Quality. US agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. Includes information on research programme, clinical guidelines and health technology assessments. Also publications, press releases and the AHRQ *Research Activities* newsletter.

Alberta Heritage Foundation for Medical Research. AHFMR supports medical and health research at Alberta universities, affiliated institutions, and other medical and technology related institutions. Assessment of medical therapies, devices and practices is performed by the AHFMR Technology Assessment program. This site provides information on ongoing resaerch projects and publications.

British Columbia Office of Health Technology Assessment BCOHTA conducts research and provides consultative expertise health care decision-makers at all levels regarding questions on health technology utilization and implementation. Information on research activites and publications is provided.

Canadian Coordinating Office for Health Technology Assessment. Information about CCOHTA including ongoing internal and commissioned projects and a forum for sharing HTA research news. Includes some full-text publications.

Catalan Agency for Health Technology Assessment. Includes information about publications, ongoing projects and other aspects of CAHTA.

Danish Institute for Health Services Research and Development. Information on

projects and publications (in Danish).

Finnish Office for Health Care Technology Assessment. Extensive information about FINOHTA, including their TA-Info newsletters, in Finnish. More limited information in English.

Health Technology Board for Scotland. Created as a new special Health Board, and came into existence on 1 April 2000. (Previously known as the Scottish Health Technology Assessment Centre.)

International Network of Agencies for Health Technology Assessment (INAHTA). INAHTA consists of a network of non-profit organisations involved with health technology assessment. The Secretariat is currently based at SBU.

International Society of Technology Assessment in Health Care (ISTAHC). (ISTAHC) is one of the world's leading scientific and educational societies in the area of health technology assessment. It is a nonprofit organization established to encourage research, education, cooperation and the exchange of information on the clinical, economic and social implications of health technologies. The Society is an international forum for those concerned with evaluation of health technology. It endeavors to stimulate scientifically based assessment activity in government and the private sector and thereby foster the optimal and appropriate use of health technologies.

Medical Technology and Practice Patterns Institute. MTPPI is a non-profit organisation established to conduct research on the clinical, economic and social implications of new and emerging health care technologies.

Medicare Services Advisory Committe (MSAC). Evidence-based health care in Australia.

National Coordinating Centre for Health Technology Assessment. Information regarding the NHS R&D Health Technology Assessment Programme including details of prioritised topics, commissioned research and full-text Executive Summaries of completed HTA Programme research projects.

New Zealand Health Technology Assessment - Clearing House for Health Outcomes and Health Technology Assessment (NZHTA) Contains information on NZHTA reports, INAHTA members and projects and other related links.

Office of Technology Assessment. Includes the full-text of US Congressional OTA (which closed September 1995) reports and publications including a number focussing on health and health technology.

RAND Corporation. RAND is a US-based nonprofit institution that aims to improve public policy through research and analysis. RAND aims to carry out high-quality, objective research addressing problems of domestic policy including health care. RAND has been studying health care issues for more than thirty years. Today, RAND conducts

one of the largest private, nonprofit programs of health policy research and analysis in the world. They publish numerous reports and other documents in areas of health care technology assessment.

SBU. Swedish Council on Technology Assessment in Health Care. SBU's task is to evaluate methods used within health care and to look critically at their costs, risks and benefits. SBU assesses the medical, ethical, social and economic impact of new and established medical procedures. This site provides background information on SBU together with details of reports, ongoing projects and the SBU newsletter.

TNO Prevention and Health.Information on the research activities of TNO Prevention and Health, including the Technology in Health Care division.

Internet Resources for Medicine and Health Care

King's Fund. Access to the site of the King's Fund, London, which aims to influence health policy and promote good practice in health and social care. Activites include policy research, service development and audit programmes, grant-giving, and information and education services for people working in and with the health service.

National Electronic Library for Health (NeLH). The role of the NeLH is to provide health care professionals and the public (through NHS Direct Online and the New Library Network) with knowledge and know-how to support health care related decisions.

Netting the Evidence: A SCHARR Introduction to Evidence Based Practice on the Internet. A comprehensive listing of links relevant to evidence-based healthcare produced by the Sheffield School of Health and Related Research. Includes links to organisations, journals, statistical software tools and other evidence-based healthcare links pages.

NMAP. Gateway to evaluated, quality Internet resources in nursing, midwifery and allied health professions, aimed at students, researchers, academics and practitioners.

OMNI. A gateway to Internet resources in medicine, biosciences, allied health and health management. Provides comprehensive coverage of UK resources in this area and access to the best resources worldwide. All resources entered into OMNI have been assessed for quality and are reviewed regularly.

Last updated January 2002

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Effective Health Care bulletins are based on a systematic review and synthesis of research on the clinical effectiveness, cost-effectiveness and acceptability of health service interventions. This is carried out by a research team using established methodological guidelines, with advice from expert consultants for each topic. The bulletins are subject to extensive and rigorous peer review.

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Volume 7 (2001-2002).

1. Effectiveness of laxatives in adults - [full text]
2. Acupuncture - [full text] - [data extraction tables]
3. Homeopathy - [full text] - [data extraction tables]

Volume 6 (2000).

1. Complications of diabetes: renal disease and promotion of self-management
2. Promoting the initiation of breastfeeding
3. Psychosocial interventions for schizophrenia
4. Management of upper gastro-intestinal cancers

5. Acute and chronic low back pain
6. Informing, communicating and sharing decisions with people who have cancer

Volume 5 (1999).

1. Getting evidence into practice.
2. Dental restoration: what type of filling?
3. Management of gynaecological cancers.
4. Complications of diabetes: screening for retinopathy; management of foot ulcers.
5. Preventing the uptake of smoking in young people.
6. Drug treatments for schizophrenia.

Volume 4 (1998).

1. Cholesterol and coronary heart disease: screening and treatment.
2. Pre-school hearing, speech, language and vision screening.
3. Management of lung cancer.
4. Cardiac rehabilitation. - Erratum
5. Antimicrobial prophylaxis in colorectal surgery.
6. Deliberate self-harm.

Volume 3 (1997).

1. Preventing and reducing the adverse effects of unintended teenage pregnancies.
2. The prevention and treatment of obesity.
3. Mental health promotion in high risk groups.
4. Compression therapy for venous leg ulcers.
5. Management of stable angina.
6. The management of colorectal cancer.

Volume 2 (1995-1996).

1. The prevention and treatment of pressure sores.
2. Benign prostatic hyperplasia: treatment for lower urinary tract symptoms in older men.
3. Management of cataract.
4. Preventing falls and subsequent injury in older people.
5. Preventing unintentional injuries in children and young adolescents.
6. Management of primary breast cancer.
7. Total hip replacement.
8. Hospital volume and health care outcomes, costs and patient access.

Volume 1 (1992-1995).

1. Screening for osteoporosis to prevent fractures.
2. Stroke rehabilitation.
3. The management of subfertility.

4. The treatment of persistent glue ear in children.
5. The treatment of depression in primary care.
6. Cholesterol: screening and treatment.
7. Brief interventions and alcohol abuse.
8. Implementing clinical practice guidelines.
9. Management of menorrhagia.

Effective Health Care is produced by CRD and published by The Royal Society of Medicine Press Ltd.

All orders and enquiries regarding subscriptions for *Effective Health Care* should be addressed to:

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Enquiries concerning the content of *Effective Health Care* should be addressed to CRD.

Click here for lists of completed systematic reviews and reviews in progress

CRD home page

CRD Publications

The Royal Society of Medicine

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University of York NHS Centre for Reviews and Dissemination

Improving access to cost-effectiveness information for health care decision making: the NHS Economic Evaluation Database

CRD Report Number 6 (2nd Edition)

May 2001

Click on the links below to view each section of the report in pdf format. You will need a copy of Adobe Acrobat Reader®. Go to the Adobe web site to download a free copy of Acrobat Reader®.

To purchase a copy of this report (price £9.50), please contact the CRD Publications Office

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Evidence from Systematic Reviews of Research Relevant to Implementing the 'Wider Public Health' Agenda

Report to be cited as:
Contributors to the Cochrane Collaboration and the Campbell Collaboration. *Evidence from systematic reviews of research relevant to implementing the 'wider public health' agenda*. NHS Centre for Reviews and Dissemination http://www.york.ac.uk/inst/crd/wph.htm August 2000.

Printed copies of the report are available on request from the CRD Publications Office (Price £20.00).

This report has been divided into sections which are available to download in PDF, Microsoft Word 97 and HTML formats, To view the PDF files you will need a copy of Adobe Acrobat Reader® (Version 4.0). Go to the Adobe web site for information about downloading a free copy of Acrobat Reader®.

This report has been organised according to policies listed in Appendix 1 of the White Paper *Saving Lives - Our Healthier Nation*.

Please ensure you have read the Introduction before accessing the individual chapters, as it contains important information on the content and organisation of the report.

CHAPTER	PDF	Word	HTML
Introduction Introduction, materials and methods, contents and acknowledgements	PDF file	Word 97 file	-
A National Contract on Cancer *Cochrane Cancer Network*: Allison Hirst, Sally Hunt, Mark Lodge and Chris Williams Contents	PDF file	Word 97 file	html file

A National Contract on Coronary Heart Disease and Stroke *Cochrane Heart Group*: Karen Rees, Debbie A Lawlor and Shah Ebrahim *Cochrane Stroke Group*: Jonathan Mant Contents	PDF file	Word 97 file	html file
A National Contract on Accidents *Cochrane Injuries Group*: Frances Bunn, Ian Roberts and Carolyn DiGiuseppi Contents	PDF file	Word 97 file	html file
A National Contract on Mental Health *Cochrane Schizophrenia Group*: Clive Adams and Simon Gilbody *Cochrane Depression, Anxiety and Neurosis Group*: Simon Wessley (with input from Philip Davies, Geraldine Macdonald and Anthony Petrosino) Contents	PDF file	Word 97 file	html file
Education *Campbell Education Group*: Philip Davies and Lizi Holmes Contents	PDF file	Word 97 file	html file
Social Care and Social Welfare *Cochrane Psychological, Developmental and Learning Problems Group*: Geraldine Macdonald, Jane Dennis and Margaret Burke Contents	PDF file	Word 97 file	html file
Crime, Drugs and Alcohol *Campbell Crime and Justice Group*: Anthony Petrosino Contents	PDF file	Word 97 file	html file
Appendix 1: Search Strategies *NHS Centre for Reviews and Dissemination*: Julie Glanville and Kate Misso	PDF file	Word 97 file	-
Appendix 2: References to all systematic reviews cited in this report	PDF file	Word 97 file	html file

This report was funded by the NHS Executive, but the choice and format of the contents is the sole responsibility of the editors and contributors.

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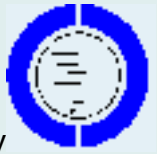
Cochrane Library Training

Cochrane Library 

CRD Training Programme

CRD has responsibility for disseminating the Cochrane Library around the UK and has been organising and conducting training since the beginning of 1998. Training has been provided for librarians, audit and clinical effectiveness leads and other people who have responsibility for disseminating this important resource around their organisations. The intention has been to train individuals who can go on to disseminate it to other people locally.

Kate Light has been appointed as the new trainer, if you are interested in attending a course she can be contacted on (01904) 433656, email: kl9@york.ac.uk.

For more information on the possible structure of Cochrane Training sessions click here.

For more information on dates currently available for training sessions in York and London click here.

Cochrane Library Materials: 2002 Issue 1

To help with further dissemination of the Cochrane Library, materials have been developed in two forms; guides and training materials, which are available to download from this site. The training materials would be particularly useful for those who have previously attended a training course on the Cochrane Library, but who now have the responsibility for training others.

Since mid-1998, the Cochrane Library has also been available via the Web. The materials available here mainly cover the CD-Rom version, but Part (2) of the Self-training guide has been adapted for the web version, and should be used in conjunction with Parts (1) and (3) of the CD-Rom guide. Where other hosts are used to access parts of the Cochrane Library (for example, accessing CDSR as part of Ovid's 'Evidence Based Medicine Reviews') the guides might be of use with background information and in particular, interpreting the odds-ratio diagrams.

All the materials from this page can be freely downloaded and copied.

Acknowledgement of the source of these as CRD would be appreciated. **Before downloading any of the materials, we would be grateful if you could leave your details and let us know how you plan to use the materials, by filling in this form**.

CD-ROM VERSION

Type	Description	Audience	Files
Self-training guide	In 3 sections: 1) Introduction: systematic reviews and the Cochrane Collaboration 2) Searching the CLib 3) Understanding the odds-ratio diagrams	An in-depth self teaching guide	PDF files (3 files) Download Introduction Download Searching Download Odds ratios
A4 guide	Brief introduction to searching the CLib	Brief handout to adapt to house style guides	Word 97 Download A4 Guide
Teaching pack	A set of PowerPoint slides showing CLib screens with brief speakers notes. Download to your computer and then open file.	For those who are unable to give an on-line demonstration of the CLib.	PowerPoint. Download Teaching Pack
Teaching pack	A set of PowerPoint slides on background information to the CLib. Other material would be needed. Download to your computer and then open file.	Supplementary material for training sessions	PowerPoint. Download Teaching Pack

Teaching guide	A Word document outlining subjects and facts to include at various stages of a CLib training session.	.	PDF file Download the teaching guide
Quiz questions	Quick questions for trainees to attempt to answer.	Supplementary material for training sessions.	PDF file Download the CLib quiz
Example questions	Questions for trainees to answer.	Supplementary material for training sessions.	PDF file Download example questions

WEB VERSION

Type	Description	Audience	Files
Self-training guide	Section (2) Searching the CLib - adapted for the web version of the CLib.	To be used in conjunction with sections (1) and (3) from the self-training guide for the CD-Rom CLib above.	PDF file Download web searching
A4 guide	Brief introduction to using the CLib	Brief handout for users to adapt to house style guides.	Word 97 file Download A4 Guide

Example questions	Questions for trainees to answer updated for the web version of the CLib.	Supplementary material for training sessions.	PDF file Download the CLib quiz

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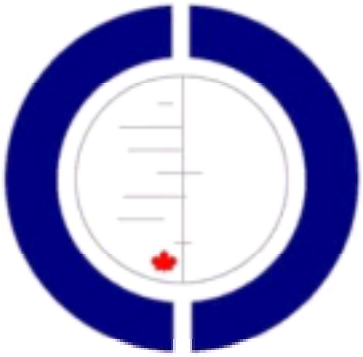

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This page was last updated on 2002-01-11 by Daren Spithoff

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www.freemedicaljournals.com

SCIENCE VOL 293 24 AUGUST 2001 1407

Introduction

The main purpose of the **Directory of Electronic Health Sciences Journals** is to assist Health Sciences Librarians manage electronic journals in their libraries. The philosophy taken is that librarians should have both easy access to information about electronic journals, and be in control of managing these resources in their libraries. Information on how to use each section found in the Directory is provided below.

Using the A-Z Listings of Journals by Title

Librarians armed with an alphabetical list of their current institutional print journal subscriptions can, by working through the A-Z listings on the homepage, determine if electronic versions of their journal titles exist. Each journal title found will have a corresponding detailed information table, such as :

Journal Name :	**Cancer**
Journal Web Address :	**http://www3.interscience.wiley.com/cgi-bin/jtoc?ID=28741**
Full-text Content :	**Full-text available**
Price Category :	**Online access provided with institutional print subscription**
Full-text from :	v. 79 (1) Jan 1997 -
Indexed in Medline :	Yes
Association :	American Cancer Society
Publisher :	John Wiley Sons, Inc.

Please note : this information was last updated on the **15/11/99**. Please check the above Journal Web Address for changes to this information.

Starting below the Journal Name are found the following sections :

Journal Web Address :	**http://...**

The **Journal Web Address** will generally direct you to the publisher's online journal homepage, if one exists. If this site does not provide full-text content, availability of full-text from a third party or commercial provider will sometimes be provided in the Notes section.

Full-text Content :	**Full-text Available**

The possible **Full-text Content** categories include :

Full-text available : meaning the complete text and graphics are provided for every article in online issues.

Partial full-text : meaning the complete text and graphics are provided for a substantial number of articles in online issues.

Abstracts : meaning abstracts are provided online for every article of journal issues.

Little or no content : meaning generally that neither abstracts or a substantial number of full-text articles are provided.

Price Category :	**Online access provided with an institutional print subscription**

The possible **Price Category** types include :

Free : meaning online access to full-text is freely available to Internet users. Registration is generally necessary.

Free trial access : meaning online access to full-text is freely available for a limited time to Internet users.

Online access provided with an institutional print subscription : meaning online access to full-text will be provided to libraries or institutions with print subscriptions, either using password or IP number checking. Registration usually requires vendor subscriber numbers which are found on mailing labels.

Online subscription/licence required : meaning online access to full-text requires an online subscription or licence which is separate to print subscriptions.

The following sections are provided for titles where this information is applicable. Prices for online subscriptions are those applicable for Australian libraries.

Full-text from :	v. 190 (3) June 1998 -
Online price with print sub. :	10% extra
Online price without print sub. :	90% of print sub price
Price per article :	$16
Notes :	Back issues older than 18 months freely available.
Indexed in Medline :	Yes
Association :	Institute of Medicine

Publisher :	Lippincott William & Wilkins

Below the information table is given the date of the last time this information was updated.

Using the Free Journals List

The Free Journals List includes all titles which are categorized as Free or Free trial access, and contain either full-text or partial full-text content. Titles from this list will generally require some sort of online registration, and the use of userids and passwords to control access. Titles from this Free List can than be used to supplement the titles a library can gain access to via print or online subscriptions. It should be noted that most free titles have changed over to restricted subscriber access after a few years airing. There will probably ever only be a very small number of long-term free titles, as free online access must create a business risk to any publisher.

Basic Steps in Managing Access

Although publicity about managing access to electronic journals will typically use phrases such as "easy", "seamless", "one-step" etc., nothing could be further from the truth. Large amounts of work will probably be required to establish a system for your library, especially if you manage it in-house. Some of the Commercial Management Systems will do this work for you, even providing a customised interface for your library. However, detailed knowledge of electronic journals management will increasingly become a basic requirement of today's librarian.

Basic tasks for in-house management can be broken down into the following steps:

1. Work out what print journals your institution is currently receiving. This can include library and probably departmental subscriptions, but not personal subscriptions, or gratis subscriptions. Collect a mailing label for each title, including ones which do not currently have electronic versions. Store the mailing labels in a file, or record subscriber numbers in a database. Subscriber numbers used by publishers are not the same as those used by subscription agents. Some electronic journals create userids and passwords out of various parts of the address label, so keeping the whole label is not a bad idea. Keep on the lookout for correspondence from publishers about requirements for accessing electronic content, and also store this information.

2. Work out which of your print titles provide subscribers with electronic content, and whether extra payments are required. The Directory of Electronic Health Sciences Journals should assist with this task.

3. Register to access publishers sites, or online content providers. This can be simply a matter of entering subscriber numbers online, or the more lengthy signing and sending of licence agreements via mail. You will often be given the choice of using access based on userid/password security, or IP network security, sometimes you can use both. IP security is based on providing the online provider with an IP range of the institutions network. If a firewall is used, provide the IP number of the firewall.

4. Provide your institution with a webpage of links to the accessible electronic journals for your institution, plus any free titles you wish to include. The Directory of Electronic Health Sciences Journals provides a list of free titles. Links can also be incorporated into the library's online catalogue.

Commercial Management Systems

The following companies can act as an agent between libraries and electronic journal publishers. Working with your records of print and online subscriptions, they will contact publishers and set up for the library a customised "front end" to available electronic journals. Access is controlled generally by a single userid/password or IP check. Each service provides free trial access for libraries.

Ebsco Online

Ebsco Online is currently provided as a free add-on service to existing Ebsco customers. Ebsco can verify the library's subscriptions with publishers and provide customers with a login to either a select list of accessible titles, or the entire file of online titles for searching. Ebsco's ability to provide this service appears to vary between international offices. Ebsco Online provides links directly to publishers sites, or to full-text via tables of contents loaded locally on the Ebsco server. Usage statistics can be calculated from the system.

SwetsNet

Following the merger of B.H. Blackwell's Subscription service with Swets, the Blackwell's Electronic Journals Navigator will be merged into SwetsNet to provide customers with access to electronic journals. SwetsNet charges include a base fee, plus additional payments for each title. The system will provide libraries with access to their electronic journals via searchable table of contents listings.

OCLC Electronic Collections Online

The OCLC ECO system can be accessed via the ECO search interface or the FirstSearch Web interface, or by direct links from homepages or online catalogues. Access to full-text content is again based on a library's print and online journal subscriptions, with the charge for ECO calculated by number of titles. The fee-per-title reduces as the number of titles registered increases. OCLC has agreements with publishers to permanently archive electronic full-text. OCLC loads the full-text onto its local servers, reducing the need for links to publisher's sites, and secondary security controls.

Ingenta

Ingenta is a non-profit organisation set up to assist educational and research institutions gain access to electronic journals using a single interface. If libraries supply Ingenta with a list of titles and subscriber numbers for their print and online subscriptions, access will be provided to the available full-text content for those titles. Ingenta does not cover every publisher, but has an impressive list. Unfortunately, the speed of the Ingenta system can sometimes be slow, making it difficult for the end user.

Catchword

Catchword is a free service providing libraries with access to full-text content from a number of publishers. Catchword will provide libraries with a Catchword identifier number, and then requires libraries to request cooperating publishers

to contact Catchword to have access switched on.

Dawson's Information Quest

Please check website for further information.

Major Full-text Providers

Links are provided below for the following major full-text providers and publisher's sites.

American Medical Association
Note: Online access provided to institutional print subscribers.

Arnold Journals Online

BioMedNet (150+ journals mostly from Elsevier Science)

Cambridge University Press
Note: Online access provided to institutional print subscribers.

Catchword (40+ publishers) see Commercial Management Systems

Elsevier Science
Note: Online access to last nine months issues (Web-editions) provided to institutional print subscribers for most titles. ScienceDirect licence provides three year backfiles.

Gale Group

Harcourt International

Highwire Press (200+ medicine/science journals from variety of publishers)
Note : majority of titles provide online access to institutional print subscribers.

Idealibrary (Academic Press, Saunders, Churchill Livingstone, Harcourt, Bailliere Tindall)

IngentaJournals (30+ publishers) see Commercial Management Systems

Journals@Ovid (360+ titles from variety of publishers)
Note : licence prices are lower for institutional print subscribers.

Karger Online

Kluwer Online

LINK (Springer-Verlag)
Note: "Basic licence" online access provided to institutional print subscribers. Site licences available.

Lippincott, Williams & Wilkins
Note : access to titles with full-text content provided to institutional print

subscribers.

Marcel Dekker

MD Consult

Medscape (free full-text content from number of journals)

Mosby
Note : access to some titles with full-text content provided to institutional print subscribers.

Nature Journals
Note : "one-user" online access provided to institutional print subscribers. Site licences available.

OCLC Electronic Collections Online (50+ publishers) see Commercial Management Systems

Oxford University Press
Note : Online access provided to institutional print subscribers.

ProQuest Online

ScienceDirect (Elsevier)
Note: Online access to last nine months issues (Web-editions) provided to institutional print subscribers for most titles. ScienceDirect licence provides access to three year backfiles.

Synergy (Blackwell Scientific & Munksgaard)

Taylor and Francis Group (including Carfax Publishing)
Note : Online access provided to institutional subscribers via either Catchword or Ingenta.

W.B. Saunders
Note : access to titles with full-text content provided to institutional print subscribers.

Web of Science (ISI)

Wiley Interscience (John Wiley)
Note : "single user" online access licence provided to institutional print subscribers. Site licences available.

Directory of Electronic Health Sciences Journals HOME

The **Directory of Electronic Health Sciences Journals** was produced with the support of the 1999 Anne Harrison Award, which is administered by the Health Libraries Section of the Australian Library and Information Association.

The DEHSJ site has been maintained in 2000 and 2001 by :

Adam Clark
Health Sciences Library
The Alfred Hospital
Commercial Road
PRAHRAN VIC 3181
AUSTRALIA
a.clark@alfred.org.au

In 2002 the site will be hosted by Hunter Health and maintained by :

Stephen Mears
Gardiner Library Service
Locked Bag 1
Hunter Region Mail Centre NSW
AUSTRALIA
stephen.mears@hunter.health.nsw.gov.au

New Electronic Journals & Other News

Seven of Mosby's "Current Problems in .." series are now available online via the Harcourt Health website. (24 Oct 2001).

As part of a major new web-publishing venture, over 60 new peer-reviewed online journal titles can be freely accessed via BioMed Central. (26 Sep 2001)

Humana Press is providing free online access to Journal of Molecular Neuroscience, and Molecular Biotechnology. (8 Aug 2001)

Search for Information

To perform a search, please use key words based on the information being sought. You can:

Use Free-Text Query
(check to use everyday language). For more information, select
Free-Text Queries
.

Perform more precise searches
(select
Quick Tips
below or
Advanced Search Help
).

Enter your query below:

Quick Tips

Exact Phrase:
Use quotation marks to find phrases ("children's health").

Or:
Use "or" between key words to find all references to one or both key words ("ulcer or sore").

And:
Use "and" between key words to find all references with both search terms ("health and system").

Near:
Use "near" between key words to find references that have the key words close to each other ("health near system").

Wildcard:
Use one asterisk after a root word to find all terms that include that root word

("research*" will find: research, researcher, researching...).

For more information on advanced searches, select
Advanced Search Help
.

AHRQ Home Page 

Browse for Information

This feature allows you to choose from a list of subject areas of interest, arranged in alphabetical orde
the subject of your choice and a menu will appear of Web site offerings with direct hyperlinks to indivic
documents. You may also use the Search feature to enter key words and find relevant materials availa
this site.

Agency Information
AIDS
Children's Health
Clinical Practice Guidelines
Consumer Information and Education
Data Development and Use
Dental Health
Drugs, Pharmaceuticals, Therapeutics
Elderly Healthcare
Evidence-based Medicine
Grants and Contracts/Funding
Healthcare Costs
Healthcare Informatics
Health Insurance/Access to Care
Health Promotion/Disease Prevention
Health Technology Assessment
Hospital Care, Cost, and Use
Long-Term Care
Managed Care
Market Forces
Medical Errors
Medical Expenditure Panel Survey (MEPS)
Medical Liability
Medical Treatment Effectiveness
Mental Health
Methods
Minority Health
Nursing Research—*New!*
Organization and Delivery
Outcomes Research
Primary Care
Publications
Quality of Care

Research Agenda
Rural Health
Women's Health

AHRQ Home Page
Department of Health and Human Services

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What's New

Last updated March 26, 2002

Items posted in the last 30 days

About AHRQ

- Events & Announcements
  - Fifth International Conference on the Scientific Basis of Health Services—*Upcoming* (3/22/02)
- Budget & Mission
  - Annual Report, Fiscal Year 2001 (PDF file, 2.5 MB) (3/22/02)
  - What Is AHRQ (PDF file, 215 KB) (3/20/02)
  - Research Grant Awards by State, Fiscal Year 2001 (3/14/02)
  - Slide Presentation (PowerPoint® file, 156 KB; HTML) (3/4/02)
- Center for Organization and Delivery Studies
  - HIV Research Network: Patient Interviews, Patient Safety, and Future Directions (3/13/02)
  - Child Health Insurance Research Initiative (CHIRI™)—*Updated* (3/7/02)
  - First Annual Meeting of the IDSRN (3/6/02)
- Job Vacancy Announcements (3/4/02)

News & Information

- How AHRQ Research Helps People (3/15/02)
  - Disparities in Health Care (3/26/02)
  - Improving Health Care for Americans with Disabilities (3/26/02)
  - Medicare Uses of AHRQ Research (3/26/02)
  - Health Care for Women (3/26/02)
- In Memoriam: Tribute to John M. Eisenberg, M.D., 1946-2002 (3/10/02)
  - John Eisenberg Mourned (3/13/02)
- Agency Press Releases
  - AHRQ National Advisory Council to Meet March 29 (3/25/02)
  - Secretary Thompson Names Carolyn Clancy, M.D., as Acting Director of AHRQ (3/22/02)
  - AHRQ's Online Hospital Statistics Tool Now Features 1998 and 1999 National, Regional and State Data (3/19/02)
  - AHRQ-Funded Study Shows Increase in Aspirin Use in Patients With Heart Disease, But Underuse is Still a Concern (3/8/02)

Clinical Information

- Evidence-based Practice

- Criteria for Determining Disability in Speech-Language Disorders: Evidence Report (File Download) (3/26/02)
- Treatment of Pulmonary Disease Following Cervical Spinal Cord Injury: Evidence Report (File Download) (3/20/02)
- Anesthesia Management During Cataract Surgery: Evidence Report (File Download) (3/20/02)
- Making Health Care Safer: A Critical Analysis of Patient Safety Practices: Evidence Report (3/19/02)
- Efficacy of Interventions To Modify Dietary Behavior Related to Cancer Risk: Evidence Report (3/19/02)
- Garlic: Effects on Cardiovascular Risks and Disease, Protective Effects Against Cancer, and Clinical Adverse Effects: Evidence Report (3/19/02)
- Criteria for Determining Disability in Speech-Language Disorders: Summary (3/15/02)
- Management of Chronic Central Neuropathic Pain Following Traumatic Spinal Cord Injury: Summary (3/14/02)

- U.S. Preventive Services Task Force
  - About USPSTF—*Updated* (PDF File, 208 KB) (3/22/02)

Funding Opportunities

- Contract Solicitations
  - Evidence-based Practice Center Coordinating Center: Request for Proposals (3/20/02)

Data & Surveys

- Healthcare Cost and Utilization Project
  - Overview of the HCUP NIS—1999 (3/26/02)
  - 1998-99 NIS Technical Documentation (3/14/02)

Research Findings

- *Research Activities* Online Newsletter, Febuary 2002 (PDF file, 350 KB) (3/20/02)

Quality Assessment

- Consumer Assessment of Health Plans (CAHPS®)
  - CAHPS® II: The Next Generation—Upcoming CAHPS® User Group Meeting (3/22/02)

Send Questions & Comments to: info@ahrq.gov

How To Use This Web Site

Following are brief explanations of the navigational tools available and listings of the major categories and subcategory offerings (with highlighted products on the AHRQ Web site).

Navigational Tools

Search: Use keywords for topical index search of site
Browse: Select from subject list for selected documents on site
What's New: Recent uploads to Web site
Frequently Asked Questions: Access to AHRQ's most requested information

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Content

About AHRQ

Budget & Mission (Budget Justification for Fiscal Year 2002/Testimony on Fiscal Year 2002 Budget Request/AHRQ Profile/Reauthorization Fact Sheet)
Strategic Plan (AHRQ Strategic Plan/Performance Plans for FY 2001 and 2002
Organization & Contacts (Key Contacts/National Advisory Council Overview/Offices & Centers)
Nursing Research
Map and Directions to AHRQ
Events & Announcements
AHRQ Job Vacancies

News & Information

Newsroom (Press Releases/Fact Sheets/Testimony, Speeches, Interviews/Press Office Contacts)
State & Local Policymakers (User Liaison Program)
Publications & Products (Publications Catalog/InstantFAX/Electronic Catalog)
FOIA Reading Room (Freedom of Information Act)
Electronic Policies (Copyright/Linking/Privacy)

Clinical Information

Evidence-based Practice (Evidence-based Practice Centers/Evidence Reports/Technical Reviews)
Outcomes & Effectiveness (Fact Sheet/The Outcome of Outcomes Research/CERTs)
Technology Assessment (Technology Assessments/Technology Reviews)
Preventive Services (Put Prevention Into Practice/U.S. Preventive Services Task Force)
Clinical Practice Guidelines (National Guideline Clearinghouse™/Guidelines Online)

Consumer Health

Health Conditions/Diseases (Now You Have a Diagnosis: What's Next?/ Common Uterine Conditions: Options for Treatment/Pneumonia: More Patients May Be Treated at Home/Understanding Your Body)
Health Plans (Choosing and Using a Health Plan/Checkup on Health Insurance Choices)
Prescriptions (Prescription Medicines and You)
Prevention & Wellness (Child Health Guide/Personal Health Guide/Staying Healthy at 50+/What You Should Know about Stroke

Prevention)
Quality of Care (Five Steps to Safer Health Care/20 Tips to Help Prevent Medical Errors/Your Guide to Choosing Quality Health Care: Summary)
Quit Smoking (Help for Smokers: Ideas to Help You Quit/You Can Quit Smoking)
Surgery (Be Informed: Questions to Ask Your Doctor Before You Have Surgery)
Información en español (Documents available in Spanish)

Funding Opportunities

Overview (Funding Opportunities)
Grant Announcements (Request for Applications/Ongoing Program Announcements)
Peer Review at AHRQ
Grant Award Resources
Policy Notices (Agency Requests/Grant Issues)
Contract Solicitations
Research Training Grants (Programs/Tools and Resources/Dissertation Questions & Answers/Trend Data)

Research Findings

Child and Adolescent Health (Funded Projects/State Children's Health Insurance Program/Supporting Research/Child Health Advisory Group/Child Health Toolbox)
Women's Health (Women's Health Highlights/Breast Cancer Research Highlights/Health Care for Minority Women)
Minority Health (Addressing Racial and Ethnic Disparities in Health Care/Improving Health Care for Ethnic and Racial Minority Populations/Excellence Centers To Eliminate Ethnic/Racial Disparities: EXCEED)
***Research Activities:* Online Newsletter**
Translating Research Into Practice: Fact Sheets
Topics:
(Elderly Healthcare/Healthcare Costs/Long-Term Care/Managed Care/Markets/Mental Health/Methods/Primary Care/Rural Health)

Quality Assessment

CAHPS®: Consumer Assessment of Health Plans (CAHPS® Fact Sheet/Questionnaires: Download)
CONQUEST—Computerized Needs-Oriented Quality Measurement (CONQUEST Summary: Download)
Measuring Healthcare Quality (Q-SPAN: Expanding and Improving Quality of Care Measures/Foundation for Accountability Abstracts)
Medical Errors & Patient Safety (Fact Sheet/20 Tips to Help Prevent Medical Errors: Patient Fact Sheet/Medical Errors: The Scope of the Problem)
Quality Information & Improvement (Americans as Health Care Consumers: The Role of Quality Information/Case Studies from the Quality Improvement Support System/Theory and Reality of Value-Based Purchasing)
Quality Indicators (Quality Indicators: Download/Prevention Quality Indicators: Download)
QuIC—Quality Interagency Coordination Task Force (QuIC Fact Sheet/Report to the President on Medical Errors/QuIC Web Site)

Data & Surveys

MEPS—Medical Expenditure Panel Survey (MEPS Web Site, Fact Sheets)
HCUP—Healthcare Cost and Utilization Project (Overview/HCUPnet/Nationwide Inpatient Sample—NIS/State Inpatient Databases—SID/State Ambulatory Surgery Databases—SASD/Kids' Inpatient Database—KID/Clinical Classifications Software: Download)
HIV & AIDS Costs & Use (HCSUS Fact Sheet)
Healthcare Informatics Standards (Federal Health Care Informatics Standards Activities/A Compendium of Selected Public Health Data Sources)

AHRQ Home Page
Department of Health and Human Services

Frequently Asked Questions

AHRQ Home Page
http://www.ahrq.gov

Topics

Question

How do I access *clinical practice guidelines online*?

Answer

The Clinical Practice Guidelines subdirectory lists available resources. This includes the National Guidelines Clearinghouse™, a comprehensive database of evidence-based clinical practice guidelines and related documents with syntheses and comparisons, and the U.S. Public Health Service Guideline on tobacco cessation.

Clinical practice guidelines sponsored by the former Agency for Health Care Policy and Research, and released from 1992 through 1996, are available online from the National Library of Medicine through an electronic full-text retrieval system called HSTAT. Select to access Clinical Practice Guidelines Online for information on the prevention and treatment of pressure ulcers and cardiac rehabilitation. Guidelines covering other topics in this series are now outdated due to more recent research findings or technological advances. Although these documents are no longer considered guidance for current medical practice, you may access electronic versions in the Clinical Practice Guideline Archive.

Guideline documents also may be downloaded using file transfer protocol (FTP) if you have an FTP client. Specify the FTP host address: nlm.nih.gov. First select HSTAT, then AHCPR, then the desired guideline from the list presented. Index files are provided.

You may download these clinical practice guideline files for your personal use only. If you want to reproduce guidelines in any form, incorporate them into other computer access systems, or adapt or update content, copyright issues must be addressed.

Select Guideline User Policies for Electronic Versions and Guideline Copyright Information for specific requirements and contacts.

Question

How do I obtain information about *clinical preventive services*?

Answer

The U.S. Preventive Services Task Force has produced two major resources:

- The *Guide to Clinical Preventive Services* is a reference source of effective clinical preventive services, such as screening tests for early detection of disease, immunizations to prevent infections, and counseling for risk reduction.
- Put Prevention Into Practice (PPIP) is a national, research-based public-private program developed to increase the appropriate use of clinical preventive services. PPIP makes it easier for health care organizations, clinicians, and their office staffs to deliver recommended prevention services and to perform them properly (select About PPIP). PPIP materials for consumers help patients ask about and keep track of their preventive health care.

Select for availability information for the *Guide* and PPIP.

Availability of Guide to Clinical Preventive Services

You may order a printed copy of the *Guide* through the Government Printing Office (Stock No. 017-001-00525-8) for $35; the GPO order desk number is (202) 512-1800.

The full text of the *Guide* is available electronically via the AHRQ's World Wide Web site. Select to access the *Guide to Clinical Preventive Services: Second Edition (1996)*. Each line is a hyperlink to the corresponding section of the full text *Guide*. You may save *Guide* sections as electronic files or print them using your Web browser's "Save" and "Print" features.

A Text Version (ASCII file) of the *Guide* is also available on the World Wide Web.

Using file transfer protocol (FTP) you may download the full *Guide* as an electronic file if you have an FTP client. Specify the FTP host address nlm.nih.gov. Select HSTAT, then GUIDE_CPS.

Availability of Put Prevention Into Practice Materials

PPIP materials are available online and in print for different audiences. Select Ordering Information for details. They range from clinician materials (such as the *Clinician's Handbook of Preventive Services*, wall posters, and preventive care flow sheets) to

consumer guides.

Question

How do I find out about *employment* with the Agency for Healthcare Research and Quality?

Answer

Inquiries about employment opportunities with the Agency for Healthcare Research and Quality are handled by the Program Support Center's Human Resource Service. Information about positions for which the Agency is currently recruiting can be obtained by calling (301) 443-3201 or (301) 504-3310 (TDD: 912-744-2299). Copies of vacancy announcements may also be obtained by calling this number.

You may access a listing of Job Vacancies with information on application procedures from the AHRQ home page under the category About AHRQ. Applications for employment are only accepted for specific vacancies; applications are not accepted for general employment consideration.

In addition, the Agency for Healthcare Research and Quality offers a Summer Intern Program for undergraduate and graduate college students in support staff and entry level professional positions.

Question

How do I find out about *grants available* from your Agency?

Answer

You may access information on Funding Opportunities from the AHRQ home page, including the Agency's research agenda, financial assistance mechanisms used for research projects, a list of grant announcements, and policy notices that apply to grants.

You may also obtain AHRQ grant announcements and a grant application kit from:

AHRQ Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907-8547
Telephone: 800-358-9295
TDD service: 888-586-6340
E-mail: ahrqpubs@ahrq.gov

The full text of requests for applications and grant announcements from AHRQ are published in the *NIH Guide for Grants and Contracts*.

Question

How do I obtain *information products* from your Agency?

Answer

You may call the AHRQ Clearinghouse toll-free at 800-358-9295 (outside the United States please call 410-381-3150). You may also send send an E-mail message to: ahrqpubs@ahrq.gov or a written request to:

AHRQ Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907-8547

The AHRQ Publications Clearinghouse can provide you with the latest copy of the Publications Catalog that lists available publications and add you to the mailing list for *Research Activities*, a free monthly newsletter from AHRQ that summarizes the results of funded research and announces new information products as they become available.

You may access Publications & Products from the AHRQ home page, which provides electronic versions of the Publications Catalog and offers links to other electronic resources.

AHRQ also offers InstantFAX, a fax-on-demand service accessible to anyone using a fax machine equipped with a touch tone telephone handset. Call (301) 594-2800, push "1," and then press the fax machine's start button for instructions and a list of currently available documents.

Current as of March 2002

How AHRQ Research Helps People

In examining what works and does not work in health care, AHRQ's mission includes both translating research findings into better patient care and providing policymakers and other health care leaders with information needed to make critical health care decisions.

Links below lead to information describing the impact of AHRQ research on the entire health care system—including patients, providers, and policymakers.

Children With Chronic Illness and Disabilities
Presents findings from AHRQ research on issues relating to care of children with asthma, diabetes, and other health care conditions and disabilities.

Disparities in Health Care
Presents AHRQ programs and research that examine and address disparities in the delivery of health care.

Health Care for Women
Discusses AHRQ research projects and findings aimed at improving health care for women.

HIV Disease
Highlights AHRQ research that has informed the health care system about costs, access, and outcomes of different approaches to HIV care.

Improving Health Care for Americans with Disabilities
Describes AHRQ research on health care delivery to people impaired by disabling illness or injury.

Medicare Uses of AHRQ Research
Details AHRQ-funded projects that have direct relevace to the needs and priorities of the Medicare program.

Men's Health Care
Summarizes the impact of AHRQ research on what works and does not work in diagnosing and treating conditions relevant to men's health.

Patient Safety
Describes AHRQ research aimed at reducing medical errors and improving patient safety.

diagnosing and treating conditions relevant to men's health.

Patient Safety
Describes AHRQ research aimed at reducing medical errors and improving patient safety.

Pharmaceutical Research Highlights
Details important insights on patient outcomes related to pharmaceutical therapy.

Prevention Research Highlights
Summarizes findings from AHRQ research on health care services that promote health.

Rural Health Care
Examines aspects of organizing, delivering, and financing care to rural populations.

The link below leads to information about AHRQ as well as how health services research affects the Nation.

What Is AHRQ
Discusses what AHRQ does and its goals, what health care services research is, and how it helps people.

AHRQ Home

Features

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Department of Health and Human Services
Department of Health and Human Services

News & Information

Newsroom
Press releases — background — budget — interviews, speeches, and testimony — fact sheets — press & inquiries — audio and video resources — electronic newsletter

State & Local Policymakers
User Liaison Program — workshops — distance learning products — staff contacts & inquiries

Publications & Products
Catalog — completed studies — research in progress — fax-back system — Web resources — governm information locator service — E-mail requests

FOIA Reading Room
Freedom of Information Act request instructions — document index

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Quality Assessment

Welcome to AHRQ's Newsroom, designed to meet the immediate needs of journalists and others who are interested in our research.

Inquiries can be directed to Karen Migdail in the Public Affairs Division at (301) 594-6120, or E-mail at KMigdail@ahrq.gov
.

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(Media Only)

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(Non-Media Only)

In Memoriam: Tribute to John M. Eisenberg, M.D., 1946-2002

Latest Headlines

3/25/02 AHRQ National Advisory Council to Meet March 29
3/22/02 Secretary Thompson Names Carolyn Clancy, M.D., as Acting Director of AHRQ
3/19/02 AHRQ's Online Hospital Statistics Tool Now Features 1998 and 1999 National, Regional and State Data

Press Releases

(includes statistical charts)

2002 / 2001 / 2000 / 1999 / 1998 / 1997 / 1996 / 1995

AHRQ Press Office Contacts

AHRQ Areas of Expertise

Children's Health	Minority Health
Data on Healthcare Cost and Use	Outcomes Research
	Primary Care
Elderly and Chronically Ill	Quality of Care
Evidence-based Medicine	Technology Assessment

Children's Health	Minority Health
Data on Healthcare Cost	Outcomes Research
and Use	Primary Care
Elderly and Chronically Ill	Quality of Care
Evidence-based Medicine	Technology Assessment
Medical Errors	Women's Health

Articles of Interest Alert

Audio News Releases

Background

AHRQ Profile

AHRQ Reauthorization

Biographies:
Director
(includes photo) and
Deputy Director

Organization: Offices and Centers

National Advisory Council Members

What Is AHRQ
(
PDF file
, 215 KB)

Budget Justification

Fiscal Year 2003
(
PDF file
, 639 KB)

Fiscal Year 2002
(Zipped
WordPerfect® file
, .5 MB)

Fiscal Year 2001
/
Fiscal Year 2000
/
Fiscal Year 1999

Electronic Newsletter Archives

Fact Sheets

Research Activities
:
Online Newsletter

Summarizes recent study findings

Testimony, Speeches, and Interviews

Tuesday, March 26, 2002

Welcome! You are connected to the **National Guideline Clearinghouse™ (NGC)**, a public resource for evidence-based clinical practice guidelines. NGC is sponsored by the Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research) in partnership with the American Medical Association and the American Association of Health Plans. Click on About NGC to learn more about us.

Start your search by typing keywords into the search box on this page, or click on a Browse NGC link or on Detailed Search.

A Non-Frames/Text Only version of the site is also available.

Search NGC:

10 results 20 results 30 results 50 results 100 results Al
Detailed Search

In Memoriam
Tribute to John M. Eisenberg, M.D

Browse NGC:
Disease/Condition
Treatment/Intervention
Organization

Compare Guidelines:
Guideline Collection
Guideline Syntheses

NGC News:
Updated synthesis: Screening for Prostate

New UIGN and updated ICSI guidelines. G
New this Week."

Subscribe to the NGC Weekly E-mail Upda

Create a Guideline Comparison Banner 

One-stop access to all online U.S. Federal Government resources
FIRSTGOV

Date Modified: 3/25/2002 8:55 a.m.

For text only browsers,
click here to see full site index
.


Face of Woman

Publications Titles

The following is a catalogue of publications arranged by topic area. A
lists of publications
.

The prices shown in this catalogue include Goods and Services Tax (

Go here for information about
how to order publications
.

- Aged Care
(Advisory Program)
- Child Health
(Advisory Program)
- Clinical Practice Guidelines
(Advisory Program)
- Communicable Diseases
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- Dentistry
(Advisory Program)
- Diabetes
(Advisory Program)
- Drugs and Poisons
(Advisory Program)

(Advisory Program)
- Diabetes
(Advisory Program)
- Drugs and Poisons
(Advisory Program)
- Drug and Substance Abuse
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- Environmental Health
(Advisory Program)
- Ethics - Animal
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(Advisory Program)
- Infection Control
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- Injury
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- Men's Health
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- Mental Health
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- NHMRC
(NHMRC)
- Nutrition
(Advisory Program)
- Public Health
(Advisory Program)
- Research
(Research Program)
- Session Reports
(NHMRC)
- Sport
(Advisory Program)
- Women's Health
(Advisory Program)
- Workforce

URL
: http://www.nhmrc.gov.au/publications/titles.htm

Produced by NHMRC June 2001

Page last modified 26 June 2001

Email Webmaster:
nhmrc.webmaster@health.gov.au

General Enquiry:
nhmrc.publications@health.gov.au

Radiation Health Series

The Radiation Health Series of publication are not issued through NHMRC.
To obtain copies of the following publication please contact the Health Protection Service [How to Order]

RH39	*Recommendations for limiting exposure to ionising radiation (1995) and national standard for limiting occupational exposure to ionising radiation*
RH38	*Recommended limits on radioactive contamination on surfaces in laboratories*
RH37	*Code of practice for the safe use of lasers in the entertainment industry*
RH36	*Code of practice for the safe use of lasers in schools*
RH35	*Code of practice for the near-surface disposal of radioactive waste in Australia*
RH34	*Safety guidelines for magnetic resonance diagnostic facilities*
RH33	*Interim statement on Australian Radiation Practice Standards*
RH32	*Intervention in emergency situations involving radiation exposure*
RH31	*Code of practice for the safe use of industrial radiography equipment*
RH30	*Interim guidelines on limits of exposure to 50/60 Hz electric and magnetic fields*
RH29	*Occupational standard for exposure to ultraviolet radiation*
RH28	*Code of practice for the safe use of sealed radioactive sources in borehold logging*
RH26	*Policy on stable iodine prophylaxis following nuclear reactor accidents*
RH25	*Recommendations for ionisation chamber smoke detectors for commercial and industrial fire protection systems*
RH24	*Code of practice for the design and safe operation of non-medical irradiation facilities*
RH23	*Code of practice for the control and safe handling of radioactive sources used for therapeutic purposes*
RH22	*Statement on enclosed x-ray equipment for special applications*
RH21	*Statement on cabinet x-ray equipment for examination of letters, packages, baggage, freight and other articles for security, quality control and other purposes*

RH21	*Statement on cabinet x-ray equipment for examination of letters, packages, baggage, freight and other articles for security, quality control and other purposes*
RH20	*Code of practice for radiation protection in dentistry*
RH19	*Code of practice for the safe use ionising radiation in secondary schools*
RH18	*Code of practice for the safe handling of corpses containing radioactive materials*
RH17	*Procedures for testing microwave leakage from microwave ovens*
RH16	*Code of practice for the safe use shortwave (Radiofrequency) diathermy units*
RH15	*Code of practice for the safe use of microwave diathermy units*
RH14	*Recommendations for minimising radiological hazards to patients*
RH13	*Code of practice for the disposal of radioactive wastes by the user*
RH12	*Administration of ionising radiation to human subjects in medical research*
RH11	*Code of practice for the safe use of soil density and moisture gauges containing radioactive sources*
RH10	*Code of practice for the safe use of ionising radiation in veterinary radiology: Part 3 - Radiotherapy*
RH9	*Code of practice for protection against ionising radiation emitted from x-rays analysis equipment*
RH8	*Code of nursing practice for staff exposed to ionising radiation*
RH5	*Recommendations relating to the discharge of patients undergoing treatment with radioactive substances*
RH4	*Code of practice for the safe use of radiation gauges*
RH3	*Code of practice for the safe use of ionising radiation in veterinary radiology: Part 1 and 2*
RH2	*Code of practice for the design of laboratories using radioactive substances for medical purposes (1980)*

Additional

1.Notes on medical procedure for radiation accident and radioactive contamination (1968)
2.Code of practice for the safe use of radioactive luminous compounds (1971) (superseded by RH38)
3.Recommendation for exemptions from licensing of gaseous tritium light devices (1975)

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URL: http://www.nhmrc.gov.au/publications/radiat.htm

2000 NHMRC - Publications Catalogue

National Bioethics Publications

As a service to readers, the following publications of the former National Bioethics Consultative Committee are from NHMRC [How to Order].

NB21	Reproductive technology (1989)	
NB20	Access to information: An analogy between adoption and the use of gamete donation (1988)	
NB19	Issues paper on infertility counselling (1990)	**Rescinded 29 February 2000**
NB18	NBCC Report to the Australian Health Ministers' Conference (1989)	**Rescinded 29 February 2000**
NB17	Bioethics organisations in the USA (1988) - Report of a visit to the USA	**Rescinded 29 February 2000**
NB16	Human embryo experimentation - A background paper and select bibliography	**Rescinded 29 February 2000**
NB15	Discussion paper on Surrogacy No. 2 - Implementation progress report (1991)	**Rescinded 29 February 2000**
NB14	Discussion paper on Surrogacy No. 2 - Implementation (1990)	**Rescinded 29 February 2000**
NB13	Surrogacy (1990) - Report One: First of two reports on surrogacy	
NB12	Surrogacy (1988) - Background papers prepared for the inaugural meeting of the NBCC	
NB11	Reproductive technology (1989)	**Rescinded 29 February 2000**
NB10	Discussion paper on access to reproductive technology (1990)	**Rescinded 29 February 2000**

NB10	Discussion paper on access to reproductive technology (1990)	**Rescinded 29 February 2000**
NB9	Access to reproductive technology (1991)	**Rescinded 29 February 2000**
NB8	Reproductive technology counselling (1991)	**Rescinded 29 February 2000**
NB7	Access to reproductive technology: Workshop Proceedings(1990)	**Rescinded 29 February 2000**
NB6	Consultation: An appraisal of community perspectives (1991) - Background discussion paper	**Rescinded 29 February 2000**
NB5	Access to information (1988) - Background paper to the NBCC report 'Reproductive technology'	**Rescinded 29 February 2000**
NB4	Donor gametes, record keeping and access to information (1989) - Prepared as an appendix to 'Reproductive technology'	
NB3	Developments in the health field with bioethical implications, Vol. 3 (1991) - Discussion paper prepared for the Australian Health Ministers' Conference	**Rescinded 29 February 2000**
NB2	Developments in the health field with bioethical implications, Vol. 2 (1990) - Discussion paper prepared for the Australian Health Ministers' Conference	**Rescinded 29 February 2000**
NB1	Developments in the health field with bioethical implications (1989) - Discussion paper prepared for the Australian Health Ministers' Conference	**Rescinded 29 February 2000**

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URL: http://www.nhmrc.gov.au/publications/bioeth.htm

PUBLICATION UPDATE

- **New Releases**
- **Aniticipated Forthcoming Publications**
- **Rescinded/Withdrawn**
  - **2001 | 2000 | 1999 | 1998 | 1997 | 1996 | 1995**

New Releases

- How to compare the costs and benefits: evaluation of economic evidence.
- Analysing the journal output of NHMRC research grants schemes.
- Clinical Practice Guidelines - Appropriate Use of Red Blood Cells. Summary 2001.
- Interim Guidelines Intellectual Property Management for Health and Medical Research
- NHMRC Guidelines on Monoclonal Antibody Production
- Health and Medical Research Strategic Review: Implementation of the Government's Response - Final Report 2001

- The Inside Guide to the National Health and Medical Research Council for the 2000-2003 Triennium

- Clinical Practice Guidelines for the Management of Advanced Breast Cancer
- NHMRC standards and procedures for externally developed clinical practice guidelines
- Effectiveness of nasal continuous positive airway pressure (nCPAP) in obstructive sleep apnoea in adults

- Joint Statement and Recommendations on Vitamin K Administration to Newborn Infants to Prevent Vitamin K Deficiency Bleeding in Infancy - in HTML or PDF

- Vitamin K for newborn babies - Information for Parents
- Nutrition in Aboriginal and Torres Strait Islander Peoples: An information Paper
- An Information Paper: Postnatal depression - A systematic review of published literature to

Prevent Vitamin K Deficiency Bleeding in Infancy - in HTML or PDF

- Vitamin K for newborn babies - Information for Parents
- Nutrition in Aboriginal and Torres Strait Islander Peoples: An information Paper
- An Information Paper: Postnatal depression - A systematic review of published literature to 1999

- Postnatal Depression: Not Just the Baby Blues
- Guidelines for the prevention, early detection and management of colorectal cancer: A guide for patients, their families and friends

- Guidelines for the prevention, early detection and management of colorectal cancer: A guide for general practitioners

- Clinical Practice Guidelines: The Management of Uncomplicated Lower Urinary Tract Symptoms in Men

- Clinical practice guidelines: Care around preterm birth
- How to put the evidence into practice: implementation and dissemination strategies
- Australian drinking water guidelines
- Australian drinking water guidelines - Summary
- How to use the evidence: assessment and application of scientific evidence
- Ethical Aspects of Human Genetic Testing – an Information Paper
- Familial aspects of cancer: a guide to clinical practice
- Psychosocial Clinical Practice Guidelines: Information, Support and Counselling for Women with Breast Cancer

- Clinical Practice Guidelines for the Management of Cutaneous Melanoma
- How to review the evidence: systematic identification and review of the scientific literature
- How to present the evidence for consumers: preparation of consumer publications
- Dietary Guidelines for Older Australians

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Anticipated Forthcoming Publications

- Responsible drinking
- Guidelines for sewerage systems - reclaimed wate

Anticipated Forthcoming Publications

- Responsible drinking
- Guidelines for sewerage systems - reclaimed wate

Rescinded/Withdrawn

2000

- Access to information (1988) - Background paper to the NBCC report 'Reproductive - Rescinded 29 February 2000

- Access to reproductive technology: workshop Proceedings (1990) Rescinded 29 February 2000

- Access to reproductive technology (1991) - Rescinded 29 February
- Acupuncture - Rescinded 29 February 2000
- Acupuncture: Consumer information brochure - Rescinded 29 February 2000
- Aspects of privacy in medical research – An information paper and guidelines for the protection of privacy in the conduct of medical research - Rescinded 29 February 2000

- Asthma in Australia: Strategies for reducing morbidity and mortality - Rescinded 29 Februar 2000

- Bioethics organisations in the USA (1988) - Report of a visit to the USA - Rescinded 29 February 2000

- Biosynthetic human growth hormone - Rescinded 29 February 2000
- Case study of screening blood donations for human T-cell lymphotropic virus Type 1 (HTL 1) - Rescinded 29 February 2000

- Chelation therapy - Rescinded 29 February 2000
- Choice or chance? The ethics of resource allocation for minority groups – Ethics of resource allocation in health – Discussion Paper No. 3 - Rescinded 29 February 2000

- Code of practice for the safe use of agricultural chemicals by aerial application - Rescinded 29 February 2000

- Consideration by institutional ethics committees of research protocols involving frozen–thawed human ova - Rescinded 29 February 2000

- Consultation: an appraisal of community perspectives (1991) - Background discussion paper Rescinded 29 February 2000

- Cows milk intolerance in children - Rescinded 29 February 2000

- Consultation: an appraisal of community perspectives (1991) - Background discussion paper Rescinded 29 February 2000

- Cows milk intolerance in children - Rescinded 29 February 2000
- Dental anaesthetic gases: Hazards and hygiene - Rescinded 29 February 2000
- Developments in the health field with bioethical implications (1989) - Discussion paper prepared for the Australian Health Ministers' Conference- Rescinded 29 February 2000

- Developments in the health field with bioethical implications, Vol. 2 (1990) - Discussion paper prepared for the Australian Health Ministers' Conference - Rescinded 29 February 2000

- Developments in the health field with bioethical implications, Vol. 3 (1991) - Discussion paper prepared for the Australian Health Ministers' Conference - Rescinded 29 February 2000

- Discussion paper on access to reproductive technology (1990) - Rescinded 29 February 2000
- Discussion paper on ethics and resource allocation in health care - Rescinded 29 February 2000

- Discussion paper on the ethics of limiting life sustaining treatment - Rescinded 29 February 2000

- Discussion paper on Surrogacy No. 2 - Implementation (1990) - Rescinded 29 February 200
- Discussion paper on Surrogacy No. 2 - Implementation progress report (1991) - Rescinded 2 February 2000

- Distributing health care resources: Ethical assumptions - Rescinded 29 February 2000
- Down’s syndrome: Surgery for tongue size - Rescinded 29 February 2000
- Embryo donation by uterine flushing - Rescinded 29 February 2000
- Emergency transport of seriously ill children - Rescinded 29 February 2000
- Ethics in medical research involving the human fetus and human fetal tissue - Rescinded 29 February 2000

- Food allergies in children - Rescinded 29 February 2000
- Framework for antimicrobial prescribing guidelines - Rescinded 29 February 2000
- Guidelines for the monitoring of research by institutional ethics committees - Rescinded 29 February 2000

- Health effects of ozone layer depletion - Rescinded 29 February 2000
- Human embryo experimentation - A background paper and select bibliography - Rescinded 29 February 2000

- Human gene therapy and related procedures - Rescinded 29 February 2000
- Implementing the dietary guidelines for Australians: Report of the subcommittee on nutrition education - Rescinded 29 February 2000

29 February 2000

- Human gene therapy and related procedures - Rescinded 29 February 2000
- Implementing the dietary guidelines for Australians: Report of the subcommittee on nutrition education - Rescinded 29 February 2000

- Issues paper on infertility counselling (1990) - Rescinded 29 February 2000
- Methadone programs - Rescinded 29 February 2000
- Mouthguards - Rescinded 29 February 2000
- NBCC Report to the Australian Health Ministers' Conference (1989) - Rescinded 29 Februar 2000

- Newborn requiring follow-up care - Rescinded 29 February 2000
- Psychological and psychiatric aspects of HIV infection - Rescinded 29 February 2000
- Report of the working party on homebirths and alternative birth centres - Rescinded 29 February 2000

- Report of the working party to investigate variations in caesarean section rates in Australia - Rescinded 29 February 2000

- Report on ethics in epidemiological research - Rescinded 29 February 2000
- Report on round table conference on human gene therapy - Rescinded 29 February 2000
- Reproductive technology (1989) - Rescinded 29 February 2000
- Reproductive technology counselling (1991) - Rescinded 29 February 2000
- Resources for health care evaluation - Rescinded 29 February 2000
- Safe use of electro-dental equipment - Rescinded 29 February 2000
- Sanitary precautions in the home in natural disasters - Rescinded 29 February 2000
- Smoking during pregnancy - Rescinded 29 February 2000
- Statement on homebirths - Rescinded 29 February 2000
- Table for acceptable weights-for-height - Rescinded 29 February 2000
- Television advertising of foods, directed to children - Rescinded 29 February 2000
- The ethics of medical resource allocation - Rescinded 29 February 2000
- The media and public health - Rescinded 29 February 2000
- The place of ethics in health care resource allocation – where to now? Ethics of resource allocation in health – Discussion paper No. 1 - Rescinded 29 February 2000

- The use of psychoactive agents in childhood - Rescinded 29 February 2000
- Veterinary use of chloramphenicol - Rescinded 29 February 2000

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1999

- Australian Guidelines for the control of legionella and legionnaires' disease (1989) -

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1999

- Australian Guidelines for the control of legionella and legionnaires' disease (1989) - Rescinded 5/2/1999

- Caffeine, Kola Drinks and Children - *Rescinded 8/11/1999*
- Falls and the older person series on clinical management problems in the elderly No.6 - *Rescinded 8/11/1999*

- Legionnaires' disease - A guide for building owners (1988) - *Rescinded 5/2/1999*
- Legionella alert (1989) - *Rescinded 5/2/1999*
- Nutrition education in schools - *Rescinded 8/11/1999*
- Oral health care for older adults - *Rescinded 8/11/1999*
- Termiticides (safe use) Code of Practice (1996) - *Rescinded 17/3/1999*
- Protocol on health screening of boat people arriving in Australia (pamphlet) (19994) - *Rescinded 28/6/1999*

- The role of polyunsaturated fats in the Australian diet - *Rescinded 8/11/1999*

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1998

- An information paper for termination of pregnancy in Australia (1997)
- Environmental, Health and Economic Implications of the Use of Chlorofluorocarbons as Aerosol Propellants and Possible Substitutes (1987)

- Australian Guidelines for Heated Spa Pools (1988)
- Australian Guidelines for Disinfecting Private Swimming Pools (1988)
- Domestic Spa Pools: Instructions for Safe and Enjoyable Pool Use (1988)
- The Spa Card (1990)
- Ecologically Sustainable Development: the Health Perspective (1992)
- Statement on Neonatal Circumcision (1983)

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1997

- Nil

1996

1996

- Management guidelines for the control of infectious disease hazards in health care establishments (1992)

- Infection control in office practice: medical, dental and allied health (1994)
- Guidelines for the prevention of transmission of viral infection in dentistry (1992)

1995

- Community health care for adolescents (1983)
- Counselling services for parents of sudden infant death syndrome cases (1978)
- Day care for the preschool child (1984)
- Health needs of preschool children in day care (1988)
- Long-term follow-up of small preterm infants (1983)
- Testing of phenyiketonuria and the prevention of embryopathy (1987)
- Statement on the care of child victims of sexual abuse (1981)
- The effects of family break-up on children (1988)
- Children and adolescents in sport (1988)
- Television and your family (1988)
- Alcohol use in paediatric preparations (1990)
- Intra-uterine growth charts (1984)
- Management of severe injuries (1990)
- Epidural use of depo-medrol (1990)
- Antenatal care (1988)
- Questions and answers on toxic shock syndrome (1991)
- Leprosy control in Australia (1985)
- Handbook on sexually transmissible diseases (1990)
- Intravenous drug use and the AIDS epidemic: A review (1993)
- Control of cross-infection with methicillin-resistant staphylococcus aureus (1992)
- Recommended radiation protection standards for individuals exposed to ionising radiation (1980)

- Code of practice on the safe use of lasers in secondary schools (1983)
- Guidelines for the safe use of lasers New releases in the entertainment industry (1983)
- Australia's radiation protection standards (1989)
- Interim statement on Australia's radiation protection standards (1991)
- Practical guide to the prevention of hospital acquired infections (1979)
- Care of pregnant women in remote areas
- Guidelines for the prevention and management of benzodiazepine dependence (1991)

- Guidelines for the safe use of lasers New releases in the entertainment industry (1985)
- Australia's radiation protection standards (1989)
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- Guidelines for the prevention and management of benzodiazepine dependence (1991)
- Code of practice for the safe use of radioactive luminous compounds (1971

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Ambient Air Quality Goals Recommended by NHMRC and Interim National Indoor Air Quality Goals Recommended by NHMRC

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Series Publication

Series on Blood Guidelines	
CP84	Blood Who needs it? - Poster
CP83	Blood Who needs it? - Consumer Brochure
CP82	Clinical Practice Guidelines - Appropriate Use of Blood Components - Pocket Card
CP81	Clinical Practice Guidelines - Appropriate Use of Red Blood Cells
CP80	Clinical Practice Guidelines - Appropriate Use of Fresh Frozen Plasma Cryoprecipitate
CP79	Clinical Practice Guidelines - Appropriate Use of Platelets
CP78	Clinical Practice Guidelines on the Use of Blood Components - Main Report will be available soon
CP77	Clinical Practice Guidelines - Appropriate Use of Red Blood Cells. Summary 2001
Series on Colorectal Cancer	
CP62	Guidelines for the prevention, early detection and management of colorectal cancer (CRC)
CP63	Guidelines for the prevention, early detection and management of colorectal cancer - A guide for patient families and friends
CP64	Guidelines for the prevention, early detection and management of colorectal cancer - A guide for genera
Guide to Clinical Practice Guidelines (toolkits)	
CP30	Guidelines for the development and implementation of Clinical Practice Guidelines
CP65	How to review the evidence: systematic identification and review of the scientific literature
CP66	How to present the evidence for consumers: preparation of consumer publications
CP69	How to use the evidence: assessments and application of scientific evidence
CP71	How to put the evidence into practice: implementation and dissemination strategies
CP73	How to compare the costs and benefits: evaluation of the economic evidence
Depression in young people	
CP37	Clinical practice guidelines: Depression in young people

CP37	Clinical practice guidelines: Depression in young people
CP38	Depression in young people: A guide for general practitioners
CP39	Depression in young people: A guide for mental health professionals
CP40	Getting up from feeling down: Young people and depression
CP41	Blue daze: A comic book for young people
Coronary heart disease	
CP34	Clinical practice guidelines for the procedural and surgical management of coronary heart disease **CP3** and bypass surgery: A consumer's guide
Early breast cancer	
	Available from National Breast Cancer Centre - Phone: (02) 9334 1700 - Fax: (02) 9326 9329 ***E-mail: directorate@nbcc.org.au*** ***Internet: http://www.nbcc.org.au***
CP31	Clinical Practice Guidelines: The management of early breast cancer
CP32	Early breast cancer: A consumer's guide
Prevention of stroke	
CP45	Clinical practice guidelines: Prevention of stroke - The role of anticoagulants, antiplatelet agents and ca endarterectomy
CP46	Preventing stroke: A consumer's reference guide
CP47	Stroke prevention: A guide for general practitioners
Unstable angina	
CP48	Clinical practice guidelines: Diagnosis and management of unstable angina
CP49	Unstable angina: A consumer's guide
Acute pain	
CP57	Acute pain management: Scientific evidence
CP58	Acute pain management: Information for consumers
CP59	Acute pain management: Information for general practitioners
Uncomplicated lower urinary tract symptoms in men	
CP42	Clinical practice guidelines for the management of uncomplicated lower urinary tract symptoms in men
CP43	'Is it my prostate doc?': A guide for general practitioners
CP44	To pee ... or not to pee ...A guide for men about their urinary symptoms
Series on diabetes	
DI4	The role of ambulatory services in the management of diabetes

DI4	The role of ambulatory services in the management of diabetes
DI2	Hypoglycaemia and diabetes
DI3	Hypoglycaemia and diabetes (Patient information leaflet)
DI1	Diabetes in older people
DI5	Diabetes and exercise
DI6	Diabetes and driving
Series on clinical management problems in the elderly	
AC1	Pneumonia in the elderly
AC2	Exercise and the older person
AC3	Minimising the adverse consequences of hospitalisation in the older person
AC4	Musculoskeletal disorders in the older person
AC5	Incontinence and the older person
AC6	Falls and the older person
AC7	Medication and the older person
Infection control	
IC5	Creutzfeldt-Jakob disease and other human transmissible spongiform encephalopathies
IC6	Infection control in health care settings: Guidelines for the prevention of transmission of infectious disea
CD15	Measles: Guidelines for the control of outbreaks in Australia
IC8	Report of the expert NHMRC panel on re-use of medical devices labelled as single use
CD16	Guidelines for the control of meningococcal disease in Australia
Diabetic retinopathy	
	Available from Diabetes Australia - Phone: (02) 6230 1155 Fax: (02) 6230 1535 ***Internet: http://www.diabetesaustralia.com.au*** ***Email: jtunks@diabetesaustralia.com.au***
CP53	Clinical practice guidelines: Management of diabetic retinopathy
CP54	Diabetes and your eyes: A consumer guide for the management of diabetic retinopathy
CP55	Preserving vision in diabetes: A quick reference guide for optometrists, nurses and other health practitio
CP56	Management of diabetic retinopathy: A guide for general practitioners
Preterm birth	
CP51	Clinical practice guidelines: Care around preterm birth
CP52	A guide for parents: Care around preterm birth

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Rheumatoid arthritis and juvenile idiopathic arthritis - etanercept and infliximab (No.

22 March 2002

The National Institute for Clinical Excellence (NICE or the Institute) has recommended the use of etar the treatment of juvenile idiopathic arthritis (JIA) and etanercept and infliximab for rheumatoid arthritis

links:

- 2002/016 NICE recommends the selective use of new drugs for arthritis in children and adults 22 Marc
- Guidance on the use of etanercept for the treatment of juvenile idiopathic arthritis 22 March 2002
- Guidance on the use of etanercept and infliximab for the treatment of rheumatoid arthritis 22 March 200
- Assessment report for etanercept for juvenile idiopathic arthritis 22 March 2002
- Assessment report for etanercept and infliximab for rheumatiod arthritis 22 March 2002

Clinical Excellence 2001 presentations available online

18 March 2002

Clinical Excellence 2001 was held at the Excel Centre in London Docklands on 5th and 6th Decembe

This year we have been able to make most of the speaker presentations available on the website (ple that not all presentations are available). Click on the link above for more information.

Hearing Aid Review

18 March 2002

The Institute has issued a short statement explaining its decision to change the date of review for its g advances in hearing aids.

Breast cancer - trastuzumab (NO 34)

15 March 2002

NICE approves Herceptin for advanced breast cancer.

NICE has today issued guidance to the NHS in England and Wales on the use of trastuzumab (brand Herceptin) for advanced breast cancer.

Listed below are the press release and guidance documents.

links:

- 2002/015 NICE approves trastuzumab (Herceptin) for advanced breast cancer 15 March 2002
- Full guidance on trastuzumab for advanced breast cancer (pdf) 15 March 2002
- Full guidance on trastuzumab for advanced breast cancer 15 March 2002

links:

- 2002/015 NICE approves trastuzumab (Herceptin) for advanced breast cancer 15 March 2002
- Full guidance on trastuzumab for advanced breast cancer (pdf) 15 March 2002
- Full guidance on trastuzumab for advanced breast cancer 15 March 2002
- Patient leaflet on trastuzumab for advanced breast cancer (pdf) 15 March 2002
- Patient leaflet on trastuzumab for advanced breast cancer 15 March 2002
- Assessment report on trastuzumab for advanced breast cancer (pdf) 15 March 2002

Appraisal of atypical anti-psychotic drugs for the treatment of schizophrenia

14 March 2002

The appeal period for the appraisal of atypical anti-psychotic drugs for the treatment of schizophrenia closed.

The Institute has received two appeals against the proposed guidance. These appeals will be heard 2002.

Appraisal Consultation Document: Computerised cognitive behaviour therapy

14 March 2002

This document has been issued to the consultees for a consultation period. Members of the public ar to comment on the document. To make comments, click on the link above and identify yourself, you w able to make comments at the end of each section of the document.

Public Board Meeting, 20th March 2002

26 March 2002

The next Board meeting will be held at 2pm on Wednesday, March 20th, 2002 in Derby in the Garde the Midland Hotel, Midland Road, Derby DE1 2SQ

links:

- Agenda for Board meeting on 20th March 2002
- Location map for Midland Hotel, Derby

Principles for Best Practice in Clinical Audit

11 March 2002

NICE has today (Monday 11th March) launched the NICE and CHI-endorsed publication Principles fo Practice in Clinical Audit. The book aims to support NHS staff by detailing the methods, tools, techniq activities related to each stage of clinical audit. It contains sections on preparing for audit, selecting a measuring levels of performance, and making and sustaining improvements in care.

Appraisal Consultation Document: Surgery for people with morbid obesity

28 February 2002

This document has been issued to the consultees for a consultation period. Members of the public ar to comment on the document. To make comments, click on the link above and identify yourself; you w able to make comments at the end of each section of the document.

Advanced Colorectal Cancer - irinotecan, oxaliplatin & raltitrexed (NO 33)

7 March 2002

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5. BTS Recommendation to Respiratory Physicians for Organising the Care of Patients with Lung Cancer - go to guideline
6. Chemotherapy and management of tuberculosis in the United Kingdom: recommendations 1998 - go to guideline
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16. Guidelines on Non-invasive ventilation in acute respiratory failure 2002 - go to guideline

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The British guidelines on asthma management: 1995 review and position statement. The British Thoracic Society et al: Supplement to February issue of Thorax 1997; Vol 52; 51

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Current best practice for nebuliser treatment. The Nebuliser Project Group of the British Thoracic Society Standards of Care Committee. Supplement to April issue of Thorax 1997; Vol 52 Supp 2

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- Nebulised bronchodilators, corticosteroids, and rhDNase in patients with cystic fibrosis
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- Nebulised drugs in palliative care
- Nebuliser therapy in childhood
- Selecting and using nebuliser equipment
- Staff education
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Guidelines on the Management of COPD. The British Thoracic Society Standards of Care Committee. Supplement to December 1997 issue of Thorax 1997, Vol 52:5.

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Suspected acute Pulmonary Embolism - a Practical Approach. The British Thoracic Society Standards of Care Committee. Thorax 1997; 52: Supplement 3 S3.

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BTS Recommendation to Respiratory Physicians for Organising the Care of Patients with Lung Cancer. The Lung Cancer Working Party of the British Thoracic Society Standards of Care Committee: Supplement to June issue of Thorax 1998; 53:1.

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Chemotherapy and management of tuberculosis in the United Kingdom: recommendations 1998. Joint Tuberculosis Committee of the British Thoracic Society. Thorax 1998, Vol 53, 7: 536-548.

- Text

The Diagnosis, Assessment and Treatment of Diffuse Paranchymal Lung Disease in Adults: The Diffuse Parenchymal Lung Disease Group of the British Thoracic Society. Thorax April 1999, Vol.54, 1

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Management of opportunist and mycobacterial infections: Joint Tuberculosis Committee guidelines 1999. Subcommittee of the Joint Tuberculosis Committee of the British Thoracic Society. Thorax 2000. Vol.55 ,3 : 210-218

- Text

Control and prevention of tuberculosis in the United Kingdom: Code of Practice 2000. Joint Tuberculosis Committee of the British Thoracic Society. Thorax 2000. Vol. 55,11: 887-901

- Text

Guidelines on the selection of patients with lung cancer for surgery. British Thoracic Society and Society of Cardiothoracic Surgeons of Great Britain and Ireland Working Party. Thorax 2001. Vol 56: 89-108

- Text

Guidelines on Diagnostic Flexible Bronchoscopy. British Thoracic Society. Thorax 2001. Vol 56; Supplement I.

- Text

Statement on malignant mesothelioma in the United Kingdom. British Thoracic Society Standards of Care Committee. Thorax 2001. Vol 56; 250-265

- Text

Guidelines for the Management of Community Acquired Pneumonia in Adults. British Thoracic Society. Thorax 2001. Vol 56; supplement IV.

- Text

BTS Statement on Pulmonary Rehabilitation,

- Text

BTS Statement on Pulmonary Rehabilitation, 2001. British Thoracic Society. Thorax 2001. Vol 56; 827–834.

- Text

BTS Statement on Malignant Mesothelioma in the United Kingdom, 2001. British Thoracic Society. Thorax 2001. Vol 56; 250–265.

- Text

Guidelines on Non-invasive ventilation in acute respiratory failure. British Thoracic Society Standards of Care Committee: Thorax 2002;57:192–211

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BTS British Thoracic Society

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Guidelines in Preparation

Management of Community Acquired Pneumonia
(Chair: Dr J MacFarlane)
Current Status: with Thorax.
Publication Date: end of 2001

Pleural Disease
(Chair: Dr R Davies)
Current status: final draft being discussed before being sent to Thorax
Publication Date: early/mid 2002

Asthma Guidelines
(Chair: Dr BG Higgins)
Current Status: The guidelines are being created jointly with SIGN (Scottish Intercollegiate Guidelines Network). A public meeting was held in Edinburgh in October 2001 to discuss the first draft. Another public meeting will be held in London on 7 December during the BTS WInter Meeting.
Publication Date: May 2002

Flying and Lung Disease
(Chair: Dr R Coker)
Current Status: The final draft has been sent to Thorax for publication.
Publication Date: early 2002

Diving and Lung Disease
(Chair: Professor DJ Godden)
Current Status: Final draft in preparation
Publication Date: early/mid 2002

Obstructive Sleep Apnoea
This will be a SIGN Guideline, endorsed by the BTS.
Current Status: The final draft guidelines are in preparation.
Publication Date: early 2002

NIPPV
(Chair: Dr W Kinnear)
Current Status: have been sent to Thorax for consideration
Publication Date: early/mid 2002

Bronchiectasis
(Chair: Professor R Stockley)
Current Status: Work began in July 2000.

(Chair: Dr W Kinnear)
Current Status: have been sent to Thorax for consideration
Publication Date: early/mid 2002

Bronchiectasis
(Chair: Professor R Stockley)
Current Status: Work began in July 2000.
Publication Date: late 2002

Pulmonary Embolism
(Chair Dr A Miller)
Current status: first draft being prepared
Publication Date: late 2002

Needle Biopsy of Lung Lesions

(Chair Dr A Mannhire)
Current status: first draft being prepared
Publication date: late 2002

COPD Guidelines

NICE has recently announced that it will be commissioning a Guideline on COPD. The Society will not therefore be revising its 1997 Guidelines, but has registered as a stakeholder in the NICE process.

Anticipated publication date: Spring 2003

Clinical Effectiveness Programme - Home Page

CLINICAL EFFECTIVENESS PROGRAMME in PRACTICE-BASED PRIMARY CARE

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GUIDELINES INITIATIVES

News ¦ Projects ¦ SIGN ¦ Quick Guides

These pages have been developed by RCGP Scotland for professionals in Primary Care to provide informatio SIGN guidelines and their implementation in practice. We aim to

- encourage GPs to participate in the development of SIGN guidelines.
- share information on implementing guidelines as well as materials developed to support them.

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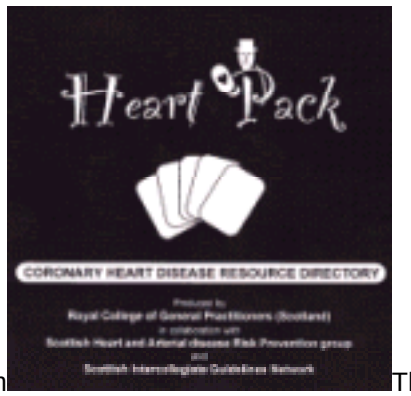
Clinical Effectiveness Programme,
Quality Department, RCGP Scotland, 25 Queen Street, Edinburgh, EH2 1JX
Tel: 0131 260 6800
Fax: 0131 260 6836

GUIDELINES INITIATIVES

Heart Pack - Coronary Heart Disease Resource Directory - on CD-Rom



Heart Pack on CDRom The Heart Pack CD has been produced by the Royal College of General Practitioners (Scotland), in conjunction with Scottish Heart and Arterial disease Risk Prevention (SHARP) and the Scottish Intercollegiate Guidelines Network (SIGN).

The CD contains the original 64 page Heart Pack directory, details of SIGN guidelines relating to heart disease, information about implementation initiatives, education and patient information, an informative, stimulating and educational video which highlights some of the key points from SIGN guidelines, and has the CHD and Stroke Risk Assessor. A full list of contents with links to sample information is available, while a PDF version of the directory can also be downloaded.

For further details on the CD Rom contact Louise Hutchison on 0131 260 6800. There are also a small number of Heart Pack posters available.

New SIGN Development Groups

There are always new SIGN development groups being created to generate new Guidelines or review groups to update current guidelines and the College are always looking for new GPs to join these groups. If you are interested in joining such a group in the future click here and complete the online registration form that will allow your up-to-date details to be saved on our database and used to recruit for new groups.

SIGN National Meetings

It is important that after a Guideline has been drafted that it

registration form that will allow your up-to-date details to be saved on our database and used to recruit for new groups.

SIGN National Meetings

It is important that after a Guideline has been drafted that it receives comments from other health care professionals. RCGP Scotland are required to have representatives at all meetings relating to primary care. These representatives are required to write a short report on the comments relating to the draft guideline and not the meeting itself that are used by the development group to finalise the guideline. Locum and travel expenses will be paid by SIGN and the £30 meeting fee is also reimbursed. The next meeting is **Osteoporosis** and is being held on **Tuesday 19 February** at the **Royal College of Physicians of Edinburgh**. If you are interested in attending this meeting please contact Louise Hutchison, otherwise click here for future national meetings.

New SIGN Guidelines

The most recent SIGN guidelines to have been published are as below. See the SIGN site for the full guidelines.

No. 50 A Guideline Developer's Handbook
It is intended that SIGN 50 should be a 'living publication', continually revised to reflect future developments in SIGN methodology. Details of any updates and new sections will be available from the SIGN site

No. 51 Management of Stable Angina
This guideline focuses on the management of stable angina in primary care and on angina presenting as a stable symptom for the first time.

No. 52 Attention Deficit and Hyperkinetic Disorders in Children and Young People
The guideline covers an introduction, the different assessment modes, management of the disorder and identification of a range of resources helpful to children and young people with ADHD and their families.

Useful Websites

Link here to The Royal College of General Practitioners (Scotland) website at www.rcgp-scotland.org.uk (This link will open a new window. Close it to return to this page.)

The publisher of *Guidelines* and *Guidelines in Practice* has a guidelines website. This site allows free access to many guidelines and provides links to related clinical effectiveness sites. www.eguidelines.co.uk (This link will open a new window. Close it to return to this page.)

The Scottish School of Primary Care (SSPC) aims to promote and co-ordinate research in primary care, and is supported by the Government and professional organistations. www.sspc.uk.com (This link will open a new window. Close it to return to this page.)

The Scottish School of Primary Care (SSPC) aims to promote and co-ordinate research in primary care, and is supported by the Government and professional organistations. www.sspc.uk.com (This link will open a new window. Close it to return to this page.)

The Health Education Board for Scotland's weight management website provides easily accessible and up-to-date information for primary care. The content of the site has been based upon SIGN Guideline 8 on Obesity. www.hebs.scot.nhs.uk/learningcentre/weightmanagement (This link will open a new window. Close it to return to this page.)

Managing Cardiovascular Risk Factors: A Distance Education Course. Details can be accessed at the web page www.medicine.gla.ac.uk/nursing/distance_learning.htm (This link will open a new window. Close it to return to this page.)

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Clinical Effectiveness Programme,
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Scotland, 25 Queen Street,
Edinburgh, EH2 1JX
Tel: 0131 260 6800
Fax: 0131 260 6836

GUIDELINES INITIATIVES

The Scottish Intercollegiate Guidelines Network (SIGN) was formed in 1993. Its objective is to improve the effectiveness and efficiency of clinical care for patients in Scotland by developing, publishing and disseminating guidelines which identify and promote good clinical practice.

SIGN is a network of clinicians and healthcare professionals including representatives of all the UK Royal Medical Colleges as well as nursing, pharmacy, dentistry and professions allied to medicine. Patients' views are represented on SIGN through the Scottish Association of Health Councils. SIGN works closely with other national groups and government agencies working in the National Health Service in Scotland. The SIGN Secretariat is based at the Royal College of Physicians of Edinburgh.

A graphical representation of the Guideline development programme is shown on this site, with indications of where GPs can get involved, through proposals for new guidelines, membership of development groups, submission of key questions, attending national Guideline meetings and peer review.

Full details of development methodology and process, as well as downloadable versions of guidelines, details of National Guideline meetings, and Guideline purchasing options are available from the SIGN web site.

Clinical Effectiveness Programme,
Quality Department, RCGP Scotland, 25 Queen Street,
Edinburgh, EH2 1JX
Tel: 0131 260 6800
Fax: 0131 260 6836

GUIDELINES INITIATIVES

Quick Guide to Guidelines

The Quick Guide is produced by RCGP (Scotland), for use in Primary Care, and comprises summaries of the main SIGN guidelines.

Quick Guides are available for download, in PDF format, from this site, or by contacting Louise Hutchison on 0131 260 6800.

The main points for primary care have been extracted from national guidelines developed by the Scottish Intercollegiate Guidelines Network (SIGN). The aim of the Quick Guide to Guidelines is to provide a summary of these key points - further information about the grade of recommendations and levels of evidence are available in the full SIGN guidelines. NB. This link will open a new browser window. Close it to return to SIGNet.

A multidisciplinary working group developed the Quick Guide to Guidelines for the RCGP:

- Dr James Beattie (RCGP Director of Guideline Development)
- Mrs Jayne Burnett (Nursing)
- Mrs Lizzie McGeechan (Nursing)
- Dr John Foster (General Practice)
- Ms Tracy Nairn (Professions Allied to Medicine)
- Ms Nicola Ring (Nursing)
- Mr David Thomson (Pharmacy)
- Dr Elaine Turner (General Practice)
- Ms Yvonne Cownie - Administrator - Quality Standards (RCGP)

NB: These summaries are solely derived from the information contained in the published SIGN guidelines. No account has been taken of any new evidence. Summaries will be updated when each SIGN guideline is reviewed.

Standards (RCGP)

NB: These summaries are solely derived from the information contained in the published SIGN guidelines. No account has been taken of any new evidence. Summaries will be updated when each SIGN guideline is reviewed.

Care has been taken to ensure that the information contained in this booklet is as accurate as possible at the time of publication. The Quick Guide to Guidelines provides only a summary of the key points for primary care derived from the SIGN guidelines, and the RCGP would recommend that further information be obtained from the full SIGN guidelines.

The Quick Guide to Guidelines has been supported by: Clinical Effectiveness Programme Subgroup of CRAG National Board for Nursing, Midwifery and Health Visiting for Scotland

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Welcome

The first of April 2001 the Danish Institute for Health Technology Assessment (DIHTA) and The Danish Hosp Centre merged to form a new Danish Centre for Evaluation and Health Technology Assessment (DACEHTA) situated as a seperate entity within the framework of The National Board of Health and is headed by the direc served by an advisory board and a scientific advisory board

Key aims include carrying out health technology assessments (HTAs) and integrating HTA-priniciples into the planning of the public health service at all levels. DACEHTA also carries out evaluations of public health sevi improving quality, standards and value for money.

Islands Brygge 67 P.O. Box 1881 DK-2300 Copenhagen S 72227400

Danish Centre for Evaluation and
Health Technology Assessment
National Board of Health
Islands Brygge 67
P.O.Box 1881
DK-2300 Copenhagen S, Denmark
Tel. +45 72 22 74 00
Fax +45 72 22 74 13
E-mail cemtv@sst.dk

The centre primarily targets health professionals and decision-makers at all levels as well as related research communities.

DACEHTA is charged with employing those activities and methods that will contribute most effectively to quality, efficiency and standards of care in the danish health service.

A web-site for the new center is under construction. Until then, this site will cover

levels as well as related research communities.

DACEHTA is charged with employing those activities and methods that will contribute most effectively to quality, efficiency and standards of care in the danish health service.

A web-site for the new center is under construction. Until then, this site will cover material relevant to DIHTA. For information relevant to the The Danish Hospital Evaluation Centre see www.ecs.dk. Material published since the first of Ápril 2001 will be accessible from both sites.

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News

The news section contains

- News in brief from the HTA Institute
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- Training & education
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PROJE

Projects/activities

The HTA Institute initiates, implements and gives financial support to a range of HTA activities in Denmark.

The Danish HTA-project database contains completed, ongoing and scheduled HTA-projects in Denmark.

Under Other activities, a range of initiatives relevant for HTA activities are described.

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Publications

The publication database contains information about publications published by the HTA Institute.

A range of the completed HTA-projects will be published in the report series Health Technology Assessment

To obtain information about ongoing and scheduled projects we refer to the page concerning the Project Data

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ABOUT THE

Presentation of DIHTA

The Danish Institute for HealthTechnology Assessment (DIHTA) was founded in 1997 within the framework o Health and with a Budget appropriation of DKK 25 million (US $ 4 million) per year and within the framework of Health.

It is the task of the Danish Institute for Health Technology Assessment to promote the use of health technolo Denmark, which includes providing information, advice, education and training concerning health technology as contributing to quality development within the health care system.

In cooperation with the health authorities at county level DIHTA shall make analyses and assessments in rela existing equipment, pharmaceuticals, methods of examination, investigation, treatment and care, methods of education and preventive health care work.

The aim of DIHTA is to realise the intentions behind the establishment of the Institute and the National Strate Technology Assessment (Den Nationale Strategi for Medicinsk Teknologivurdering), which was issued by the Health in 1996.

The Institute receives advice from the Institute Advisory Board and the Institute Scientific Board. The Institute which has 22 members, represents the main stakeholders within the Danish health care system at political, a industry/trade levels.

The Scientific Advisory Board, which has 9 member, gives multi-disciplinary advice to the Institute.

DIHTA has a staff which, due to its multi-disciplinary make-up, are able to perform the multi-faceted tasks fac accordance with the stated objectives and in compliance with high professional standards.

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* SIDSTE

Velkommen

Pr. 1. april 2001 er MTV-instituttet sammenlagt med Evalueringscenter for Sygehuse i en ny centerdannelse Evaluering og Medicinsk Teknologivurdering (CEMTV). Centeret er en særskilt enhed i Sundhedsstyrelsen o centerchef. Centeret rådgives af et centerråd og et videnskabeligt råd.

Et vigtigt mål er at udføre medicinsk teknologivurdering (MTV) samt at udbrede mtv-principperne på alle nive sundhedsvæsenet og indføre MTV i den løbende drift og planlægning af det offentlige sundhedsvæsen. Cen endvidere evaluering af virksomheden i sundhedsvæsenet med henblik på at fremme kvalitetsudviklingen og ressourceanvendelse.

Vigtige målgrupper er de sundhedsfaglige miljøer, beslutningstagere på alle niveauer og forskningsmiljøerne.

CEMTV er ansvarlig for at vælge sine opgaver, aktiviteter og metoder ud fra, at indsatsen skal bidrage bedst muligt til kvalitet, effektivitet og service i det danske sundhedsvæsen.

En ny hjemmeside for CEMTV er under udvikling. Foreløbig dækker denne hjemmeside det tidligere MTV-instituts område. For oplysninger knyttet til det tidligere Evalueringscenter for Sygehuse se www.ecs.dk. Materiale udgivet siden 1. april 2001 vil være tilgængeligt fra begge adresser.

Klik her hvis du løbende vil opdateres med nyheder fra CEMTV

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News in brief

New edition of HTA-Newsletter

December 14 - 2001
DACEHTA

News in brief - overview

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Health Technology Assessment

A national R&D programme for the NHS

Dept of Health logo

The National Coordinating Centre for Health Technology Assessment coordinates the HTA Programme under
R&D Division

Link to DH R&D page

NCCHTA is a member of the International Network of Agencies for Health Technology Assessment (INAHTA) f
exchange and collaboration among HTA agencies .
Link to INAHTA website

INAHTA logo

[test data zone]

P.A.S. Ambulance Consultants

Click on above to return to PAS/NAPAS Index or any underlined item for further details

P.A.S. Ambulance Consultants is a Company that has been trading as Independent Ambulance Consultant's since 1987.

It presently works for over 200 clients including multi-National Company's, NHS Trusts and others providing direct advice, or Ambulance Provision through members of the National Association of Private Ambulance Services (NAPAS)

Peter Littledyke the Senior Consultant has over 38 years experience of Ambulance Services throughout the UK, and the Company employs a number of Associated Consultants, who are specialists in other differing aspects of Ambulance Services, all of whom have between 20 and 30 years practical experience in their fields.

Peter Littledyke has been involved in many inquiries and projects over the years including, the Miller Report, The McCarthy Report, The House of Commons Emergency Services Expenditure Committee Report. More recently The Ambulance Service National Dispute and The London Ambulance Service Inquiry, together with many other Public and Private Inquiries and investigations requiring expert Independent evidence or Independent views.

Peter Littledyke is National Director of NAPAS a wholly owned Self Regulatory National Association of Private Ambulance Services and Professional Ambulance Services that have been operating for the past five years, in the UK and which has now been extended to include Europe.

The Company specializes in providing solutions to practical problems within Ambulance Services, together with Professional Ambulance Service Provision through the Inspected P.A.S. Ambulance Network including, Ambulance Vehicle and equipment Design projects. Our latest development is "P.A.S. First Call" a system, designed to provide NHS Trusts and Repatriation Services with cost effective estimates, for any given journey, either in the UK or Europe at low cost, coupled with complete journey planning throughout, and central billing. Providing additional available resources to a high quality standard, and assisting NHS Services to improve their own business plans and charter standards through mutual cooperation and support.

Year on Year P.A.S. Ambulance Consultants has increased turnover, and its profits from its many and varied activities. Its client base continues to increase, mainly obtained through satisfied client's recommendations or repeated extra business, through provision of Private, Professional and Paramedic Ambulance Service's, many clients of who describe them as *"Simply the Best".*

Click on any underlined subject for more details

Free-Phone 08000-929-112 all inquiries are welcome

Credit card payments may now be made via PAS First Call

P.A.S Repatriation Services

Medical Repatriation by Road, Rail or Air, all present constraints and difficulties that have to be addressed, be they, Medical Conditions or just simple cost

P.A.S. Through NAPAS Member Services provide expertise in these aspects.

The vast majority of Patient Repatriations are covered by Insurance, and our services are working on a daily basis with all of the major Insurance Repatriation, and Assistance Companies, P.A.S. First Call Central Assistance provides an essential central coordinating service for many of the UK's leading Assistance Companies. For the transportation by Road, Rail, Sea, and Air, with sick or injured patients being repatriated from across the world back to, and from the United Kingdom and the Irish Republic, on a daily basis.

We also undertake on a more direct basis Repatriation of the uninsured patient, for this type of service, cost becomes a more critical fact, as it may be left to individuals, relatives, or even employers, to raise funds to pay for such case's. P.A.S. are there to help and assist where ever possible, we can suggest possible means for raising funds, and methods of reducing overheads and costs to an absolute minimum.

The best advise remains, for all people who are traveling abroad from the UK is "to obtain Comprehensive travel Insurance and they should always have an E111 with them". For those who are traveling within the UK, the British National Health Service provides outstanding emergency treatment, but as with most countries, repatriation costs are not covered.

Should you require any advice regarding engagement of Professional, Private, or Paramedic, Service in the P.A.S. Ambulance Network

Telephone PAS Central Assistance **+ 0044-(0) 1733-350916 (UK) Fax-Link**

OR FREE-PHONE FROM THE UK 08000-929-112

E-mail: pas112@Cyberware.co.uk

Credit card payments may now be made via PAS First Call

Useful Links for information concerning Medical Repatriation and ASSISTANCE

GESA INTERNATIONAL ASSISTANCE

EAST MIDLANDS AERO-MEDICAL SERVICES

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Precise journey planning throughout the UK and Europe

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P.A.S. "First Call" satisfied clients now include hundreds of Individuals, NHS Trusts, Repatriation Companies, Assistance Services, NHS Ambulance Services, Private Hospital providers, Health Insurers, to name but a few.

Since October 1997 P.A.S. "First Call" have been appointed by many International Assistance Companies to provide on an exclusive basis, throughout the UK and Eire, all Land Ambulance Operations. Thereby providing a positive and Professional Ambulance Service to there many and varied International clients on both, an immediate and pre-booked basis.

Since October 1996 P.A.S. "First Call" have been providing services to referred clients from the British Red Cross, Tripscope, NHS Hospital Trusts, NHS Ambulance Trusts, Private Hospitals, The AA, The R.A.C., and many others. Many of who have had to undertake many telephone calls, in an attempt to secure such services. They found eventually that it required only one telephone call to 0044 (0) 1733-350916 Fax-Link **you can now call Free-phone 08000-929-112**

Services engaged by P.A.S. "First Call" are provided only through Regulated and Inspected NAPAS Services. These Services have over the past six years, undertaken many thousands of successful Professional Ambulance Service transportation journeys, including, simple movements and Intensive Care Movements. NAPAS and P.A.S. Have become the UK and Eire's leading Private Ambulance Services.

Having taken on a number of major National Contracts P.A.S. "First Call" continue to expand at a controlled rate, and we can continue offer selected Repatriation Service providers, an opportunity, to be included within this planned expansion. So that they may also make overall savings in operational costs, and provide a true Paramedic, Professional, Private service of quality, coordinated throughout by specialist PAS Ambulance Consultants using the PAS Ambulance Network

Below are links to a few of the services that we have provided land ambulance transportation for throughout the UK and Eire.

We also provide Road Ambulance transportation across central Europe, when patients are unable to be flown due to their medical conditions.

Medic-Air European Wayfarers 24-7 Travel Protection Group Europ-Assist

Inter-Partner Assistance Mondial Assistance

Click on any underlined subject for more details.

Inclusions of links are for interest purpose's only and in no way implies PAS endorsement

Free-Phone 08000-929-112 all inquiries are welcome

Credit card payments may now be made via PAS First Call

P.A.S. Ambulance Network

Click on above to return to PAS/NAPAS Index or any underlined item for further details

The P.A.S. Ambulance Network extends throughout the UK and Eire.

From the West Coast of Ireland, to Essex on the East Coast UK.

From Inverness in Northern Scotland, to Cornwall in the South of England.

P.A.S. "First Call" can call upon the services of Professional, Private and Paramedic, Ambulance Services to undertake any Repatriation Service at Home or Abroad.

42 Professional NAPAS Services, operating from over 98 individual bases.with

40 Medical Cars (Category 1)

28 Low-profile Ambulances (Category 2)

13 Accident & Emergency Ambulance (Category 2)

98 Extended Equipped Ambulances (Category 3)

Employing the following Qualified Staff

4 First Aider's (Grade A)

37 Intermediate Technicians (Grade B1)

248 Ambulance Technicians (Grade B)

103 Extended Trained Paramedics (Grade C)

48 Medical Doctors (Grade C Plus)

440 qualified and experienced staff over the full ranges of Ambulance Aid Duties.

Last year NAPAS Members received NO written Complaints with regard to the services employed and all past complaints have been satisfactory resolved (5 in 12 years)

During the past year NAPAS Members received 507 Commendations about the services

employed.

FACTS THAT SPEAK FOR THEMSELVES

"SIMPLY the BEST"

Footnote: This listing has been updated on the 27th June 2001.

Click on any underlined subject for more details

Free-Phone 08000-929-112 all inquiries are welcome

Credit card payments may now be made via PAS First Call

P.A.S. Professional Ambulance Services

Click on above to return to PAS/NAPAS Index or on any underlined item for further details

All P.A.S. Ambulance Service provisions are supplied through NAPAS Member Services.

NAPAS Member Services are Regulated, Inspected, Professional, Private providers of Ambulance Services.

NAPAS Operational staff, are qualified by both Training and Experience, and hold current National Certification in Ambulance Aid, or appropriate State Registration Nursing Qualifications or have undertaken an appropriate conversion course.

Services provided by the Voluntary Sector or the Charitable Sector cannot join NAPAS, membership is only open to Professional Providers of Ambulance Services.

NAPAS services meet in every respect with the, "Department of Health, Ambulance Policy Advisory Groups "Code of Practice for Private Ambulance Operators".

They also conform to the Criteria requirements for "The Voluntary Health Insurance Board for Southern Ireland"

Members of NAPAS are Professional Providers of Ambulance Services and as such, Under take their individual responsibilities in accordance with the Highest National Principles.

A number of NAPAS services also specialize in Air Ambulance Repatriation Services, and together with Professional Qualified In Flight Nurse's and Doctors undertake these services, we also engage from time to time other Associated Member services, depended upon the patients possible likely requirements, through P.A.S. "First Call" or the P.A.S. Paramedic and Ambulance Network

We provide Professional Ambulance Expertise for all types of events as well as for Repatriation, such as, Equestrian, Motor Sports, Professional Boxing, Pop Concerts, Corporate Events, Motor Cycle Racing, Kick boxing, Film Productions, etc.

NAPAS SERVICES WORK WITHIN THE VARIOUS GOVERNING BODIES RULES AND REQUIREMENTS.

Listed below are a few of the Organisations that we provide Professional Ambulance Services for, the links are for interest purposes only so that potential clients can see the different types of events that Professional Ambulance Aid Services are provided for.

PAS do not endorse any individual site or organisation.

Under the British Boxing Board of Control Requirements for:

Joe Pyle Boxing. Sports Network Europe. Matchroom Promotions, Golden Fists Boxing

The World Boxing Organisation. Ringside Promotions. St. Andrews Boxing,

Morrison Boxing. TKO Boxing

Under British Eventing Rules for members of the

British Horse Trials Association British Pony Society

Under the Corporate Events Association Rules for

Outdoor Wizards. KDM Events. Finishing Touch Events. Cavendish Sporting Events. Eventive. Banzi. Global Solutions. Pure Solutions. The Event Business.

The Inspire Partnership. Dragons Alive. Catalyst Events. Wilton Mill. W.B.I.A..

Under British Dirt Riders Association Rules for

KIS Promo-Sport and Red Bull

Through Compliance of Local Authority Licensing Conditions for

Sheffield City Council Events. Reading Council Events. Southwark Council Events

Twickenham Council Events. British University Sports

Amateur Fencing Association. Scottish Fencing Association. City of London Road Run.

The Ice Hockey Super league

A few Local Authority Social Services Departments

Westminster Social Services: Hatfield Social Services: Islington Social Services

Herts County Council Social Services and Education. Hackney Social Services

Milton Keynes Social Services: Wandsworth Social Services: Camden Social Services

Film Medical and Stunt Paramedic Standby.

BBC Productions - Yorkshire-TV - Granada TV - Gorgeous Productions.

The above Organisations and Clients represent a small number of the varied duties currently being undertaken by PAS Professional Ambulance Services. These services may be booked on a central basis through PAS First Call Central Assistance

Free-Phone 08000-929-112 all inquiries are welcome

Credit card payments may now be made via PAS First Call

Click on any underlined subject for more details

PRIVATE AMBULANCE SERVICES

Click on above to return to PAS/NAPAS Index or on any underlined item for further details

With the past lack, of any form of Regulation, in the Private Ambulance Service sector, either in the UK or Eire, regulation was required to meet the urgent demands of both clients and the responsible Private Ambulance Services. P.A.S. Ambulance Consultants formed (in 1988) firstly "The P.A.S. Group" as a Self-Regulatory organisation for Private and Professional Ambulance Services, to provide a basis for provision of services, in accordance with anticipated Public Expectations.

"The P.A.S. Group" was well received by the Industry, as a way forward to Regulation of an otherwise disorganized sector. This Group achieved the basis for National Standards, but at the time required heavy subsidy by P.A.S. Ambulance Consultants it was decided in early 1992 that a more formal basis should be established. This would provide for Independent Management, and still allow Individual members to run their own Individual Companies, but within a General framework of Self-Regulation still based on the basic principle of Public Expectations.

This New organisation became

"The National Association of Private Ambulance Services" (NAPAS).

During the past few years, we have seen a number of attempts in the UK to create Private Ambulance Groups. Some by well meaning individuals, and some by less well meaning individuals, many of whom appear to be motivated by reduced standards, illusions of grandeur, or Financial benefits. Attracting members, many of whom have failed to meet with the NAPAS minimum criteria, and who appear to feel that unless they belong to some form of group, their individual futures are doubtful, this is not far from the truth.

The current situation in the UK and Eire remains the same as in 1988, "Let The Buyer Beware", unless of course that Buyer obtains the services of a Professional Ambulance Service such as those, inspected and approved Registered NAPAS Members. Who undertake to work in accordance with self imposed Regulation, written in accordance with Public Expectation, not written in accordance with any form of lowered expectations, created to pander, or pacify either "wanabe" individuals or other inadequate service providers.

Paramedic, Repatriation Services are available through P.A.S. "First Call" and the PAS Ambulance Network **simply call 0044 (0) 1733-350916 24 hours Service**.

Or **Free-Phone 08000-929-112**

Credit card payments may now be made via PAS First Call

If you have suffered an Accident, then you will be entitled to a NHS Ambulance to convey you to a place of treatment usually the nearest accident and Emergency Department at the time of the accident. But what then happens if you decide to opt for further treatment on a private basis

In the UK and Ireland you will have to engage the services of a Private Ambulance Company to undertake your transportation, it will be in your own interest to only use a NAPAS Regulated Service, NAPAS services can be contracted through PAS First Call or on a direct basis.

If through the results of the accident you have incurred additional costs, you may be entitled to recover those costs through legal action?

A useful site for further advice is Accident Compensation.Com.

Site links are provided for interest only and PAS/NAPAS do not endorse any of these services

Click on any underlined subject for more details.

A-Z index of SHOW sites

A-Z INDEX OF SHOW SITES

Listing SHOW member sites.

To display an A-Z index that only includes sites that have a certain text sequence within their title, enter the text in the bo
click 'Go'. To return to the full A-Z list after a custom list has been generated, leave the box blank and click 'Go':

A | B | C | D | E | F | G | H | I | L | M | N | O | P | Q | R | S | T | W | X | Y |

A

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Annandale & Eskdale Local Healthcare Cooperative
Argyll and Clyde Acute Hospitals NHS Trust
Argyll and Clyde Health Board
Argyll and Clyde Health Council
Association of Managers in General Practice (Scotland)
Association of Scottish Trust Chief Pharmacists
Ayrshire and Arran Acute Hospitals NHS Trust
Ayrshire and Arran Health Board
Ayrshire and Arran Health Council
Ayrshire and Arran Primary Care NHS Trust

B

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Borders General Hospital NHS Trust
Borders Health Board
Borders Primary Care NHS Trust
Breastfeeding in Scotland
Business Advisory Group

C

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Cancer Scenarios: An aid to planning cancer services in Scotland in the next decade
Chief Scientists Office
Child Health Support Group
Clinical Governance
Clinical Resource and Audit Group
Common Service Agency

D

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Data Protection for NHSScotland
Diagnostics Scotland
Downfield Practice
Dumfries & Galloway Child Health Services
Dumfries and Galloway Acute and Maternity Hospitals NHS Trust
Dumfries and Galloway Health Board

Dumfries and Galloway Health Council
Dumfries and Galloway Infection Control Team
Dumfries and Galloway Primary Care NHS Trust
Dumfries and Galloway Strategy for Nursing and Midwifery

EClick to go to top of page top

E-mail in the NHSiS
eCare
Edinburgh Sleep Centre
Electronic Clinical Communications Implementation

FClick to go to top of page top

Fife Acute Hospitals NHS Trust
Fife Health Board
Fife Health Council
Fife Primary Care NHS Trust
Forth Valley Acute Hospitals NHS Trust
Forth Valley Health Board
Forth Valley Health Council
Forth Valley Primary Care NHS Trust
Forums

GClick to go to top of page top

Glasgow Health Information
Glasgow Palliative Care Network
Glasgow Pharmacy Services
GPASS
GPASS User Group
Grampian General Practices
Grampian Health Board
Grampian Health Council
Grampian Primary Care NHS Trust
Grampian University Hospitals NHS Trust
Greater Glasgow Health Board
Greater Glasgow Health Board Pharmacy
Greater Glasgow Health Council
Greater Glasgow NHS Board Area Drugs and Therapeutics Committee
Greater Glasgow Primary Care NHS Trust

HClick to go to top of page top

Hairmyres
Hairmyres Hospital
Health Education Board for Scotland
Health Services Research Unit

Health Technology Board for Scotland
Heart Attack First Aid
HEBS Support Groups Database
Highland Acute Hospitals NHS Trust
Highland Health Board
Highland Health Council
Highland Primary Care NHS Trust

IClick to go to top of page top

Information and Statistics Division (ISD) Scotland
Information Management & technology in General Practice
Information Management and Technology (IM&T) in General Practice
Information Management and Technology for NHS Scotland
ISSG Technical Support (Previously GPNET)
IT Security

LClick to go to top of page top

Lanarkshire Acute Hospitals NHS Trust
Lanarkshire Health Board
Lanarkshire Health Council
Lanarkshire Primary Care NHS Trust
Law Hospital NHS Trust
Local Health Care Co-Operatives
Lomond and Argyll Primary Care NHS Trust
Lothian Health Council
Lothian Local Medical Committee
Lothian NHS Board
Lothian Primary Care NHS Trust
Lothian Psychologists' CPD (Continuing Professional Development) Group
Lothian University Hospitals NHS Trust

MClick to go to top of page top

Managed Clinical Networks for Coronary Heart Disease - Dumfries & Galloway
Management in the NHS in Scotland
Mental Health and Well Being Support Group
Monklands Hospital

NClick to go to top of page top

National Services Division (NSD)
News
NHS Complaints Procedure
NHS Greater Glasgow - Pharmacy Health Promotion
NHSNet
NHSScotland IT Security

NHSScotland Property & Environment Forum Executive
North Glasgow University Hospitals NHS Trust
Nursing Council on Alcohol

OClick to go to top of page top

Office for Public Health in Scotland
Orkney Health Board
Orkney Health Council

PClick to go to top of page top

Partners Project
Pentlands Medical Centre
Practitioner Services (PSD)
PROTEC data protection
Public Appointments in NHSScotland

QClick to go to top of page top

Queen Elizabeth National Spinal Injuries Unit, Scotland

RClick to go to top of page top

Renfrewshire and Inverclyde Primary Care NHS Trust
Review group on Retention of Organs at Post Mortem
Review of the Public Health Function in Scotland
Review of the Public Health Function in Scotland
Royal Alexandra Hospital NHS Trust

SClick to go to top of page top

Sandyford Initiative
Scottish Advisory Committee on Distinction Awards
Scottish Association of Health Councils
Scottish Audit of Surgical Mortality - SASM
Scottish Birth Record Project
Scottish Care Information
Scottish Centre for Infection and Environmental Health
Scottish Council for Postgraduate Medical and Dental Education (SCPMDE)
Scottish Executive Health Department
Scottish Health Advisory Service
Scottish Health Economics Network (SHEN)
Scottish Health Information Network
Scottish Health on the Web - Help pages
Scottish Health Service Centre
Scottish Health Survey 1998
Scottish Healthcare Supplies

Scottish Intercollegiate Guidelines Network
Scottish Liver Transplant Unit
Scottish MRSA Reference Laboratory
Scottish National Blood Transfusion Service
Scottish National Sleep Centre
Scottish Opthalmic Oncology Service
Scottish Partnership Forum
Scottish Poisons Information Bureau
Scottish Practice Nurses Association
Scottish Programme for Clinical Effectiveness in Reproductive Health
Scottish Resuscitation Group
Shetland Health Board
Shetland Health Council
SHOW Style Guide (PDF)
SHOW Support Site
South Central Edinburgh Local Health Care Co-operative (LHCC)
South Glasgow University Hospitals NHS Trust
Statement of Fees & Allowances to GPs (Red Book)
Stewartry Local Health Care Co-operative (LHCC)
Strategic Alliance partnership

TClick to go to top of page top

Taking Action 1998-2002, a strategic framework for IM&T in the NHSiS
Tayside Health Board
Tayside Health Council
Tayside Primary Care NHS Trust
Tayside Regional Diabetes Network
Tayside University Hospitals NHS Trust
Telemedicine
Terra Nova House Practice

WClick to go to top of page top

West Lothian Healthcare NHS Trust
Western General Hospital
Western Isles Health Board
Western Isles Health Council
Wheech
WHO - International Travel and Health
Wishaw General Hospital
Working Backs

XClick to go to top of page top

XML for NHSScotland
XML in Healthcare

YClick to go to top of page top

Yorkhill NHS Trust

Logo

OCCUPATIONAL HEALTH AND SAFETY
for
GENERAL MEDICAL AND DENTAL PRACTITIONERS AND THEIR STAFF

Short Life Working Group Report
SCOTTISH EXECUTIVE HEALTH DEPARTMENT

This document is also available in pdf format (86k)

Contents

1. Introduction

1.1 "*Our National Health, A plan for action, a plan for change*" reinforced the Ministerial commitment to provide an occupational health and safety service to General Medical and Dental Practitioners and their staff which was made in the occupational health and safety strategy for NHSScotland staff entitled "*Towards a Safer Healthier Workplace*". Ministers are concerned that staff working in the wider NHSScotland receive the same occupational health and safety service as their colleagues and have facilitated this with £0.5 million funding for this year and each of the following two years. This aim links with the wider aims in "*Revitalising Health and Safety*" and "*Securing Health Together*" and to Ministers commitment to provide Small and Medium Enterprises with access to occupational health, as part of the overall commitment to improve the health of the Scottish working population.

2. Short Life Working Group Membership

2.1 Membership of the Short Life Working Group has been drawn from all parties with an interest in the provision of an occupational health and safety service for General Medical and Dental Practitioners and their staff. The Group reports to the Scottish Partnership Forum through the Occupational Health and Safety Strategy Implementation Group (OHSSIG) which has responsibility for ensuring the action points in *"Towards Safer Healthier Workplace*" are achieved.

Mr Ray Watkins	Chair, Chief Dental Officer, SEHD
Mr Bill Welsh	Secretary, Directorate of Human Resources, SEHD
Dr Colin Blair	Community Dentist, UNISON
Dr Robert Donald	Dental Practitioner, BDA
Mr Alex Killick	Director of HR, Tayside PC NHS Trust
Dr David R Love	General Medical Practitioner, Joint Vice Chair of SGPC
Mrs Mary Mitchell	Practice Managers, IHM
Mrs Thelma McGuire	Occupational Health Director, Lothian NHS OHS
Mr Chris Naldrett	Directorate of Finance, SEHD
Mr Michael Proctor	Directorate of Policy, SEHD
Dr Chris Pugh	Occupational Health Manager, OHSAS (Tayside/Fife)
Mr Tony Wells	Chief Executive, Tayside PC NHS Trust

Dr Hugh Whyte Directorate of Policy, SEHD

3. Remit

3.1 The Remit of the Short Life Working Group reflects the commitment made in *"Towards a Safer Healthier Workplace"* and is:

"To review how Occupational Health and Safety (OHS) costs and provision of the service can be met for General Medical and Dental Practitioners and their staff."

4. Health and Safety Responsibilities

Legislative

4.1 The Group acknowledge that Health and Safety Legislation and employment law are reserved matters under the Scotland Act 1998 and are for the Westminster Parliament. It is also the responsibility of the Westminster Parliament to ensure that European Community legislation is enacted within the UK. A brief resume of current health and safety legislation is set out in the Annex.

People Working in the Practice

4.2 Everyone has a right to a safe working environment and all have a responsibility to work together to ensure that it is maintained. This right applies whether the individual is employed or self-employed and regardless of the time they are employed in the practice. To achieve this aim everyone should work together to promote and develop safe working practices and procedures for their own benefit and that of patients. It is in the interests of everyone that individuals actively seek to attend health and safety training, to put the training into effect and inform managers when improper or unsafe procedures are used which could put peoples health or safety at risk.

Employers

4.3 Under existing legislation, employers have a duty to provide a safe working environment. They also have a responsibility to ensure the tasks and activities carried out in the workplace are properly risk assessed and action taken to minimise risk to the health and safety of staff and others using the premises. The ultimate legal responsibility rests with the General Medical or Dental Practitioner. While that legal responsibility cannot be delegated, General Medical and Dental Practitioners will wish to ensure that they have a structure in place which promotes and develops health and safety with staff. That structure should include appropriate audit and monitoring arrangements to make sure that current health and safety practices and procedures are working.

5. Occupational Health and Safety Service

Occupational Health and Safety Service

5.1 The case for the provision of an OHS Service for General Medical and Dental Practitioners and their staff has already been accepted by Ministers. Staff in NHSScotland already have access to an OHS

Service which is at least at the minimum level standard of service outlined in *"Towards a Safer Healthier Workplace"* and there is no good reason why those in the wider NHS should be treated differently and less well, to the detriment of their well being.

5.2 The Group recognise that NHS Boards may wish to provide an OHS Service to groups other than General Medical and Dental Practices and their staff and it is open to them have that debate within their organisation locally. No additional cash funding will be available however and any extension of the service should not be to the detriment of the service provided for NHSScotland or General Medical and Dental Practitioners and their staff.

Funding the Service

5.3 "*Our National Health*" committed funding of £0.5 million a year for 2001/02 and the following two years to provide an occupational health and safety service for General Medical and Dental Practitioners and their staff. This money is ring fenced. The Group recognise that Health Boards are providing varying levels of an OHS Service for General Medical and Dental Practitioners and their staff. Some are therefore well prepared to provide the kind of service envisaged and will be able to use the funding to consolidate the level of service they currently provide, however, others may not be so well prepared. The Group also recognise that the provision of a full OHS Service will have staff resource implications for the NHSScotland which will impact on the OHS Service ability to deliver immediately. It would therefore be an unreasonable aim to ask OHS Service to provide a full occupational health and safety service immediately and it is therefore proposed that a stepped service is introduced over the three year period. The proposed priority stepped service is set out in Section 5.15 on OHS Standard Priority Waves. NHS Boards may however wish to devote additional funding and move to the full service in a shorter timescale.

Allocation of Funding

5.4 The Group discussed the four options identified for disbursing funding for the OHS Service. The options were to provide the funding to:

- the GPs and Dental Practitioners;
- NHS Boards, who would then fund the OHS Service for the NHS Board area directly or through the Primary Care Trust or LHCC;
- Primary Care Trusts, who would fund the OHS Service in their areas;
- the OHS Service direct for the provision of the service.

5.5 On balance the Group concluded that NHS Boards would provide the best repository for the funding. This would allow NHS Boards to consider how the comprehensive OHS Service should be delivered in their area and ensure implementation of the OHS Service from 1 October 2001 and for the following two years for which funding is available. It will be for each NHS Board locally to determine how best to commission the OHS Service, this could be done by the NHS Board direct, through the Primary care Trust or LHCC. In future it is anticipated that funding for OHS for General Medical and Dental Practitioners and their staff will continue to be provided as part of the normal funding allocation to NHS Boards. The Group further discussed the allocation of funding between NHS Boards and considered funding in accordance with the number of GPs, Dentists and estimated staff in each NHS Board area and compared the allocation calculated in this way to that using the Arbuthnott formula. The results using both methods were similar and the Group therefore recommend using Arbuthnott to identify individual NHS Boards allocations.

Standard of the Service

5.6 To be consistent and fair across the wider NHSScotland, the Group consider that the aim must be to provide General Medical and Dental Practitioners and their staff with at least the standard minimum service for OHS provided to NHSScotland staff. It is important that as well as an occupational health service, the service provided should also include advice on risk assessment and health and safety issues. The advice should recognise that General Medical and Dental Practitioners will continue to be legally responsible for the health and safety of their staff at work and for meeting the requirements of the

legislation. The OHS Service advice should help General Medical and Dental Practices to fulfil the legal requirement and form the basis for a jointly developed health and safety needs assessment.

5.7 Given the constraints and differing levels of service provision and expertise within Health Board areas the Group propose to introduce the OHS Service in three priority stepped waves. The first wave should ensure the clinical services are set in place and enable the OHS Service to build in years 2 and 3 towards a comprehensive service. In determining the OHS Standard Priority Waves account has been taken of:

- clinical occupational health priorities;
- the aims of "*Revitalising Health and Safety*";
- the aims of "*Securing Health Together*".

5.8 A vital aspect of the process is that the provision of the OHS Service must contribute towards the aims of:

- increased awareness of the occupational health service;
- improved access to the occupational health service;
- improved awareness of health and safety issues;
- minimise health and safety risk to staff and patients;
- reduced accidents and injuries to staff;
- reduced ill-health retirements;
- improved rehabilitation processes.

5.9 The NHS Board will be responsible for ensuring implementation of the Service. A service agreement should be made with the OHS Service outlining the standard of service to be provided based on the OHS Standard Priority Waves. The service agreement should clearly inform Medical and Dental Practices of the service to be provided.

Equity of Access

5.10 As outlined in the occupational health and safety service strategy "*Towards a Safer Healthier Workplace",* NHS Boards are encouraged to ensure occupational health and health and safety provision is integrated within their area and has the capacity to provide the appropriate level, quality and standard of service.

5.11 Access to the OHS Service should be open to everyone working in the practice, whether self-employed or employed, permanent or temporary.

Promoting OHS

5.12 General Medical and Dental Practitioners as employers have a legal responsibility to ensure the health and safety of their staff. They must therefore look to actively promote and tackle health and safety by encouraging the adoption of good health and safety practice at all times.

5.13 Practices are encouraged to develop links with Scotland's Health at Work (SHAW) and to promote good personal health for all working in the Practice.

5.14 The OHS Service in partnership with the NHS Board, Primary Care Trust and LHCC's should publicise and raise General Medical and Dental Practitioners and their staff awareness of the OHS Service available together with the positive advantages of accessing the free service.

OHS Standard Priority Waves

5.15 The following OHS Standard Priority Waves reflect the Group's conclusion that the proposed OHS Service should be brought into practice in stepped waves over three years. In preparing the stepped waves it is recognised that some OHS Services may already be providing a service to medical and dental

practitioners and their staff and may be in a good position to easily achieve the first wave requirements. In these circumstances the Group would wish to encourage the OHS Service to bring forward and develop as full a service as practicable as early as possible. Progress against the milestones will be assessed as part of the monitoring process. Use of techniques such as risk assessment and health and safety needs assessment will help inform the development of OHS Services in their settings.

2001/02

- pre-employment checks of all prospective employees
- screening programmes as part of a Risk Management Strategy
- health surveillance programmes
- confidential counselling service
- immunisation programmes
- return to work/rehabilitation/ill health early retirement assessment
- accidental blood exposure treatment programme (including advice on needlestick injuries)
- advice on compliance with statute and common law

2002/03

- advice on data collection and monitoring (the Occupational Health Minimum Dataset in HDL(2001)22 is commended to General Medical and Dental Practices)
- advice on health at work (stress, management of aggression, manual handling)
- advice on programmes for the elimination of accidents which cause personal injury
- advice and assistance with risk assessment programmes
- advice on health and safety education and training

2003/04

- advice on health promotion programmes
- advice on benchmarking and safety audit

5.16 Clinical Governance circulars NHS MEL(2000)29 and NHS MEL(1998)75 highlight the need for appropriate collection of information. Take up and provision of the OHS Service for General Medical and Dental Practitioners and their staff should be part of the peer audit and review of the service through the OHSSIG. The OHS Service will be required as part of the audit process to show the benefit gained from funding devoted to the OHS Service and should therefore maintain a statistical database detailing the service outcomes. Practices have a responsibility to ensure they maintain and collect appropriate data to show they are meeting their legal obligations. They may also wish to seek quality assurance accreditation for occupational health and safety. Collectively, practices, Primary Care Trusts, LHCC's and occupational health and safety services are recommended to share appropriate best practice and data/information.

Accountability

5.17 The Group recommend that NHS Boards are held accountable through the Performance Assessment Framework.

5.18 Accountability for service delivery is clear, but in order to implement the OHS Service within independent clinical practices, good communication and clear responsibilities as highlighted in this document between Health Boards, Primary Care Trusts, LHCC's, Practices and the OHS is essential.

6. Recommendations

The Working Group makes the following recommendations:

1. An OHS Service which includes advice on health and safety issues and which is comparable to that provided to NHSScotland staff should be provided for General Medical and Dental Practitioners and their staff.

2. NHS Boards with the OHS Service locally should determine whether they wish to extend the OHS Service to groups other than General Medical and Dental Practitioners and their staff.

3. General Medical and Dental Practitioners should ensure they have a structure in place that actively promotes, develops and encourages the adoption of good health and safety practices with everyone in the practice.

4. Everyone working in the practice should work to promote and develop safe working practices and procedures for their own benefit and that of patients.

5. A stepped OHS Service, leading to a full service, should be introduced over the next three years.

6. Funding should be allocated using the Arbuthnott formula to NHS Boards to enable them to ensure implementation of the service locally through an appropriate OHS Service with effect from 1 October 2001.

7. The OHS Service should be responsible for implementing the service locally, based on the OHS standard stepped priorities to the required standard.

8. Where an OHS Service is able, it should aim to develop a full service as early as possible.

9. NHS Boards should be held accountable for the provision of the service through the Performance Assessment Framework.

10. The aims of "Towards a Safer Healthier Workplace" and the Occupational Health Minimum Dataset are commended to all General Medical and Dental Practices.

11. NHS Boards, Primary Care Trusts, LHCC's and the OHS Service should promote the use of the service with all staff working within their Practices.

Annex Legislation Framework

Health and Safety at Work Act

Primary care medical and dental practitioners have legal obligations under the Health and Safety at Work Act 1974 (HSWA). They have a duty to protect their employees and others that may be affected by their work activities such as contractors, agency staff, patients and visitors. Under HSWA employers must ensure their employees are appropriately trained and proficient in the procedures necessary for working safely. Employees have duties to comply with systems and procedures put in place by employers to ensure their health, safety and welfare; they also have a duty not to do anything that would put others at risk.

Management of Health and Safety at Work Regulations

Under the Management of Health and Safety at Work Regulations 1999, employers must carry out a risk assessment and must have arrangements for the effective planning, organisation, control, monitoring and

review of the preventive and protective measures. They must also provide their employees with adequate health and safety training. The Medical Devices Agency have recently published a helpful booklet on risk assessment related to devices for GPs and Dentists entitled *"Devices in Practice: A Guide for Health and Social Care Professionals".*

Control of Substances Hazardous to Health (COSHH)

The COSHH Regulations 1999 are designed to protect employees against recognised hazards. COSHH requires employers to control hazardous substances to protect employees and others who may be exposed from work activities. Where prevention is not reasonably practicable, employers must take steps to eliminate, reduce or control the risk of exposure by using the measures listed in Schedule 3 to the Regulations. These measures include: the design of work processes and engineering control measures so as to prevent or minimise exposure in the work place; instituting means for safe collection, storage and disposal of waste; and specifying procedures for taking, handling and processing contaminated samples. Employers must carry out a risk assessment considering all the factors pertinent to the work and make an informed and valid judgement about the risks, the steps that need to be taken to achieve and maintain adequate control, and whether health surveillance is necessary.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

RIDDOR requires the reporting of work-related accidents, diseases and dangerous occurrences. It applies to all work activities, but not to all incidents. The information collected enables the enforcing authorities to identify where and how risks arise and investigate serious accidents. The enforcing authorities can then help and advise on prevention action to reduce injury, ill health and accidental loss. Accidents (including physical violence) connected with work and which result in an over three day injury to an employee or self–employed person must be reported to the enforcing authority. Reportable work-related diseases must be reported to the enforcing authority under RIDDOR as should incidents or accidents which do not result in a reportable injury, but which clearly could have done.

Working Time Regulations

The Working Time Regulations are an important addition to health and safety protection for workers. Government policy favours maximum flexibility in implementation but believes that all workers should be protected from the risks of working long hours, which could affect their health and safety. The Regulations protect the most vulnerable workers against working excessive hours and gives a right to rest breaks, rest periods away from work and paid annual leave.

While many of their staff will be covered general medical and dental practitioners are classed as self employed and are therefore excluded from the scope of the Working Time Regulations which implement the EC Working Time Directive (93/104/EC).

Disability Discrimination Act

The Disability Discrimination Act deals with discrimination against disabled people – that is, when someone treats a disabled person less favourably than someone else without justification, for a reason related to their disability. Discrimination also occurs if, without justification, a "reasonable adjustment" for the disability is not made. The Act applies to all those who provide goods, facilities and services to the public.

CANCER IN SCOTLAND: ACTION FOR CHANGE
NATIONAL IMPLEMENTATION/INVESTMENT PLAN - 2001-2002

This document is also available in pdf format (188k)

Contents

Health in Scotland 2000

This document is also available in pdf format (436k)

Contents

Health and Homelessness Guidance

September 2001
Scottish Executive Health Department

This document is also available in pdf format (220k)

Contents

CORONARY HEART DISEASE/STROKE TASK FORCE REPORT

This document is also available in pdf format (484k)

CONTENTS

General Comments to SHOW

Use the form below to make comments on or to suggest corrections to the contents of SHOW. Unfortunately we are currently unable to respond to queries concerning vacancies or specific clinical conditions. We would be grateful if you would complete our user survey.

Personal Details (Optional)

Name | Organisation

Email | Telephone

Your Comments

Disclaimer

Your email address and personal details, if submitted, will only be used to reply to your comments or queries and will not otherwise be stored, used or passed on to any third parties unless this is specifically requested in your comments.

Introduction

What is AGREE?

AGREE is an international collaboration of researchers and policy makers who seek to improve the quality and effectiveness of clinical practice guidelines by establishing a shared framework for their development, reporting and assessment.

Who are the participants?

The collaboration has the participation of a core of European countries: Denmark, Finland, France, Germany, Italy, the Netherlands, Spain, Switzerland a the United Kingdom as well as Canada, New Zealand and the USA (See list of AGREE members)

What is contained in the research programme?

AGREE is an integrated research programme currently funded by the BIOMED-2 Programme of the European Union. ***Project: PL96-3669***

It comprises several research projects, including:

1. The creation of an appraisal instrument (AGREE) to assess the quality of clinical guidelines

2. The development of standard recommendations for guideline developers

3. A comparison of guideline development programmes.

4. A content analysis of guidelines on asthma, diabetes and breast cancer

5. An appraisal of individual recommendations.

How to contact AGREE?

The AGREE collaboration is co-ordinated by the Health Care Evaluation Unit at St George's Hospital Medical School in London. Contact: Françoise Cluzeau (email: f.cluzeau@sghms.ac.uk)

<?php //Cerramos los DIVs con este include y los botones del scroll
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Click here to see the Agree participants at the Barcelona Workshop

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AGREE Instrument

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(needs Winzip to extract it and Adobe Acrobat Reader to be viewed)

Comparison of Guideline Development Models

International comparison of guideline programmes

Jako Burgers, Richard Grol, Niek Klazinga, Akke van der Bij, Marjukka Mäkelä, Joost Zaat and The AGREE Collaborative Group

Background

Clinical practice guidelines are being used in many countries throughout the world to improve quality of patient care. An increasing concern is the number of guidelines of low quality (1,2) and guidelines tha contain conflicting recommendations (3,4). There is a need for a common, valid and transparent approach to develop good clinical practice guidelines. However, different guideline development methods a still being used (5). In a previous study of the AGREE Collaboration the collaborative countries have been presented and illustrated the variations in policies and approaches to clinical guidelines across countries (6). Most countries developed guidelines within a national guideline programme, other countries have plans to set up a guideline programme.

The aim of this study is to describe different guideline programmes in detail. A systematic survey has been conducted using a framework of relevant criteria derived from the literature. This enables us to compare the programmes and highlight the strenghts and weaknesses.

Methods

For conducting the survey the following steps were taken:

1. selection of guideline programmes
2. design of questionnaire
3. feedback results and check for validation purposes

Selection of guideline programmes (see Table 1.)
We will describe guideline programmes of countries involved in the AGREE Collaboration. All these countries except Spain have guideline programmes. To widen the scope of our study, we also selected t technology assessment programme from Sweden and the programme of the National Health and Medical Research Council from Australia

Design of questionnaire
A conceptual framework that should cover all relevant aspects of guideline programmes was produced using criteria for (good) guideline programmes from different authors (6-11). Based on this framework we designed a questionnaire (see Appendix 1.). This questionnaire was discussed in the workshop of the AGREE Collaboration in May 2000. Based on the discussion eight additional questions were formulated to complete the picture (see Appendix 2.).

Check of data for validation purposes
The answers received were summarised in tables. Some answers were not completely clear, so specific questions were formulated for each guideline programme. We asked the key informants to check th tables and to answer the specific questions. Now we are waiting for their responses.

Results

Preliminary results of this study will be expected in January/February 2001. These will be discussed at the workshop of the AGREE Collaboration in March 2001.

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Table 1. Selected guideline programmes, organisations responsible for guideline development

Appendix 1. Questionnaire for description of guideline development programmes

Appendix 2. Additional questions

Recomendations for Guideline Development

Available soon

Appraisal of Individual Recomendations

Introduction

The AGREE-collaboration has developed an instrument for the appraisal of clinical guidelines. By filling-in the instrument, a global appraisal of guidelines is obtained. This is because the instrument is focused on the guideline as a whole, not on the separate individual recommendations.

There is a risk that a global appraisal does not adequately reflect the quality of the individual recommendations of the guideline. For example, while a guideline may generally be built on strong evidence, certain important individual recommendations may rest on weak evidence only. In such cases, appraisal of the individual recommendations, instead of the guideline as a whole, may improve the validity of t appraisal.

The project 'Appraisal of Individual Recommendations of Clinical Guidelines' can be seen as a validation study of the global AGREE-instrument (version May 1999), leading to suggestions for further improvement of the validity of this instrument. An article is in preparation and a poster will be presented in March 2001 during the European Forum on Quality in Health Care in Bologna, Italy.

Objectives

The key objectives of this project were;

1. To develop appraisal criteria for individual recommendations reflecting the dimensions of the AGREE global appraisal instrument
2. To appraise guidelines using the appraisal criteria for individual recommendations and the global AGREE appraisal instrument
3. To explore the relationship between the quality of individual recommendations and the global quality of the guideline
4. To identify additional resources required for appraising recommendations
5. To determine whether the benefits of appraising recommendations justify additional resources needed compared to global appraisal.

Methods

Seven countries planned to appraise the individual recommendations of four guidelines, which had already been appraised using the global AGREE-instrument. Appraisers had to fulfil certain criteria. For the appraisal of individual recommendations, an instrument based on the global instrumen and it's first version of dimensions was developed. Scores from both types of appraisal were compared. If there was a considerable difference between scores, a member of the AGREE-collaboration would look for an explanation.

Preliminary conclusions

Sixteen appraisals have been completed by now. Additional appraisals are underway. Our preliminary conclusions from this material are:

- There was a significant relationship between the scores derived by the two ways of appraising clinical guidelines.
- The global AGREE-instrument consists of 22 questions, each leading to a score. About 20% of these scores differed from the score derived by appraising individual recommendations.
- The global instrument nearly always gives a higher (=more positive) score for a guideline than if recommendations were appraised individually. On average the score of the global instrument was 20% higher than the score of the appraisal of individual recommendations.
- The questions with the greatest differences between scores were:
    - The recommendations are specific and unambiguous?
    - The guideline is supported by tools for application?
    - Review criteria have been provided with the guideline to assess the adherence to the guideline?
- Whenever there was a difference between scores of the two instruments, the score from individual appraisals was more often regarded accurate.
- The format of the instrument to appraise individual recommendations was not considered helpful by most appraisers.
- Finding the causes for the differences between scores of the two instruments has lead to a series of suggestions for improvement of the global AGREE-instrument. Examples are:
    - In the introduction of the AGREE-instrument you must warn appraisers about how easily they can get a too positive impression of a guideline, when an item (for example evidence) is sometimes present.
    - You have to explain what is meant by review criteria. Some appraisers think that a minimal data set is the same as review criteria, which is not so.

In order to prevent the causes which have led to the score differences, the wording of the global AGREE-instrument has been changed. Version August 2000 has been developed and is currently being validated.

Preparation group

P. ten Have, N. Klazinga, H. Varonen, J. Grimshaw, M. Makela, B. Burnand, G. Ollenschläger, on behalf of the AGREE Collaboration.

Content Analysis of Guidelines

Available soon

AGREE

Publication

The AGREE Collaboration. Guideline development in Europe: an international comparison. *International Journal for Technology Assessment in Health Care, 2000*. 16:4, 1036-1046.

Work presented at conferences

Promoting the rigorous development of clinical guidelines in europe through the creation of a common appraisal instrument
Second International conference on Scientific Basis of Health Services.
Amsterdam, October 1997.
Presented by Prof. Peter Littlejohns

ISQUA Conference on Quality in Health Care.
Budapest, October 1998.
Presented by Prof. Peter Littlejohns

The identification and reconciliation of differences between clinical guidelines in Europe
European Forum on Quality Improvement in Health Care,
Stockholm, May 1999.
Presented by Dr. Margaret Thomason.

Validating clinical guidelines: The development of a European Appraisal instrument (EUCAIG)
International Society for Technology Assessment in Health Care,
Edinburgh, June 1999.
Presented by Dr. Albert Jovell.

Understanding the reasons for differences in guideline recommendations and their clinical and resource implications
Third International Conference on the Scientific Basis of Health Services.
Toronto, October 1-3, 1999.
Presented by Dr. Françoise Cluzeau

Assessing the quality of clinical guidelines internationally: Development and initial testing of the AGREE Instrument
6th European Forum on Quality Improvement in Health Care.
Bologna, 29-31 March 2001.

Poster presented by Claire McNally

Several projects from the AGREE Collaboration were presented at the **International Society for Technology Assessment in Health Care (ISTAHC), Philadelphia, 3-6 June 2001**:

- **AGREE Instrument. Description & testing**
  Dr. Françoise Cluzeau
- **Comparison of guideline development models**
  Dr. Jako Burgers
- **Content analysis of guidelines**
  Prof. Gene Feder
- **Appraisal of individual recommendations**
  Prof. Günter Ollenschläger
- **Guideline development: a multidimensional process**
  Dr. Melissa Brouwers

Forthcoming presentations or conferences

Clinical Practice Guidelines 2002
Satellite Symposium of ISTAHC 2002
June 7-8, 2002
Kaiserin-Frederich-Haus
Robert-Koch-Platz 7
10115 Berlin (Mitte)
Germany

Clinical Practice Guidelines 2002
Satellite Symposium of ISTAHC 2002
June 7-8, 2002
Kaiserin-Frederich-Haus
Robert-Koch-Platz 7
10115 Berlin (Mitte)
Germany

To address the increasing interest in the development and use of clinical practice guidelines, AGREE is co-sponsoring a satellite symposium at the ISTAHC conference. The symposium is organized by th
German Agency for Quality in Medicine AquMed.

For further details visit: http://www.istahc2002.de

International Workshop on Clinical Practice Guidelines

Casa de Convalescència, Barcelona (Spain), March 20th 2001

The Agree Project
Assessment of Guidelines Research and Evaluation

Program

16:00 - 16:15

Welcome to participants
Organizers

16:15 - 17:15

Clinical Practice Guidelines Programs
Chair: Rosa Rico (Osteba, Spain)

Panel:
Guidelines development in Scotland: The Scottish Intercollegiate Guidelines Network
Juliet Miller (SIGN, Scotland)

Health Technology Assessment and Guidelines
Pia Brunn Madsen (DIHTA, Denmark)

Process or product? An ONtario, Canada perspective to guideline development
Melissa Brouwers (McMaster University, Canada)

From evidence-based medicine to clinical efectiveness in Hong Kong
Dickson Chang (Hospital Authority, Hong Kong, China)

17:15 - 18:15

Dissemination & Implementation of Clinical Practice Guidelines
Chair: Albert J. Jovell (Fundació Biblioteca Josep Laporte)

Panel:
The Guidelines Project (El Proyecto GUIAS): presentation
Albert J. Jovell (FBJL)

International approach to clinical practice guidelines: the AGREE collaboration
Françoise Cluzeau (Saint George's Hospital Medical School, United Kingdom)

Panel:
The Guidelines Project (El Proyecto GUIAS): presentation
Albert J. Jovell (FBJL)

International approach to clinical practice guidelines: the AGREE collaboration
Françoise Cluzeau (Saint George's Hospital Medical School, United Kingdom)

The guideline-gov experience: future directions
Jean Slutsky (Agency for Health Research and Quality, USA)

The impact of clinical parctice guidelines in France
Pierre Durieux (Hôpital Européen Georges Pompidou, France)

Regional use of guidelines in Finland
Marjukka Mäkelä (Finnish Office for Health Care Technology, Finland)

18:15 - 18:40

Coffee - break

18:45 - 20:10

Perspectives on Clinical Practice Guidelines in Spain
Chair: Josep Anton Bombí (Dean of the School of Medicine, University of Barcelona and Vice-President Balearic and Catalan Academy of Medical Sciences)

Panel:
The perspective of the providers
Alicia Granados (General Director, Catalan Institue of Health)

The perspective of the clinicians
Adolf Díez (Head of Medical Department, Hospital del Mar)

The perspective of the pharmaceutical industry
Joaquim Camprubí (MSD Spain)

The perspective of the health care manager
Joaquim Esperalba (Manager, Hospital de Sant Pau)

The perspective of medical profession
Miquel Bruguera (President, Barcelona Medical Association)

20:10 - 20:45

Policy Impact of Clinical Practice Guidelines
Chair: Juli de Nadal (Parc Taulí Foundation)

Panel:
Clinical Practice Guidelines and clinical decision making: strengths and limitations
Gene Feder (Queen Mary and Westfield College, United Kingdom)

Clinical Practice Guidelines: future directions
Jeremy Grimshaw (University of Aberdeen, Scotland)

Clinical Practice Guidelines: future directions
Jeremy Grimshaw (University of Aberdeen, Scotland)

20:45

Presentation of closing speech

Carles Solà (President University Autònoma de Barcelona)

Closing Speech
Eduard Rius (Ministry of Health, Catalonia)

This workshop is funded under a grant of the European Union for the AGREE collaboration and economic support to the Guidelines project of the Fundac
Biblioteca Josep Laporte by MSD and Fundació Universitat Autònoma de Barcelona.

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HTA research priorities

Listed by year (most recent first) and technology area. Last updated March 2001
To find details of HTA projects relating to these priorities please search for the relevant priority number on ou
Research Projects page

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2001

Diagnostic Technologies & Screening Panel

- **Endoscopic ultrasound in gastro-oesophageal cancer** (Primary Research) 01/01
- **New tests for tuberculosis** (Secondary Research) 01/02
- **The role of MRI scanning in investigation of the biliary tree** (Primary Research) 01/03
- **Screening for thrombophilia** (Secondary Research) 01/04
- **Microbiological sampling of infected diabetic foot ulcers** (Secondary Research) 01/05

Pharmaceuticals Panel

- **Steroid induced osteoporosis** (Secondary Research) 01/06
- **Antipsychotic drugs in challenging behaviour** (Primary Research) 01/07
- **Pharmacological interventions in children and young adults with hyperactivity** (Primary Research) 01/08
- **Topical non-steroidal anti-inflammatory drugs** (Primary Research) 01/09
- **Treatment of chronic constipation in the elderly – laxatives versus dietary and lifestyle changes** (Primary Re

Therapeutic Procedures Panel

- **Absorbent products for urinary/faecal incontinence** (Primary Research) 01/11
- **Left ventricular assist devices and heart failure** (Secondary Research) 01/12
- **Implantable glucose sensors for insulin dependent diabetes mellitus** (Primary Research) 01/13
- **Mechanical support for sprained ankles** (Primary Research) 01/14
- **Pulmonary rehabilitation for chronic obstructive pulmonary disease** (Primary Research) 01/15
- **Psychological interventions in poorly controlled asthma** (Secondary Research) 01/16
- **Psychological interventions in poorly controlled diabetes mellitus** (Primary Research) 01/17

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2000

Priorities commissioned on behalf of the National Institute for Clinical Excellence

- **The Clinical effectiveness and cost-effectiveness of Riluzole: motor neurone disease** (Rapid Review) Ref: 00
- **The clinical effectiveness and cost-effectiveness of autologous cartilage transplantation : treatment of carti** Review) Ref: 00/02
- **The clinical effectiveness and cost-effectiveness of wound care : various applications** (Rapid Review) Ref: 0
- **The clinical effectiveness and cost-effectiveness of Glycoprotein IIb/IIIa's : unstable angina & coronary syn** Review) Ref: 00/04
- **The clinical effectiveness and cost-effectiveness of Orlistat & Sibutramine : obesity** (Rapid Review) Ref: 00/0
- **The clinical effectiveness and cost-effectiveness of Pioglitazone : type II diabetes** (Rapid Review) Ref: 00/06
- **The clinical effectiveness and cost-effectiveness of implantable cardioverter defibrillators : arrythmias** (Rap
- **The clinical effectiveness and cost-effectiveness of Donezepil, Rivastigmine & Galantamine : Alzheimer's di** Review) Ref: 00/08
- **The clinical effectiveness and cost-effectiveness of Ribavarin & Alpha Interferon : Hepatitis C** (Rapid Review

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1999 *Priorities set by the Standing Group on Health Technologies in November,1999*

Acute Sector priorities

- **Tonsillectomy/Adeno-tonsillectomy in children with recurrent throat infections** (Primary Research) Ref: 99/20
- **Cardiac rehabilitation** (Secondary Research) Ref: 99/21
- **Exercise programmes in mild to moderate claudication** (Primary Research) Ref: 99/22
- **Implantable cardiac defibrillators** (Secondary Research) Ref: 99/23

- **Pulmonary rehabilitation** (Primary Research) Ref: 99/24 This topic has not yet been advertised
- **Larval therapy** (Primary Research) Ref: 99/25 This topic has not yet been advertised

- **The value of intensive follow-up after curative surgery for colorectal cancer** (Primary Research) Ref: 99/10

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Mechanical support for sprained ankles*** *(Primary Research) Ref: 99/58*
- ***Planned caesarean section*** *(Primary Research) Ref: 99/59*
- ***Uterine artery embolisation*** *(Primary Research) Ref: 99/60*
- ***High dose therapy and progenitor cell transplantation*** *(Primary Research) Ref: 99/61*
- ***Renal artery stenosis*** *(Primary Research) Ref: 99/62*

Diagnostics & Imaging priorities

- **Functional cardiac testing in coronary heart disease** (Primary Research) Ref: 99/26
- **Magnetic Resonance Imaging in newly-diagnosed breast cancer** (Primary Research) Ref: 99/27
- **Inflammatory joint diseases** (Primary Research) Ref: 99/28
- **Methods of assessing urinary incontinence** (Secondary Research) Ref: 99/29
- **Diagnosis of shoulder pain** (Secondary Research) Ref: 99/30

- **Endoscopic ultrasound in gastro-oesophageal cancer** (Primary Research) Ref: 99/31 This topic has not yet bee

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Role of D-Dimer assay in Deep Vein Thrombosis (DVT)*** *(Secondary Research) Ref: 99/63*
- ***Varicose veins*** *(Primary Research) Ref: 99/64*
- ***Quantitative measurement of cerebral blood flow in early diagnosis of acute stroke*** *(Primary Research) Ref: 9*
- ***Positron Emission Tomography in the pre-operative assessment of lung cancer*** *(Primary Research) Ref: 99/6*
- ***Laparoscopic ultrasound in gastrointestinal cancer*** *(Primary Research) Ref: 99/67*
- ***Imaging in premature babies*** *(Primary Research) Ref: 99/68*
- ***Detection of gastrointestinal parasites*** *(Primary Research) Ref: 99/69*

Methodology priorities

- **Eliciting what consumers value about the processes of health care** (Methodological Research) Ref: 99/51
- **Accommodating ethnic minority groups when evaluating outcomes of treatment** (Methodological Research) R
- **Developing methods for appraising and reviewing qualitative research** (Methodological Research) Ref: 99/53
- **The impact of different outcome measures on users' decisions** (Methodological Research) Ref: 99/54
- **The validity of aggregation methods in cost-utility analysis** (Methodological Research) Ref: 99/55
- **The validity of performance indicators in health care** (Methodological Research) Ref: 99/56
- **The use of the results of economic evaluations in decision making** (Methodological Research) Ref: 99/57

Priorities commissioned on behalf of the National Institute for Clinical Excellence

- **Neuraminidase inhibitors for the prevention and treatment of influenza** (Rapid Review) Ref: 99/13
- **Coronary Artery Stents for the treatment of Coronary Heart Disease (CHD)** (Rapid Review) Ref: 99/15
- **Effectiveness and cost-effectiveness of routine wisdom teeth extraction** (Rapid Review) Ref: 99/16
- **Effectiveness and cost-effectiveness of Taxanes in breast and ovarian cancer.** (Rapid Review) Ref: 99/17
- **Clinical effectiveness and cost-effectiveness of liquid based cytology in cervial screening.** (Rapid Review) R
- **Clinical effectiveness and cost effectiveness of inhaler systems (devices) for childhood asthma.** (Rapid Rev

HTA reviews commissioned via the call-off contracts between the universities of Birmingham, Southampton and York and the NHS Executive.

- **Clinical and cost-effectiveness of the main methods of treatment for patients with MS** (Rapid Review) Ref: 99

Pharmaceutical priorities

- **Dressings used in the treatment of chronic wounds** (Primary Research) Ref: 99/42
- **Treatment of hypertension immediately post-stroke** (Primary Research) Ref: 99/43
- **Combined oral contraceptives (COCs) for symptomatic endometriosis** (Primary Research) Ref: 99/44

- **Drugs for obesity** (Systematic/Primary Research) Ref: 99/02
- **Trastuzumab (Herceptin) therapy for women with metastatic breast cancer** (Secondary Research) Ref: 99/06 HTA prioritisation process
- **Cost-effectiveness of COX2 inhibitors compared with older NSAIDS** (Secondary Research) Ref: 99/07 This Pri withdrawn due to overlap with work in progress by West Midlands DEC team and an ongoing CCOHTA project

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Low molecular weight heparin in preventing and treating deep vein thrombosis and pulmonary embolism*** *(S Ref: 99/74*
- ***Drugs for the management of neuropathic pain*** *(Primary Research) Ref: 99/75*
- ***Drugs for normotensive diabetic patients with micro-albuminuria*** *(Primary Research) Ref: 99/76*
- ***Evaluation of using fetal cells in antenatal screening*** *(Secondary Research) Ref: 99/77*

Population Screening priorities

- **Neonatal screening for congenital heart disease** (Secondary Research) Ref: 99/45
- **Screening for oral cancer** (Primary Research) Ref: 99/46
- **Screening to prevent postpartum infection with Group B streptococcus or ureaplasma urealyticum.** (Primary 99/47
- **Minimising anxiety of parents waiting for, and receiving, results of antenatal tests** (Primary Research) Ref: 99

- **Neonatal hearing screening in detection of hearing impaired infants** (Primary Research) Ref: 99/49 This topic advertised
- **Mammography for women aged under 50 with a significantly increased risk of breast cancer because of fam risk** (Primary Research) Ref: 99/50 This topic has not yet been advertised

- **Informed patient choice in antenatal care** (Primary Research) Ref: 99/03
- **Informed patient choice in breast screening and cervical screening** (Primary Research) Ref: 99/04
- **Screening for gestational diabetes.** (Primary Research) Ref: 99/09

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***First trimester ultrasound screening for fetal abnormalities*** *(Systematic/Primary Research) Ref: 99/78*
- ***Early treatment of screening detected neonatal cystic fibrosis*** *(Primary Research) Ref: 99/79*
- ***Screening for neonatal biliary atresia*** *(Secondary Research) Ref: 99/80*

Primary and Community Care priorities

- **Cost-effectiveness and patient-based adherence to home-based cardiac rehabilitation** (Primary Research) Re
- **Psychological treatments for postnatal depression** (Primary Research) Ref: 99/33
- **Support for carers of people with dementia** (Primary Research) Ref: 99/34
- **Management of patients with chronic disease** (Primary Research) Ref: 99/35
- **The cost-effectiveness of group versus individual speech and language therapy for children** (Primary Resea

- **The cost-effectiveness of early intervention for the prevention of challenging behaviour in severe learning d** (Primary Research) Ref: 99/37 This topic has not yet been advertised
- **Effectiveness and cost-effectiveness of hospital hostels in comparison to standard care for new long stay p** Research) Ref: 99/38 This topic has not yet been advertised
- **Psychological interventions in medically unexplained or poorly controlled physical illness** (Primary Researcl topic has not yet been advertised
- **The cost-effectiveness of wet combing for the detection and treatment of head lice in children** (Primary Rese topic has not yet been advertised
- **Treatments for children diagnosed with attention deficit hyperactivity disorder (hyperkinetic disorder)** (Prim 99/41 This topic has not yet been advertised

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Physical medicine modalities and patient education for neck pain*** *(Primary Research) Ref: 99/70*
- ***Child abuse and neglect: Health Visitor involvement in the management of vulnerable and at risk families*** *(P Ref: 99/71*
- ***Psychological treatment for the unexplained condition of chronic pain*** *(Primary Research) Ref: 99/72*
- ***Homeopathy for eczema*** *(Primary Research) Ref: 99/73*

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1998 *Priorities set by the Standing Group on Health Technologies in November,1998*

Acute Sector priorities

- **Artificial synovial fluid for osteoarthritis** (Primary Research) Ref: 98/07
- **Blood saving procedures** (Primary Research) Ref: 98/08
- **Dialysis therapy for patients with end-stage renal disease (ESRD)** (Primary Research) Ref: 98/09
- **Routine pre-operative testing** (Primary Research) Ref: 98/10
- **Transcranial magnetic stimulation** (Primary Research) Ref: 98/11

- **New non-pharmaceutical interventions for epilepsy** (Primary Research) Ref: 98/12 Referred back to the HTA pr
- **Percutaneous transluminal coronary angioplasty (PTCA) vs PTCA with stenting vs medical treatment** (Seco 98/13
- **Sedation of children for minor clinical procedures** (Secondary Research) Ref: 98/14 Referred back to the HTA

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Episiotomy*** *(Primary Research) Ref: 98/48*
- ***Pulmonary rehabilitation for chronic lung disease*** *(Primary Research) Ref: 98/49*
- ***Radiotherapy for macular degeneration*** *(Primary Research) Ref: 98/50*
- ***Left ventricular assist devices and heart failure*** *(Secondary Research) Ref: 98/51*

Diagnostics & Imaging priorities

- **Sense and sensitivity of biochemical tests used in allergic disease** (Primary Research) Ref: 98/15
- **Computer aided diagnosis in breast screening** (Primary Research) Ref: 98/16
- **The role of computed tomographic colonography (CTC)** (Primary Research) Ref: 98/17
- **Sentinel lymph node biopsy** (Primary Research) Ref: 98/18

- **Cost effectiveness of image guided surgery** (Primary Research) Ref: 98/19
- **Methods of predicting the aggressiveness of prostate cancer** (Primary Research) Ref: 98/20 Referred back to t process
- **Cost effectiveness of diagnostic tests for tuberculosis** (Secondary Research) Ref: 98/21 Referred back to the H process

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Different methods of biliary imaging*** *(Primary Research) Ref: 98/52*
- ***Brain specific proteins for assessment in emergency*** *(Secondary Research) Ref: 98/53*
- ***Liquid based technologies in cervical cytology*** *(Primary Research) Ref: 98/54*
- ***Role of D-dimer assay in DVT*** *(Primary Research) Ref: 98/55*
- ***Positron Emission Tomography in the preoperative assessment of lung cancer*** *(Primary Research) Ref: 98/5*

Methodology priorities

- **How stable are the conclusions of cost-effectiveness analyses in place and time?** (Methodological Research)
- **What influences patients' understanding of trials and their willingness to participate?** (Methodological Resea
- **What are the effects on the external validity of clinical trials of socio-demographic exclusion criteria?** (Meth
  Ref: 98/24

- **Methods for data monitoring and interim analysis of trials** (Methodological Research) Ref: 98/25
- **Do preferences act as an effect modifier?** (Methodological Research) Ref: 98/26
- **The development and validation of methods for assessing the quality and reporting of diagnostic studies** (M
  Research) Ref: 98/27
- **Methods for making best use of retrospective analysis of critical incidents** (Methodological Research) Ref: 98

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Accommodating ethnic differences when evaluating outcomes of treatment*** *(Methodological Research) Ref: 9*
- ***Is third party randomisation an effective safeguard against bias in RCTs?*** *(Methodological Research) Ref: 98/*

Pharmaceutical priorities

- **Management of unstable angina** (Secondary Research) Ref: 98/29
- **Bisphosphonates for metastatic disease** (Secondary Research) Ref: 98/30
- **Cannabinoids for multiple sclerosis and spinal cord injury** (Primary Research) Ref: 98/31
- **Treatment of chronic constipation in the elderly** (Primary Research) Ref: 98/32
- **Opioids for chronic non-malignant pain** (Primary Research) Ref: 98/33

- **Leukotriene receptor antagonists for adults with asthma** (Primary Research) Ref: 98/34
- **Medical treatments for stable angina** (Primary Research) Ref: 98/35
- **Using prognostic indicators to estimate the outcome of adjuvant systemic therapies in breast cancer** (Seco
  98/36

- **Neuraminidase inhibitors for Influenza A and B** (Secondary Research) Ref: 98/01
- **New drugs for acute ischaemic stroke** (Secondary Research) Ref: 98/02
- **New drugs for Parkinson's disease** (Primary Research) Ref: 98/03
- **SERMs for osteoporosis** (Secondary Research) Ref: 98/06

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***New anti-obesity drugs - a framework for research*** *(Secondary Research) Ref: 98/59*
- ***Low molecular weight heparin in preventing and treating deep vein thrombosis, pulmonary embolism and u the NHS*** *(Secondary Research) Ref: 98/60*
- ***Management of kidney transplant patients*** *(Secondary Research) Ref: 98/61*

Population Screening priorities

- **Antenatal screening for asymptomatic bacteriuria** (Primary Research) Ref: 98/37
- **The role of automated cervical screening devices** (Secondary Research) Ref: 98/38
- **Early treatment of hearing impaired infants** (Primary Research) Ref: 98/39

- **Can screening for glaucoma prevent blindness?** (Primary Research) Ref: 98/40 Referred back to the HTA priori
- **Management of amblyopia** (Primary Research) Ref: 98/41 Referred back to the HTA prioritisation process
- **Neonatal screening of inborn errors of metabolism using tandem mass spectrometry** (Primary Research) Ref to the HTA prioritisation process

- **Human papilloma virus (HPV) testing** (Systematic/Primary Research) Ref: 98/04

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Screening for gestational diabetes*** *(Primary Research) Ref: 98/62*
- ***Partner notification in sexually transmitted disease*** *(Primary Research) Ref: 98/63*

Primary and Community Care priorities

- **The long term effects of treatment for depression in primary care** (Primary Research) Ref: 98/43
- **Interventions to reduce falls and fall related injuries in elderly people** (Primary Research) Ref: 98/44
- **Appropriate long term use of proton pump inhibitors in the treatment of dyspepsia** (Systematic/Primary Rese

- **Dietary advice and strategies to promote weight loss or maintenance in non-insulin dependent (type-2) diab** Research) Ref: 98/46 Referred back to the HTA prioritisation process
- **Brief psychosocial interventions following deliberate self-harm** (Primary Research) Ref: 98/47 Referred back t prioritisation process

- **Paediatric home care services** (Secondary Research) Ref: 98/05

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Targeted interventions aimed at reducing the risk of delayed presentation with breast cancer*** *(Primary Resea*
- ***Near patient tests for c-reactive protein in primary care*** *(Primary Research) Ref: 98/65*
- ***Memory clinics for people referred with dementia*** *(Primary Research) Ref: 98/66*
- ***Linearity and other aspects of hearing aids*** *(Secondary Research) Ref: 98/67*
- ***Ultra rapid opioid detoxification*** *(Primary Research) Ref: 98/68*
- ***Comparison of group with individual speech and language therapy*** *(Primary Research) Ref: 98/69*

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1997 *Priorities set by the Standing Group on Health Technologies in November,1997*

Acute Sector priorities

- **Primary and secondary prevention of pressure sores** (Primary Research) Ref: 97/06
- **Current methods of management of methicillin-resistant Staphylococcus aureus (MRSA)** (Secondary Resear
- **Pulmonary artery flotation catheters** (Primary Research) Ref: 97/08
- **Thoracoscopic splanchnicectomy for pain relief in abdominal malignancy** (Primary Research) Ref: 97/09
- **Comparison of minimal access surgical treatment vs medical treatment for gastro-oesophageal reflux disea** Research) Ref: 97/10
- **Cochlear implantation for deaf children** (Primary Research) Ref: 97/11

- **Alternative skin substitutes vs human skin allograft** (Primary Research) Ref: 97/33
- **Bioresorbable membranes** (Primary Research) Ref: 97/34
- **Moderate induced hypothermia for severe head injury in children** (Primary Research) Ref: 97/35
- **Gastrointestinal endoscopy done in different settings and by different professionals** (Primary Research) Ref:

- **Evaluation of paediatric small bowel transplantation** (Primary Research) Ref: 97/01
- **Evaluation of adult small bowel transplantation** (Primary Research) Ref: 97/04

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Emergency angioplasty for acute myocardial infarction*** *(Primary Research) Ref: 97/45*
- ***Management of dyspnoea in advanced cancer*** *(Secondary Research) Ref: 97/46*

Diagnostics & Imaging priorities

- **Investigation of chest pain presenting in general practice** (Secondary Research) Ref: 97/12
- **Cost-effectiveness of magnetic resonance angiography versus conventional angiography** (Secondary Resea
- **Use of dipsticks and diagnostic algorithms in the diagnosis of urinary tract infection** (Primary Research) Ref
- **Tumour marker tests in clinical management** (Secondary Research) Ref: 97/15

- **Diagnosis of heart failure in secondary care** (Primary Research) Ref: 97/36
- **Diagnosis of acute abdominal pain** (Secondary Research) Ref: 97/38

- **Coronary artery disease** (Primary Research) Ref: 97/02
- **Review of PET scanning** (Secondary Research) Ref: 97/03

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Haemostatic variables in the management of cardiovascular disease*** *(Primary Research) Ref: 97/47*
- ***Cost-effectiveness of ambulatory blood pressure monitoring in hypertensive pregnancies*** *(Primary Research*
- ***Cost-effectiveness implications of reducing x-ray exposure in children*** *(Primary Research) Ref: 97/49*

Methodology priorities

- **Measures of surgical adverse events and their monitoring** (Methodological Research) Ref: 97/16
- **Health status measures for people with cognitive impairment** (Systematic/Primary Research) Ref: 97/17
- **Systematic Reviews: are gold standards always required ?** (Methodological Research) Ref: 97/18
- **Methods of involving health care consumers in identifying and prioritising possible topics for NHS R&D** (Me Research) Ref: 97/19

- **Are different modes of organisation associated with different levels of payback from R&D investment?** (Met Research) Ref: 97/39
- **Benefits and risks of sub-group analysis in RCTs** (Methodological Research) Ref: 97/40

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***How stable are the conclusions of cost-effectiveness analyses in place and time?*** *(Methodological Research)*
- ***Methods for data monitoring and interim analysis of trials*** *(Methodological Research) Ref: 97/51*
- ***Measuring utilities*** *(Methodological Research) Ref: 97/52*

Pharmaceutical priorities

- **New Drugs for dementia** (Primary Research) Ref: 97/05

- **Routine influenza and pneumococcal immunisation for elderly people** (Primary Research) Ref: 97/20
- **Recombinant factor VIII in haemophilia A** (Secondary Research) Ref: 97/21
- **Pharmacotherapy for benign prostatic hyperplasia** (Primary Research) Ref: 97/22
- **Inhaler devices for asthma and chronic obstructive pulmonary disease** (Secondary Research) Ref: 97/23
- **Thromboprophylaxis in medical patients** (Secondary Research) Ref: 97/24

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Drug thromboprophylaxis - in pregnant women with a previous episode of thromboembolic disease*** *(Primar 97/53*
- ***Drug thromboprophylaxis in pregnant women undergoing delivery by caesarean section*** *(Primary Research)*
- ***New drugs for migraine*** *(Primary Research) Ref: 97/55*

Population Screening priorities

- **Interventions to promote individual behaviour changes in health care settings** (Secondary Research) Ref: 97/
- **Screening for postnatal depression** (Primary Research) Ref: 97/31
- **Screening for chlamydial trachomatis** (Primary Research) Ref: 97/32

- **Opportunistic screening for hazardous and harmful alcohol consumption** (Primary Research) Ref: 97/44

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Molecular screening for colorectal cancer*** *(Secondary Research) Ref: 97/60*
- ***Weight monitoring in infancy*** *(Secondary Research) Ref: 97/61*
- ***Screening for gestational diabetes*** *(Secondary Research) Ref: 97/62*
- ***Antenatal screening for asymptomatic bacteriuria*** *(Secondary Research) Ref: 97/63*

Primary and Community Care priorities

- **Different ways of delivering contraceptive services to teenagers.** (Primary Research) Ref: 97/25
- **Rehabilitation of older patients: day hospital compared with rehabilitation at home** (Primary Research) Ref: 9
- **Home treatment compared with admission for mental health problems** (Secondary Research) Ref: 97/27
- **Presenting risk in different ways to patients and professionals** (Primary Research) Ref: 97/28
- **Treatment of depression in adolescents** (Primary Research) Ref: 97/29

- **Management strategies for chronic fatigue syndrome** (Primary Research) Ref: 97/41
- **Treatment of anorexia nervosa** (Primary Research) Ref: 97/42
- **Brief interventions for anxiety, depression and life difficulties delivered by CPNs** (Primary Research) Ref: 97/

The following priorities (shown in italics) are those for which HTA funding is not currently available but which are recommended to other NHS as high priorities.

- ***Monitoring diabetes in primary care using near patient testing for haemoglobin A1C*** *(Primary Research) Ref:*
- ***Stopping treatment with proton pump inhibitors (for dyspepsia) where clinically appropriate*** *(Primary Resea*
- ***Cost-effectiveness of alternative methods of opiate detoxification*** *(Secondary Research) Ref: 97/58*
- ***Patient held records*** *(Secondary Research) Ref: 97/59*

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1996 *Priorities set by the Standing Group on Health Technologies in November,1996*

Acute Sector priorities

- **Adjuvant therapies for older women with breast cancer** (Primary Research) Ref: 96/03
- **Minimally invasive bypass grafting (MIBG)** (Primary Research) Ref: 96/04
- **Angioplasty vs reconstructive surgery vs use of stent/graft combinations vs other forms of treatment** (Prima 96/05
- **Oesophageal stents** (Primary Research) Ref: 96/06

- **Revision of joint replacements** (Primary Research) Ref: 96/28
- **Percutaneous endoscopic gastrostomy** (Primary Research) Ref: 96/29
- **Limb reconstruction** (Primary Research) Ref: 96/30
- **Epidural injections in the management of sciatica** (Primary Research) Ref: 96/31
- **Hydrotherapy treatment** (Primary Research) Ref: 96/32

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Anterior cruciate ligament reconstruction*** *(Primary Research) Ref: 96/53*
- ***Subfertility treatments and policies*** *(Secondary Research) Ref: 96/54*
- ***Subfertility treatments and policies (A study of UK policies on subfertility)*** *(Primary Research) Ref: 96/55*

Diagnostics & Imaging priorities

- **Imaging of thrombo-embolic disease** (Primary Research) Ref: 96/07
- **Imaging in the management of patients with acute stroke** (Primary Research) Ref: 96/08
- **Molecular diagnostics in microbiology** (Primary Research) Ref: 96/09
- **Protocol for monitoring of diabetes control** (Secondary Research) Ref: 96/10

- **Urine albumin testing for early detection of diabetic complications** (Secondary Research) Ref: 96/33
- **Synovial fluid cytoanalysis** (Primary Research) Ref: 96/34
- **Intravascular ultrasound** (Secondary Research) Ref: 96/35

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Decision support systems*** *(Primary Research) Ref: 96/56*
- ***Decision support systems*** *(Secondary Research) Ref: 96/57*
- ***CT, MRI and cerebral blood flow imaging using radionuclides in dementia*** *(Primary Research) Ref: 96/58*
- ***Use of Single Photon Emission Computerised Tomography (SPECT)*** *(Primary Research) Ref: 96/59*
- ***Angiography and colour flow doppler in arterial disease*** *(Primary Research) Ref: 96/60*

- **Telemedicine** (Primary Research) Ref: 96/02

Methodology priorities

- **Methods of incorporating equity into economic evaluations** (Secondary Research) Ref: 96/24
- **How to assess technologies while on different points of the learning curve** (Secondary Research) Ref: 96/25
- **Validating methods for assessing the quality of non-randomised observational studies** (Secondary Research
- **Measurement of patient satisfaction** (Secondary Research) Ref: 96/27

- **Quality of life measures in chronic diseases of childhood** (Secondary Research) Ref: 96/48
- **Priority setting and public preference** (Secondary Research) Ref: 96/49
- **The role of modelling in prioritising and planning trials** (Secondary Research) Ref: 96/50
- **Integrating RCTs on competing interventions which have not been directly compared to each other** (Second 96/51
- **The inclusion of non-English language trials in systematic reviews** (Secondary Research) Ref: 96/52

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Synthesis of evidence from non-randomised studies*** *(Secondary Research) Ref: 96/69*

- **Beta Interferon in Multiple Sclerosis: Outcome Measures** (Primary Research) Ref: 96/70
- **Methods for the review of methodological issues** (Secondary Research) Ref: 96/71

Pharmaceutical priorities

- **Alternative anaesthetic agents in day surgery** (Primary Research) Ref: 96/15
- **Different treatments for severe psoriasis** (Secondary Research) Ref: 96/16
- **Treatments for eczema** (Secondary Research) Ref: 96/17
- **New neuroleptics** (Secondary Research) Ref: 96/18
- **New neuroleptics** (Primary Research) Ref: 96/19

- **Botulinum Toxin A in cerebral palsy** (Primary Research) Ref: 96/36
- **Strategies for the management of non-ulcer dyspepsia** (Secondary Research) Ref: 96/37
- **SSRI anti-depressants in comparison to tricyclics: factors influencing prescribing** (Primary Research) Ref: 9
- **SSRI anti-depressants in comparison to tricyclics: trial to establish relative cost-effectiveness** (Primary Res

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Aspirin for venous ulcers*** *(Primary Research) Ref: 96/62*
- ***The cost-effectiveness of abciximab*** *(Primary Research) Ref: 96/63*
- ***Management of hypertension, and the contribution of newer anti-hypertensives*** *(Primary Research) Ref: 96/6*

- **The "statins"** (Secondary Research) Ref: 96/14

Population Screening priorities

- **Screening for prostate cancer** (Primary Research) Ref: 96/20
- **Systematic screening for sight threatening diabetic retinopathy using existing methods** (Primary Research) I
- **Screening for atrial fibrillation in the over 65s** (Primary Research) Ref: 96/22
- **The effects of screening on health promoting behaviour** (Secondary Research) Ref: 96/23

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Molecular screening for colorectal cancer*** *(Primary Research) Ref: 96/65*
- ***Screening for gestational diabetes*** *(Primary Research) Ref: 96/66*
- ***Screening for thrombophilia*** *(Secondary Research) Ref: 96/67*
- ***Screening for medical conditions which are manifested by short stature*** *(Primary Research) Ref: 96/68*

- **Screening for Helicobacter pylori** (Secondary Research) Ref: 96/01

Primary and Community Care priorities

- **Different techniques of shared clinical decision-making** (Primary Research) Ref: 96/11
- **Management of venous leg ulcers in the community** (Primary Research) Ref: 96/12
- **Management of irritable bowel syndrome in primary care** (Primary Research) Ref: 96/13

- **Long term follow up following psychotherapy and cognitive behaviour therapy** (Primary Research) Ref: 96/39
- **Acupuncture for the management of pain in primary care** (Primary Research) Ref: 96/40
- **Day care services for the severely mentally ill** (Secondary Research) Ref: 96/41
- **Outreach ophthalmology clinics in general practice** (Primary Research) Ref: 96/42
- **Alternative care settings for elderly people after acute illness: nursing home versus acute admission versus hospitals** (Primary Research) Ref: 96/43
- **The use of acute diagnostic ultrasound in general practice** (Primary Research) Ref: 96/44
- **Educational interventions for adolescent diabetics** (Secondary Research) Ref: 96/45
- **Community support teams for people with learning disabilities and challenging behaviour** (Primary Research
- **Interventions to promote breast feeding** (Secondary Research) Ref: 96/47

1995 *Priorities set by the Standing Group on Health Technologies in November,1995*

Acute Sector priorities

- **Stenting and other innovative methods of aortic aneurysm repair** (Primary Research) Ref: 95/02
- **Various interventions in the management of varicose veins of differing severity** (Primary Research) Ref: 95/0
- **Effectiveness and cost-effectiveness of different knee prostheses with particular reference to quality of life** Ref: 95/10
- **High-dependency/intensive care: new and existing models** (Primary Research) Ref: 95/15
- **Outcome measures in ITU medicine** (Secondary Research) Ref: 95/55

- **Renal satellite units** (Primary Research) Ref: 95/31
- **Cost-effectiveness of cochlear implantation for deaf children** (Primary Research) Ref: 95/34
- **Geriatrician intervention following fracture for elderly patients** (Secondary Research) Ref: 95/36
- **Functional electrical stimulation for tetraplegic patients** (Primary Research) Ref: 95/39

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Effectiveness, adverse outcome and acceptability of the use of trusses and surgical interventions for the m inguinal hernia*** *(Primary Research) Ref: 95/42*
- ***Effectiveness and cost-effectiveness of recognised specialist treatment strategies for adult survivors of kn sexual abuse*** *(Primary Research) Ref: 95/43*
- ***Stereotactic brain surgery (gamma knife, LINAC) versus conventional brain tumour surgery*** *(Primary Resear*
- ***Cost-effectiveness of medical abortion (RU486) versus the standard surgical procedure*** *(Primary Research)*

Diagnostics & Imaging priorities

- **Image-guided minimally invasive therapy: insertion of central venous catheters under image guidance vers methods** (Primary Research) Ref: 95/16
- **Diagnosis of endometrial abnormalities** (Primary Research) Ref: 95/17
- **Diagnostic tests for glaucoma** (Primary Research) Ref: 95/18

- **Diagnostic tests for tuberculosis** (Primary Research) Ref: 95/26
- **High-frequency ultrasound in breast imaging** (Primary Research) Ref: 95/32

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Use of angiography and colour flow Doppler in arterial disease*** *(Primary Research) Ref: 95/44*
- ***Aneuploidy detection in uncultured amniotic fluid cells for 48-hour diagnosis of Down's syndrome*** *(Primary*

Methodology priorities

- **Size of group randomised trials** (Secondary Research) Ref: 95/04
- **Publication and other selection biases in systematic reviews** (Secondary Research) Ref: 95/12
- **Action research: standards for judging its appropriateness** (Secondary Research) Ref: 95/19
- **Evaluation of the use of standardised measurement of outcome in health technology assessment** (Primary R
- **Audit in health technology assessment** (Primary Research) Ref: 95/21

- **Sample size in the context of effect size especially in quality of life measurement** (Secondary Research) Ref:

Pharmaceutical priorities

- **Antimicrobial prophylaxis in surgery: comparative efficacy and cost-effectiveness of different regimens in t** (Primary Research) Ref: 95/03
- **Efficacy and cost-effectiveness of rhDNase in cystic fibrosis** (Primary Research) Ref: 95/08
- **Treatment of established osteoporosis** (Secondary Research) Ref: 95/11
- **New antiepileptic drugs and existing therapies** (Primary Research) Ref: 95/13
- **Use of interferon alpha in the treatment of chronic hepatitis C** (Primary Research) Ref: 95/24

- **Intrathecal pump systems for giving opioids in chronic pain** (Secondary Research) Ref: 95/35
- **The cost-effectiveness of depot neuroleptic preparations** (Secondary Research) Ref: 95/38
- **The efficacy, cost-effectiveness and long-term tolerability of implantable contraceptives** (Secondary Researc

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Hospital parenteral nutrition*** *(Primary Research) Ref: 95/45*
- ***Epoprostenol in haemodialysis and haemofiltration*** *(Primary Research) Ref: 95/50*
- ***Use of antibiotic bone cements*** *(Primary Research) Ref: 95/52*

Population Screening priorities

- **Cross-cutting issues: uptake rates across screening programmes and ethnic/social groups** (Secondary Res
- **Screening for congenital dislocation of the hip** (Systematic/Primary Research) Ref: 95/23

- **Cost-effectiveness of screening for hypercholesterolaemia versus case finding for familial hypercholestero** Research) Ref: 95/29
- **Cross-cutting issues: the implications of false negatives in screening programmes** (Secondary Research) Re

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Screening for renal failure and other serious urological/renal disease*** *(Systematic/Primary Research) Ref: 95/4*

Primary and Community Care priorities

- **Health promotion among the UK's South Asian and Afro-Caribbean communities with respect to cardiovasc stroke** (Primary Research) Ref: 95/06
- **Targeted health visiting of high-risk families** (Primary Research) Ref: 95/07
- **Evaluating the effectiveness of discharge arrangements for the elderly** (Secondary Research) Ref: 95/09
- **Brief psychological treatments for depression in general practice** (Secondary Research) Ref: 95/22

- **Cost-effectiveness of minor surgery in general practice** (Primary Research) Ref: 95/25
- **Cost-effectiveness of open-access echocardiography in heart failure** (Primary Research) Ref: 95/27
- **Management of patients on long-term benzodiazepine medication** (Primary Research) Ref: 95/30
- **Exercise prescription schemes** (Primary Research) Ref: 95/33
- **Cost-effectiveness of health promotion in schools** (Secondary Research) Ref: 95/37

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Cost-effectiveness of different options for organising the extended role of the pharmacist*** *(Primary Research*
- ***Evaluation of strategies to deal with frequent consulters to primary care*** *(Primary Research) Ref: 95/53*

[Commissioned Research Projects] [HTA Home Page]

[1993] [1994] [1995] [1996]
[1997] [1998] [1999] [2000] [2001]

1994 *Priorities set by the Standing Group on Health Technologies in November,1994*

Acute Sector priorities

- **Comparison of new and established treatments for benign prostatic hyperplasia** (Primary Research) Ref: 94/
- **Evaluation of bone marrow transplantation and peripheral blood stem cell treatment for malignancy** (Secon 94/12
- **Laparoscopic gynaecological surgery** (Primary Research) Ref: 94/16
- **Specialist centres vs local access services for eg vascular surgery** (Primary Research) Ref: 94/20
- **Management of hip fractures in fit patients** (Primary Research) Ref: 94/24

- **Comparative effectiveness of treatments for cervical intraepithelial neoplasia - laser vs diathermy vs knife v** (Primary Research) Ref: 94/31
- **Cost-effectiveness of new physiotherapy treatments using electrotherapy, short-wave diathermy and low-p** Research) Ref: 94/32
- **Cost-effectiveness of different service models (GP, A&E, Minor Injury Units) for the management of minor i** Research) Ref: 94/33
- **Evaluation of laser treatment in glaucoma** (Primary Research) Ref: 94/38
- **Evaluation of extending nursing roles in: minor surgical procedures; nurse-led outpatient repeat visits; pre- routine examination of the newborn** (Primary Research) Ref: 94/40
- **Evaluation of extending nursing roles in: minor surgical procedures; nurse-led outpatient repeat visits; pre- routine examination of the newborn** (Primary Research) Ref: 94/40

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Evaluation of photodynamic laser therapy*** *(Systematic/Primary Research) Ref: 94/59*
- ***Evaluation of the use of lasers in cancer palliation*** *(Systematic/Primary Research) Ref: 94/61*

Diagnostics & Imaging priorities

- **Evaluation of genetic analysis of haematological disorders** (Primary Research) Ref: 94/15
- **Evaluation of methods for identifying and monitoring the treatment of osteoporosis** (Secondary Research) R
- **Digital imaging techniques for monitoring diabetic retinal disease** (Primary Research) Ref: 94/18
- **Evaluation of PET scanning, eg for epilepsy and lung cancer** (Primary Research) Ref: 94/19
- **Assessment of new biochemical markers of myocardial injury** (Secondary Research) Ref: 94/30
- **The impact of bone density measurements in osteoporosis management** (Primary Research) Ref: 94/64

- **Second generation computed tomography and related developments** (Secondary Research) Ref: 94/28
- **Evaluation of Helicobacter pylori detection tests in the management of patients with abdominal discomfort** Ref: 94/41
- **Evaluation of cytogenetics laboratory technology** (Primary Research) Ref: 94/43
- **Endoscopic ultrasound diagnosis of early gastrointestinal cancers** (Secondary Research) Ref: 94/44
- **Imaging of tumours for conformal radiotherapy** (Primary Research) Ref: 94/47

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Diagnostic methods in the management of breast disease*** *(Primary Research) Ref: 94/53*

Methodology priorities

- **Increasing the scope for evaluating technologies using routine data** (Primary Research) Ref: 94/06
- **Methods for the evaluation of diffuse technologies** (Secondary Research) Ref: 94/07
- **Methods for preparing clinical guidelines** (Primary Research) Ref: 94/08
- **Methods for evaluating area-wide or unit interventions** (Secondary Research) Ref: 94/09
- **Methods for technology horizon scanning (obtaining information on emerging technologies)** (Secondary Re
- **Preliminary appraisal of technologies prior to full economic evaluation** (Primary Research) Ref: 94/25

- **Methods to assess and use the non-specific aspects of care ("placebo effects")** (Secondary Research) Ref: 9
- **Development of methods for discounting the costs and benefits of interventions in health care** (Secondary R

Pharmaceutical priorities

- **Acid suppression vs antibiotics against H. Pylori in peptic ulcers** (Secondary Research) Ref: 94/01
- **Antimicrobial prophylaxis in surgery: review and dissemination of its use in dirty surgery** (Secondary Resea
- **Alternative analgesics following day case surgery** (Secondary Research) Ref: 94/11
- **The use of laxatives in the elderly** (Secondary Research) Ref: 94/23

- **Antimicrobial prophylaxis in total hip replacement surgery** (Secondary Research) Ref: 94/29
- **Evaluation of second-line drugs in patients with established rheumatoid arthritis** (Primary Research) Ref: 94/
- **Selection of antimicrobial therapy in acne vulgaris** (Primary Research) Ref: 94/48

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***Antimicrobial prophylaxis in surgery: placebo trials in CABG*** *(Primary Research) Ref: 94/50*
- ***Carboplatin in cancer (pharmaco-economic analysis)*** *(Primary Research) Ref: 94/51*
- ***Comparative assessment of new antiepileptics with existing therapies.*** *(Primary Research) Ref: 94/52*
- ***Evaluation of current nebulised drug generation and delivery*** *(Primary Research) Ref: 94/62*
- ***Use of antenatal TRH in combination with corticosteroids to mothers at risk of pre-term delivery*** *(Primary Re*

Population Screening priorities

- **An evaluation of screening for abdominal aortic aneurysm** (Primary Research) Ref: 94/02
- **Child health surveillance: an evaluation of visual screening, screening for speech and language delay inclu economic analysis** (Secondary Research) Ref: 94/05
- **Screening for ovarian cancer** (Secondary Research) Ref: 94/26

- **Informed decision making across healthcare** (Secondary Research) Ref: 94/27
- **Hearing loss in the over-60s: a pilot study on early provision of hearing aids and an evaluation of the most screening method** (Primary Research) Ref: 94/46

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***A review of the cost-effectiveness of screening for biliary atresia in infancy*** *(Primary Research) Ref: 94/49*

Primary and Community Care priorities

- **Evaluation of complementary therapies: manipulation therapies** (Primary Research) Ref: 94/13
- **Evaluation of genetic counselling in general practice** (Primary Research) Ref: 94/14
- **Evaluation of the cost-effectiveness of early discharge and the role of hospital at home and community nur** Research) Ref: 94/21
- **The role of GPs, midwives and other primary care workers in antenatal and postnatal care** (Primary Researc

- **Effectiveness of health visitor domiciliary visiting** (Secondary Research) Ref: 94/36
- **Cost-effectiveness of key aspects of chiropody services** (Primary Research) Ref: 94/37
- **Evaluation of approaches to rehabilitation of elderly people with locomotion disability due to osteoarthritis** Ref: 94/39
- **Evaluation of physiotherapy for cerebral palsy** (Primary Research) Ref: 94/42

The following priorities (shown in italics) are topics which, although of importance to the NHS, are not considered by the SGHT to be of high e merit funding or expense of effort within the NHS HTA programme.

- ***An evaluation of the safety, efficacy and cost-effectiveness of acupuncture*** *(Primary Research) Ref: 94/54*
- ***Evaluation of counselling and psychotherapy for cancer patients*** *(Primary Research) Ref: 94/55*
- ***Evaluation of occupational therapies to prevent and lessen the consequences of elderly people falling*** *(Prim 94/56*
- ***Evaluation of home oxygen therapy for infants and children*** *(Primary Research) Ref: 94/57*
- ***Evaluation of physiotherapy: day-hospital vs home*** *(Primary Research) Ref: 94/58*
- ***Evaluation of strategies to take patients off long-term medication*** *(Primary Research) Ref: 94/60*

[Commissioned Research Projects] [HTA Home Page]

[1993] [1994] [1995] [1996]
[1997] [1998] [1999] [2000] [2001]

1993 *Priorities set by the Standing Group on Health Technologies in November,1993*

Acute Sector priorities

- **Coronary artery bypass graft vs angioplasty vs medical management** (Secondary Research) Ref: 93/01
- **Stroke rehabilitation** (Primary Research) Ref: 93/03
- **Stroke rehabilitation** (Primary Research) Ref: 93/03
- **Spinal surgery as an approach to the management of low back pain and sciatica** (Primary Research) Ref: 93/
- **Total hip replacement prostheses** (Secondary Research) Ref: 93/11
- **Regionalisation of intensive care services** (Systematic/Primary Research) Ref: 93/12
- **Comparative efficacy and cost-effectiveness of established and new treatments for menorrhagia** (Primary R
- **Patient information** (Primary Research) Ref: 93/19
- **Effectiveness and cost-effectiveness of paramedic training and pre-hospital management protocols in traur care** (Primary Research) Ref: 93/23

- **Outpatient services for chronic pain control** (Secondary Research) Ref: 93/31
- **Laparoscopic vs conventional (mini-) cholecystectomy** (Secondary Research) Ref: 93/39
- **The management of end-stage renal disease** (Secondary Research) Ref: 93/40

Diagnostics & Imaging priorities

- **Myocardial ischaemia pre intervention** (Secondary Research) Ref: 93/04
- **Near patient testing in hospitals** (Primary Research) Ref: 93/06
- **Near patient testing in general practice** (Secondary Research) Ref: 93/15
- **Imaging in the management of low back pain** (Primary Research) Ref: 93/17
- **Prostatic carcinoma** (Secondary Research) Ref: 93/21

- **Pre-operative testing** (Secondary Research) Ref: 93/55

Methodology priorities

- **Ethical issues in the design and conduct of trials** (Secondary Research) Ref: 93/41
- **Timing of health technology assessments and assessing fast-changing health technologies** (Secondary Res
- **Factors that limit the quality, number and progress of randomised controlled trials** (Secondary Research) Re
- **The improvement and assessment of qualitative methods for HTA** (Secondary Research) Ref: 93/44
- **Comparing the use of randomised controlled trial designs with quasi-experimental studies and/or observati assessing health technologies** (Secondary Research) Ref: 93/45
- **Different approaches to deciding the size and methods of data monitoring in trials** (Secondary Research) Re
- **Different approaches to the measurement of outcomes in health technology assessment** (Secondary Resear
- **Evaluating approaches to assessing the costs of health technologies** (Secondary Research) Ref: 93/48
- **How best to design and conduct patient and staff questionnaires when assessing health technologies** (Sec Ref: 93/49
- **Developing the use of alternative statistical methods in health technology assessment** (Secondary Research
- **The generalisability of randomised controlled trials** (Secondary Research) Ref: 93/51
- **The science of critical reviews of the literature** (Secondary Research) Ref: 93/52
- **The use of consensus development methods for assessing health technologies and producing practice gui** Research) Ref: 93/53
- **Methods for assessing the impact of the results of health technology assessments and evaluating program disseminating their results** (Secondary Research) Ref: 93/54

Pharmaceutical priorities

- **Prevention of DVT and PE in patients undergoing hysterectomy and total hip replacement** (Secondary Resea
- **Long-term outcomes of drug use in asthma** (Primary Research) Ref: 93/14
- **Effective strategies for repeat prescribing** (Primary Research) Ref: 93/22

- **Wound care management, including sore prevention** (Secondary Research) Ref: 93/29
- **The risks and benefits of home total parenteral nutrition** (Secondary Research) Ref: 93/38

Population Screening priorities

- **Screening for colorectal cancer** (Primary Research) Ref: 93/02
- **Screening for stroke through identifying and effectively treating high blood pressure** (Secondary Research) R
- **Review of the management of borderline or mildly dyskaryotic cervical smears** (Primary Research) Ref: 93/08
- **Antenatal screening for HIV** (Primary Research) Ref: 93/24
- **Evaluation of methods of screening forc** (Systematic/Primary Research) Ref: 93/25
- **Screening for hearing impairment in children** (Secondary Research) Ref: 93/27
- **Psychosocial aspects of screening for genetic diseases** (Secondary Research) Ref: 93/56

- **Ultrasound screening during pregnancy** (Secondary Research) Ref: 93/30
- **Screening for cystic fibrosis** (Secondary Research) Ref: 93/32
- **Screening for haemoglobinopathies** (Secondary Research) Ref: 93/33
- **Screening for fragile X** (Secondary Research) Ref: 93/34
- **Screening for fragile X** (Secondary Research) Ref: 93/34
- **Neonatal screening for inborn errors of metabolism** (Secondary Research) Ref: 93/36
- **Screening for melanoma** (Secondary Research) Ref: 93/37

Primary and Community Care priorities

- **Counselling in primary care for mental health problems** (Primary Research) Ref: 93/07
- **The role of nurse practitioners in primary care** (Primary Research) Ref: 93/13
- **The effectiveness of physiotherapy for musculo-skeletal conditions** (Primary Research) Ref: 93/16
- **24-hour primary care centres as a model for providing out of hours care** (Primary Research) Ref: 93/20

- **Young persons' contraceptive services** (Secondary Research) Ref: 93/28
- **The community provision of hearing aids** (Secondary Research) **Ref: 93/35**

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These pages are maintained by Phillip Simons
This page last updated on 15 January 2002

hta logo

NHS R&D Health Technology Assessment Programme

HTA monographs on CD-ROM

Version 1 (Launch version) of the CD-ROM of HTA monographs is now available.

This CD-ROM contains the electronic text in Adobe 'Acrobat' format of all monographs published by the HTA Programme u
22 (excluding some not yet been published at the time the CD-ROM was created).

In addition a powerful 'Search' feature allows you to search across all the monographs for particular words or combinations

The product has been designed for use with the **searchable** version of Adobe 'Acrobat' Reader 5. This is provided free of
CD-ROM.

Order a copy of *HTA on CD* Frequently Asked Questions about HTA on CD

We plan to issue the next version early next year. This will be an update of the launch version and will contain the latest m
also like to add improvements suggested by users. We would therefore be grateful to receive your comments. Please use
provided on the CD-ROM.

HTA Home Page

If you have any difficulties with this page or if you have any comments please contact Phillip Sim
This page last updated on 15 January 2002

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NHS R&D Health Technology Assessment Programme

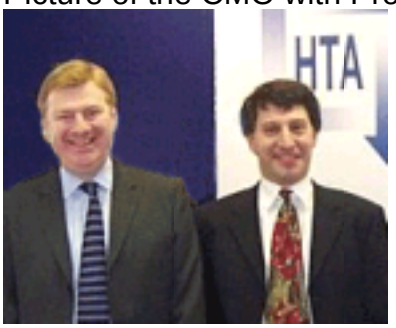
What's New in the HTA programme

Latest publications
HTA monthly email bulletin
Forthcoming events
HTA Update (newsletter)

NEW Themed HTA Update (mental health) NEW
Annual Report 2001
HTA Information Sheets
News from the HTA programme

CMO visits NCCHTA (22 February 2002)

Picture of the CMO with Professor John Gabbay



The Chief Medical Officer (CMO), Sir Liam Donaldson, with Professor Joh
Co-ordinating Centre for Health Technology Assessment (NCCHTA) at th

The CMO visited the NCCHTA in February for a constructive meeting featuring presentations by key staff. Discussions fo
consumer involvement in HTA, along with lessons learned from particular projects and the impact of National Service Fran

The CMO's own report of the visit is now available on the 'CMO at Large' section of his website.

Other news items

Themed HTA Update (mental health)

The first HTA Themed Update is now out, and this issue focuses on Mental Health. A copy is being delivered to the releva
and PCGs across the country, but we hold a small stock at the NCCHTA so please let us know if you would like an extra o

You can also download a PDF file of the Themed Update (60 kbytes).

The HTA Annual Report 2001

The HTA Annual Report 2001 is a twelve-page summary of progress and a brief description of how the programme works. web version which contains full details of progress on HTA Priorities and Projects as well as details of those involved in ad year.

You can also view/download a electronic version of the printed report (672 kbytes)

Full details are on our Annual Report page

Consumers in NHS Research - new publication

The Consumers in NHS Research Support Unit have produced a new publication 'Getting involved in research: a guide for consumers who are either thinking about getting involved in research and development in the NHS, or are still new to it.

You can download an electronic version of this publication from the Consumers in NHS Research website publications pa

New publications

132 reports have now been published in the HTA monograph series. The latest are:

Vol 5, number 25. **A rapid and systematic review of the evidence for the clinical effectiveness and cost-effectivene raltitrexed for the treatment of advanced colorectal cancer.** M Lloyd-Jones *et al*. [View publication details]

Summary points [An executive summary is also available.]

- When used as first-line therapy, the combination of either irinotecan or oxaliplatin with an infusional fluorouracil/folin extend median progression-free survival by 2–3 months compared with FU/FA alone, although with increased toxici to extend overall survival.
- However, raltitrexed appears to reduce both progression-free and overall survival compared with FU/FA.
- When used as second-line treatment, irinotecan monotherapy appears to extend median progression-free survival b overall survival by approximately 2 months compared with FU/FA alone, again at the cost of increased toxicity.
- Preliminary data suggest that, as second-line treatment, oxaliplatin plus 5FU may extend median progression-free s or irinotecan monotherapy.
- Further evidence is needed about the relative merits of irinotecan and oxaliplatin for patients with advanced colorec

HTA Information Sheets

You can now view/download information sheets in rich text format about the various parts of the HTA Programme:

1. Overview of the Programme
2. Identifying questions for assessment
3. Prioritisation - *deciding which topics should be researched*
4. Commissioning
5. Monitoring and Editorial Review
6. Communications
7. The role of consumers in the HTA Programme.
8. HTA and the National Institute for Clinical Excellence

HTA monthly email bulletin.

A bulletin giving a brief update on HTA activities including the latest monographs, newly commissioned projects and details are sent out monthly by email **only**.

- Download/view a copy of **this month's** bulletin in Rich Text Format.
- Subscribe to the HTA email bulletin list (free)

Previous bulletins:

February 2002
January 2002

HTA Update 2001

You can download an electronic version of this four-page document in Adobe Acrobat format (81 kbytes).

Forthcoming events

9-12 June 2002, Hotel Intercontinental, Berlin	**ISTAHC 2001** For further details see http://www.istahc2002.de/
4 - 5 December 2002, Birmingham International Conference Centre	Clinical Execellence 2002 For further details see http://www.sterlingevents.co.uk/NICE_pages/NICE.html

News from the HTA programme

- CMO visits NCCHTA, 22 February 2002
- **100th monograph** NHS research programme achieves important landmark
- Creation of a new, national, rapidly responsive research function for health technology assessment.
- Commissioned research on the role of HPV testing in screening for cervical cancer.
- Prostate cancer screening
- Systematic review of the evidence on routine pre-operative testing
- Primary research into the costs and benefits of paramedic skills in pre-hospital trauma care
- National and international standing of the HTA programme

NHS research programme achieves important landmark. (29th March 2001)

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The NHS's research effort achieved a major milestone this month with the publication of its 100th report into the cost-effec treatments, therapies and services.

As medical knowledge continues to expand, the reviews are providing doctors and other front line specialists with clearer a information about the merits of different treatments and diagnoses — looking at both existing and new forms of care.

The programme, managed by the National Co-ordinating Centre for Health Technology Assessment (NCCHTA) based at t Southampton, was set up in 1996. It helps the NHS decide which research projects it should fund and ensures that the res to a high standard by the most suitable researchers from all over the country. When the findings are known, the NCCHTA communicate results to doctors and specialists working in the field.

The 100th monograph looks at treatments for people with the chronic skin disease psoriasis and it is the latest in a series o leading to improvements in the care offered to thousands of people in the NHS.

In addition to the 100 reviews published so far, a further 192 research projects are currently underway all around the UK.

The reviews cover a wide range of specialties, including primary care, coronary heart disease and children's and cancer se approaches take time to become standard practice but some have already led to significant improvements.

- One HTA study is now leading to reductions in the number of false-negative tests for women being screened for cer
- A research project looking at hearing problems in young babies, undertaken at Southampton, is resulting in the intro screening programme. This is detecting problems more quickly and leading to earlier help for children with hearing
- Better care can also save the NHS money. Two reviews by the Centre have looked at the merits of different types o The new National Institute for Clinical Excellence has now developed guidance for the NHS that could save it aroun

Professor John Gabbay, director of the NCCHTA, said the publication of the 100th monograph was an important landmark of improved approaches to health care.

'The NCCHTA is continuing to ensure that high quality research information on the costs, effectiveness and broader impac health care is produced as efficiently as possible to help patients, clinicians and managers,' he said.

'The NCCHTA works closely with other bodies who are helping to improve the quality of health care. The publication of the represents an achievement for the whole of the NHS research community.

'Working with the National Institute for Clinical Excellence, we are helping to introduce better forms of care based on more of good practice and clinical effectiveness.'

[ends]

Editors: for further information, please see notes below.

'Working with the National Institute for Clinical Excellence, we are helping to introduce better forms of care based on more of good practice and clinical effectiveness.'

[ends]

Editors: for further information, please see notes below.

Notes to editors:

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Southampton SO16 7PX.

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Website: http://www.ncchta.org

Email: hta@soton.ac.uk

Additional notes

1.) The HTA programme of research is managed by the NCCHTA under contract from the NHS Executive R&D Directorate

2. The 100th monograph is entitled '*A systematic review of treatments for severe psoriasis*'. The main author is Prof Christ the Dermatology Centre, Hope Hospital, University of Manchester School of Medicine. The conclusion is that there is firm e effectiveness of only some of the systemic treatments currently used for severe chronic plaque psoriasis. The research do others don't work, only that the evidence in support of their use is not particularly strong.

3. The first monograph was published in February 1997, and was entitled '*Home parenteral nutrition; a systematic review*'.

Creation of a new, national, rapidly responsive research function for health technology assessment. Back to lis
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In the past year a national network of academic centres has been established in the universities of Birmingham, Sheffield, York (InterTASC – Technology Assessment Scientific Centres) under contract to the HTA programme to produce 30 to 40 per year on technologies of high priority to the NHS. Rapid reviews on specified topics are prepared to a high standard, wi format and a demanding deadline (generally within 3 to 6 months of commissioning). This new research capacity makes p appraisal programme of the National Institute for Clinical Excellence, providing the evidence base upon which guidance is illustrative examples are set out in more detail below.

1. **Effectiveness and cost effectiveness of different hip prostheses.**

   Two HTA monographs (*Health Technology Assessment* 1998; 2: nos. 6 and 20) reviewed all available evidence on co associated with alternative hip prostheses. Over 60 types of prosthesis are in use in the NHS and they differ widely in outcome data are most robust for the older and cheaper designs. Using this evidence, NICE has developed guidance recommends the use of prostheses having the lowest documented failure rates, at a potential saving of up to £8m per England and Wales.

2. **Effectiveness and cost effectiveness of prophylactic removal of wisdom teeth**

   An HTA review has revealed no evidence of benefit from the prophylactic removal of impacted wisdom teeth. Using thi has developed guidance that will reduce unnecessary surgery in this condition at a potential saving of up to £5m for th and Wales.

3. **Evidence for the effectiveness and cost effectiveness of coronary artery stents**

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3. **Evidence for the effectiveness and cost effectiveness of coronary artery stents**

This is a rapidly changing area of technology which is of great importance to the National Service Framework on coron Using the evidence of an HTA rapid review, NICE has developed guidance encouraging the routine use of stents durin angioplasty in all suitable cases. The cost is fully justified by the improved clinical outcomes and the reduction in the n procedures.

4. **A programme of research on the management of multiple sclerosis, developed in consultation with patient groups.**

The effectiveness and cost effectiveness of interferon beta for multiple sclerosis has been intensely debated. The HTA providing evidence to support an imminent appraisal by NICE (*Health Technology Assessment* 1998; 2: no. 4). Howev have pointed out that there are many other important aspects of treatment for which research evidence is incomplete a consultation with the Multiple Sclerosis Society and neurologists, the HTA programme has commissioned a group of 5 will be completed in the first half of 2000. Some will inform the appraisal of interferon beta by NICE and the whole serie subsequent development of guidelines for the management of MS. This project is an exemplar of the HTA programme patients in research commissioning.

Commissioned research on the role of HPV testing in screening for cervical cancer. Back to list of news items | B

A commissioned systematic review (*Health Technology Assessment* 1999; 3: no. 4) concluded that selective testing for hu can improve the management of women found to have mild/borderline abnormal smears on cervical screening. Following p report in August 1999, the HTA programme arranged a seminar at which researchers and policy makers explored the evid practical implications. In December the National Screening Committee recommended the introduction of HPV testing for th within the UK Screening Programme; this is now being piloted.

The systematic review also identified gaps in evidence relating to the wider use of HPV testing as an alternative or adjunct primary screening test in the national programme. We have now commissioned a randomised trial on this topic. The Natio Screening Programme costs £135m a year and has caused recurrent public concern. The properly evaluated introduction technology to improve the overall effectiveness of screening would be of great benefit to the NHS. Other HTA work in this a recent rapid review on liquid based cytology which underpins a current appraisal on that topic from NICE. With regard to th screening programmes in general, a recent HTA monograph (*Health Technology Assessment* 2000; 4: no. 5) has reviewe false negative results and the ways in which their impact can be minimised.

Prostate cancer screening. Back to list of news items | Back to top of page

The development of the PSA test and its possible application in the early detection of prostate cancer has been the subjec professional and public debate. The HTA programme has a carefully structured portfolio of research designed to provide th for policy and practice. Two systematic reviews (*Health Technology Assessment* 1997; 2: nos. 2 and 3) showed that there evidence to support introduction of PSA screening and that the relative effectiveness of alternative treatments for early pro unknown. These conclusions have since been supported by HTA reports from several other countries and have helped to uncontrolled dissemination of PSA testing. A primary research project has now been commissioned to compare treatment screen-detected early prostate cancer (radical prostatectomy, radical radiotherapy or 'watchful waiting'). The feasibility pha randomised trial is examining the performance of PSA testing in the screening context, patients' attitudes to screening, pat for treatment of early prostate cancer and willingness to accept treatment randomisation. In parallel, the evolving internatio being regularly reviewed to keep decision makers fully informed in this controversial area.

Systematic review of the evidence on routine pre-operative testing. Back to list of news items | Back to top of page

The routine use of pre-operative tests such as ECG, blood count and serum biochemistry is widespread and of unproven b review commissioned by the HTA programme (*Health Technology Assessment* 1997; 1: no. 12) found no evidence that ro effective or cost effective. The NHS cost of routine testing is not known but in the United States the estimated cost is $30 b *England Journal of Medicine* 2000; 342: 168-175). There is large potential for disinvestment without detriment to clinical ca was endorsed by SMAC and will support guideline development by NICE during the current year.

Primary research into the costs and benefits of paramedic skills in pre-hospital trauma care. Back to list of new of page

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Primary research into the costs and benefits of paramedic skills in pre-hospital trauma care. Back to list of new
of page

Commissioned primary research concluded that paramedic protocols increase the mortality from serious trauma involving
(*Health Technology Assessment* 1998; 2: no. 17). These findings have prompted DH initiatives on the training and role of p

National and international standing of the HTA programme. Back to list of news items | Back to top of page

The NHS HTA programme has attracted wide international interest for its innovation and productivity. Senior programme m
accept invitations to speak at international meetings, most recently in Sweden, Denmark and Finland. Several overseas ag
for health technology assessment have arranged visits to the NCCHTA in Southampton. The research outputs of the progr
distributed both in paper form and electronically; almost 120,000 copies of HTA monographs have now been supplied by t

[HTA Home Page]

These pages are maintained by Phillip Simons
This page last updated on 19 March 2002

hta logo

NHS R&D Health Technology Assessment Programme

Call for Proposals

The deadline for the December 2001 Call for Proposals has now passed. **No further applications can be accepted.**

Many thanks to all who have applied. You will receive an acknowledgement within the next few days.

The next Call for Proposals is due to appear here at 9.30am on **22 May 2002.**

Don't forget to use your browser's 'Refresh' or 'Reload' button to see the latest version of this page.

In the meantime you may find it useful to look at:

- A brief description of how the HTA commissioning process works
- the Outline Proposal section on our Frequently Asked Questions page
- MRC Guidelines for good clinical practice in clinical trials. As an NHS R&D funding body we require all applicants fo comply with these guidelines.
- The Department of Health's Research Governance page.

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If you have any difficulties with this page or any comments about it please contact Phillip Simons (pps@soton.ac.uk)

This page last updated on 21 February 2002

Department of Community Health
Faculty of Medical and Health Sciences
Division of Community Health
University of Auckland
http://www.auckland.ac.nz/mch

Having the role in research and teaching in the public health sciences, the Division has expertise in Health Promotion, Health Protection, Disease Prevention and Control and in Health Services planning, policy, management and effective practice.

The Division provides teaching and research programmes for people working across the health sector from mainstream public health through to clinical practice. The Division hosts the Effective Practice Institute which teaches programmes in evidence-based healthcare, clinical economics, systematic reviews and evidence-based guideline development and implementation. This institute is the main provid

of training programmes in guideline development in New Zealand.

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Centre for Quality of Care Research (WOK)
WOK Nijmegen
http://www.ehm.kun.nl/ehm/hsv/wok/

The Centre for Quality of Care Research (WOK), a formal collaboration of Nijmegen University and Maastricht University established in 1989, is one of the leading centres in Europe in the field of research on and development of quality in health care.

The Centre aims at research and development on quality in health care, particularly on determinants of and methods, tools, instruments and programmes for effective quality improvement. The ultimate go of the research and development work of the Centre is to stimulate systematic quality improvement in clinical practice and to improve patient care.

The Centre for Quality of Care Research supports professional organisations, health care institutions, managers and policy makers in implementing quality improvement in practices and institutions by providing research evidence on protocols and guidelines for practice, on instruments and indicators for evaluation of care, on cost-effective strategies for implementing changes in practices and on conditic

and systems for managing quality improvement. The results of these research efforts are used at a national as well as at an international level.

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Health Services Research Unit (HSRU)
University of Aberdeen Medical School
http://www.abdn.ac.uk/hsru/

The Health Services Research Unit (HSRU) has a Scottish remit to research the best ways to provide health care, and to train those working in the health services in research methods. In pursuit of this remit, the Unit has established a comprehensive portfolio of health services research focusing on four main programmes: 'health care assessment', 'mental health research', 'effective professional practice' and 'participation in health care'. The research methods used depend on the question being addressed, but the principal methodologies are systematic reviews, pragmatic randomised controlled trials,

quasi-experimental studies, sample surveys and qualitative methods.

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Comparison of Guideline Development Models

Table 1. Selected guideline programmes, organisations responsible for guideline development

Country	Name of organization	Website
Denmark	Danish College of General Practitioners	http://www.dsam.dk
Finland	Finnish Medical Society Duodecim	http://www.duodecim.fi
France	Agence Nationale d'Accréditation et d'Evaluation en Santé (ANAES) (before 1997 ANDEM)	http://www.anaes.fr
	French Federation of Comprehensive Cancer Centres (FNCLCC)	http://www.fnclcc.fr
Germany	Arbeitsgemeinschaft der Wissenschaftlichen Medizinschen Fachgesellschaften (AWMF)	http://www.awmf.de
Italy	Agency for Regional Health Services (ARHS)	http://www.assr.it
The Nederlands	Dutch Institute for Healthcare Improvement (CBO)	http://www.cbo.nl
	Dutch College of General Practitioners	http://www.artsen.net
Sweden	Swedish Council on Technology Assessment in Health Care (SBU)	http://www.sbu.se
Switzerland	Swiss Medical Association	http://www.fmw.ch
United Kingdom	Centre for Health Services Research Unit of University of Newcastle upon Tyne (North of England)	http://www.ncl.ac.uk/chsr
	Royal College of Physicians of London	http://www.rcplondon.ac.uk
	Scottish Intercollegiate Network (SIGN)	http://www.sign.ac.uk
Australia	National Health and Medical Research Council (NHMRC)	http://www.health.gov.au/hfs/nhmrc
Canada	Cancer Care Ontario Practice Guidelines Initiative	http://www.cancercare.on.ca/ccopgi
New Zealand	New Zealand Guidelines Group	http://www.nzgg.org.nz
USA	Agency in Healthcare Research and Quality (AHRQ) (before 1999 AHCPR)	http://www.ahrq.gov
	US Preventive Service Task Force	http://www.ahrq.gov/clinic/uspstfix.ht
	National Institutes of Health (NIH)	http://consensus.nih.gov

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Comparison of Guideline Development Models

QUESTIONNAIRE FOR DESCRIPTION OF GUIDELINE DEVELOPMENT PROGRAMMES

Clinical practice guidelines are being used by health care systems around the world to improve the delivery of patient care. An increasing concern is the number of guidelines that contain conflicting recommendations. Hence, there is a need for a common, valid and transparent approach to develop good clinical guidelines. Prior to 1990, consensus development methods were generally used for developing guidelines. Since the rise of evidence-based medicine, the methodology of guideline development has gradually changed. Nowadays, different guideline development models are used.

In our study we aim to describe and compare guideline development programmes from various international settings. We have developed a framework comprising of 33 items that should enable us to describe and compare guideline programmes in a neutral and valid way. Our questionnaire is based on this framework.

This questionnaire should be filled in by key informants of guideline development programmes. Hence, we would be very pleased, if you could spend some time filling in the questionnaire. This questionnai should take you no more than twenty minutes.

Your co-operation is much appreciated.

Jako Burgers

AGENCY RESPONSIBLE

1. Name Agency _____

2. Country _____

3. Website _____

4. Type of Organisation

p Academic Institution
p Medical Speciality Society
p Disease Specific Society
p Internationa Agency
p Managed Care Organization
p Manufacturer
p National Government Agency
p Private Organization
p Professional Association
p Regional/Local Government Agency
p Other .....

5. Funding

p Own budget
p Governmental support
p Pharmaceutical support
p Other .....

6. Estimated budget for guideline development (Average cost per guideline)

p 0 - 5000 ECU
p 5000 - 10000 ECU
p 10000 - 25000 ECU
p 25000 - 50000 ECU
p 50000 - 100000 ECU

6. Estimated budget for guideline development (Average cost per guideline)

p 0 - 5000 ECU
p 5000 - 10000 ECU
p 10000 - 25000 ECU
p 25000 - 50000 ECU
p 50000 - 100000 ECU
p 100000 - 200000 ECU
p 200000 ECU

7 Historical Details

- year of founding ----------

- reason for founding ----------

- year of first guideline development ----------

- reason for guideline development ----------

---

8. Role and function of agency in health care system ----------
---

SCOPE AND PURPOSE

9. Central aim/mission statement concerning guideline development ……
……
……
……

10 Objectives
(more than one answer possible)

p Appropiate clinical care
p Cost containment
p Both
p Other .....

11. Level of care
(more than one answer possible)

p Public Health
p Primary Care
p Secondary Care
p Tertiary Care

12. Target users
(more than one answer possible)

p Physicians
p Paramedical professions
p Nurses
p Patients
p Health Care Organisations / Hospitals
p Policymakers

13. Scope of guidelines
(more than one answer possible)

p Screening
p Prevention

13. Scope of guidelines
(more than one answer possible)

p Screening
p Prevention
p Diagnosis
p Treatment / management

14. Who selects topics

.....
.....

GUIDELINE DEVELOPMENT GROUP

15. Average number of members in a guideline development group

p 0 - 5
p 5 - 10
p 10 - 15
p 15 - 20
p >20

16. Average number of disciplines in a guideline development group

p 0 - 3 disciplines
p 3 - 5 disciplines
p 5 disciplines

17. Methodological support

p Experts of guideline development and methodology participate in guideline development group
p Experts of guideline development and methodology are consulted only if necessary
p No involvement of methodological experts

18. Involvement of patients
(more tha one answer possible)

p Yes, by participation in development group
p Yes, by surveys of patients views / preferences
p Yes, by review by representatives for patient organisations
p No

METHODOLOGY OF GUIDELINE DEVELOPMENT

19. Method used to colect evidence
(more than one answer possible)

p Hand searches of published literature (primary and/or secondary sources)
p Searches of electronic databases
p Searches of patient registry data
p Searches on unpublished data

20. Methods used to analyse evidence
(more than one answer possible)

p Decision analysis
p Meta-analysis
p Systematic review
p Non-systematic review
p Experience based

21. Methods used to formulate recommendations
(more than one answer possible)

p Subjective review
p Informal expert consensus
p Formal expert consensus (consensus conferences, nominal group technique or Delphi technique)
p Evidence-linked (weighting according to a rating scheme)

22. Method of review
(more than one answer possible)

p Clinical validation - pilot testing
p Clinical validation - trial implementation period
p Comparison with guidelines from other groups
p External peer review
p Internal peer review

PRODUCT

23. Number of guidelines produced

p 0 - 10
p 10 - 20

23. Number of guidelines produced

p 0 - 10
p 10 - 20
p 20 - 30
p 30 - 50
p >50

24. Average size of guideline

p 0 - 2 pages
p 2 - 5 pages
p 5 - 10 pages
p 10 - 15 pages
p 15 - 25 pages
p 25 - 50 pages
p >50 pages

25. Different versions
(more than one answer possible)

p Extensive version with notes / references
p Short version
p One or two page summary
p Patient version

26. Tool for application
(more than one answer possible)

p No tools
p Algorithms / flow charts
p Balance sheets
p Risk tables
p Patient leaflets

DISSEMINATION

27. Media used
(more than one answer possible)

p Paper
p CD-ROM
p Internet

28. Estimated budget for dissemination (average budget per guideline)

p 0 - 5000 ECU
p 5000 - 10000 ECU
p 10000 - 25000 ECU
p 25000 - 50000 ECU
p 50000 - 100000 ECU
p 100000 - 200000 ECU
p > 200000 ECU

IMPLEMENTATION STRATEGIES

29. Health professional orientated interventions
(more than one answer possible)

p Educational materials
p Conferences
p Local opinion leaders
p Outreach visits
p Patient mediated interventions
p Audit and feedback
p (computer) reminders

30. Use of financial incentives

p Yes, specify .....
p No

31 Organisational interventions
(more than one answer is possible)

p Changes in settings / site of service delivery
p Changes in physical structure, facilities and equipment
p Changes in medical records systems
p Changes in scope and nature of benefits and services
p Presence and organisation od quality monitoring mechanisms

31 Organisational interventions
(more than one answer is possible)

p Changes in settings / site of service delivery
p Changes in physical structure, facilities and equipment
p Changes in medical records systems
p Changes in scope and nature of benefits and services
p Presence and organisation od quality monitoring mechanisms
p Ownership, accreditation and affiliation status
p Other, specify .....
.....

EVALUATION

32. Updating

p Updated on regular basis
p Updated irregularly
p Not updated

33. Use of monitoring and documentation (systematic data collection)

p Yes
p No

Additional remarks:

……
……
……
……
……
……
……
……
……
……

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Comparison of Guideline Development Models

Additional questions

1. Experts involved in guideline development: *(more than one possible answer)*

	Always involved	Only if necessary
Informatics, library sciences	p	p
Clinical epidemiology	p	p
Statistics	p	p
Communication	p	p
Health economics	p	p
Social Sciences (psychologist, sociologist, etc..)	p	p
Please, specify...	p	p
Other, please specify...	p	p

2. Is there a methodological training for members of the guideline development group before starting with the guideline development?

p yes, obligatory
p yes, optional
p no

3. Who is responsible for editing the guideline? *(more than one answer possible)*

p all members of guideline development group
p chairman and/or secretary of the guideline development group
p standing editorial staff
p editorial committee that varies among diferent guidelines
p other, please specify.....

4. Is there a process of guideline authorisation?

p yes, formal authorisation by endorsement by professional organisation of the target users
p Yes, authorisation otherwise, please specify .....
p No

5. Is there any regular quality system for your guideline programme? *(more than one answer possible)*

p yes, by developing and publishing criteria for good guideline development ('guidelines for guidelines')
p yes, by revising guidelines based on comments from the professional community

p No

5. Is there any regular quality system for your guideline programme? *(more than one answer possible)*

p yes, by developing and publishing criteria for good guideline development ('guidelines for guidelines')
p yes, by revising guidelines based on comments from the professional community
p yes, by appraising existing guidelines
p yes, we submit the guidelines to a clearing house of guidelines
p yes, otherwise, please specify .....
p no

6. Is there a formal method for updating guidelines?

p yes, please specify .....
p no

7. Who are, apart of yourself, key resource persons of your programme?

8. What are the plans for further development of your guideline programme for the near future?

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