Influence of evidence-based guidance on health policy and clinical practice in England

P Coleman, J Nicholl

Abstract

***Objectives*—To examine the influence of evidence-based guidance on health care decisions, a study of the use of seven different sources and types of evidence-based guidance was carried out in senior health professionals in England with responsibilities either for directing and purchasing health care based in the health authorities, or providing clinical care to patients in trust hospitals or in primary care.**

***Design*—Postal survey.**

***Setting*—Three health settings: 46 health authorities, 162 acute and/or community trust hospitals, and 96 primary care groups in England.**

***Sample*—566 subjects (46 directors of public health, 49 directors of purchasing, 375 clinical directors/consultants in hospitals, and 96 lead general practitioners).**

***Main outcome measures*—Knowledge of selected evidence-based guidance, previous use ever, beliefs in quality, usefulness, and perceived influence on practice.**

***Results*—A usable response rate of 73% (407/560) was achieved; 82% (334/407) of respondents had consulted at least one source of evidence-based guidance ever in the past. Professionals in the health authorities were much more likely to be aware of the evidence-based guidance and had consulted more sources (mean number of different guidelines consulted 4.3) than either the hospital consultants (mean 1.9) or GPs in primary care (mean 1.8). There was little variation in the belief that the evidence-based guidance was of "good quality", but respondents from the health authorities (87%) were significantly more likely than either hospital consultants (52%) or GPs (57%) to perceive that any of the specified evidence-based guidance had influenced a change of practice. Across all settings, the least used route to accessing evidence-based guidance was the Internet. For several sources an effect was observed between use ever, the health region where the health professional worked, and the region where the guidance was produced or published. This was evident for some national sources as well as in those initiatives produced locally with predominantly local distribution networks.**

***Conclusions*—The evidence-based guidance specified was significantly more likely to be seen to have contributed to the decisions of public health specialists and commissioners than those of consultants in hospitals or of GPs in a primary care setting. Appropriate information support and dissemination systems that increase awareness, access, and use of evidence-based guidance at the clinical interface should be developed.**

(*Quality in Health Care* 2001;**10**:229–237)

Key messages

- Substantial variation in the knowledge, use, and perceived influence of published sources of evidence-based guidance exist between health professionals working in different health settings.
- Senior health professionals are not proactive in seeking out evidence-based guidance on the Internet and most rely on it being disseminated to them by post.
- Local factors other than dissemination policies may influence use.
- Information systems that support the use of evidence-based guidance for public health policy, and commissioning decisions should be developed at the clinical interface.

Keywords: evidence-based guidance; guidelines; evidence-based medicine

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The key challenge for the evidence-based movement in all countries pursuing quality improvements in the standards of patient care is to close the gap between what is known, on the one hand, and what happens in clinical practice on the other.[1] Throughout the 1990s a large volume of important primary and secondary resources, such as the international Cochrane Collaboration[2 3] and national and regional Health Technology Assessment (HTA) research programmes,[4] have developed with many others to provide the infrastructure necessary to get evidence into practice. Recent developments in England have included a high profile policy agenda committed to fostering a climate in the NHS[5 6] wherein managers and clinicians examine their beliefs and practice critically against the best research evidence available.

The extent to which any published source of guidance in isolation is likely to affect policy and clinical practice is limited,[1] but this is not to say that guidance is not "valued" by the health professionals for whom it is provided, or that it does not contribute in some way to shaping attitudes or influencing behaviour. The effectiveness of any guidance depends on many

"Topic driven" case studies of six DEC reports:
Specified topics:
- Cervical screening intervals
- Insertion of grommets
- Antenatal checks
- Breast reconstruction following mastectomy
- Dilatation and curettage
- Triple therapy for *Helicobacter pylori.*

Component studies:
(1) A postal survey of use generally in senior health professionals.
(2) A postal survey of use of specific topics (subsample).
(3) Follow up telephone interviews (subsample).
(4) "Before" and "after" study of routine data and follow up in three zones in England (South & West, NHS North & West region, and other England.)
(5) Costs study.

Box 1 Evaluation of the South & West health region's Development and Evaluation Committee (DEC) reports.

factors: health professionals have to know that the guidance exists; the output has to be easy to access both in terms of availability and readability; and the content has to be relevant. There must be agreement with how the guidance is generated and how the evidence is interpreted. All these factors are necessary (but not sufficient) conditions to be met before the evidence may be acted upon, and the complex process may be disrupted at any point by other changes and circumstances. Little is known about the organisation of evidence-based guidance and the processes involved in its dissemination from the perspective of health professionals, yet each point where their knowledge or views of the guidance diverge from those producing it is a potential barrier to implementing the evidence.

In February 1999 we were commissioned to evaluate a regional system of rapid review of the evidence, appraisal, and recommendation by a peered committee based in the South & West (S&W) health region of England known as the S&W Development and Evaluation Committee (DEC).[7] We adapted the design of one of the studies in the evaluation (box 1) to capture a much wider picture of the patterns of use of several different evidence-based guidance, thus allowing the results for the S&W region to be included both in a national survey and also to be dealt with separately for purposes of the evaluation. To identify measures that might improve the potential of the guidance to influence healthcare practice positively we have studied the patterns of knowledge and issues around the use of evidence-based guidance in senior health professionals.

Methods

A postal questionnaire that had previously been piloted was sent to a sample of 566 directors of public health and directors of commissioning/purchasing responsible for directing local health policy and commissioning services in the health authorities, consultants (who were also clinical directors) providing specialist care in trust hospitals, and lead GPs in primary care groups (PCGs) providing care to patients in primary care. The sample were all in senior posts in the NHS and were selected on the assumption that their perceptions and spheres of influence might reasonably be expected to be key indicators of the wider impact of evidence-based guidance.

SAMPLE FRAME AND POPULATION

The sample was drawn from all eight health regions in England stratified into three zones as follows: (1) all hospitals and health authorities in the S&W region, (2) all hospitals and health authorities in the NW region, and (3) all hospitals and health authorities in three health districts selected randomly in each of the other six English health regions, grouped together as "other England". The sample of 12 lead GPs from each of the eight English health regions was selected randomly from the available PCG information.

The clinical specialties included (general surgery, plastic surgery, obstetrics and gynaecology, women and child health, paediatrics, ear nose & throat, gastroenterology, and oncology) in acute hospitals were those that might be influenced specifically by the six reports selected for the evaluation (box 1).

The final sample consisted of 95 directors of public health and directors of commissioning/purchasing responsible for policy and public health locally in 46 health authorities (a sample of 46% of all authorities in England); 375 clinical directors/consultants in 162 hospitals (representing 41% of all acute and/or community trusts but excluding ambulance trusts), and the lead GPs in 96 PCGs identified from a communication from the Department of Health detailing contact details and information available at the time of the survey (n=362), yielding a 27% sample of PCGs.

The questionnaire and up to two follow up reminders were sent with a letter addressed to each person in the sample by name and job title, identified in the case of the health authorities and the hospitals from a health services directory[8] and for the GPs as described above.

SOURCES OF EVIDENCE-BASED GUIDANCE

After panel discussions with local information specialists and two health economists, seven sources of evidence-based guidance were selected to represent international, national, and local sources and to typify the different types of evidence-based guidance available in England at the time of the study (table 1).

QUESTIONNAIRE

Against each source of evidence-based guidance the sample was asked about awareness and use ever, and how the information was accessed (appendix 1). The systematic reviews of the Cochrane Collaboration are available only electronically, but at the time of the survey

Table 1 Summary of selected guidance

Title	*Source*	*Website*	*Description*	*Focus/dissemination*
Effective Health Care Bulletins (EHCB)	NHS Centre for Reviews and Dissemination, University of York, UK	http://www.york.ac.uk/inst/crd/ehcb	Systematic reviews using established guidelines and peer review of clinical effectiveness/cost effectiveness studies of health care interventions. Bimonthly publication.	National. Circulation 60 000 copies disseminated widely and freely to NHS and other health providers through distribution networks.
Bandolier	Pain Relief Unit, The Churchill, Oxford, UK	http://www.jr2.ox.ac.uk/Bandolier	Commentary, research updates, and abstracts of reviews of evidence-based health care. Monthly publication.	National coverage by NHS regions and direct to GPs. Circulation approx. 23 000 copies
Cochrane Library	UK Cochrane Centre , Oxford, UK	http:/www.cochrane.co.uk	Systematic reviews of research evidence and clinical trials data using explicit quality criteria. Quarterly publication	International. Electronic access (Internet and CD-ROM).
Health Technology Reports	National Co-ordinating Centre for Health Technology Assessment (NCCHTA), Wessex Institute, University of Southampton, UK	http://www.hta.nhsweb.nhs.uk	Commissioned programmes of research into clinical/cost effectiveness of health technology interventions supported by the Department of Health Research & Development (R&D) Division.	National. Freely available to NHS/local authority/educational organisations, etc in UK on application.
NHS Executive S&W Development and Evaluation Committee Reports or "Wessex DEC" reports	Wessex Institute, University of Southampton, UK	http://www.hta.nhsweb.nhs.uk/rapidhta	Information for purchasers and clinicians through systematic review of best available evidence and peered committee recommendation. Approx. 12 topics annually 1991-2000.	Local/regional. Routine dissemination widely within NHS Executive S&W plus selected mailing list outside S&W
Effectiveness Matters	National Centre for Reviews and Dissemination (NCRRD), University of York, UK	http://www.york.ac.uk/inst/crd/em	Summary abstracts and updates of important reviews published in the EHCB. Biannual publication.	National. Dissemination as for EHCB above plus distribution to GPs direct. Circulation 90 000 copies
Trent working group on acute purchasing reports or "Trent DEC" reports	Trent Institute for Health Services Research, Universities of Leicester Nottingham and Sheffield, Sheffield, UK	http://www.sheffield.ac.uk/uni/academic/R-Z/tiwgap/index.htm	Information for purchasers and through systematic review of best available evidence, seminars and peered committee recommendation. Approx. 16 topics annually 1996–2000.	Local/regional. Routine distribution to NHS clinician providers and purchasers locally plus selected mailing list outside Trent.

all the other sources were available either electronically or in printed format. The sample was asked to indicate all the methods usually used to access that particular source of evidence-based guidance. The options were the Internet, special request through a library (reflecting proactive ways of accessing information), direct mail, circulated within organisation (typical of passive routes to information), and an "other" category.

To develop a proxy measure of what the value of each source was to our sample, we included three statements about "quality", "usefulness" as a practical decision making tool, and perceived "influence on practice". The increasing intensity in the three statements was adapted purposively from a communication model[9] and moved from "beliefs means action" to capture the perceived impact of each source for the participants who were asked to indicate their agreement with each statement on a 5 point Likert scale ranging from "agree strongly" to "disagree strongly".

There was a "free text" section for additional comments and a box to indicate the participant's willingness to take part in a follow up interview.

ANALYSIS OF DATA

Responses were processed in an Access database and analysed using SPSS for Windows using χ^2 tests. Statistical significance was set at $p<0.05$ and 95% confidence intervals (95% CI) were calculated for key estimates.

Results

RESPONSE RATE

Responses were received from 414 of the 566 in the original sample. Six forms were returned by the post office as undelivered. There were six refusals and one response was by letter rather than questionnaire. Adjusting for non-receipt and refusals, a response rate of 73% (407/560) was achieved. The response by health setting was 79% (n=75/95), 73% (n=270/370), and 65% (n=62/95) in the health authorities, hospitals, and primary care, respectively. No differences were observed between the proportions of responses received and the sample frame by health region or health setting (health authorities/hospitals/GP).

AWARENESS AND USE OF EVIDENCE-BASED GUIDANCE

Of the 407 respondents, 82% (n=334) had previously consulted at least one source of evidence-based guidance. In total, 1037 contacts with different evidence-based guidelines were reported, 973 with specified sources and a further 64 with "other" (predominantly Royal College guidelines). Seven of the 334 had consulted "other" sources exclusively. Differences in the proportions of respondents who reported no use of any source ever were observed between the three settings (three health authorities (4%), 55 hospitals (20%), and 15 GPs (24%)). Variations in the patterns of use of evidence-based guidance were found between hospital consultants and GPs, and between directors of public health and directors of commissioning/purchasing in the health authorities. The source used most often by

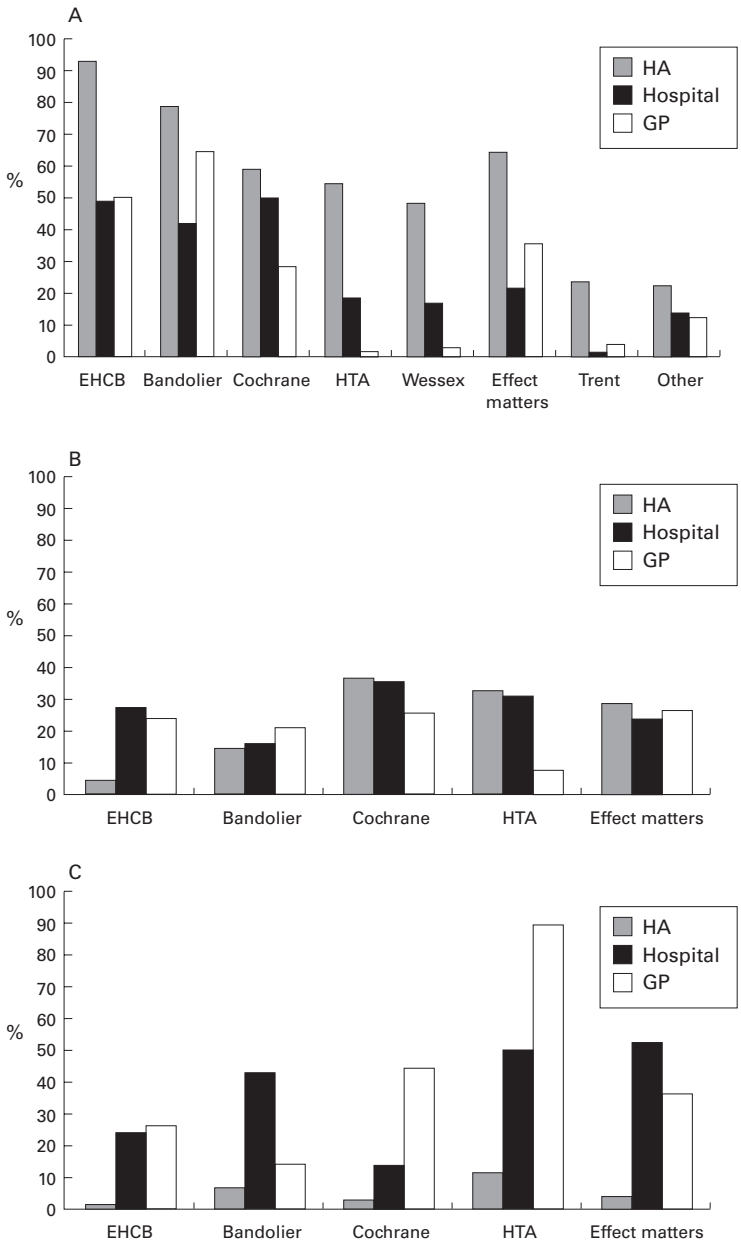

Figure 1 (A) Use ever of evidence-based guidance by health setting. (B) Awareness of evidence-based guidance but not used ever by health setting (national sources only). (C) Lack of awareness of evidence-based guidance by health setting (national sources only). HA = health authority; EHCB = Effective Health Care Bulletins; HTA = NHS Technology Assessment Programme Reports; Effect Matters = Effectiveness Matters.

respondents from health authorities was the Effective Health Care Bulletins produced in York, while the Cochrane Collaboration was used most often by respondents in hospitals and Bandolier by GPs (fig 1A). Substantial differences between awareness and use were observed between respondents across the three health settings (fig 1B and C). The total number of respondents divided between "use ever" and "awareness" by the individual sources of evidence-based guidance (national only) are shown in table 2.

ACCESS TO EVIDENCE-BASED GUIDANCE

Four respondent users of evidence-based guidance did not complete this question. Of those reporting past use of any evidence-based guidance, 84% (277/330) usually used one method only to access the information although the method varied between different guidance. The method used most frequently was "direct mailing", which was reported by 57% of user respondents (190/334, 46% of all respondents) and accounted for 41% of all types of contact (457/1070); 29% (97/334) of users had accessed at least one source of evidence-based guidance by the Internet but, overall, the Internet represented only 12.6% of all types of contact and was similar to the proportion of specific requests for an item—for example, through a library (12.1%). No difference was observed in the use of the Internet to access any source of evidence-based guidance across the three health settings.

Table 2 Use and awareness of selected guidance by numbers of respondents

Source	*No of respondents*
Total number of respondents (n=407) who had used EBG ever (national sources only)	
Effective Health Care Bulletin	232
Bandolier	211
Cochrane	197
HTA reports	92
Effectiveness Matters	131
Total number of respondents (n=407) aware of EBG but not used (national sources only)	
Effective Health Care Bulletin	93
Bandolier	67
Cochrane	140
HTA reports	114
Effectiveness Matters	105
Total number of respondents (n=407) unaware of EBG (national sources only)	
Effective Health Care Bulletin	82
Bandolier	67
Cochrane	70
HTA reports	201
Effectiveness Matters	171

EBG = evidence-based guidance.

QUALITY, USEFULNESS AND INFLUENCE ON PRACTICE

There was little difference between the three health settings in the proportion of user respondents who either "agreed strongly" or "agreed" with the statement "I think this is a source of good quality evidence-based guidance" (fig 2A). Proportional differences in those who "agreed" or "agreed strongly" with the statement " . . . this source of evidence-based guidance is useful in the decisions I have to make" were observed for two of the four sources of evidence-based guidance with sufficient numbers of users from each health setting for comparisons to be made (fig 2B).

In users of any evidence-based guidance a clinical/health policy split emerged in the proportion who "agreed" or "agreed strongly" with the statement that " . . .this evidence-based guidance has contributed to changing my clinical/purchasing practice" (65 of 75 health authorities (87%), 140 of 270 hospitals (58%), and 35 of 62 GPs (57%)). Differences in the levels of agreement with this statement between the three health settings were observed for all the evidence-based guidance specified (fig 2C).

"LOCAL" EFFECT

A positive association was seen in the proportions of professionals using a source of evidence-based guidance between the region in which the professional was based and that in which the guidance was published and/or produced (table 3). This reached statistical significance for the two regional DEC initiatives in the S&W and Trent regions whose reports were disseminated routinely and locally, and also for the NHS Technology Assessment Programme Reports, Effectiveness Matters, and Bandolier which had different distribution practices.

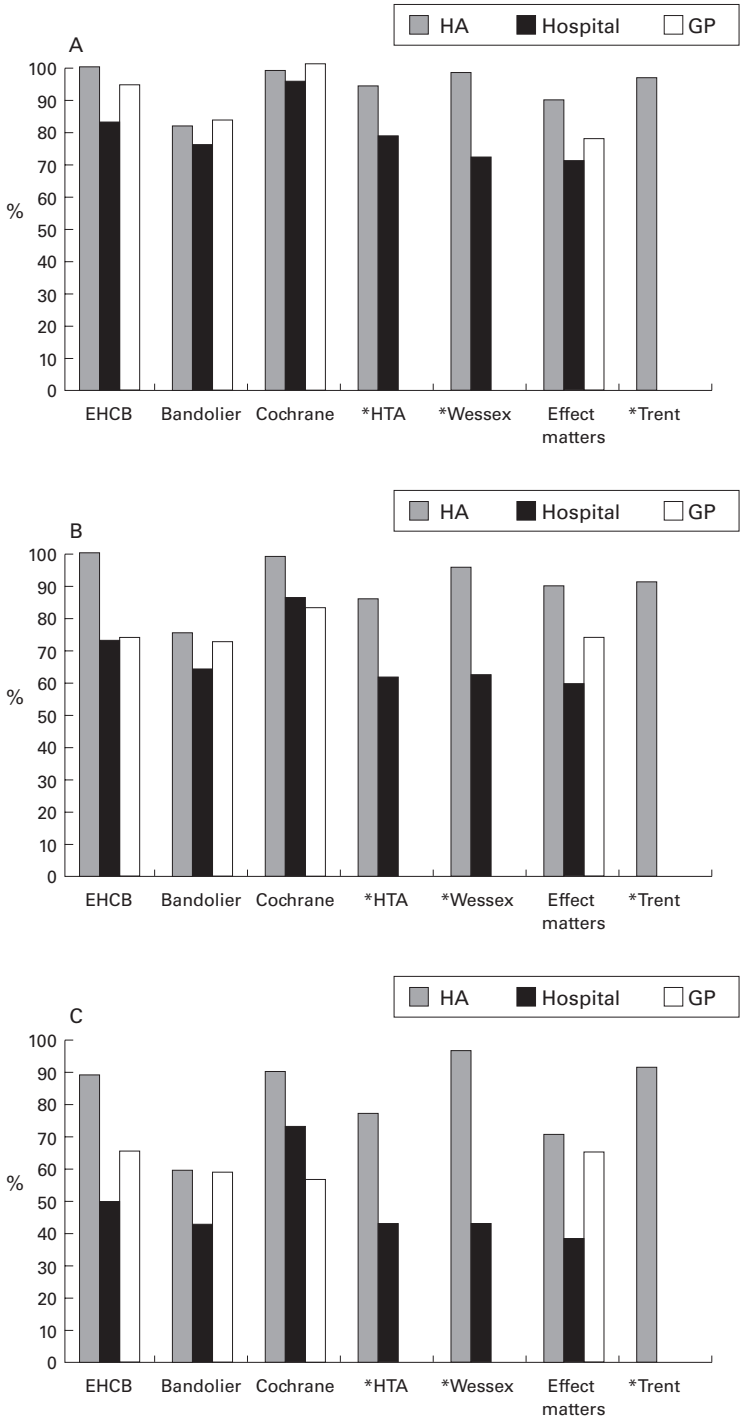

*Figure 2 Proportions of users of evidence-based guidance who "agreed" or "agreed strongly" with the statements (A) "… this is a source of good quality evidence-based guidance", (B) "this source of evidence-based guidance is useful in the decisions I have to make", and (C) "… this source of evidence-based guidance contributed to changing my clinical/purchasing practice" by source of guidance and health setting. HA = health authority; EHCB = Effective Health Care Bulletins; HTA = NHS Technology Assessment Programme Reports; Effect Matters = Effectiveness Matters. *Less than five user respondents in hospitals and/or general practice (not shown).*

ADDITIONAL COMMENTS

Additional comments were received from 22% of respondents. The qualitative analysis of the texts is available elsewhere.[7] Clear differences emerged between professionals in the clinical and non-clinical settings. Directors of public health and directors of commissioning/purchasing were more positive about the value of specific sources and evidence-based guidance generally. The clinicians were more reserved, perceiving a lack of evidence in some clinical specialties (particularly ear nose and throat, palliative care, and mental health); bias in both the selection of the original papers included in some of the reviews and in how their results were interpreted; failure to address the clinically relevant questions; and issues of confidence in applying population-based results to individual patients in a clinical setting.

Discussion

PRINCIPAL FINDINGS

Our survey yielded a comprehensive picture of the knowledge, use, and perceived impact of several different sources of evidence-based guidance available in England in senior clinicians and policy makers based in three different health settings. The results indicate that published sources of evidence-based guidance are used, but there are clear differences in knowledge, use, and perceived influence of different sources of guidance between the professionals based in the three health settings. Those responsible for health policy and commissioning in the health authorities are much more likely to believe that evidence-based guidance has influenced their practice than doctors who provide clinical care in hospitals or primary care. Our study indicated that senior health professionals in any setting were not particularly proactive in seeking out information of this type on the Internet and relied on it being disseminated to them by post. A local effect was observed between the health region in which the professional is based and the region where the guidance is produced and/or published. Not unexpectedly, this was evident for the two regional DEC initiatives, but it was true also for some of the national sources (table 3).

VALIDITY/COMPARABILITY WITH OTHER STUDIES

The finding that positive beliefs about the quality of guidance do not necessarily translate into changing practice in a clinical setting has been reported previously in a Canadian study of hospital doctors[10] and an Australian study of GPs.[11] Our finding that 29% used the Internet to access evidence-based guidance confirms similar findings of a relatively low use of the Internet compared with other ways of accessing information reported in 1998 for GPs[12] and hospital doctors.[13] Our data extend the finding to include senior professionals responsible for public health and commissioning.

Table 3 Reported use (%) by professionals in health region where evidence-based guidance is produced/published ("local") and use by all others

Title	*Local region (before reorganisation in 1999)*	*Local respondents' use*	*All other respondents' use*	*Difference*	*95% CI*
Effective Health Care Bulletin	Northern & Yorkshire	65.4	56.4	9.0	–10.0 to 27.9
Bandolier	Anglia & Oxford	74.2	50.0	24.0	8.0 to 40.4**
Cochrane	Anglia & Oxford	64.5	47.1	17.0	–0.1 to 35.0
HTA	S&W	31.0	20.0	11.0	1.0 to 21.0*
Wessex DEC	S&W	57.7	7.9	50.0	39.8 to 59.7**
Effectiveness Matters	Northern & Yorkshire	61.5	30.2	31.0	12.1 to 50.6**
Trent Acute Purchasing (DEC)	Trent	32.3	4.3	28.0	11.4 to 44.6**

*p<0.05; **p<0.01.

The sources of evidence-based guidance included in this study were typical of the different sources and types of publication available in England in 1999 (table 1). The UK Cochrane Centre is in Oxford but the collaboration is, of course, international. We have no reason to believe that the national and regional sources of evidence-based guidance in our selection were uncharacteristic of those developed in other countries to manage the evidence base. With the exception of Cochrane (available only electronically), all the sources in our selection were published both electronically and in printed format and were disseminated by post or on request. Again, we would expect that this is not very different from the way in which evidence-based guidance is organised in other countries. We therefore expect that our findings will be relevant to the international evidence-based movement.

METHODOLOGICAL ISSUES

We are unable to say whether the perceived impact of evidence-based guidance in non-respondents was different from that in respondents, but the overall response rate of 73% in a population of this type is high, and the rate of 65% achieved from the GPs compares well with a rate of 67% reported in a previous GP based survey undertaken in England.[12] There is some evidence that non-response represents a diminishing relevance of the topic to the non-respondent compared with the respondent,[14] and also that self-reported adherence to evidence-based recommendations is overestimated when compared with objective measures.[15] As we cannot eliminate either of these sources of potential bias, the perceived impact of evidence-based guidance in professionals in each health setting may be inflated and our results should be interpreted as giving a "best possible scenario".

IMPLICATIONS FOR POLICY MAKERS

Our study shows that awareness, use, and perceived impact of evidence-based guidance is much greater in those responsible for directing or purchasing health policy in the health authorities than consultants in hospitals or GPs in a primary care setting. One explanation, which is also supported by the "additional comments" received in our survey, is that research in populations can help to inform purchasing decisions and policy but is often unhelpful in informing clinical decisions about individual patients.[16] Our results also show that different groups of health professionals exhibit distinct preferences for different types of evidence-based guidance. This suggests a need for systems to produce, filter, target, and package the evidence in ways that reflect these preferences. Taking into account dissemination policies (table 1), the positive association found between the use and locality of publication and/or production of the national sources of evidence-based guidance indicates that local factors other than dissemination may influence use. The lack of awareness of important sources of evidence such as the NHS Technology Assessment Programme Reports, which was particularly marked in the GPs in our study (fig 1C), also raises issues about how best to get the evidence to the notice of key providers of health care. The finding that electronic methods were used less commonly than the traditional routes to the published evidence may change over time, but we found no difference in Internet use to access evidence-based guidance by the health professionals across any of the settings. While acknowledging therefore that the complex nature and processes of clinical and non-clinical decision making are very different, our data indicate strongly that information systems such as exist to support the use of evidence-based guidance for public health policy and commissioning decisions should be developed at the clinical interface.

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Conflict of interest: none.

Confidential

MEDICAL CARE RESEARCH UNIT

UNIVERSITY OF SHEFFIELD

Sheffield School of Health and Related Research

NHS R&D survey to assess the impact of Evidence-based Guidance on clinical and purchasing practice

Please will you answer all the questions which apply to you and return the form in the pre-paid envelope provided?

1. Please complete this table indicating whether or not you have consulted any of the sources of evidence-based guidance listed in making decisions relating to your work.

		Please tick all that apply		
Title	***Source***	*Consulted*	*Aware of but not consulted*	*Unaware*
Effective Health Care Bulletins	York	☐	☐	☐
Bandolier	Anglia & Oxford	☐	☐	☐
Cochrane Library	Oxford/w.w.w	☐	☐	☐
NHS Health Technology Assessment Programme Reports	National	☐	☐	☐
Wessex DEC Reports	NHS South & West Region	☐	☐	☐
Effectiveness Matters	York	☐	☐	☐
Trent Working Group on Acute Purchasing Reports	NHS Trent Region	☐	☐	☐
Other, if 'Other'please detail ⇩				
		☐		

*If you are **unaware of** or have **not consulted** any sources of evidence-based guidance listed THANK YOU for your help.*

Please return the form to the Medical Care Research Unit in the pre-paid envelope provided.

*If you have **consulted at least one** of the sources of evidence-based guidance listed above, please continue.* ⇨

2. For **each** source of evidence-base guidance you ✓ 'consulted' in **Q1** please complete this table indicating how you **usually** access the information.

	Please tick more than one box for each source if appropriate				
Title	*Internet*	*Direct mailing list*	*Circulated within organisation*	*Specific request (direct or via library)*	*Other*
Effective Health Care Bulletins	☐	☐	☐	☐	☐
Bandolier	☐	☐	☐	☐	☐
Cochrane Library	☐	☐	☐	☐	☐
NHS Health Technology Assessment Programme Reports	☐	☐	☐	☐	☐
Wessex DEC Reports	☐	☐	☐	☐	☐
Effectiveness Matters	☐	☐	☐	☐	☐
Trent Working Group on Acute Purchasing Reports	☐	☐	☐	☐	☐
Other, if 'Other'please detail ⇩					
	☐	☐	☐	☐	☐

3. For **each** source of evidence-based guidance you have consulted please complete this table to reflect most closely your level of agreement with this statement:

"I think this is a source of good quality evidence-based guidance"

Title	*Agree strongly*	*Agree*	*Not sure*	*Disagree*	*Disagree strongly*
Effective Health Care Bulletins	☐	☐	☐	☐	☐
Bandolier	☐	☐	☐	☐	☐
Cochrane Library	☐	☐	☐	☐	☐
NHS Health Technology Assessment Programme Reports	☐	☐	☐	☐	☐
Wessex DEC Reports	☐	☐	☐	☐	☐
Effectiveness Matters	☐	☐	☐	☐	☐
Trent Working Group on Acute Purchasing Reports	☐	☐	☐	☐	☐
Other, if 'Other'please detail ⇩					
	☐	☐	☐	☐	☐

4. For **each** source of evidence-based guidance you have consulted please complete this table to reflect most closely your level of agreement with this statement:

"This source of evidence-based guidance is useful in the decisions I have to make"

Title	*Agree strongly*	*Agree*	*Not sure*	*Disagree*	*Disagree strongly*
Effective Health Care Bulletins	☐	☐	☐	☐	☐
Bandolier	☐	☐	☐	☐	☐
Cochrane Library	☐	☐	☐	☐	☐
NHS Health Technology Assessment Programme Reports	☐	☐	☐	☐	☐
Wessex DEC Reports	☐	☐	☐	☐	☐
Effectiveness Matters	☐	☐	☐	☐	☐
Trent Working Group on Acute Purchasing Reports	☐	☐	☐	☐	☐
Other, if 'Other'please detail ⇩					
	☐	☐	☐	☐	☐

5. For **each** source of evidence-based guidance you have consulted please complete this table to reflect most closely your level of agreement with this statement:

"The recommendations contained in this evidence-based guidance have contributed to changing my clinical or purchasing practice"

Title	*Agree strongly*	*Agree*	*Not sure*	*Disagree*	*Disagree strongly*
Effective Health Care Bulletins	☐	☐	☐	☐	☐
Bandolier	☐	☐	☐	☐	☐
Cochrane Library	☐	☐	☐	☐	☐
NHS Health Technology Assessment Programme Reports	☐	☐	☐	☐	☐
Wessex DEC Reports	☐	☐	☐	☐	☐
Effectiveness Matters	☐	☐	☐	☐	☐
Trent Working Group on Acute Purchasing Reports	☐	☐	☐	☐	☐
Other, if 'Other'please detail ⇩					
	☐	☐	☐	☐	☐

6. Please include any additional comments on evidence-based guidance:

7. To help us understand more about the influence of evidence-based guidance on clinical/purchasing practice we plan to undertake a small number of short (less than ten minutes) interviews by telephone. Would you be willing for us to call you? Yes ☐ No ☐

All the information you give to this survey is strictly confidential and will not be used in any way that could identify you.

THANK YOU FOR YOUR HELP

Please return this form to the Medical Care Research Unit in the pre-paid envelope provided.

If you have any queries about this survey please contact:

Evidence-based Guidance Survey
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School of Health & Related Research
The University of Sheffield
Regent Court 30 Regent Street
Sheffield S1 4DA

Direct telephone line: 0114 222 0779.

1 NHS Centre for Reviews and Dissemination. Getting evidence into practice. *Effective Health Care Bull* 1999;**5**(1).
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