Cochrane Airways

Cochrane Airways "whole of scope" priority-setting project

A survey and stakeholder group to identify key review questions in airways disease

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Background

Cochrane Airways is an editorial group that works with authors (typically healthcare professionals and researchers) to produce Cochrane systematic reviews on asthma, chronic obstructive pulmonary disease (COPD), bronchiectasis, sleep apnoea, cough, interstitial and other lung diseases. Cochrane Airways is part of Cochrane – a global independent network of researchers, professionals, patients, carers and people interested in health. Cochrane Airways was formed in 1995 and is based at St George's, University of London, but our editorial team is international.

Cochrane Airways publishes Cochrane Reviews on the effects of treatments in the management of obstructive or inflammatory diseases of the airway. Our reviews cover the following topics:

- Chronic and acute asthma (including allergic/atopic asthma, exercise-induced asthma, and occupational asthma)
- Stable and acute chronic obstructive pulmonary disease (COPD, aka chronic bronchitis/emphysema)
- Obstructive sleep apnoea
- Bronchiectasis
- Interstitial lung disease, idiopathic pulmonary fibrosis and pulmonary sarcoidosis
- Pulmonary hypertension
- Chronic and sub-acute cough (cough lasting over 3 weeks)

Asthma and COPD effect a lot of people around the world and cost health services a lot of money. Therefore we have a lot of reviews on these topics and they can tend to dominate discussion because there are more people living with them. However, because there are fewer people living with the other diseases such as ILD and IPF, there has been less research – but these topics are very important for the people living with them. Cochrane Airways has always experienced a tension in dealing with the many different topics in our scope – it is all too easy to focus on asthma and COPD when setting priorities, and we have done in the past because we wanted to be able to go into detail. But the smaller disease areas also deserve attention, hence our decision to conduct a "whole-of-scope" prioritisation exercise.

This work is based on the Cochrane Knowledge Translation Priority-setting guidance. The project was led by Emma Dennett with support from Rebecca Fortescue, Liz Stovold and the team at Cochrane Airways.

Purpose

To launch a "whole of scope" prioritisation programme to increase transparency and ensure relevance of Cochrane Airways Reviews.

- Primary aims:
    - Identify up to 10 priority reviews of importance to the public (patients, carers, healthcare professionals and researchers) from a patient survey.
    - Establish a rolling program of prioritisation where one to five priority review questions are identified every six months.
- Secondary aims:
    - Engage stakeholders (especially consumers) across our scope/listening exercise.
    - Identify potential new consumers/authors/collaborators/funding streams.

Approach

A plan for the priority-setting exercise was published on our website in advance.

Cochrane Airways Priority-Setting Group

We convened a group of stakeholders, called the Cochrane Airways Priority-Setting Group (CAPSG), to prioritise research questions that will be developed into a series of Cochrane Reviews. We planned to generate research questions in two ways: 1) a one-off survey promoted on social media in 2019; and 2) a rolling priority setting process. The survey invited the public to submit their own questions about respiratory health. The rolling project will consider the key new questions and updates of reviews identified from our existing work scanning for new research, the updating classification project, review proposals and requests from guideline producers.

These research questions may result in the update of an existing review, reveal a gap in our scope that requires a new Cochrane Review, or they may be a true uncertainty – a question with no research evidence to answer it.

We intended for the CAPSG to include the following people:

- Three people living with a respiratory condition such as asthma, COPD or bronchiectasis, interstitial lung disease (ILD) or people who care for them – either as a family member, friend or carer.
- Four external stakeholders, such as healthcare professionals, including doctors and nurses, people linked to organisations that are involved with healthcare research, providing patient information, developing guidelines, or funding research.
- Three Cochrane stakeholders, for example people working in the Cochrane Fields, Cochrane Airways authors and members of our editorial board.

Members of the CAPSG must not be employed by a drug company or device manufacturer, or to have received money for travel or speakers' fees from a drug company or device manufacturer within the last three years.

At all stages, we aimed to hold a space for participants to suggest ways to modify the process, agree (or not) to the process, be heard and feel heard, and to live with the overall result even if there was disagreement about individual items. In this way, we planned for patients and stakeholders to directly affect and shape the future direction of the work of Cochrane Airways.

Survey - "Your lungs, your questions"

We posted and promoted a survey on social media and by email to ask patients, carers and healthcare professionals for their most important questions about respiratory health. This survey was conducted in 2019, and will be repeated in three to five years' time if it proves successful.

The survey was conducted in Google docs and ran from the 23 July to the 9 September 2019. The survey was initially in English only and then also in Russian and Spanish for the final week. The survey asked people to name their primary condition, what role they identified as having e.g. patient, carer or researcher and what they wanted to know about preventing and treating lung diseases (box 1).

Your lungs, your questions.

1. What lung disease do you (or the person/people you care for) have? Choose one or more:
   - Asthma
   - chronic obstructive pulmonary disease (COPD)
   - obstructive sleep apnoea (OSA)
   - bronchiectasis
   - interstitial lung disease
   - idiopathic pulmonary fibrosis
   - pulmonary sarcoidosis
   - pulmonary hypertension
   - chronic and sub-acute cough (cough lasting over 3 weeks)
   - Other (please specify)
2. Do you mainly identify as a:
   - Patient
   - Carer
   - Healthcare professional
   - Researcher
3. What do you want to know about preventing and treating lung diseases? Please be as specific as possible (for example what disease does your question concern? What sort of treatment are you interested in? What is it that bothers you about your condition that you want the treatment to help? Why?)

Figure 1. Survey text

Rolling priority-setting project

We plan to use the following sources of information to identify lists of reviews for updating or new reviews: a) Review topics identified with new evidence; b) Highly accessed/cited reviews; c) Reviews with significant new evidence (large trials) identified by literature surveillance (i.e. horizon scanning); d) unsolicited review proposals; e) reviews identified by a guideline group/experts/CAPSG/stakeholders. Background information such as the number of studies avaible to answer a particular question will be provided to the CAPSG to decide about which topics are a priority for Cochrane Airways. This is not yet done, and will be added to the final version of the report.

Results

Cochrane Airways priority-setting group

We received 19 applications, with no representation from Cochrane Fields or our editorial board. We selected 12 people to join the group, and rejected seven applications. There are six heath care professionals including a respiratory nurse specialist, a GP trainee, an ED doctor, and a consultant. There are three people who identify as living with an airways disease and one carer. Of these members, two are also researchers and one used to be a commissioner. One member is an author with Cochrane Airways. There are two representatives from UK lung organisations; Asthma UK and the British Lung Foundation (BLF) (which merged into one organisation during the process). One person was from Egypt, living in Oman and one person was from the USA. The rest of the participants lived in the UK.

We held three online Zoom meetings . In the first meeting we did a round of introductions, and introduced members of the CAPSG to Cochrane Airways and the purpose of the project. We took time to stress that this was a safe space for people to speak. Anyone was free to send their thoughts by email, or arrange a time to speak on the phone to Emma, including to report inappropriate or offensive behaviour. We explained the survey and the results, and asked people how they would like to rank the priorities. We allowed some time for people to discuss the uncertainties and ask for clarifications.

In the second meeting, we reviewed the results of the first round of ranking. We also discussed how to do the second round –we suggested people vote for their top 5, but people preferred to vote for their top 10. For the third meeting we reviewed the second round of ranking, confirmed that all participants could 'live with' the final top 12 uncertainties identified and discussed possible review questions (PICOs) that could be developed from the uncertainties. Participants were asked to complete an evaluation and to say whether they would like to be involved in the ongoing priority-setting exercise. We also discussed the next steps that would be conducted by Cochrane Airways – namely running some searches to scope out existing evidence (including Cochrane Reviews) for the research questions, and developing them into research question in a PICO format for Cochrane Reviews as appropriate.

Results of the survey

We received 147 responses in English, 14 responses in Russian and none in Spanish. Forty-six people (31%) had asthma, 35 (24%) had COPD and 20 (14%) had bronchiectasis. For the other diseases, there were between 7-1 survey respondents (figure 2). Of the 147 respondents, 100 (69%) identified as a patient, 31 (21%) identified as a healthcare professional and the rest identified as carers or researchers.

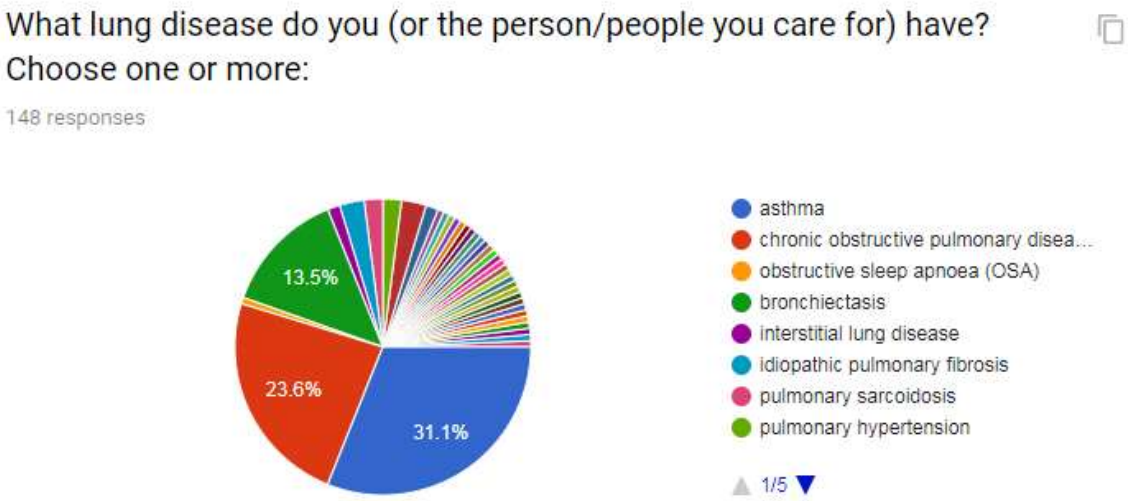

Figure 2. Answers to question 1. number of survey respondents with diseases

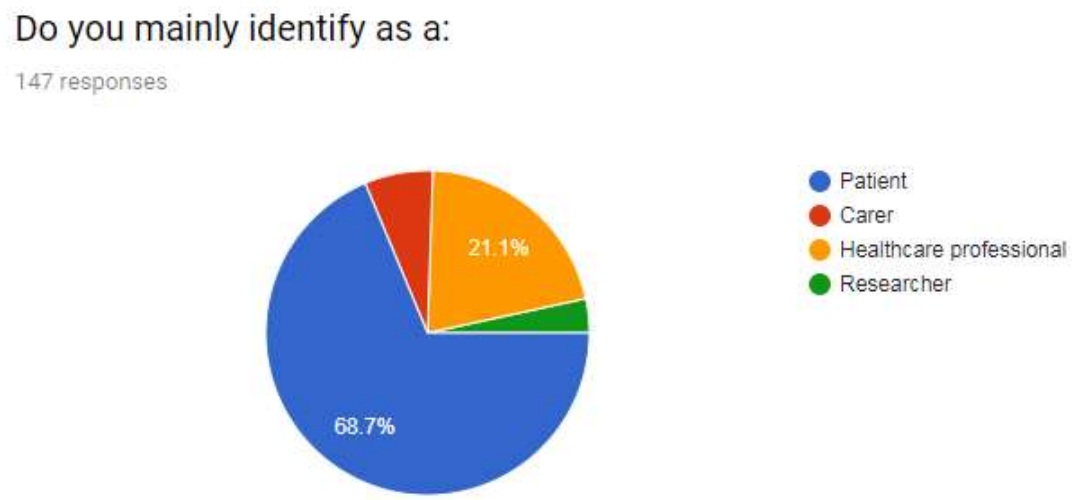

Figure 3. Answers to question 2. how respondents identified themselves for the purpose of the survey

We received 163 responses which required data cleaning to make them suitable for the CAPSG to rank. 125 people had given an uncertainty (answer to question 3). ED went through all the uncertainties and made sure each uncertainty specified the disease it related to (so that it could be separated from the other answers in the survey). Many of these uncertainties were broken down into more than one question. This was checked and edited by another person at Cochrane Airways (RF). ED took all the questions and put them into a word document, before removing all the questions that were incomplete (N = 26), not applicable (N = 8), being answered by a Cochrane review in progress in our group (N = 11), or where a topic lies outside of Cochrane Airways scope

e.g. smoking cessation, which is handled by Cochrane Tobacco Addiction Group (N = 5). Where the same question appeared multiple times, the duplicates were removed and the number of times it was suggested was added in parenthesis. This gave 100 uncertainties. These research questions were grouped into themes (box 2). After some discussion, we decided to include all the disease areas together under these themes.

The final list of 100 uncertainties was checked by a stakeholder member of the CAPSG. We asked them check whether or not they felt a) we did a fair job of redrafting the questions, b) there were any uncertainties where we made too much of a leap and didn't respect the submitter's point of view, and c) this was a reasonable list for the CAPSG to look at. The stakeholder felt that these were reasonable interpretations.

Themes developed by grouping the public uncertainties

1. Triggers
2. Evidence mapping
3. Treatments (interventions) - drugs
4. Treatments (interventions) – non-drug
5. Treatments (interventions) – mixed
6. Prognosis
7. Diagnosis
8. Prevention and cures
9. Service provision
10. Other

We had planned to provide additional information around the evidence for a particular uncertainty, but with 100 uncertainties and no budget for the project, we felt unable to do this in a meaningful way. We also felt that doing the assessments in a non-systematic way that we would introduce bias to the process. We therefore asked the members of the CAPSG if they could rank the uncertainties without this information, which they agreed to do.

First round ranking

Eleven out of 12 (92%) members of the CAPSG voted in the first ranking exercise. People chose their top ten uncertainties, and we used weighted rank where each person's number one rank was given 10 points; the number two rank was given 9 points and so on. This we called the "weighted score" and we looked at these alongside the number of votes for a particular topic. We brought forward all the uncertainties that received two or more votes, or a score of ten or more points. This gave us a list of 29 uncertainties (Table 1)

Code	Uncertainty	Weighted score	Votes [b]
A	New evidence mapping exercise for COPD	34	5
B	Interventions for difficult to treat non-atopic asthma	32	4
C	Interventions to prevent asthma deaths (e.g. how to identify an at-risk patient)	31	6
D	New evidence mapping exercise for interventions to prevent asthma (e.g. vitamin D, allergen exposure, childhood exposure to air pollution etc.)	27	5
E	Personalized/targeted therapies for ILD guided by genotype or phenotype	26	3
F	New evidence mapping exercise for asthma	25	3
G	Interventions to prevent/cure IPF	20	3
H	Interventions to improve engagement with self-management and education for people with IPF	19	3
I	Interventions to improve engagement/adherence to routine care for parents of children with long term respiratory conditions	19	3
J	Interventions to help health care professionals identify at-risk patients with asthma/other long-term respiratory conditions	16	3
K	Improving access to routine reviews for respiratory conditions for adults and children with mental health problems and learning disability	15	3
L	Role of health coaching/motivational interviewing in COPD	15	3
M	Long term effects of inhaled steroids (ICS) and short-acting beta2-agonists (SABA) in asthma	14	2
N	Interventions to improve awareness and knowledge of bronchiectasis health care professionals	13	3
O	New evidence mapping exercise for biologics for asthma	13	2
P	Diagnostic criteria for exacerbations	12	3
Q	Interventions for small airway inflammation and chronic rhinosinusitis	10	2
R	Interventions tailored for older people with asthma	10	1
S	Interventions to avoid triggers for asthma	10	1
T	Interventions to help identify asthma triggers	10	1
U	Interventions to improve cough in people with interstitial lung disease (ILD)	10	1
V	New evidence mapping exercise for Idiopathic Pulmonary Fibrosis (IPF)	10	1
W	Interventions to treat early/mild bronchiectasis	9	2
X	Interventions to prevent bronchiectasis	9	2
Y	Causes/prognosis for adult-onset asthma	7	2
Z	Care pathways to improve access to specialist respiratory services	6	3
Aa	Interventions to maintain normal activities for children with asthma/avoid exercise induced asthma (so they can enjoy normal play)	5	2
Bb	Development of core outcome sets for biologics for asthma that are not focused solely on exacerbation reduction	4	2
Cc	Interventions that improve symptoms/quality of life/maintaining normal activities (rather than focusing on exacerbation reduction alone) for asthma	3	2

Table 1 Footnotes: a) Weighted rank: Number one rank was given 10 points; the number two rank was given 9 points and so on. These were summed to give a weighted score. Scores greater than 10 are presented; b) Votes: the number of people who chose an uncertainty. Uncertainties with 2 or more votes are presented.

Second round ranking

All twelve members of the CAPSG voted in the second ranking exercise. People chose their top ten uncertainties, and we used weighted rank where each person's number one rank was given 10 points; the number two rank was given 9 points and so on. We were looking for approximately 10 research questions that would be suitable for systematic reviews. Because we had decided not to map out precise systematic review questions, and because there was a big drop in points between the questions ranked joint tenth and the thirteenth question, we decided to take forward the top 12 research questions. The final 12 uncertainties are reported below.

Rank	Uncertainty	Weighted score
1	Interventions to prevent asthma deaths (e.g. how to identify an at-risk patient)	66
2	New evidence mapping exercise for COPD	55
3	Interventions to improve engagement/adherence to routine care for parents of children with long term respiratory conditions	50
4	Interventions to improve engagement with self-management and education for people with IPF	42
5	Personalized/targeted therapies for ILD guided by genotype or phenotype	39
6	New evidence mapping exercise for interventions to prevent asthma (e.g. vitamin D, allergen exposure, childhood exposure to air pollution etc.)	36
7	Care pathways to improve access to specialist respiratory services	35
8=	Interventions for difficult to treat non-atopic asthma	34
8=	Interventions to prevent/cure IPF	34
10=	Improving access to routine reviews for respiratory conditions for adults and children with mental health problems and learning disability	32
10=	Interventions to help health care professionals identify at-risk patients with asthma/other long-term respiratory conditions	32
10=	Interventions to improve awareness and knowledge of bronchiectasis for healthcare professionals	32

Table 2 final uncertainties. These were based on a weighted rank (see table 1 caption)

After the ranking, we reviewed the list to ensure that reviews highlighted as priorities for LMIC and by patients have been retained. Most of the uncertainties had been identified by patients, and there were none that we could identify as relevant for people residing in LMIC.

Evaluation

Our reflections: The CAPSG was dominated by white people from Western countries, particularly the UK. We need to consider how to widen participation and to provide a safe space for people with different cultural heritage. We rejected seven applications to join the CAPSG. Mostly these applications were made through Task Exchange. We think it is possible that people didn't understand the task properly (possibly because it was an unusual task for Task Exchange) which led to very brief responses which we felt unable to shortlist. In hindsight, we realised that these applications would have led to a more diverse group so we should learn from that for next time.

The survey was distributed through social media; therefore, the questions would have been submitted by people who have ready access to social media and either follow Cochrane Airways or organisations such as the BLF and ELF, who tweeted the survey for us. It is possible that this will have led to a biased set of questions and representation on the CAPSG. We had one question in the top 12 that includes people with mental health issues and learning disabilities, which represents people in marginalised groups. Evidence mapping could be a useful alternate way to address the lack of inclusivity for people from LMIC, and other people who are not represented in our survey and group. This would put the onus on people who are privileged at the societal level to do the work, rather than expecting marginalised people to hold us to account for our oversights.

The patient members of the CAPSG had direct experience of living with asthma, bronchiectasis or COPD (or a combination of these), but not the rarer diseases within our scope. The group acknowledged this, and asked for information about the burden of living with other respiratory diseases so that they could take these into account when ranking. However, the healthcare professionals had treated people with respiratory diseases other than asthma and COPD, so we didn't feel this was a huge threat to the exercise. Furthermore, there was a mixture of diseases represented in the 12 uncertainties. One disappointment was that the evidence map for obstructive sleep apnoea (OSA) was not prioritised into the final 12 uncertainties – we believe this would make a good candidate for evidence mapping and we plan to look for funding to complete this.

Evaluation by the CAPSG members: We asked all members of the CAPSG to complete an evaluation so we would know what to change about our approach to priority-setting going forwards. We asked the following questions:

1. Did you feel your opinions were listened to during the process?
2. Were you happy with the consensus result? If no, why not?
3. What improvements would you recommend for next time?
4. Would you like to participate in this again? If no, why not?
5. Approximately how many hours did you spend on the tasks between meetings? On what?
6. Were you happy with the report we prepared? If not, why not?
7. Did you get enough information from Cochrane Airways to support you throughout the process? In not, what would you have like to have received?
8. Any other comments?

Eight out of 12 people (67%) completed an evaluation that was sent by email. Most people felt that the meetings were about the right length. One person said that the first meeting felt too short and someone else said "a little more time would be helpful". Seven people felt listened to, one person felt that other people tended to monopolize the discussion. Everyone was happy with the final result.

There were some improvements suggested for the future iterations:

1. "Separate the PowerPoint from the host zoom PC"
2. "I wasn't quite sure what was going to happen at the meetings. For example, I hadn't realised that we were going to be agreeing PICOs at the January meeting and so wasn't prepared enough to contribute meaningfully".
3. "It might be helpful to understand what topics/subjects are a Go / No Go for Cochrane before starting the ranking to perhaps ensure rankings are done for topics that will actually be considered by Cochrane".
4. "Perhaps it would be helpful to include the panel in the process of choosing the initial topics for ranking if possible. It might be helpful to have a primer/lit review or something that briefly discusses what's out there (or what Cochrane has on the subject)… ideally, we should be familiar but a refresher is always helpful"
5. Provide "some clarification regarding the uncertainties prior to the first ranking"
6. Provide a "clear framework from start to avoid discussions that are not related to the topic"

Eight people said that they would recommend the project to a friend or a colleague. Most people spent between two to four hours working on the rankings. One person spent up to six hours. In response to the question 'Did you get enough information from Cochrane Airways to support you throughout the process?' Most people said that yes, they did. One important point was "(I am) unsure still as to if we were collecting informed opinions and/or science-based evidence" and someone else raised that some people seemed uncertain of some of the technical language.

In the open comments question, several people mentioned that a minority of people were allowed to dominate the discussion with comments unrelated to terms of reference for the role. Someone felt that we should have spent more time "getting to know each other and/or setting 'ground rules'". Positive comments were that it was a "great experience and I enjoyed the diversity of backgrounds involved", and "a pleasure and a privilege to be involved".

In hindsight it would have been better to allow two hours for the introductory meeting so we could be less rushed, and to set some ground rules for the discussion. We could also consider providing more learning opportunities with introductory material. We will explore setting ground rules and providing more information ahead of time to allow a wider discussion at the meetings going forward.

The main issue was a tension highlighted at the beginning of the process – namely that the process is complicated and there is a lot of evidence to look at in order to make an informed decision. In an ideal world, we would have been able to provide information on all the existing Cochrane reviews and evidence in a particular area and a view from Cochrane Airways perspective on the topic. However, it is very time-consuming to do this and we had 100 uncertainties to deal with, which made it impossible given the resource that we had for the project. We will, however, take this on board for the rolling priority-setting project. There will be fewer priorities for each

meeting and we plan to give members of the CASPG information about each uncertainty prior to meetings.

Another issue came up following the evaluation was someone felt inhibited in sharing, and they speculated whether this could have led to a different result than running a face-to-face meeting.

The need for formal scoping was highlighted strongly by this group. Over the next year, we plan to explore formal scoping for some of the uncertainties and as we develop proposals for grant funding. This scoping work might range from a full 'scoping review', which aims to map out the existing evidence in a broad research area using a clear framework, to a scoping (preliminary) search, which aims to assess the size of the research literature and give an overview of the range and depth of the existing research in a less resource intensive way.

At the beginning of this project, we'd planned that the survey would be repeated every three to five years. However, at this stage, we believe that it may be better to run more focussed surveys in specific areas. Perhaps the rolling priority-setting project will meet our needs. The intention of this work was to run a "whole of scope" priority-setting exercise that met with central Cochrane's requirements, which was always going to be a messy process. The survey was a good 'jumping off point' for this formal priority-setting work and it allowed us to explore uncertainties from every disease area in our scope and highlighted some of the key concerns.

Developing the PICOs for Cochrane Reviews

The uncertainties identified are not suitable for Cochrane Reviews in their raw form. Some of the would requires one or more reviews to answer the uncertainty, some already have Cochrane reviews that may need updating, and some are absolute evidence gaps. There needs to be some formal scoping done for each uncertainty.

We plan to scope each of the top 12 questions arising from the survey in one of two ways that we have developed from the CADTH method and a table that we produced for an overview of interventions for bronchiectasis:

1. 'Scoping search report'. We have developed a protocol for a scoping search report which will enable us to run searches around a particular PICO or set of PICOs and report the trials found. In turn, this scoping search report will allow a decision to be taken on what reviews should be done to answer the uncertainty.
2. 'Overview tables. An overview table aims to pull together the current Cochrane Reviews addressing a particular uncertainty and to assess how many new trials there may be for inclusion in an update. This will allow us to identify reviews that need to be updated. The production of the scoping search reports and the overview tables may generate a range of topics that would need further consideration by the CAPSG during the rolling priority-setting programme.

This work is ongoing and will be reported on the Cochrane Airways Website as it progresses.

Discussion

This is report on Cochrane Airways priority-setting process up to the point where the uncertainties have been selected. We have described the process of conducting a patient survey, establishing a

stakeholder group (CAPSG), and the analysis of the survey data by the stakeholder group. The second phase will be a rolling programme where we will prioritise the selection of priority topics for Cochrane reviews from ongoing work such as literature surveillance and review proposals submitted by prospective Cochrane authors. Because of the emphasis on providing formal scoping, or gap mapping, highlighted by the survey and the CAPSG, we are discussing ways that we could provide more scoping, in a way that is manageable for Airways staff.

The process was very rewarding, valuable, validating, and also time consuming. It was rewarding because it was enjoyable to work with a range of stakeholders and hear their opinions – on the whole they were supportive of the project and how we went about it. It was also good to hear about people's own struggles living with respiratory diseases. The project was valuable because we now have a clear steer on what topics Cochrane Airways should be working on in the next few years, and also that people want us to use existing evidence to help make our decisions about which reviews to do. It was validating because this is the direction of travel we have been moving towards, and now we have a stronger mandate for changing how we work that we can present to central Cochrane and our funder. It was time-consuming because it feels like something "extra" that we need to do – however it is misleading to think of this as being something extra. Cochrane Airways aims towards a curated collection of reviews, and in order to curate, it is better to plan our reviews from a position of knowing what evidence there is out there and planning out the reviews needed first.

Problems with the online format of the meetings were highlighted – namely that it was hard to get to know people, and that some people were inhibited to speak. We certainly see the value in face-to-face meeting and will look at whether we can run face-to-face priority-setting in the future, though the coronavirus pandemic may move groups further online.

We were aware going into the project that there is a tension between working at a high level to allow for the whole of the Cochrane Airways scope to be considered, but that this also means it was impossible to provide the detailed information that people need to make decisions about priority-setting. This is a tension we have dealt with at Cochrane Airways over the past 10 years, however this project has allowed this to be brought into the open and for stakeholder perspectives to be heard and documented. We plan to provide more information about each uncertainty for consideration going forward (e.g. the PICO, related reviews, relevant RCTs and other research evidence). This will also necessitate us to evaluate the complete workload of Cochrane Airways and to identify the time and resources needed to fulfil this requirement. We are looking forward to priority-setting becoming part of the integral work of the group and continuing to involve stakeholders.

Conclusions

With this report, we have partially fulfilled the primary aim which was to provide a list 10 priority reviews of importance to the public from a patient survey. It is partially fulfilled because we still need to conduct some scoping exercises and refining the uncertainties into PICOs for Cochrane reviews. We are also part-way to fulfilling the secondary aim of engaging with stakeholders, including patients with asthma and COPD. Many of them want to be involved with the resulting reviews and plain languages summaries.

We will use the uncertainties to apply for a new programme grant from the NIHR. Using feedback from the evaluation, we will use this to shape the planned rolling priority-setting programme.

Next steps

Rolling priority-setting

We will use the following sources of information to identify lists of reviews for updating or new reviews. Cochrane Airways staff will produce a spreadsheet of review topics including:

a. Review topics identified with new evidence (as part of updating classification program)
b. Highly accessed/cited reviews
c. Reviews identified by a guideline group
d. Reviews with significant new evidence (large trials) identified by literature surveillance (i.e. horizon scanning)
e. Review proposals
f. Reviews identified by experts
g. Reviews identified by CAPSG

Dissemination

This report is the first dissemination from the project. It is published on our website, promoted on social media and all people who completed the survey and sent to those who provided their email address. As the PICOs for Cochrane reviews are developed from formal scoping exercises, the review titles will be listed on the Cochrane Airways website. High-ranking reviews with a plan for publication or for which we seek new authors will be added to Cochrane's priority review list. We will disseminate the results in the following ways:

1. List of priority reviews added to website
2. Publish a detailed report on the Cochrane Airways website and share it with the working group, anyone who asked to be notified, and in our newsletter and on social media.
3. Regular project updates on Twitter and Facebook (follow @CochraneAirways) – longer pieces will be added as news items to our website and linked from newsletters and social media
4. We will consider submitting a paper describing and evaluating the process for publication in a journal.

We will disseminate published reviews using the KT dissemination brief.

Review production

We have not as yet secured any additional funding to complete reviews identified (our funding is mainly for the editorial process, rather than writing reviews). Therefore, we will attempt to use the following avenues to produce the reviews:

a. Inviting our 'trusted teams' who we know are able to produce high-quality reviews within reasonable time frames.
b. Via applications from new and existing teams who have seen adverts for the reviews on our website, Twitter and the Cochrane Priority Review list.
c. Put forward selected reviews to the Cochrane Review Support Programme (CRSP) after discussion with the Circulation and Breathing (C&B) network.
d. Put together a bid for a new NIHR programme grant.

e. Complete 1 to 3 priority reviews at the editorial base if time allows.
f. Looking for smaller funding calls to support individual reviews.

Longer term evaluation

We plan to complete a longer term, analytical evaluation at the end of years 2, 3, 4 and 5 considering the following:

a. How many of the reviews were published?
b. Comparison of metrics of these reviews versus all other reviews published that year, including altmetric, citations and number of citations in guidelines.
c. How many studies were included in the reviews?
d. How many reviews led to a change in practice? i.e. introduction/recommendation of a new treatment, or disinvestments.

Alpha-1 antitrypsin deficiency

At the time of the survey, we did not regard alpha-1 antitrypsin deficiency as being part of Cochrane Airway's scope. Since this time, we have clarified with the Editor in Chief's office that will become part of our scope. The following questions were submitted about this topic:

1. Interventions to reduce progression/avoid triggers/exacerbating factors
2. DTA review for early and accurate diagnosis
3. Update/replace existing augmentation review, including NRS/registry data
4. Pulmonary rehabilitation for people with A1ATD (subgrouped for augmentation therapy versus no augmentation therapy)
5. Inhaled therapy for A1ATD
6. Prognosis review (including DCLO, FEV1; subgrouped for augmentation versus no augmentation)

This area will be scoped and submitted to the rolling prioritisation exercise.