CompreHensive geriAtRician-led MEdication Review (CHARMER)
A programme grant to develop and test a practitioner behaviour change intervention for deprescribing in the hospital setting

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Wednesday 20th April 2022
14:00 – 15:30

MINUTES

1. Attendees:

David Alldred (DA)
Debi Bhattacharya (DB)
Lizzie Bywater-Florance (LBF)
Allan Clark (AC)
Jaheeda Gangannagaripalli (JG)
Jackie Martin Kerry (JMK)
Katherine Murphy (KM)
Martyn Patel (MP)
Megan Pritchard (MP2)
Sion Scott (SS)
Erika Sims (ES)
Dave Taylor (DT)
Miles Witham (MW)
David Wright (DW)

2. Apologies:

Jennie Griffiths (JG2)
Victoria Keevil (VK)
Bethany Atkins (BA)
Janet Gray (JG1)
Ian Kellar (IK)
Martin Pond (MP1)
Caroline Smith (CS)
Jo Taylor (JT)
David Turner (DT1)
Sujata Walkerley (SW)

Action Points:	Who?	Completed?
Follow up with VK on item 3	DB	Y
Add Research fish to media meeting agenda	LBF	Y
Previous minutes (12.01.22) agreed to be uploaded to website	LBF	Y
Organise a small group meeting to go over ideas for CRN ageing	Janet Hood	Y
Recirculate Implementation Handbook and encourage thoughts to be sent around via email	BA	Y
Redraft NIHR Letter	DB	Cover in meeting

3.	**Minutes of previous meeting – 12th January 2022 (DB)** DB noted the outstanding action 'VK to consider possible options for measuring quality of deprescribing consultations and discuss with DB'. SS explained the outcome was that VK said it was important to measure whether the resultant care the patient gets and how satisfying the consultation was. Developed the separate questionnaire which has been circulated and covers this point. DB to catch up with VK to check she agrees this is covered by this. Action: DB to follow up with Victoria Keevil Dissemination - we now have a plan for a much more structured plan around social media. We were inadequately prepared for the Researchfish submission date; this needs to be picked up at the Media Meeting. Action: LBF to add to Media Meeting agenda The previous minutes were agreed and LBF can remove the remaining comments from them and upload them to the website. Action: LBF remove comments and upload to website.
4.	**WP progress update – see newsletter** **WP1** DB noted that the newsletter has gone out. Invited any comments or queries one WP1. We have had an update on the COS manuscript just today. JMK notes that we have received feedback and the editor has requested some changes and that some detail has been added to the supplementary files and show at what point things have been accepted and rejected. Most changes are quick edits but need to be fitted into the 150 remaining words. MW noted that we could put all the methods into the supplementary and that what 'Age and Aging' like is putting a brief couple of paragraphs on methods and point people to the supplementary for the full methods. DB agreed that this would help to not take up so much air space and improve readability.

	WP2 DB said that the Implementation handbook is a skeleton structure at the moment and that form working with the sites we have gotten good feedback on how to pitch the extra detail form the questions they have been asking. **WP5** DB The exciting message is that we are actually moving with this. BA has moved over from WP2 to WP5 and we have a number of people signed up for the dissemination framework workshop in June. **PCAG** DW praised JMK for getting all of those meetings together. DB said the plan is to capture the work from them in the methods for one of the WP3 protocol papers, specifically in process evaluation protocol paper.
5.	**Feasibility study (MP2) – see evaluation plan** Are there any thoughts or comments on what we have submitted? DB notes JMK picked up that there are a couple of objectives which are not reflected in the table. So in the protocol, as it has evolved since the last PMG, we have wanted to focus on this NOT being an intervention where we would direct clinicians on clinical decisions and so the adverse event monitoring needed to be proportionate so we had a statement in the protocol which reflects this but that they will still be responsible for reporting any adverse events and 'incidents' e.g. complaints/problems related to the discussion and decision and in the discharge letter there will be email address and phone number to report any issues. It's been integrated into the clinical pathway rather than the research bit. We have decided to capture any 'incidents' separately, e.g. complaints with relation to the discussion or decision. MW voiced that we are using a model not designed for this type of trial that is for individuals having drug / device therapies. So there is harms which we have had a previous discussion about and finding harms is still important and we need to capture some of these adverse events. Some other trials say that only adverse events that are CLEARLY related to the studies intervention are reported.

The thing about complaints is fine. But maybe 'A death or hospitalisation that is directly linked / caused by the prescribing processes is fine but the danger is capturing adverse events which are not caused by the study process.

DW for that table for evaluation we need to show how we are going to capture that. It's just another line we need in the table to say that the PMG will review all reported events and assess. Agrees with MW.

KM asked as a result of that do you need to include that in the risk register?

DW – Agreed but that the risk is limited

DB – When required add to the RR there are negative implications.

It was agreed that we need to check what we have in terms of monitoring for significant adverse events. And to address the issue of **'evaluate and refine approaches for safety monitoring'** from the evaluation plan, that we need PMG will review, on an ongoing basis, the data regarding adverse outcomes associated with the intervention to determine whether the monitoring process is proportionate.

The next thing in the evaluation plan was 'refine estimates for the scope to increase pdx in acute hospitals in England'. DB – We have a huge body of literature telling us there is scope for stopping medicines before they cause harm but we need to make sure that there *is* substantial scope for it but we need so what we have in the protocol that we will get a pharmacist or doctor to use the stop tool to see proportionately what proportion of medicines could be stopped on the intervention wards.

SS wanted to make clear that the person doing that would not be an intervention pharmacist it would be a clinical trials pharmacist because otherwise it would be another intervention.

The Logic Model

JMK updated that it has been done during WP2 and now just needs tweaking so she can try and work on it next week.

	DB We have the mechanisms of action and the BCTs and now it's more about presentation so that it flows nicely and you can see how each intervention component related to barrier and the BCT. Feasibility Study MP2 summarises from the newsletter that we had a good experience with the REC so making the minimal changes they asked for and the CAG review is on 12th May. The timeline is that in March it was submitted to ethics and CAG and the REC thing has gone through as planned. They have a pre-process before the committee and they asked for more information to progress it to the meeting. To combat this we have submitted with a cover letter now but the extra work has meant we are about a month behind timeline. The full HRA approval won't be ready until end of May beginning of June so the feasibility study was planned for beginning of May/beginning of June will be shifted backwards about 4 weeks. We have been working with the sites to get their capability and capacity assessments as quickly as we can. We hope that it will be straight forward from here so we don't shift back into summer holidays making it tricky to do the feasibility study.
6.	CRN Ageing Event (DB) A long standing item on the agenda from quite early on in CHARMER and now DB has caught up with MW and decided now is a time for this. (We returned to this later in the meeting when MW returned.) - MW We need to be clear about we want to achieve and it is that we want 40 hospitals / investigators lined up to do the main trial. There are different ways to do this. Suspected that getting an event might be difficult in that it would need to be short and in webinar form as they may be geris/clinicians so need it to be easy to attend. We would also need to think about what audiences we want to reach. What we're the thoughts around the table to know how to support from the CRN perspective. We need to work out how to get enough hospitals on board for the main trial, we need about 42 where the CRN can help and there are enough departments to make this happen. Being clear about who we want to reach is important and then we can think about the best way of reaching them It was agreed that virtual is the way to get best attendance.

	JG – Have the societies can help with this BGS, patient societies and the pharmaceutical societies as well as the CRN database would help this. Action: LBF to organise a small group to go through some ideas DA, MW, DW, DB, SS, KM and KM will bring another person with her. MW also raised that it's worth thinking about how multi-professional can the local investigators be? DA agreed that certainly it should include both geriatricians and pharmacists and also opened up to specialist nurses and cardiac to increase potential capacity. If we are looking at nurses and pharmacists that they have support and buy in from the geriatricians otherwise there will be problems with time commitments. MW strongly in favour of having a very wide range. DT suggest also try the gerontology section of the RSM to publicise the trial for recruiting sites.
7.	**Planned Manuscripts – See Related Documents (DB)** LBF shared the spreadsheet. DB – In our policy was that we would propose any manuscripts at the PMG so we could decide as a group whether the team would be appropriate and something that we would want to do. WP1 COS (Developing a core outcome set for hospital deprescribing trials for older people under the care of a geriatrician) - confirmed with PMG and out for review. WP1 COS (Subject/ Opinion/commentary methods of developing a core outcome set) and WP1 COS (Subject challenges experienced with recruiting older people for core outcome set study and recommendations) were also both previously proposed. JMK states that late last year the PMG agreed these would both be useful to put them in for WP1. They were going for a May 2022 submission. JMK almost has a draft together for them. WP1 Opinion Commentary one came about because found that the Delphi gave 47 outcomes to discuss in workshop and thought there must be better ways and that there was also problems with the software so more of that will be picked up in the 3rd WP1 paper (challenges recruiting).

WP2 (Codesign of a theory and evidence based hospital deprescribing change intervention) Codesign workshops already proposed and progressing well we have a full final draft coming out to team for comment shortly.

New Proposals:

Main protocol paper (including sampling of sites implementation team and handbook outcomes and data linkage but light on process evaluation detail)

&

'Applying realist concepts and behavioural science to evaluate mechanisms…'

Main protocol paper is DW and DA proposal.

DW noticed that nobody started on it so JG who has just joined the team is going to get on with this. Can we change the author rules to allow JG to author on this? We will look at the authorship criteria as the next item on the agenda.

SS & DB – leave the meeting.

We want to discuss manuscript authorship criteria. DB says that minor tweaks were made because we could see issues there that would be problematic and showed what has already been added that the co-applicants will automatically meet the criteria. So we suggest that at least 1 of the criteria needs to be met.

DW took over from DB and states that we just say that if at least one of the four criteria are met then they meet the requirements for authorship. Only 2 of them are possible for a protocol paper. So change to one criteria for a protocol paper and two for other papers. This would make JG appropriate.

DA agreed with this. But made the point that the guidelines for the BPA from ICMJE are a little bit more appropriate when we have such large authorship if you look at the ones in the policy at the moment – number 4 is hard for everyone to do. Action: DW to propose these rewording suggestions to DB to give us more flexibility.

AC commented that these are guidelines and that we would just have to vote and agree to add JG.

8.	Primary Care Group (JMK) JMK raised 2 questions / suggestions from the PCAG 1. That the pharmacists provide a 1 page leaflet showing that your medication has been changed whilst in hospital. DA would disagree with doing this because it is an intervention in and of itself. It's part of a wider issue that the discharge letter usually goes to the GP and generally very little goes to the patient. DW agreed with DA. KM voices that her gut feeling is that the more info the patient has the more inclined they will be, and we're obliged to give the patient as much info as possible and is in favour of informing the patient as much as possible. ES comments that the intervention is focussed at the start and not at the patient. The deprescribing activity is guideline driven already so if we start to develop additional materials which go above routine care that becomes part of the intervention. MP agreed that there is not a lot of point in giving them info about the fact they've ALREADY been consented to take part in the study in being admitted to the ward. The NNUH discharge letter goes to the GP and the patient which contains the info about their medications changed and why. DW added that if the intervention has been delivered correctly, then the patient already knows what has been implemented and why. The group agrees not to agree here with the PCAG. 2. PCAG said the quality of discharge letters was variable - do you want to have a checklist of what is already in a discharge letter? The flow of info between hospitals and primary care and would this affect CHARMER. DW stated this is very similar to point 1. We need to discuss with SS whether our intention is about successful in deprescribing in hospital or whether it's maintained at 3-6 months.
9.	Patient Involvement (KM)

	PPI pleasingly going well and is very positive. From the last PMG meeting they have been asked to contribute to presentations to the wider team, were very involved with WP3 and summarises the information from the newsletter. DT spoke to that he found that it is helpful to be in many different conversations and contributing. The training received at Leicester has been helpful and if more is needed we will reach out. KM depending on what is expected of them moving forwards we will reach out for more training.
10.	**Budget (DB)** Updated and research budget items were discussed.
11.	**Costed extension NIHR draft letter (DJW) – presented at meeting** LBF Shared. ES comments that it's too early to request the cost of extension but need to add into this that budget will be reviewed regularly to determine where costs can be saved. DB – we cannot work within our phase one allocation. ES – We need to formally ask for the contract end date to be later in the project from June 2023. We are asking for a rightward shift to reflect the delay in the programme. But not asking for funding because they won't review it until you've gotten to the end of feasibility and know whether you can do the definitive trial or not and therefore know how much you'll need. They will release phase 2 money ahead of time but you can only request more once this has been released. MW agreed that this should work because it's a single contract with a break clause at the end of phase 1. It was agreed that we don't try to underestimate the time it will take to finish the feasibility and to change the wording to 'move' the check point rather than 'extend' or 'extension' to give assurances that we're making good progress. (The PSC is attended by the programme manager at the NIHR, who seems supportive of what we are proposing and agrees a rightward shift wouldn't be a problem.)

12.	**Changes to the team (DJW)** JG has joined us and LBF is here temporarily. The new permanent Research Administrator, Janet Hood, will be joining us in May. Janet has worked in NIHR research at the UoL for some time.
13.	**Risk register / horizon scanning – see related documents (DJW)** The NIHR portfolio was discussed. Can also add the number of hospitals who have expressed interest. SS agreed.
14.	**AOB** DA invited to speak at the European Geriatric Medicine Society Conference (EuGMS) but unavailable so he proposed DB to present instead. Action: Recirculate the implementation handbook and email thoughts on this.
15.	**Date of next meeting to be agreed (DJW)** Wednesday 6th July 2022 14:00 – 15:30