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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Programme Management Group Meeting

Wednesday 18th January 2023

14:00 – 15:30

MINUTES

1. Attendees:

David Alldred (DA)
Bethany Atkins (BA)
Erica Berardi (EB)
Debi Bhattacharya (DB)
Allan Clark (AC1)
Antony Colles (AC2)
Janet Gray (JG1)
Amber Hammond (AH)
Ian Kellar (IK)
Victoria Keevil (VK)
Jackie Martin Kerry (JMK)
Vanessa Millar (VM)
Katherine Murphy (KM)
Caroline Mulvaney (CM)
Martyn Patel (MP)
Megan Pritchard (MRP)
Sion Scott (SS)
Erika Sims (ES)
Jo Taylor (JT)
David Turner (DT1)
Sujata Walkerley (SW)
Miles Witham (MW)

2. Apologies:

Jennie Griffiths (JG2)
Dave Taylor (DT)
David Wright (DW)
Michael Sheridan (MS)

Action Points:	Who?	Completed?
Letter to NIHR re extension and the variation form (when available) to be circulated to group.	DB	Yes

Gantt chart to be updated and circulated once design of definitive trial has been agreed and the trial planned out.	MP	
Meeting to agree definitive trial design to be arranged asap	SS	Yes

3.	**Minutes of previous meeting –** Previous meeting minutes were reviewed and the need to edit them prior to uploading to the website was discussed, in particular finance figures and references to particular sites and CRNs to be removed. DB referred back to the section of the minutes on EQ5D to clarify what had been agreed regarding capturing baseline EQ5D as well as 3 month EQ5D. Other data to be collected includes age and co-morbidities and HES (hospital episode statistics) data (certain elements only). We will have lots of data to characterise so DB asked do we need baseline EQ5D? DT answered that yes he would recommend it to show any changes and difference in changes between the control and intervention groups. If one group has better health at 3 months we won't know whether they started with better health or not without the baseline data. Although there were some difficulties in getting EQ5D in the feasibility study this was due inefficiencies in the screening for consent procedures (via ward based staff rather than research nurses doing it independently) Review of actions – RPS was contacted to see whether CHARMER could attend but the agenda had already been fixed so it was not possible. We have been invited to present at a BGS conference in April in Edinburgh. Data sharing agreement is now complete. A variation to contract form was requested in winter 2022 and this has now been made available by NIHR for us to make an extension request. DB to circulate for comment before submitting to NIHR.

4.	**WP Newsletter (DB)** The newsletter was circulated prior to the meeting. There were no comments raised regarding its content.
5.	**WP4 – Definitive Trial (DB)** DB presented the summary data from the feasibility study to begin a discussion around the patient population and level of intervention implementation. The data indicates that concerns that patients were frailer than we had intended were unfounded as death rates, co-morbidity rates and dementia rates are not higher than expected and comparable to pre-covid and other deprescribing trials. DB asked for opinion from the team. MW and VK confirmed that the population do not look too frail for the trial. DB presented the summary of the number of potentially inappropriate medicines per patient for a random sample of 20 people. The median number per patient is 1 which has not changed since 2019 when the CHARMER application was submitted. MW asked if the data could be skewed i.e. with a small number of patients having lots of inappropriate medications rather than an even distribution. MRP answered that there seemed to be a good distribution across the population with lots having 1 or 2 inappropriate medications. **Implementation of intervention** The site allowed one month for set-up rather than the 2/3 weeks at the other sites achieved a better level of implementation. **Action plans** <u>Pharmacist workshops</u> A lot of variation in preparation time. The easier we can make it for the PIs the better i.e. by providing more material and thus more facilitation so that they do not have to manage the time themselves. No major issues identified.

Geriatrician videos

Originally intended as an informal 10-minute videos to be watched individually but discovered that it worked better in a more formal group training session where attendees can discuss things with colleagues.

Briefings

They were implemented very differently by the 2 sites that had them. Have decided that we should maintain flexibility i.e. sites can ether do them ad-hoc or pre-plan them. However, sites will need to be clear about how they are going to do them in their plan.

Benchmarking

This was the most challenging aspect of the study. There was a lot of variation in the process followed and who was involved, only 1 used electronic query.

There were several reasons for not doing it electronically e.g. IT people not having clinical knowledge, resourcing of IT team, communication issues & clinicians not being able to access the data

At one site business intelligence IT got involved and this slowed the whole process and they resorted to manual capture. Where the process was electronic junior doctors were tasked with doing the data input.

SS added that with a longer implementation period and more time to implement the benchmarking more sites will be able to adopt automation

Could it be rolled out afterwards? Not a problem as long as we explain the challenges

Preparation for the definitive trial - what does it mean? Learning from the feasibility study is that we need a longer period to implement the intervention e.g. 3 months, so have longer for benchmarking set-up. Also, implementation needs to be supported by someone focussed on implementation rather than just the PI for optimum results.

IK asked whether sites will be given action plans to do and may therefore not engage with them if they have not designed the implementation themselves. DB answered that for the briefings sites were told they must decide how they will run them themselves. For the definitive trial this approach will be used for all aspects of the intervention.

Recruitment

	Initially sample size estimation was based on readmission rates which gave us 40 +sites. Had hoped with time to get a better primary outcome measure e.g. frailty scores but this wasn't possible within the time available and so we went into the feasibility study with just EQ5D and readmission rates. Have been significant challenges with recruitment. Only a small proportion consented of those approached. Things we can change: number of patients approached, will stipulate that nurses approach for consent and remove gate-keeping of clinical staff, will therefore get better rates as for previous similar studies. The number of refusals to take part based on the reason "Research not of interest/too burdensome" was higher than expected – could this be due to training of nurses? Perhaps we need to stress to patients that they are not consenting to intervention but are consenting to some form filling. MW suggested that if the rest of the ward team is ready to support study, lay the ground work and is enthusiastic patients are more likely to say yes. This may help to reduce refusals. Due to time constraints in the feasibility study, we will aim to manage the recruitment phase differently in the main trial. With more time and better preparation we should be able to increase the number of patients consenting. **Primary outcome measures** DB: Readmission rates is not the ideal primary outcome measure however it is no longer feasible to use QOL based on a 30% consenting rate so we have no choice but to use readmission rates. In the grant we said we would look for a 10% difference in readmission rates between control and intervention groups. As we are now looking at a longer time for site set-up i.e. 3 months instead of 1 the duration will be longer, the trial will cost more and will also be delayed. Consequently we are now considering a stepped wedge design. This was originally dismissed due to the length of time needed but now we will have a longer trial anyway and we know we can use that extra time for set-up so it is looking more efficient.

	We need to do more analysis and work through the detail and how many steps are needed so we can check we are able to do this. ES has begun looking at the detail: the change will reduce sites needed from 44 to around 20, but all 20 would have to start at the same time, is it feasible? Do we have enough resource?
5	**Manuscripts** (DB) We have published the COS. Opinion piece submitted this week. WP2 co-design was rejected by Implementation Science (they wanted results not design) have resubmitted to RSAP this week. WP3 – Feasibility study: original plan was 1 protocol paper focusing on trial elements and a separate one for process evaluation parts. Now proposing we submit one that combines both, this is now urgent. This gives us some space to write results and then move onto feasibility trial evaluation data for which we propose 2 papers. DB asked if there were any objections and there were none. Spreadsheet will be updated accordingly.
6.	**Gantt chart (SS)** We are on track with the feasibility study but a little behind with the definitive trial. We are monitoring any delays. ES asked that the letter to NIHR be circulated so that different institutions know that it is coming. This was agreed.
7.	**Programme Steering Committee (MRP)** The next meeting is on 22nd March. It is an important meeting as we will be transitioning to main trial by then. MRP asked for suggestions for the agenda. ES suggested the following: a summary of today's meeting and the proposed decisions based on our findings, the draft protocol for the definitive trial, how we have adapted trial design. Will need plenty of time to discuss each item as well as anything they want to pick up on in the protocol.

	KM suggested a presentation would be helpful and ES that a written report ahead of time is essential. ES will share the Flucare report with MRP as an example.
8.	**Planned Dissemination (KM)** The focus over the next few months will be to raise awareness of what we are doing as much as possible via horizon scanning and constantly reaching out to relevant organisations. The RPS, BGS, Getting It right first time and the BPS are the main organisations where we will be checking for opportunities to share the study. We are active on social media, have a good following and are publishing weekly tweets. Thanks to BA the website is fully updated and looking good.
9.	**Risk Register / Horizon Scanning / Budget (SS)** Risk register - nothing has been added since the last meeting in Oct 22. The time for NHS digital to do their work was the last item added. No risks were raised during the meeting. Budget – nothing of note to report.
10.	**NIHR reporting** We will circulate the draft NIHR variation to contract request for comment.
11.	**Changes to team** Vanessa Millar takes on the role of CHARMER research administrator now that Janet Hood has left. VM has been working on the IMAB-Qi study with SS and DB in the last few months. Caroline Mulvaney has just started on CHARMER as an RA to help with WP4, she is based at Leicester.
12.	**AOB** MP added that he can help edit the upcoming protocol paper if needed.
13.	**Date of Next Meeting** 26 April 2023.