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 5th October 2022
14:00 – 15:30

MINUTES

1. Attendees:

David Alldred (DA)
Debi Bhattacharya (DB)
Allan Clark (AC)
Jaheeda Gangannagaripalli (JG)
Ian Kellar (IK)
Victoria Keevil (VK)
Jackie Martin Kerry (JMK)
Katherine Murphy (KM)
Amber Hammond (AH)
Michael Sheridan (MS)
Jo Taylor (JT)
Martyn Patel (MP)
Sion Scott (SS)
Erika Sims (ES)
David Turner (DT1)
Sujata Walkerley (SW)
Megan Pritchard (MRP)
Janet Gray (JG1)

2. Apologies:

Jennie Griffiths (JG2)
Bethany Atkins (BA)
Martin Pond (MP1)
Dave Taylor (DT)
Miles Witham (MW)
David Wright (DW)

Action Points:	Who?	Completed?
CHARMER to attend RPS & BGS conferences.	DB/SS	✓
DT to add text to data sharing agreement.	DT	✓
MRP to contact JG regarding Leicester data security details for data sharing agreement.	MRP/JG	✓
ALL to comment on delaying the phase one report.	ALL	✓

3.	**Minutes of previous meeting – 6th July 2022 (DB)** In the process of recruiting undergraduates to administer Satisfaction with Deprescribing Questionnaire to participants after discharge from hospital. A substantial amendment was submitted to permit virtual consent for patients and consultees; this has now been approved and will be available during the feasibility trial. JG confirms that HES data is received every month from NHS Digital. NIHR annual report has been submitted and accepted.
4.	**WP Newsletter (DB)** The newsletter gave a brief overview of the work packages: <u>WP1</u> WP1 is in the dissemination phase. Lizzie has put a video together for the Core Outcome Set Paper and JMK is working on synchronising it with the main manuscript. <u>WP2</u> WP2 is in the output stage. Based on the learning from the feasibility study there is likely going to be more changes to refine the intervention in terms of implementation. <u>WP3</u> Originally 4 sites would be recruiting patients, but this has now changed to 3 sites recruiting patients and one implementing the intervention only. <u>WP5</u> There were no comments regarding WP5. <u>Media</u> VK had previously mentioned it would be beneficial to attend EUGMS which the team were able to attend. DB asks the team if there is anything further to plan for 6-8 months' time. KM adds that the branding of CHARMER needs to be increased and expanded on social media. There is no dedicated staff member working on this but in the future this needs

	to be more proactive. KM asks if there is a wider network CHARMER could engage with. MP mentions there is a British Geriatrics Society (BGS) meeting that CHARMER could attend next year (Spring & Autumn) and they usually have a theme which could relate to CHARMER. DB asks if there are any other avenues to raise awareness for the definitive trial. SS mentions the Royal Pharmaceutical Society (RPS) should be attended by CHARMER and posters with QR codes could be submitted. **ACTION: CHARMER to attend RPS & BGS conferences.** <u>Public and Patient Involvement</u> The PPI group are drafting a paper on how to approach the community engagement plan as they want to engage a wider community. It is in the early stages of development so will be included in the next management meeting in three months.
5.	**WP3 – Trial and Process Evaluation (JMK)** JMK has put together a summary (circulated prior to the meeting) to date of what the team are trying to establish for recruitment, the handbook, how long setup is, how the intervention is delivered and whether changes need to be made ahead of WP4. Certain factors at sites effecting the delivery. Capability and capacity has taken longer than expected so the sites have had less time for implementation. The first site tried to implement in two weeks, but this was not enough time. Feedback from the sites suggest they need at least 8 weeks, if not 12 weeks. R&D teams have struggled with the trial being directed at clinicians over patients. All sites have struggled with identifying consultees (no professional consultees have been used yet) and patients are very unwell. MRP adds there was a concern from staff that the professional consultee should not be someone that is under pressure to enrol patients on the study – it would not be appropriate to approach those on the ward as a consultee as it would not be an unbiased view from the patient. However, DB suggests there may be a misunderstanding that the patients are recruited for the intervention when it is actually the clinicians that are.

	Recruiting sites have managed to recruit over 100 patients as requested, but feedback from them show that patients may have been more unwell than expected so have not been approached for consent. Sites have identified missed opportunities if a patient was discharged on a weekend, moved to a different ward when they were ready to consent, or medically fit to consent outside the data collection period. DB explains that based on this the CHARMER primary outcome measure cannot be patient orientated such as quality-of-life. This means the sample size for the definitive trial will be around 40 hospitals as opposed to 12-14 if quality of life was chosen. However, if readmission rates is chosen as the primary outcome measure it is important to have some patient orientated outcomes. The team are looking to capture quality of life from patients at baseline and three months post discharge. MP suggests asking patients for consent to contact to increase consent rates. The only reason for having the baseline is to show the intervention and control are comparable so DB asks whether the three months post discharge would be sufficient. DT1 suggests baseline data would be preferable as it can be used to assess change but the EQ5D data assesses health now rather than retrospectively so if baseline is assessed at different periods for each site, then there will be a variety of responses. If a patient can only be approached when they are medically fit the sample will be restricted, whereas if a proxy was used for all patients it would result in a fuller sample. DB adds that sites are approaching for consent at different times anyway, i.e. when medically stable and when acutely unwell so the baseline differences are apparent. VK adds it is difficult to establish a baseline as ideally it needs to happen before the patient is ill which is impossible. In addition, ideally randomisation should produce interchangeable groups so baseline variation will affect this. DT1 can use the baseline data from the feasibility trial to assess the quality and help inform the team on a decision for the definitive trial. AC agrees it would be better to collect quality-of-life data but is not overly concerned if it is not used. AC asks if any other data is being collected from patients and MRP clarifies that age, gender, residence pre-admission, comorbidities, primary diagnosis, and medications are being collected at baseline. AC asks whether follow-up data needs to be collected if baseline data is not considering the issues and how a reviewer did not recommend it originally. DB would like to collect patient-oriented data regardless and suggests that if the baseline collection is dropped then the only issue will be

	consenting to contact for follow-up data. VK asks if there is time to trial this in the feasibility study and DB confirms this can be trialled with Salford. Process Evaluation JMK flags that no primary care stakeholders have come forward for an interview because their patient was involved in the CHARMER study so far. A conceptual fidelity framework: *Carroll C, Patterson M, Wood S, Booth A, Rick J, Balain S. A conceptual framework for implementation fidelity. Implement Sci. 2007 Nov 30;2:40. doi: 10.1186/1748-5908-2-40. PMID: 18053122; PMCID: PMC2213686.* has been adapted for the CHARMER study to look at how the intervention was delivered, and observations through the Pharmacist Workshop and Geriatrician Video. Challenges experienced at some sites regarding the implementation of the CHARMER intervention components were discussed: Sites have suggested that if the Action Plan needs to be implemented at an organisation level senior staff need to be engaged. Most Action Plans in the feasibility study have therefore been implemented at departmental/ward level. DB adds that it has been implemented as a research requirement rather than an organisational goal. JMK suggested that creating a video for the Pharmacist workshop and pausing it for certain activities during the workshop would help some issues. DB adds that another reason for creating a video was to eliminate variation in the workshop to increase fidelity. JMK has found that sites are not always completing the questionnaires at the end of the video.
6.	**WP4 – Definitive Trial (JG/DA)** The first WP4 meeting will take place the w/c 12th October and will take the comments from this meeting on board. There has been lots of learning from the feasibility study so it will help to design the definitive study. JG has been working on the data sharing agreement, which is nearly done, but needs DT1 to add text for the purpose, and Leicester's data security details. MRP may have the Leicester data so will contact JG regarding this. This application can be submitted once

	the CAG approvals are back. CAG have a 35-day review period so MRP will email them for an update if there have been no updates next week. **ACTION: DT1 to add text to data sharing agreement.** **ACTION: MRP to contact JG regarding Leicester data security details for data sharing agreement.** 34 EoIs have been submitted currently. MW has been engaging with the CRNs and CRN East Midlands have been emailing all CRNs regarding the definitive study. ES adds that the CRN would like to use CHARMER as an example of engaging with the research team early in the project to help recruitment. DB explains that a half day event will be put in place to discuss the learnings from WP3 and the plan for WP4.
7.	**Gantt Chart (DB)** A report needs to be submitted at the end of January to NIHR including the primary outcome measure, and the outcomes/findings of the feasibility study. Northwick Park are starting data collection in October. Salford have started on 03.10.2022 and will end at the end of October followed by a follow-up period three months afterwards. DB explains that rather than waiting for the HES data, the sites will also provide readmission data to the CHARMER team. All data from NNUH and WWL will have been received prior to the report but the follow up data from Salford will not be available prior to submission. DB suggests that as there has been a lot of learnings from the feasibility trial the team need more time to effectively refine the intervention for the definitive trial. **ACTION: ALL to comment on a request to delay the phase one report.**
8.	**Programme Steering Committee (DB)** The next meeting is planned for March 2023. If the PMG agrees a request to delay then DB needs to plan a new break date ahead of this. The chair of PSC would need to draft a letter of support for the extension of the break date.

9.	**CRN Aging Meeting (DB)** DB/SS put together some text to make it clear what the PI's need to do. DB presented this to consultant pharmacists with an interest in elderly medicine which resulted in more EoIs. DB presented to the older people's special interest group for UKACPA raising awareness of CHARMER. MW will secure a slot at BGS to raise awareness of CHARMER now DB/SS have supplied the text.
10.	**Planned Manuscripts (DB)** There are six planned manuscripts (3 for WP1, one for WP2, and two for WP3). Janet has sent out details to the research fellows involved in the different work packages.
11.	**Output and Engagement (DB)** DB asks if anyone has done anything that is not represented in the output and engagements list. The group did not raise anything.
12.	**Risk Register / Horizon Scanning / Budget (DB)** The risk register and budget were discussed.
13.	**Any other business** VK asks who to contact for any technical queries and DB clarifies SS will address these queries and forward as necessary.
14.	**Date of Next Meeting** January 18th 2023.