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 5th July 2023

14:00 – 15:30

MINUTES

1. Attendees:

David Alldred (DA)	Vanessa Millar (VM)
Debi Bhattacharya (DB)	Martyn Patel (MP)
Allan Clark (AC1)	Jackie Martin Kerry (JMK)
Kelly Grant (KG)	Sion Scott (SS)
Amber Hammond (AH)	Michael Sheridan (MS)
Jackie Martin Kerry (JMK)	David Taylor (DT2)

2. Apologies:

Bethany Atkins (BA)	Antony Colles (AC2)
Erica Berardi (EB)	Janet Gray (JG1)
Ian Kellar (IK)	Victoria Keevil (VK)
Caroline Mulvaney (CM)	Erika Sims (ES)
Jo Taylor (JT)	Miles Witham (MW)
David Wright (DW)	Sujata Walkerley (SW)
David Turner (DT1)	

Action Points:	For	By
Reply to Project Steering committee regarding their comments raised on the trial design	DB	
Investigate cost-effectiveness implications of involving the AHSN in implementation with David Turner.	DB/DT1	Agreed would record contact time with each Trust as a high level estimate
Circulate the WP3 infographic amongst the team before sending to PCAG for comment	VM	Done
Phase 1 expenditure to be confirmed and communicated prior to next meeting	DB/VM	

3.	**Previous meeting minutes** The previous meeting minutes were reviewed and it was agreed that they can be posted to the website without any revision. It was noted when reviewing the previous minutes that we have yet to respond to the project steering committee comment requesting information about using a 3-month follow-up instead of 1-month as per a previous trial. The reply will be actioned as a matter of urgency.
4.	**WP update** DB referred to the newsletter that had been circulated and shared some brief highlights. For WP1 and 2 we are currently focusing on outputs. With regards to WP3 the protocol paper has been submitted for publication and comments have been received back to which we have responded. There were no major revisions requested. In WP3 we are about to begin work on raising awareness of CHARMER to increase the likelihood of the deprescribing initiated in hospital being continued after discharge by primary care if appropriate and also to get GPs involved in process evaluation (PE) to provide feedback on CHARMER. The project steering committee were concerned at the

	lack of GP involvement in PE in the feasibility study. DB asked if anyone had any thoughts about how we might tackle these 2 challenges. • MP suggested asking the Primary Care Advisory Group (PCAG) about how to advertise to colleagues. He also mentioned putting an article in the Health Service Journal (HSJ). The HSJ goes to all NHS providers • KM reminded the team that we also plan to get in contact with the Royal College of GPs (RCGP) but we are waiting to have dissemination material ready before we do that (an infographic is being created). DB decided the infographic would be circulated after the meeting for comment and could be used for the HSJ as well as being sent to the RCGP. • DA asked whether we are still going to expand the reach of the initiative and include practice pharmacists and PCN pharmacists as they do a lot of the reconciling post discharge? DB commented that yes, we had talked about raising awareness but not about doing anything specifically. DA added that we don't know yet which GPs to target, once we have sites confirmed we could send an infographic or flier to LMCs and PCN prescribing leads in those areas to alert them to the study and what to expect. The material needs to go to the PCAG first for them to review and comment. DB agreed and thought that we could send to the PCAG within a week or 2. DA referred to a previous project where they had not sent out mail shots as they had separate control and intervention sites and didn't want to alter the care for control patients. As this is a stepped wedge design study the circumstances are different, we might increase our baseline a little but it would be fine to boost the affect at control sites. • JMK mentioned that she will circulate a planning document of different organisations that we could engage with before sending to the PCAG. If people could check that we have not missed off any organisations that would be helpful **Action: Circulate the WP3 infographic amongst the team before sending to PCAG for comment.** WP4 will be covered in more detail later in this meeting.

	WP5 is progressing well, BA is planning to issue the Dissemination Framework manuscript at the end of July and launch the framework in the autumn. We will give a further update when the manuscript is accepted.
5.	**WP 4** **<u>5.1 EOIs and Site Selection</u>** We need 24 sites for the trial, 20 will be randomised and 4 will be spare in case of dropouts. Currently we have EOIs from 29 sites, but we won't know if they fulfil the eligibility criteria until they complete the site assessment forms. The forms are due to go out very soon to CRN members, R&D and also to PIs at trusts. How do we go about selecting sites, what are people's views? Practical considerations include - Capability and capacity (C&C) - we are asking if sites can provide C&C in one stage with the condition that they would be happy to agree the data sharing agreement later or whether they wanted to do it formally in 2 stages - Capability of the CRN – some trusts will do follow up data collection telephone calls etcetera, some won't. Some use trusts within their region to do that. - Throughput of patients – we are asking PIs to estimate this, do we select sites therefore with high throughput? - Electronic prescribing – we need sites to have this in place by 1st Oct. If sites have only recently implemented EP however this could be a risk. Another consideration is: do we purposefully sample rather than randomly select to increase diversity of patients? We are in a good position to be able to select so we should decide what are our criteria are before we do this exercise. DB replied that we are in a good position in terms of recruiting a range of sites for CHARMER, with sites ranging in size, location and patient demographics. DA added that the EOIs are spread across the country and in different CRN areas so we will be trying to stop medicines in different populations anyway and we will be consenting every patient that comes through the door. AC1 was asked for his opinion of sampling. He noted that we are aiming for a representative sample of university and teaching versus district hospitals and a representative sample of multiple wards versus single wards. We can then look to see

	in the exploratory analysis whether those things affect the impact of the CHARMER intervention. DA added that he wasn't sure what a representative sample of hospitals looks like but did think that selecting on the basis of high throughput of patients may favour large trusts and university hospitals and so this is something to consider. MP was also asked his opinion – he thought that if we use readiness to do capacity and capability that might weed out a few sites anyway. If we have the luxury of choosing, he agreed we would want to have reasonably representative mix of teaching hospitals to district general hospitals as per the ratio that you see across the NHS as it is more about the staff attitudes and getting staff involved and doing the deprescribing rather than the patient mix. He added that we haven't asked sites what kind of wards they have and have just asked for geriatrician and pharmacist input. DA clarified that we have asked about length of stay and are excluding wards that have stays less than 48 hours and also excluding wards where they are exclusively for patients who are medically fit for discharge and are just awaiting social care packages. We have not explicitly excluded wards such as orthogeriatric wards but this is something we may have to check with sites as it's not the type of ward where we want to implement the intervention. DA concluded that the general approach will be to look at the practical issues and whether the trust can actually deliver what we need them to deliver, not worrying too much about geography and diversity because that should happen anyway. And then we can do some work to look around university and teaching versus district hospitals. **5.2 Trial Flow Diagram** DA shared a diagram of the trial plan created by AH and talked through the different steps (see attached). In terms of ethics approval DB and DW attended the ethics meeting which went very well. The Confidentiality Advisory Group (CAG) are also happy and their only condition is that HRA approval is required. The process has gone very smoothly and we hope approval will be given imminently.

	The site assessment forms will be sent out by the 7th July and we hope to inform sites by the end of the month. Regarding randomisation we plan to do this before we have the capability and capacity confirmation. This is partly because all sites need to start at the same time and this gives them the time to be able to set up and to be able to provide what we need. This is particularly important for those sites who are randomised to the first wedge as they will be doing intensive data collection and also implementing the intervention quickly, we need to randomise sites so that we can let them know and they can put resources in place. Also, in terms of the CRN, so that they know when they need to provide those 2 FTE nurses to start doing that intensive data collection for one month, we need that capability and capacity confirmation by mid-September. We were originally going to ask them to do that in two stages i.e. give capability and capacity approvals so that we could enrol patients, start the trial and then the second stage of that would be to give C&C in relation to the data sharing agreement for sending patient identifiers to NUH as the data safe haven which would then be transferred to NHS Digital. MW came up with the idea of asking sites if they would be prepared to confirm C&C in one stage but with the condition that they will then agree the data sharing agreement later rather than that having two formal stages of C&C. We will ask sites in the site assessment form whether they would be happy with that. Following on from this there is the site initiation visit, CRN training later in September, and then baseline data collection starting at all sites on the 1st of October. DA asked for comments on the plan. AC commented that sites may pull out at the C&C stage, especially for step 1 sites and this doesn't leave much time to implement a back-up plan. DB clarified that they will know their allocation from the 31st July and so should be telling us immediately if they can't do it. DB thought there is a greater risk of sites pulling out that have been allocated to later wedges as they will say they can't commit that far in advance. AC pointed out that they will still need to collect data during the control phase so will be doing something during this phase. The discussion concluded that there are some risks doing the study in this way and there are no obvious solutions but decisions have been based on our experience and the work of the feasibility study and so will go ahead as planned.

5.3 Sustaining the intervention post-implementation

We need to start thinking about maintaining momentum post-implementation and also what happens if staff leave or rotate. How do new staff engage post-implementation?

JMK and DB have discussed contacting sites on a regular basis to prompt them to provide information on staff changes and extended leave which would help with process evaluation to see if briefings didn't happen. Also, it has been suggested that the project manager have a service delivery plan with the PI, which would include what happens if somebody leaves or is on leave and whether a replacement is given the intervention.

DB added that she has contacted the Academic Health Science network (AHSN) based in the East of England (the networks are tasked with supporting the implementation of innovations in the NHS). They proposed that during the active implementation phase having a weekly catch-up with each project manager and setting up communities of practice and having quarterly meetings with them. They would carry on throughout the life of the project, so there will be some people attending quarterly meetings who are in the acute intensive data collection period whilst others might be 9 months in and that way, they would be sharing learning. The AHSN should be joining the team from next week which will be in time to be able to influence what the agreement looks like with the trusts and they will be in a position to share with us the sorts of things that they think will support continued engagement and maintain service delivery.

AC commented that this will have a cost implication for the cost-effectiveness of the intervention so we should get DT1's point of view before deciding. DB agreed and added that the SoECAT could probably absorb the costs of the AHSN as they were not high.

DA asked if there was a plan yet for what happens when staff rotate, do they run the workshops and videos again? DB answered that this will be contained in the service delivery plan which the sites will need to put together. The idea would be for us to see the plan before they begin and we could then look to see how well they implemented that as part of the process evaluation.

	Action: Check with DT1 the cost-effectiveness implications on the intervention of involving the AHSN in implementation.
6.	**Planned manuscripts** DM shared the spreadsheet. We have papers for WPs 1,2,3 and 5 in preparation. There is also an opinion piece form WP1 that JMK is working on about the challenges in engaging older people.
7.	**Planned Dissemination & Media Engagement** **7.1 Website and Twitter engagement** DB shared the figures showing number of visitors to the website since its creation and where they access the site from. Initially most visits are to the home page but then from March visits have been focussed more on the work packages and most of them are just organically arriving through Google searches. Twitter numbers are growing nicely, figures show that we get a lot of impressions as a result of the blogs we have done especially the WP3 ones. We should therefore plan to write more blogs. **7.2 Letter to CQC and Patient Safety Commissioner** We have drafted a letter to the CQC, to the new national Patient Safety Commissioner for England and to the Chief executive of NHS, Amanda Pritchard. KM asked is there anybody else within your horizons that we should be writing to, to make them aware of the work? SS mentioned that from an NHS England prescribing perspective we are covered as Tony Avery, who's a national clinical director for prescribing is actively involved in the study and was doing some filming for us a couple of weeks ago for part of the CHARMER intervention. DA mentioned David Webb, chief pharmaceutical officer at NHS England who has taken over from Keith Ridge. We reached out to Keith and Richard Cartel at the start but we need to decide whether to also contact David Webb. This can be taken to the media meeting to discuss. **Action for media group to discuss contacting David Webb**.

8.	**Gantt chart** Looking at the current chart if we continue to time we will finish 6 months after the planned end date. Once we find out how much money we've got, we think there is enough money to do a non-cost extension if nothing else changes.
9.	**Risk register** During the meeting SS added the issue of hospitals not providing capability and capacity. For the NHS strikes SS changed the impact to high as consultants are due to strike and they are the ones essentially receiving our intervention. AC added that another risk to be added is the current lack of a trial manager.
6.	**AOB** - MP mentioned that he is going to the autumn British Geriatrics society meeting in Birmingham. Sion asked if we could still submit an abstract to get either a poster or oral presentation on the results of the feasibility study. MP confirmed the deadline for abstracts is 1st Sep at 5pm. Include VK as part of the submission too Action: - Finance – DB clarified that despite best efforts we have not been able to obtain coherent figures for the project spend in Phase 1. The issue is being addressed and we will share up-to-date figures before the next meeting. DA added that they expect to have an underspend at Leeds and that an amendment to the financial schedule may be required. He will arrange to speak to DB about it separately.
7.	Next meeting – 5th October 2023