Clinical Research Network
West Midlands

WARWICK
WARWICK MEDICAL SCHOOL
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PARTICIPATE

Excellent recruitment to clinical research in the West Midlands: the role of GP research champions

Over the last year in the West Midlands, well over 20,000 people have been recruited into primary care research, including about 3,000 from Coventry, Warwickshire, Herefordshire and Worcestershire alone. This reflects how research has become an increasingly core part of the "business" of primary care in the West Midlands.

One development driving this is the presence of GP research champions across the area - local GPs who have a passion for primary care research. There are now fifteen such champions, each jointly employed with a CCG and engaged in raising the profile of primary care research at CCG level, encouraging GP practices to be involved in research, supporting practices to participate in studies and advocating the local uptake of research findings.

Where appropriate, GP research champions attend local practice meetings, practice nurse and manager forums, PLT and GP registrar events.

They are always keen to seek more ways to promote and embed primary care research in everyday work. If you would like to have more information about the GP research champion active in your area, please contact your local research facilitator. If you are interested in knowing more about the role of a GP research champion, and would like an informal conversation with our clinical specialty research lead, please get in touch via the editor [details below].

In this edition we feature articles on a number of current studies:

- PACE: point of care testing to target antibiotics for chronic pulmonary disease exacerbations (page 4)
- Accu-rate: a primary care based cross sectional survey, testing patients' blood pressure (BP) monitors using the OMRON PA350 digital BP tester. (page 2)
- I-WOTCH: the effectiveness and cost effectiveness of a multi-component self-management intervention targeting withdrawal of strong opioids in comparison to best usual care for people living with chronic non-malignant pain. (page 2)
- Learning from patient experience of participating in research (Pilot Survey 2016) (page 7)

If you would like to contribute to Participate or for further information please contact Jenny Oskiera email j.oskiera@warwick.ac.uk

COVENTRY, WARWICKSHIRE, WORCESTERSHIRE, HEREFORDSHIRE PRIMARY CARE RESEARCH UPDATE

POINTS OF INTEREST

- NEW STUDY - ACCU-RATE
- CURRENT STUDY - ALL HEART
- LOCAL RESEARCH - I-WOTCH
- CRN - PATIENT EXPERIENCE OF PARTICIPATING IN RESEARCH

CONTENTS

NIHR at 10
improving the health and wealth of the nation through research

New Studies

Accu-rate Study

Accuracy of patient-owned blood pressure monitors compared to Omron PA350 monitor checker

This is a primary care based cross sectional survey, testing patients' blood pressure (BP) monitors using the OMRON PA350 digital BP tester. Monitors will be inflated following a standard process as recommended by each monitor manufacturer and the British Hypertension Society, with a pass rate of +/- 3mmHg or less from the PA350 reading.

GP Practice involvement

1. **Complete a database search and check lists for exclusions**
2. **Send invite letters (research facilitator will complete this via Docmail)**
3. **Send reminder letters to non-responding patients two weeks after the initial mailing (research facilitator will complete this via Docmail)**

Practice reimbursement

Your practice will receive a **£320*** search fee for the initial practice database search.

**Values are an indication and can vary depending on number of patients entered into the study from your practice.*

If you are interested in the study, or would like to find out more, please contact: Jenny Lee, Research Facilitator
Email: Jennifer.lee@warwick.ac.uk Phone: 02476 575 919

i-WOTCH
IMPROVING THE WELLBEING OF PEOPLE WITH OPIOID TREATED CHRONIC PAIN

WARWICK
CLINICAL TRIALS UNIT

Newly funded I-WOTCH study on opioid withdrawal for chronic pain

Strong opioids are increasingly being prescribed for chronic non-malignant pain including expensive transdermal preparations. However there is limited data supporting the effectiveness of long term use, with adverse effects often outweighing the benefits of long term opioid treatment for pain. The National Institute of Health Research (NIHR) has funded a new multi-centre randomised controlled trial: I-WOTCH (Improving the Wellbeing of people with Opioid Treated CHronic pain).

The study will test the effectiveness and cost effectiveness of a multi-component self-management intervention **targeting withdrawal of strong opioids** in comparison to best usual care (the control intervention) for people living with chronic non-malignant pain. The intervention will include a group educational programme based on cognitive behavioural principles plus 1-1 support with a trained I-WOTCH nurse.

We will be recruiting eligible participants from primary care by initially searching and screening of GP lists from those GP practices that are recruited to the study. Eligible patients who provide consent will be randomised and then followed up at base line, 4, 8 and 12 months. Our primary outcome measure is activities of daily living and main secondary outcome measure is opioid use. Other secondary outcomes include pain, sleep, quality of life and resource use.

We will also be recruiting nurses, and training them to deliver the I-WOTCH intervention with lay facilitators.

The study will commence September 1st 2016

Funding Acknowledgement: This project was funded by the National Institute for Health Research HTA (project number 14/224/04)

If your GP practice is interested in the study or you would like further information please contact:
Dr Harbinder Sandhu, Associate Professor, Warwick Clinical Trials Unit, Warwick Medical School, University of Warwick
Email: harbinder.k.sandhu@warwick.ac.uk phone: 02476 574939

The CEDAR Randomised Controlled Trial

the children's ear pain study

The CEDAR trial aims to discover if painkilling ear drops can reduce antibiotic consumption in children aged 12 months to 10 years presenting to primary care with acute otitis media (AOM), by directly treating the ear pain caused by the infection. The trial has three arms: (1) active ear drops (Auralgan) administered with usual care; (2) placebo ear drops and usual care; and (3) usual care only. Usual care is as per NICE guidelines, i.e. advice about the use of rescue analgesia for symptom management, with or without a delayed antibiotic prescription.

Why is this trial important to the NHS?

AOM is common in children under 10 and causes pain and distress to children and their families. Despite good evidence that most children will not benefit clinically from antibiotics, they are still prescribed for most children with AOM. Antibiotics don't treat the child's pain, in most cases do not help to treat the infection (because many ear infections have a viral origin), but can cause side effects (such as diarrhoea) and contribute to the problem of antibiotic resistance.

We want to find out if pain-killing ear drops can help to reduce ear pain in children with ear infections, if they could help children feel better more quickly and reduce unnecessary antibiotic use. If we show the drops work, clinicians will have a better treatment to offer children in the future, and the drops could even become available over-the-counter at pharmacies.

The CEDAR intervention

The ear drops are Auralgan, which contain benzocaine (a pain killer) and phenazone (an anti-inflammatory drug). They are manufactured by Pfizer Consumer Healthcare and currently available as an over-the-counter medicine in Australia, New Zealand and other countries. They are not available in the UK. Auralgan ear drops have a robust safety profile and are known to be as safe as other commonly prescribed medicines for children, such as antibiotics.

Which children are eligible for this trial?

Children aged between 12 months and 10 years with ear pain within the last 24 hours, if the clinician's working diagnosis is otitis media and if they do not require a same-day antibiotic under NICE guidelines.

What is involved for children and their parents?

Parents/guardians of participating children will be asked to complete a daily (paper or online) Symptom and Recovery Questionnaire about their child's symptoms, on the same day as recruitment and over the next seven days. If the child has been randomised to receive ear drops, the parent will be asked to given them the ear drops, every 1-2 hours and up to 12 times per day, until the child's pain is relieved. A small number of parents will be invited to take part in a longer qualitative interview. After three months, parents will be asked to complete a brief postal or online questionnaire about their child's quality of life.

What is involved for recruiting primary care sites?

Sites will opportunistically identify and recruit to a target of 6 children, explaining the research to parents and taking informed consent and assent as required. Clinicians will complete the baseline Case Report Form and enter the data online. Practice staff will explain to parents of children allocated to one of the ear drops arms how to give the ear drops and tell them what is involved in follow-up. After three months, sites will be asked to complete a review of the child's primary care medical notes. Additional database searches are optional. Sites will be appropriately reimbursed for all CEDAR activities through a combination of research costs and approved NHS support and treatment costs.

The CEDAR trial is a National Institute for Health Research (NIHR) portfolio study funded by the Health Technology Assessment (HTA) Programme (ref 18/33/18).

University of BRISTOL · University of Southampton · Cardiff University / Prifysgol Caerdydd · Bristol Randomised Trials Collaboration · CEDAR the children's ear pain study · Funded by NHS National Institute for Health Research

For further information or to register your interest please contact the CEDAR study team at cedar-trial@bristol.ac.uk, or email the Trial Manager Harriet Downing at harriet.downing@bristol.ac.uk

New Studies

PACE:
Primary care use of a C-Reactive Protein (CRP)

Background: Experts agree that the growing problem of antibiotic resistance needs to be tackled. Prescribing in a more individualised way could help to achieve this. In the current climate, GPs are likely to come under increasing pressure to use point of care tests more often. This should only be done, however, if there is proof that it will actually benefit the patients. PACE is an innovative study that involves testing for a specific biomarker (CRP) in patients suffering from acute exacerbations of COPD and determining whether the result will help effectively personalise prescribing decisions, with the aim being to reduce overall antibiotic use without compromising patient recovery.

Patient population and recruitment:

- **Inclusion criteria:** Participants with a diagnosis of COPD in their clinical record, aged 40 years or more, presenting in primary care with a current acute exacerbation
- **Recruitment deadline:** 31st January 2017

Practice involvement:

- **Mailout:** Invitation packs will be sent to all eligible COPD patients to inform them about the study and encourage them to contact the practice before taking any rescue antibiotics
- **Baseline visit:** Eligible patients will be randomised either to management according to best current practice alone or to best current practice with the addition of a CRP POCT. All participants will have a posterior pharynx swab and sputum sample taken
- **Week four follow up:** At week four participants will visit their practice again for their follow-up appointment during which another posterior pharynx swab sample and sputum sample will be taken

For more information: www.pace-study.co.uk. Main contact details: jenny.riga@phc.ox.ac.uk

TAPS:Treatment of Aches and PainS Trial

The study

- The **STarT Back trial** showed that stratified care, based on matching treatment to prognosis (low, medium, or high risk of ongoing problems), was clinically and cost effective
- **TAPS is a flagship clinical trial** to test if this approach also works for people with neck, shoulder, knee and multi-site pain (and back pain)
- Practices will be randomised to deliver one of two approaches for patients presenting with musculoskeletal pain, either **stratified care** or **usual care**

What does it mean for your practice?

- Agree to be randomised to the control or intervention arms of the trial
- Deliver the trial interventions
- For intervention arm practices - for patients with MSK pain, use of a brief template to assess prognosis & inform treatment decisions
- For control arm practices - for patients with MSK pain, use of a brief template to record levels of pain intensity
- Attend study related meetings
- For intervention arm practices - one 1-hour set-up meeting, and two 2-hour training workshops
- For control arm practices - one 1-hour set-up meeting
- Provide feedback on delivering the intervention (in intervention practices)

What are the benefits for your practice?

- Fully funded: reimbursements tied to level of involvement
- Revalidation activities: participating in research and training
- Involvement in developing and testing new ways of working

This research is funded by the NIHR Programme Grants for Applied Research programme (Grant reference number: RP-PG-1211-20010). The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.

If you are interested in finding out more, please contact TAPS Trial Manager Stephanie Tooth phone: 01782 734835 email: s.j.tooth@keele.ac.uk

CANDID

CANcer DIagnosis Decision rules

CANDID (CANcer DIagnosis Decision rules) needs YOU!

In primary care the key areas of concern for both doctor and patients are delay in diagnosing cancer, getting high risk patients referred first, and keeping investigation to a minimum. There have been few valid studies to assist decision-making in primary care, either to get a patient referred quickly or to assist in making sure an anxious patient is effectively reassured. This study seeks to work out which of the symptoms and examination findings are the most effective in predicting lung or colon cancer.

As this study approaches closure in 2017 we are really keen to maximise recruitment in the limited time available. As at the end of August 2016 practices within our area have recruited a total of 630 patients to the study from 35 practices.

New practices can still sign up for this study which is reimbursed at almost £100 per recruited patient.

The clinician role within this study is to opportunistically identify eligible patients who are then contacted further about the study by one of our research nurses. Should the patient wish to enter the study our research nurse will consent the patient at the practice and complete the required paperwork.

A further method of recruitment is a retrospective search of the two week wait list to identify potential recruits who can then be mailed out to with details of the study. The CRN West Midlands South team are able to complete the mail out on behalf of the practice. Should they express an interest our research nurse will follow this up on behalf of the practice.

Promotional material for display in waiting rooms is available for this study. http://www.southampton.ac.uk/candid/primary_care_staff/index.page

If you are participating in this study and you feel further information for patients highlighted in the waiting area would be beneficial do please let us know and we can provide a range of flyers and other promotional materials.

CANDID

Are you here today to see the doctor with bowel symptoms,

OR

with lung symptoms lasting 3 weeks or more?

Your Practice is taking part in a research study called CANDID and, if you are over 35, your GP or Nurse Practitioner *may* ask if you would like to take part.

The study is looking at common early symptoms, or combinations of symptoms, to try and identify which may be important for a possible diagnosis of cancer, and which are not. When doctors and researchers are trying to understand more about diseases like cancer, we often ask thousands and thousands of people to share information with us about their symptoms and lifestyles. When we have large amounts of information, we can sometimes identify factors that look like they have an impact on the development of disease. That's why at this surgery we're inviting patients who have chest or bowel symptoms of any kind to take part in the CANDID study. Being asked to take part does not mean anybody thinks you have a serious illness or cancer , only that you have some of the symptoms we are looking at.

If you are invited to take part, you will have the study explained to you (including being given the contact details of the study team) and given the opportunity to ask any questions you may have *before* you make your decision about whether or not you wish to be recruited to the study. You can decide today, or take the information home and decide later. Even if you agree to participate you can change your mind at any time.

University of Bristol · University of Birmingham · Keele University · The University of Manchester · The University of Nottingham · University of Oxford · University of Southampton · UCL

NHS National Institute for Health Research This research is funded by the NIHR (National Institute for Health Research) NSPCR (National School for Primary Care Research)

For further information, please contact your research facilitator, Jenny Lee email: Jennifer.Lee@warwick.ac.uk, phone: 02475 575 919

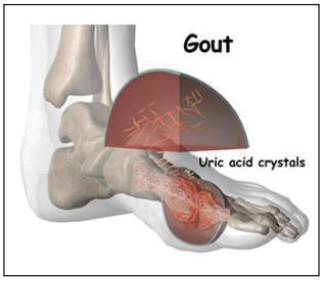
FAST

FAST (Febuxostat versus Allopurinol Streamlined Trial) is a major multicentre clinical trial evaluating long term cardiovascular safety of febuxostat in comparison with allopurinol in patients with chronic symptomatic hyperuricaemia (gout). This is a very simple study, with a very low workload for participating practices.

So far, more than 90 practices in the West Midlands are taking part, and patient recruitment has commenced, with over 4,800 patients taking part nationally. Thank you so much to those of you who are on board, and we look forward to expanding this exciting trial to any other practices who may be interested.

Would your practice be interested in helping us with this important study?

Participating practices will receive a £500 fee for completing the database search, in addition to £5 per month per patient for the duration of the trial. All medication will be prescribed by the trial sponsor, and so there will be no prescribing costs to GP practices.



The Trial Manager is Jen Dumbleton, and her contact details are: email: jennifer.dumbleton@nottingham.ac.uk, phone: 0115 823 1053. Further details can also be found on the trial website: www.fast-study.co.uk.

Current Studies

HOME-BP
(Home & Online Management & Evaluation of Blood Pressure Trial)

Study Aims

Blood pressure is a key risk factor for cardiovascular disease, the largest cause of morbidity and mortality worldwide. Increasingly widespread access to the Internet and mobile phones means that digital interventions are accessible to the majority of patients at any time when they need it. The web-based HOME-BP programme has been developed to help patients in management of high blood pressure, incorporating previously identified effective intervention components (self-monitoring, pre-planned medication titrations and behavioural support). The programme also encourages patients to self-monitor and to choose healthy lifestyle modifications.

This trial will assess whether use of the HOME-BP programme for self-monitoring and self-management of uncontrolled hypertension of patients on medication results in greater control of systolic blood pressure over one year, in comparison to usual care.

We are looking to recruit patients who have access to the internet and will be able to use and comprehend the website. Patients should have uncontrolled hypertension (mean BP reading of >140 or >90 mmHg) and should be receiving medication for hypertension control.

Recruitment period: May 2016 – June 2017

Recruitment target: 236 patients

The HOME-BP study is recruiting practices for the main trial following a successful pilot study which reached its target in January 2016.

What does the trial involve for the practice?

Suitable patients (identified by electronic searches) will be asked to make an appointment with the practice nurse who will screen them for eligibility. Through the study the nurse will also conduct optional support appointments and can send motivating messages through the website. Participants will complete the baseline questionnaires online and will be automatically randomised into self-monitoring or usual care groups. Participants in both groups will book an appointment with the prescriber (a GP) for a medication review.

Participants in the self-monitoring group will enter their blood pressure readings for a week each month on the website. The prescriber will be informed of patients' readings through the intervention and will be responsible for actioning emails regarding medication change. Six and 12 month follow up assessments will be conducted by an independent study nurse.

USER FRIENDLY WEBSITE AND NO PAPER CRFs
SIMPLE SCREENING & PATIENT REGISTRATION,
OPTIONAL PHONE REMINDERS

If you would like to be a participating practice for the HOME-BP study, then please email: home.pb@phc.ox.ac.uk or call us at 01865 617196.

ALL HEART

ALL HEART (Allopurinol and cardiovascular outcomes in patients with ischaemic heart disease) is a major multi-centre trial of allopurinol up to 600mg daily versus no treatment added to usual therapy in patients aged 60 years and over with ischaemic heart disease. The aim is to establish whether allopurinol improves cardiovascular outcomes in this population.

Suitable patients are identified in primary care by their GPs; those that respond favourably attend an appointment with a research nurse. Patients will be randomised to either allopurinol or no drug to be given in addition to their usual medications. Allopurinol will be started at 100mg daily for two weeks, then titrated to 300mg daily for two weeks, then titrated to 600mg daily if tolerated.

Patients will then be followed up for a period of around four years to count the number of heart attacks, strokes and cardiovascular deaths that occur.

Participating practices will receive a fee for completing the database search, in addition to per patient payments.

Recruitment has started in the West Midlands. Would your practice be interested in helping us with this important study?

We already have 39 practices signed up, and many thanks to the first practices to start the study in the region, who have already recruited 123 patients.

The Trial Manager is Jen Dumbleton, and her contact details are as follows: jennifer.dumbleton@nottingham.ac.uk, 0115 823 1053. Further details can also be found on the trial website: http://allheartstudy.org/.

NIHR Clinical Research Network

Learning from Patient Experience of Participating in Research (Pilot Survey 2016) July 2016, Mana Golsorki and Roger Steel

Patient Experience of Participating in Research Survey - Results

The report following this survey, carried out earlier this year by the Central Patient and Public Involvement & Engagement Team, is now available. CRN WM was one of three Local Clinical Research Networks (LCRNs) which developed and piloted the survey and returned the largest number of responses (318 of 597).

What we did and why

We ran a national pilot patient satisfaction survey about experience of clinical research to find out:

- What information came back from patients and what it told us
- How we could make best use of this information to improve the experience of research
- More about the best ways to gather information on patient experience in future

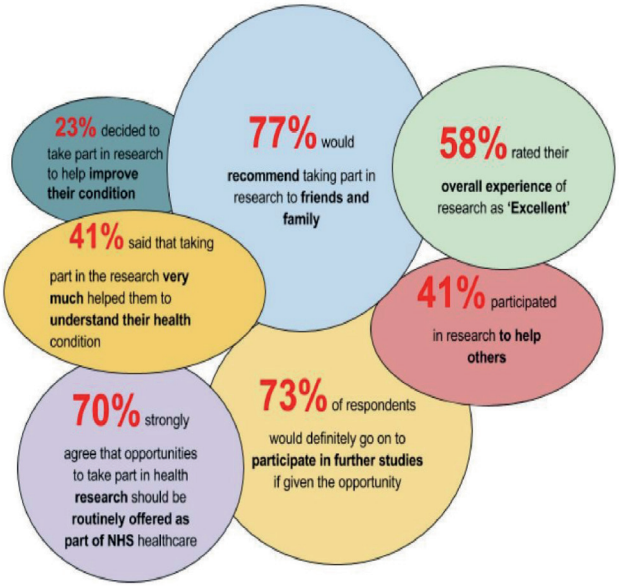
How we did it

- We invited our LCRNs to take part using the same nationally agreed questions at a range of NHS sites in their area
- Three LCRNs took part and we received responses from 597 patients and public
- We carefully analysed the information from the survey to understand what it could tell us
- We also asked the three participating LCRNs about their experience of running the survey

What we found out: some highlights

The following themes also emerged as areas of experience important to patients[1]:

1. **Relationship with staff** (respect, dignity, information, friendliness and professionalism)
2. **Location** (distance, travel, accessibility. suitability)
3. **Time** (time to decide whether to take part, respect for patients and carers time in study, flexibility of research appointments etc.)
4. **Knowing results of study** (study outcomes, potential impact, value of participation)
5. **Information during study** (extent, visibility, accessibility, relevance, timing, frequency and clarity)
6. **Information about new studies**[2] (visibility, accessibility, clarity relevance)



Main recommendations

- Four specific questions used in the pilot are recommended for all future surveys because the responses provided information that we could act upon at a national level
- We recommend that future surveys use at least one key question within each of the six themes (above)
- Only use questions about respondents' backgrounds (demographics) where there is already relevant data available (baseline) to compare it with, otherwise the time in collecting and collating this data is unlikely to be worthwhile
- When organising surveys, early planning with LCRN partner organisations is likely to save time later in the process and help realise local benefits
- Identify a survey lead for each NHS site to ensure everything is in place at the right time
- Develop a survey strategy taking into account sample size etc. planned around the intended local use of the information collected
- Use the six themes (above) to identify NHS site level actions for Continuous Improvement
- Use the six themes (above) as areas for checking and assessing by clinical study teams, study support service, and specialties when opening a new clinical study

For more details about the background, the questions and complete results of the Patient Experience Survey pilot email: crnppie@nihr.ac.uk or speak to Jackie Condliff Tel: 0151 282 4534

1 Derived from a combination of analysed free text comments (both positive and negative) cross referenced with response scores to any related survey questions.

2 This theme was derived from comments made by a small number of people using a free text comment field in the questionnaire. It is significant because the information was entirely spontaneous and concerns patient access to research, a strategic priority in the Clinical Research Network.

The NIHR Learning Management System (LMS) has migrated to a new platform: CRN Learn

All courses (e-learning and taught) require pre-registration with an NIHR, NHS or university email account. Online courses will be available immediately on confirmation of the user's email address (using an activation code sent to the user's email account).

NB. All introductory and refresher course materials are available to participants prior to attending the workshop. Slides are available to view online or download and print. Detailed course books are no longer provided.

Good Clinical Practice (GCP) e-learning

This free course can be used as an introduction or refresher. The course takes between two and four hours to complete. The e-learning module includes primary and secondary care pathways. Separate sections focussing on consent in a paediatric setting and with adults who may lack capacity are also available to complete either as part of the GCP module or stand-alone to complement generic courses.

Register and book via: http://learn.nihr.ac.uk/

One Day Introduction to GCP Workshop			
20 October	East Birmingham	5 December	Birmingham
16 November	Coventry	5 December	Shrewsbury
30 November	Wolverhampton		

Half Day GCP Refresher Workshop			
26 October a.m.	Birmingham	30 November a.m.	Birmingham
4 November a.m.	Oswestry	30 November p.m.	Birmingham
9 November p.m.	Coventry	5 December a.m.	Burton
10 November p.m.	Dudley	5 December a.m.	Coventry
NB. Additional refresher courses are available to book throughout 2016. If you are due an update this year please book ahead so that we can ensure sufficient places are available			

Other Events, Useful Links & Resources

National Cancer Intelligence Service Understanding Cancer e-learning programme

Free online course available following registration via: http://www.mylearningspace.me.uk/moodle/

Contact the CRN WM workforce development team via TrainingCRNWMgeneric@uhb.nhs.uk

TASMINH4 – My Story

By Brian Newcombe as told to Tracey Adcock, research nurse

I was diagnosed with hypertension in 1995-6, despite the fact that I took regular exercise and maintained a healthy diet. Measurement of my blood pressure had been taken over numerous surgery visits, at three to six monthly intervals, up until December 2015. Over this period my blood pressure slowly increased and consequently so did my medication. Arranging appointments, driving and parking, waiting my turn and seeing my GP were all quite stressful and overall I felt my well-being was being adversely affected.

Taking back control

When I received an invitation to take part in TASMINH4, this was an ideal opportunity for me to take back ownership of my condition. After an initial assessment, I was found to be a suitable candidate, lent a monitor and given guidelines on how to monitor my blood pressure twice daily for one week each month. In January 2016 I started participating in this study.

Blood pressure monitoring was done in my own home, in my own time, in a calm and relaxed atmosphere and completely hassle free. Results are posted to my doctor and feedback via a phone call received on any alterations needed to my medication.

"It's simply that easy"

To date, this has been a totally rewarding experience; I feel responsible; I can see at first-hand what is happening; I have taken decisions on my life-style which have benefited my blood pressure.

Overall, I believe that as a direct consequence of my participation the TASMINH4 study, I have been able to reduce my medication and feel so much better within myself.

healthwatch Warwickshire

Healthwatch Warwickshire and the Clinical Research Network Annual Conference 22nd June 2016 in Leamington Spa

Healthwatch is the independent consumer association for users of health and social care services. The theme of this Warwickshire conference was "Giving you a Voice" and as quoted by Chris Bain, Chief Executive in his opening vision statement:

"to give the people of Warwickshire an effective voice in improving health and social care"

The local CRN WMS primary care team were invited to attend following the success of our involvement in the April 2016 Warwick district workshop. Rebecca Harrison, research facilitator and Claire Talbot, research nurse represented the team and were able to hear about Healthwatch progress over the last year and listen to keynote speakers, as well as promote primary care research.

Enter and View Programme

Of particular interest to us in their annual report, was the success of Healthwatch's "Enter and View" programme involving visiting GP surgeries in the county to provide patients with an opportunity to share their experience of primary care. Since the start of 2015, 2,000 patients had a discussion opportunity in 60 surgeries across Warwickshire, with in excess of 130 recommendations (82% have been acted upon already). Immediate feedback from surgeries that have embraced the opportunity to capture anonymous patient feedback through this independent means was very encouraging,

It was interesting to listen to the experiences of the speakers at this event: Dr. Neil Churchill, Director for Patient Experience, NHS England who is committed to forging a partnership with patients that puts the patient at the centre of decision making, and Paul Devlin, part-time Chief Executive Officer of National Association for Patient Participation (NAPP) who spoke about building better participation - supporting and harnessing the contribution of Patient Participation Groups - who he described as

"the critical friends of the practice"

Rebecca and Claire found it invaluable to spend time talking to members of the public, Healthwatch members and other key health & social care workers to raise awareness of local and national primary care research being undertaken. National research awareness campaigns such as "Ok to Ask" were promoted.

Another of our research graffiti walls was displayed for people to write what research meant to them: **Fantastic, Knowledge, Change, Forwards, Improving Care, Under-funded.**

In conversation with…

Tom Wallis,

Business Partner Alcester Health Centre

We went to visit Tom Wallis and met other staff at Alcester Health Centre, where we were most impressed by the warm welcome, the awareness of research, and the immediate recognition of the CRN as an integral part of the health centre team by all staff.

Over a cup of coffee in a light and airy meeting room, Tom explained that he had first become aware of research within a primary care setting at a South Warwickshire CCG meeting where his eyes had been opened to the benefits of engagement, and the practice started a dialogue with the local CRN team. CRN guidance and expertise, together with the structure and financial rewards available, helped Alcester take the plunge into research activity, something they have not regretted.

"no-one has ever been unhappy to be contacted about research"

All new patients are made aware that this is a research active practice by way of leaflets, the practice website, PPG activity and being informed by staff. Without research engagement, practices can become stagnant and set in their ways; research stimulates discussion of the various treatment options available, whilst offering the possibility of improved future diagnoses and remedies.

CRN assistance

Any study that comes via the CRN is guaranteed to be of a high standard and to have rigorously complied with all regulatory requirements.

Sarah Joshi, CRN research nurse, has a base at Alcester where she regularly runs research recruitment clinics consenting patients to studies and often providing incidental additional health care to participants, who love the extra time and attention given to them. Patients feel empowered to take more interest in their own health care.

For further information please contact the CRN research facilitator for South Warwickshire, Becky Harrison, email: r.l.harrison@warwick.ac.uk

Why do it?

Tom emphasised the many benefits of research participation in general practice and summarised these succinctly as:

- Increased proactive management of patient conditions
- Research nurse presence releases more time to spend with patients
- Greater investment in their own health management by patients
- Creating a more interesting working environment for GPs
- Assisting with recruitment and retention of GPs
- Remuneration for research – practices are also businesses
- Help with CQC, QOF and CPD
- The 'softer' social benefits of research through networking with like-minded practices

What next?

In the future, Tom could see Alcester Health Centre as a beacon practice, helping to disseminate research through other practices and working with practice managers new to research. EMIS Enterprise was seen as the way forward, making the research process more efficient for all and working better for patients.

"big data is becoming essential for the NHS's future…"

On a personal note, Tom felt that the bottom line was that:

"altruistically, this is a good thing, it is our duty to look to the future"

Research Design Service (RDS)

If you would like any further information, please contact us on rds@warwick.ac.uk or via www.rds-wm.nihr.ac.uk

Do you have a good research idea that you'd like to develop further into a grant application? The RDS can help by providing methodological expertise and advice on all aspects of research design.

The RDS exists to provide help and advice to NHS researchers and others working in partnership with the NHS in preparing research proposals for submission to peer reviewed funding competitions. As the RDS is funded by the NIHR such help is provided free of charge

Here are some of the ways we can help:

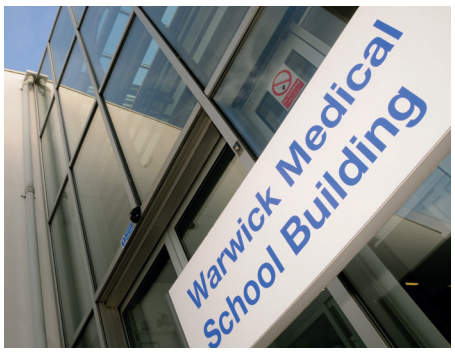
- Formulating research questions
- Building an appropriate research team
- Involving patients and the public
- Designing a Study
- Appropriate methodologies for quantitative and qualitative research
- Identifying suitable funding sources
- Regulatory issues
- Writing lay summaries
- Identifying the resources required for a successful project

Essentials in Primary Care:

New training opportunities for primary care teams

We are excited to announce a new education programme running at Warwick Primary Care in 2016/17.

Primary care is the *"jewel in the NHS crown"*. *"If General Practice fails, the whole NHS fails"*. Warwick Primary Care therefore works in partnership with primary care providers, commissioners and patients to deliver a stronger primary care.



Our conversations with local clinicians encouraged us to think creatively about the professional development support that we offer. Our Community Care module was well received by people who attended, and we will be continuing (and extending) the primary care modules we offer. But we also heard that you wanted different formats, focused on the key clinical challenges that you are dealing with in daily practice. You wanted sessions offering new, practical ideas that will help change your practice.

Essentials in primary care masterclass series

Based on your feedback, we have redesigned the programme for the year ahead. In 2016/17, the Essentials in Primary Care module will run as a Masterclass series. Each one day bespoke event will tackle one of five essential elements of primary care policy and practice:

- problematic polypharmacy
- palliative care
- the primary care consultation
- primary mental health care
- over diagnosis

Each Masterclass will be delivered by experienced primary care experts – clinicians and researchers who actively work in primary care, and area leading work to develop and implement new ideas.

You will have opportunities to critically consider new ideas and research; to practice and develop your critical appraisal and quality improvement skills; and to apply your thinking to the challenges in your own work setting.

This module will help healthcare professionals develop and enhance knowledge, skills and understanding in the essentials which lie at the heart of primary care.

You can sign up for one, some, or all of the classes. If you register for the full series, and complete an assignment, you will receive a Post Graduate Award (worth 20 credits towards a Postgrad Certificate, Diploma or Master's degree).

The programme starts in December 2016.

More details are available on the webpage http://www2.warwick.ac.uk/fac/med/study/cpd/module_index/md988-old or you can contact the course lead Joanne Reeve j.reeve.1@warwick.ac.uk

*SAVE THE DATE*SAVE THE DATE*SAVE THE DATE*SAVE THE DATE*

46th Annual Scientific Meeting of the Society for Academic Primary Care

12th - 14th July 2017 University of Warwick

SAPC www.sapc.ac.uk

In 2017, Warwick Medical School will once again host the

Annual RCGP Midland Faculty Education, Research and Innovation Symposium

After a hugely successful 2016 event we invite you to 'SAVE THE DATE', Thursday 18th May 2017 and join us for an inspiring and re-energising day of networking, sharing and learning.

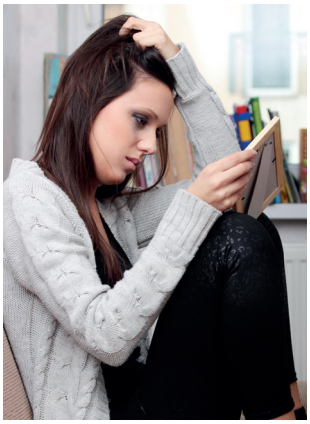
Details of booking and abstract submission for 2017 will appear in due course on the WMS Primary Care pages of the Warwick Medical School website.

To catch up with what you may have missed last time visit our 2016 event pages http://warwick.ac.uk/rcgp2016

For further information, please contact Helen McGowan, h.mcgowan@warwick.ac.uk

Young people who are being bullied – do they want general practice support?

Emma Scott, Jeremy Dale, Rachel Russell and Dieter Wolke



Background

Childhood bullying is a major risk factor for health, education and social relationships, with effects persisting into adulthood. It affects half of all children at some point, with 10–14 % experiencing bullying that lasts for years. With the advent of cyberbullying, it can happen at all times and places. There have been calls for GPs to take a more active role in identifying and supporting young people who are being bullied. This paper explores young people's and parents' opinions about whether general practice should be involved in identifying and supporting young people who are being bullied.

Methods

Two hundred six young people (85.9 % female, mean ± sd age 16.2 ± 3.2 years) and 44 parents were recruited through established bullying charity websites and their social media channels to complete an online questionnaire comprising multiple-choice questions and unlimited narrative responses. Questionnaire responses were analysed by age and gender using descriptive statistics. A descriptive analysis of the narrative responses was undertaken and key themes identified.

Results

Young people (90.8 %) and parents (88.7 %) thought it was important for GPs to be better able to recognise and help young people who are being bullied. Most recognised the link between bullying and health. The doctor's independence was seen as advantageous. Young people preferred completing a screening questionnaire to disclose experience of being bullied than being asked directly. They expressed concerns about how questions would be asked and whether information would be shared with parents/guardians. Parents were supportive of the use of a screening questionnaire, and most expected their child's disclosure to be shared with them.

Conclusion

Young people and parents recruited through anti-bullying websites and social media would welcome greater GP involvement in identifying and supporting young people who are being bullied and their families, provided it is offered in a caring, compassionate and confidential manner.

"As long as they were friendly and genuine I would quite happily talk about problems if someone was there to listen. I wouldn't talk if it was spoken about in a generic way like a check mark against their daily tasks." (female,22)

BMC Family Practice BMC series – open, inclusive and trusted 201617:116 DOI: 10.1186/s12875-016-0517-9

NEWS FROM OUR PRACTICES: ACHIEVEMENTS OVER AND ABOVE

Congratulations!

STUDY RECRUITMENT *Our congratulations go to:*

- **Bennfield Surgery,** who was the top recruiter in NHS Coventry and Rugby CCG during 2015-16
- **Westside Medical Centre** on achieving the highest West Midlands All Heart recruitment so far
- **Atherstone Surgery,** September's highest recruiter to CANDID; the study team would like to highlight the hard work of Fiona Gooding, Marcia Sheriff and all the local research staff.
- **Hazelwood Group Practice,** well done to Linda Eagles, practice nurse, for recruiting over 25 patients to CANDID

PROMOTING RESEARCH

Two healthcare assistants at **Spring Gardens Medical Group** have been working extremely well on recruitment to the PROOF-ABPM study. We would like to thank Dawn Lucas and Julia Rowberry on their high recruitment levels, 44 patients in a relatively small timeframe, even though Julia was new to research.

Mortimer Medical Practice – for their timely response to research participation offers

Copsewood Medical Centre – for hosting our GCP training sessions on 13th and 20th September

Discharge Summaries Study

Study summary

Discharge summaries are a crucial document for patient safety in the care transition process from secondary to primary care. Care transitions have been shown to be a risky time for patients, with respect to medication errors, risk of readmission and missed opportunities for follow-up. This is particularly true for elderly patients, especially those with cognitive impairment or lack of social support.

Despite much investment by secondary care in improving the discharge summary, the way in which GP surgeries handle discharge summaries has been very little studied. This project attempts to understand the systems in place for processing discharge summaries in primary care and to estimate a rate of error for compliance with actions requested by secondary care.

Local research activities:

- **Data collection from 30 patients' EHRs (2 days)**
- **Discussions with the admin staff**
- **Producing a process map of practice systems**
- **Interviewing the practice manager and a senior clinician**

Practices who sign up need to do the following:

- **Set up computer log-ins**
- **Provide basic demographic information**
- **Identify local codes for the researcher to generate the sample of EHR for review**
- **Set aside 1 hour of time for interview (2 staff)**

For further information, please contact your local CRN office, phone: 02476 575 919

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Are oral steroids effective in treating the symptoms of acute lower respiratory tract infection in non-asthmatic adults? The Oral Steroids for Acute Cough (OSAC) placebo-controlled randomised trial

OSAC
THE OSAC (ORAL STEROIDS FOR ACUTE COUGH) TRIAL

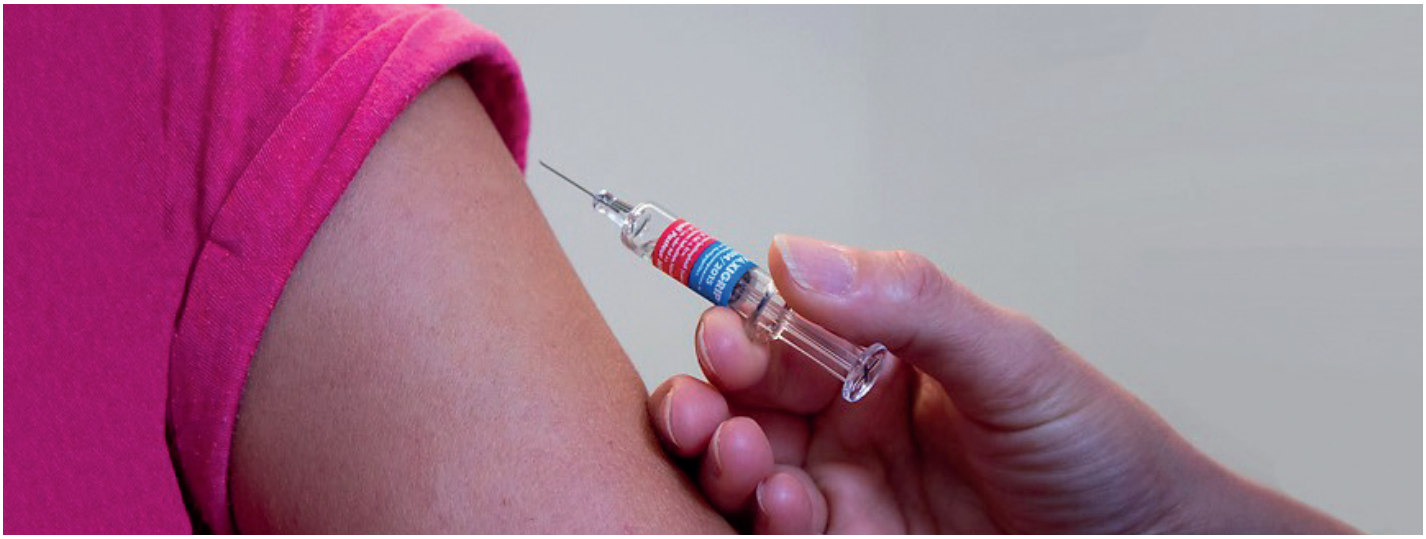
BACKGROUND: The majority of UK adults experience at least one lower respiratory tract infection (LRTI, or acute bronchitis) a year. Despite an absence of evidence in this patient group, some GPs prescribe inhaled or oral corticosteroids. OSAC sought to demonstrate 'proof of concept' symptomatic effectiveness of a moderate dose of oral corticosteroid for adults without asthma or COPD with acute LRTI.

METHODS: OSAC was a double blind, placebo controlled RCT set in GP practices in England, powered to investigate if oral prednisolone reduces the duration of moderately bad or worse cough and/or the severity of its associated symptoms, when compared to placebo, by at least 20%. Adults (≥18 years) with acute (≤28 days) cough, for whom same-day antibiotics were not clinically indicated, and without asthma or COPD, received 40 mg oral prednisolone or matched placebo for 5 days. Symptom diaries, completed for up to 28 days, measured two primary outcomes: the duration of moderately bad or worse cough; and the average severity of all symptoms on days 2 to 4 on a scale of 0–6. We sought to demonstrate a minimum clinically important reduction of 20% in each outcome.

RESULTS: 398 participants were randomised to either prednisolone or placebo tablets (198 and 200 respectively) from 54 UK primary care sites. Attrition was lower than expected, giving over 85% power for the two primary outcomes. Data were analysed on an intention-to-treat basis. The median duration of moderately bad or worse cough was 5 days in both groups (IQRs 2–8 and 3–8 for prednisolone and placebo respectively). Adjusting for trial centre and baseline characteristics, this gave a hazard ratio of 1.11 (95% CI 0.89 to 1.39, p = 0.35). Symptom severity was lower in the prednisolone group (mean 1.99 vs 2.16), adjusted difference -0.090 (-0.212 to 0.003, p = 0.152).

CONCLUSIONS: We found no evidence that a moderately high dose of oral corticosteroid reduced either duration of moderately bad (or worse) cough, or symptom severity at days 2 to 4 in adults without asthma or COPD with LRTI not requiring immediate antibiotic treatment. Lower dose oral or high dose inhaled corticosteroids are also unlikely to be beneficial.

PUBLICATION: Thorax 2015;70:A50 doi:10.1136/thoraxjnl-2015-207770.93



Vaccinations are More Effective When Administered in the Morning

New research from the University of Birmingham has shown that flu vaccinations are more effective when administered in the morning.

The findings, published in the journal *Vaccine*, suggest administering vaccinations in the morning, rather than the afternoon, could induce greater, and thus more protective, antibody responses.

24 general practices in the West Midlands, UK, were analysed between 2011 and 2013 in a cluster-randomised trial during the annual UK influenza vaccination programme. 276 adults aged over 65 were vaccinated against three strains of influenza, either in morning surgeries (09:00 - 11:00) or afternoon surgeries (15:00 - 17:00).

In two of the three given influenza virus strains, those in the morning cohort saw a significantly larger increase in antibody concentration one month following vaccination, when compared with those in the afternoon cohort. In the third strain, there was no significant difference between morning and afternoon.

Dr Anna Phillips, the Principal Investigator of the study from the School of Sport, Exercise and Rehabilitation Sciences at the University of Birmingham explained,

"We know that there are fluctuations in immune responses throughout the day and wanted to examine whether this would extend to the antibody response to vaccination. Being able to see that morning vaccinations yield a more efficient response will not only help in strategies for flu vaccination, but might provide clues to improve vaccination strategies more generally."

The influenza vaccination is part of the seasonal vaccination programme carried out by general practices across the UK, and in many other countries, with a particular focus on patients over 65 years old.

Despite this, the influenza virus is responsible for between 250,000 and 500,000 deaths each year worldwide. The age-related decline in immunity reduces the ability of older adults to produce adequate antibody responses following vaccination, compromising the given protection.

Other interventions to improve outcomes of vaccination have been attempted with limited success, including exercise routines and additives to the vaccine itself.

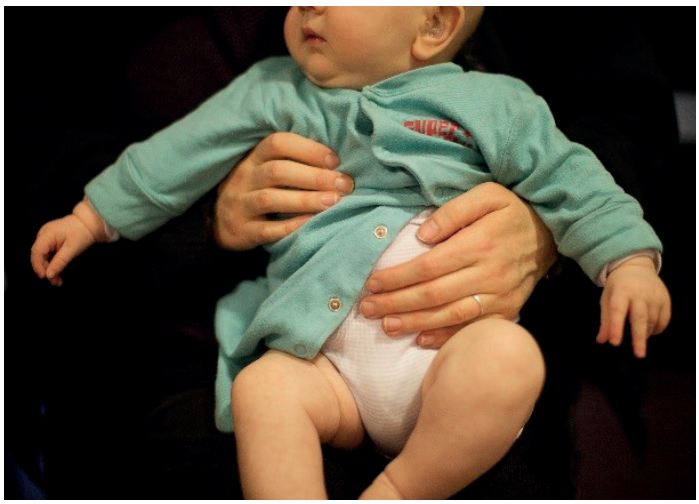
Professor Janet Lord, a co-investigator on the study from the Institute of Inflammation and Ageing at the University of Birmingham, said,

"A significant amount of resource is used to try and prevent flu infection each year, particularly in older adults, but less than half make enough antibody to be fully protected. Our results suggest that by shifting the time of those vaccinations to the morning we can improve their efficiency with no extra cost to the health service."

The team will now look to investigate further in a large scale study. This is important to see if the morning vaccination strategy benefits a wide range of over 65s including those with conditions like diabetes, liver and kidney disease that impair immunity. They will also look to see if the morning vaccination strategy is effective for the pneumococcal vaccine that protects against pneumonia; a vaccine recommended to all individuals aged 65 years old in the UK.

The full paper is available online: http://dx.doi.org/10.1016/j.vaccine.2016.04.032

The study was funded by an MRC Lifelong Health and Wellbeing Collaborative Research Grant.



DUTY – Diagnosis of Urinary Tract infection in Young children

Aim

To develop algorithms to accurately identify pre-school children in whom urine should be obtained; assess whether or not dipstick urinalysis provides additional diagnostic information; and model algorithm cost-effectiveness

Method

One hundred and seven clinical characteristics (index tests) were recorded from the child's past medical history, symptoms, physical examination signs and urine dipstick test. Prior to dipstick results clinician opinion of UTI likelihood ('clinical diagnosis') and urine sampling and treatment intentions ('clinical judgement') were recorded. All index tests were measured blind to the reference standard, defined as a pure or predominant uropathogen cultured at ≥ 105 colony-forming units (CFU)/ml in a single research laboratory.

Urine was collected by clean catch (preferred) or nappy pad. Index tests were sequentially evaluated in two groups, stratified by urine collection method: parent-reported symptoms with clinician-reported signs, and urine dipstick results. Diagnostic accuracy was quantified using area under receiver operating characteristic curve (AUROC) with 95% confidence interval (CI) and bootstrap-validated AUROC, and compared with the 'clinician diagnosis' AUROC. Decision-analytic models were used to identify optimal urine sampling strategy compared with 'clinical judgement'.

Results/conclusion

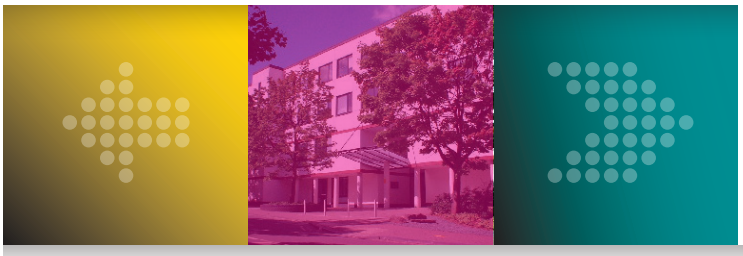
A total of 7163 children were recruited, of whom 50% were female and 49% were < 2 years old. Culture results were available for 5017 (70%); 2740 children provided clean-catch samples, 94% of whom were ≥ 2 years old, with 2.2% meeting the UTI definition. Among these, 'clinical diagnosis' correctly identified 46.6% of positive cultures, with 94.7% specificity and an AUROC of 0.77 (95% CI 0.71 to 0.83). Four symptoms, three signs and three dipstick results were independently associated with UTI with an AUROC (95% CI; bootstrap-validated AUROC) of 0.89 (0.85 to 0.95; validated 0.88) for symptoms and signs, increasing to 0.93 (0.90 to 0.97; validated 0.90) with dipstick results.

Nappy pad samples were provided from the other 2277 children, of whom 82% were < 2 years old and 1.3% met the UTI definition. 'Clinical diagnosis' correctly identified 13.3% positive cultures, with 98.5% specificity and an AUROC of 0.63 (95% CI 0.53 to 0.72). Four symptoms and two dipstick results were independently associated with UTI, with an AUROC of 0.81 (0.72 to 0.90; validated 0.78) for symptoms, increasing to 0.87 (0.80 to 0.94; validated 0.82) with the dipstick findings. A high specificity threshold for the clean-catch model was more accurate and less costly than, and as effective as, clinical judgement. The additional diagnostic utility of dipstick testing was offset by its costs. The cost-effectiveness of the nappy pad model was not clear-cut.

Importance

Clinicians should prioritise the use of clean-catch sampling as symptoms and signs can cost-effectively improve the identification of UTI in young children where clean catch is possible. Dipstick testing can improve targeting of antibiotic treatment, but at a higher cost than waiting for a laboratory result. Future research is needed to distinguish pathogens from contaminants, assess the impact of the clean-catch algorithm on patient outcomes, and the cost-effectiveness of presumptive versus dipstick versus laboratory-guided antibiotic treatment.

Publication: doi: 10.1370/afm.1954 Annals of Family Medicine **July/August 2016** vol. 14 no. 4 **325-336**
http://www.annfammed.org/content/14/4/325



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46th Annual Scientific Meeting
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PIONEERING CHANGE

12th - 14th July 2017
University of Warwick

Social Events
Wednesday 12th July - Welcome Reception
Thursday 13th July - Conference Dinner

Abstract submission deadline: 19th February 2017

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