



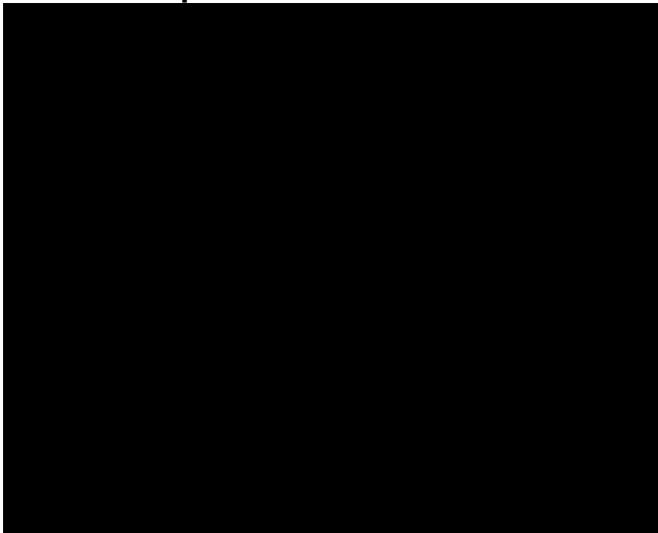
**PACE Trial
Trial Management Group Meeting #11**

Thursday 4th November 2004

1. Welcome

Introductions and welcome to all present

2. Those present



3. Apologies



4. Agreement of agenda

The agenda was agreed and additionally, the Patient Clinic Leaflet (PCL) was tabled for discussion at this meeting.

5. Previous minutes

All present accepted the minutes of the last meeting. Apologies were offered for the delay in circulating the last TMG minutes, and it was recognised that some action points may be outstanding for some people as a consequence of this.

6. Matters arising not on the agenda

A review of the action points from the last meeting.

The following action points are still outstanding:

TMG10 - A1: [REDACTED] to contact [REDACTED] R&D for a sponsorship and indemnity letter.

TMG10 - A2: SOP to be written by [REDACTED] regarding what is required of an independent expert to (blindly) assure differentiation of the therapies.

TMG10 - A3: [REDACTED] to write a SOP on supervision and rating of audio-recordings of therapy sessions.

TMG10 - A4: [REDACTED] to contact [REDACTED] about swapping experts, and also to discuss the use of the Therapy Integrity Scale

a) Tele- / Video-conferencing

[REDACTED] reported that videoconferencing had been researched but was very costly. Tuesday morning teleconference meetings have now been instigated using the BT Meet me service for the PIs and [REDACTED].

ACTION 1: [REDACTED] to send details of BT meet me to each treatment leader for possible use with supervision.

For CBT, the IoP have videoconferencing facilities that might be used for supervision.

For APT, [REDACTED] has not yet considered teleconferencing for supervision as this has not yet been relevant.

ACTION 2: Treatment leaders will investigate local set up of either video or teleconferencing.

b) MREC submission

[REDACTED] noted the hard work that had been put in to make a submission to MREC with the latest protocol and CRFs on 15th October. All involved were thanked.

c) Equipment

[REDACTED] and [REDACTED] are looking at digital recording and are looking at cost effectiveness before purchasing.

ACTION 3: [REDACTED] to recommend digital recording equipment to [REDACTED] in order to organise purchasing.

d) Therapeutic integrity

Therapy integrity scales are now finalised and discussion took place regarding how many tapes need to be assessed to assure therapeutic competence.

ACTION 4: [REDACTED] to supply the new version of the Therapy integrity scale to [REDACTED] so that it can be submitted to MREC.

Supervision has changed to be more flexible. There is now a minimum criteria for supervision (monthly by telephone, four times a year face-to-face).

Staff from the KCH centre explained that they have been using time in their PACE team meeting for therapists to practise selling the trial and role-playing different therapies. This has proven both useful for both practice for the therapists and for integration of the Kings PACE team.

ACTION 5: All centres to consider instigating this model: regular meetings for all local centre PACE teams, with time made to discuss aspects of treatment and use of role play, to practise selling and doing the therapies and troubleshooting.

ACTION 6: All meetings should be minuted and distributed with descriptions of what is being put in place so that all centres can learn from each other and work in the same way. SOPs will be written on the basis of these to ensure that policy is the same between all centres. This policy was accepted by TMG.

e) Honorary contracts

ACTION 7: All London centres to ensure that there are honorary clinical contracts between London centres.

f) Research nurse training

Research nurses need to know the therapies in detail, and it was advised that they should sit in on assessments for all four arms of the trial.

g) Clinic appointment letter

We agreed to not to standardise the clinic appointment letter, since all clinics had their own versions, and this would not be a part of the trial.

ACTION 8: [REDACTED] to modify the protocol and create an amendment and submit this to the MREC.

h) Exclusion of patients who had already received a supplementary therapy

ACTION 9: [REDACTED] to modify CRF to check that the RN asks whether the patient has received any of the three supplementary therapies from a fatigue clinic in the past. An amendment is to be created and submitted to the MREC. Additionally, [REDACTED] to check whether this is in the current version of the protocol, and if not, modify the protocol and notify MREC accordingly.

i) SCID

CIDI has now been changed back to the SCID as in the original application. This decision was taken because the CIDI was a very long instrument and no trainers were available in the UK. This means that we are now using the same psychiatric interview as in the FINE trial. The SCID can take up to two hours to complete, so the PIs need to identify relevant sub-sections of the SCID for use in PACE. It was decided that the following sections should be included: depressive and anxiety disorders, and screening for substance misuse, eating disorders and psychosis. The PIs still need to decide whether the somatoform section should go in.

ACTION 10: The three PIs to organise piloting of the SCID particularly the somatoform areas.

Dementia and delirium are not included in the SCID. The PACE trial has no upper age limit. In the protocol, we have decided to rely on the clinical assessment of the clinic doctor. TMG accepted this. ■■■ and ■■■ both reported having found actual and suspected dementia cases in routine clinics in the past.

ACTION 11: All centre leaders to ensure that doctors know how to do a clinical assessment for dementia. This to be re-evaluated with each new member of medical staff.

j) CSRI

ACTION 12: Training in use of the CSRI is to be given by ■■■ on the 30th November.

k) Actigraphy

The equipment has been ordered and a representative from the manufacturer has confirmed that ■■■ will be available on the 30th to give training.

ACTION 13: When the training programme is finalised, ■■■ to contact the manufacturer to confirm the time, date, place and number of those attending for actigraphy training.

Actigraphy is to be given at baseline only, as a predictor. This is on the basis of research by the Dutch Nijmegen group who found it useful as a predictor (the more passive, the poorer outcome), but not useful for outcome.

ACTION 14: ■■■ and ■■■ to create a new CRF for the patient to record when they sleep or remove the watch. This to be submitted as an amendment to MREC.

l) Trial database

■■■■ has resigned and will be leaving mid-January. Data management training will need to be brought forward.

It has been decided that ■■■■■ will work alongside ■■■ to help write a manual for the databases (their use and maintenance).

ACTION 15: ■ to investigate SQL programming training for the Research Assistant at ■.

ACTION 16: ■ to discuss with ■ in what is required for the database manual. ■ to ask ■ to help in training the other data managers alongside ■ and ■.

m) Recruitment for second wave centres

ACTION 17: PIs to send ■ and ■ job adverts, descriptions and person specifications for use recruiting staff in their centres next year.

■ noted Agenda for Change will impact on this.

ACTION 18: Second wave centres to access information (available on the internet) on Agenda for Change and alter the job descriptions accordingly.

7. TSC minutes

These were reviewed by all. It was noted that the finalised manuals have still to be sent to the TSC.

ACTION 19: once received from the therapy leads, ■ to send the current version of all manuals to the TSC.

8. Final approval of therapies

The morning meeting of treatment leaders, PIs and ■ was reviewed with each leader speaking to their own manuals.

Treatment manuals are now to be completed by 15th November and then submitted to MREC.

a) SSMC

- A description of the therapies will *not* be incorporated into the SSMC manual. Instead the PCL will be incorporated as an appendix to this document.
- A further appendix will be a leaflet for patients on work, disability and benefits which will include information on the Disability Discrimination Act, available from the CBT participant's manual, with kindly given permission.
- There will be a minimum of three sessions with the SSMC clinic doctor. ■ believes this is practical. SSMC clinic doctor will see the participant for the first time for SSMC within a month of randomisation. This second change (from a fortnight previously) is to reduce load on patients of number of visits to the hospital in the first two weeks.

b) APT

- Some selective physiology will now be added into the APT manuals.

c) CBT

- Minor changes only to be made.

d) GET

- It has been decided that relaxation is appropriate to GET as long as specific muscle relaxation techniques are used and no non-muscle imagery employed.
- A rationale to explain the need for caffeine reduction will be added.
- A rationale to explain the need for reduction of daytime napping will be added.

e) In general

There were a few items that need to be standardised across all of the manuals (these are 'action' points in the minutes to the morning meeting):

- Generic information will be consistent across all the manuals.
- The patient process handout included in the CBT manual is to be distributed to all for modification for each therapy.
- CGI to be added into all of the therapists manuals, to be scored by the therapist in session 14 and by the SSMC doctor after the end of the participant's involvement in the trial.
- Adding problem solving / trouble shooting information will be added into the therapist manuals.
- Relative sheets, explaining the treatment should be available as a separate handout from the participants' manual.

ACTION 20: In line with the treatment manuals, ■■■ to modify the protocol to state that nothing may be copied, disseminated, put on the internet or given away.

The TMG gave congratulations and thanks to the treatment leaders for their hard work and an excellent job done.

f) Formatting of manuals

The following were discussed:

- Manuals will be produced one sided to allow space for notes to be written in.
- Manuals will be held in a ring binder for ease of use.

g) Copyrights and sharing PACE material

■■■ spoke to the discussion on copyrighting held at the morning treatment leaders meeting, and the publication of material which will incorporate some of the PACE information but will not be the same as the PACE material.

Discussed issue of colleagues from children's services ■■■■■ requesting the APT manual for their own research. This led to further discussion regarding collaboration and copyrighting and how we judge who we release the manuals to. The advantage is that they will be testing the manuals with a different group.

ACTION 21: PIs and treatment leaders to have further discussion on the matter of releasing the manuals for use in other trials, considering such issues as... “Do they stand alone without the added training given specifically by their authors?”

ACTION 22: TMG agreed that release of materials will be decided on an ad hoc basis at TMG meetings.

ACTION 23: ■ to number the manuals and these to be released on an assigned number basis. These to be recalled when no longer used or if superceded. (institution assigned number + manual number). Participant manuals to be numbered too. (centre number = manual number)

It was agreed that all trial materials must be returned by staff who leave.

9. Therapist competence and integrity

It was noted that:

- whoever the independent raters are, they need to be well versed in all four therapies so that they are able to distinguish between them.
- Cut-offs for competence on the therapeutic integrity scale have not yet been decided, and that this still needs to be done.
- part of ongoing supervision is to have ongoing training. If a person was repeatedly failing to meet standard, this would need to be addressed locally, and possibly brought as a general issue to the TMG.

ACTION 24: ■ and treatment leaders to come to a consensus on a cut off scores for competence and integrity.

a) APT

- The last training for APT will be 8th and 9th December.
- There will be peer review to sign off competence using role plays, supervision, and watching or listening to two video/audio-taped sessions.
- ■ has no concerns about the therapists on the basis of tapes listened to, but noted that ■ has only had one tape from ■ (■) which ■ received today.
- The therapy competence scale is being used to judge competence.
- ■ is confident that the APT therapists will be ready for the start of the trial.

b) CBT

- ■ is happy with the competence of all the CBT therapists.
- ■ is collecting two tapes from each therapist to rate competence.
- CBT training finished on the 3rd November.
- Experienced therapists have expressed difficulty in keeping the sessions within the agreed time allowance, and some items are spilling into the next session as a result.

- The frequency of seeing participants has proven problematic, but using telephone sessions has been useful to overcome this.
- Two people are rating tapes of competence for CBT, one treatment leader, one another peer. Where there are discrepancies, these are discussed.

c) SSMC

- [REDACTED] noted a need to pilot SSMC.
- The issue of taping sessions of clinic doctors giving SSMC was revisited. Debate followed regarding the importance and practicability of doing this.

ACTION 25: All PIs to ask the centre doctors whether they are happy for all the SSMC sessions to be taped for the purpose of judging competence and integrity.

ACTION 26: All PIs to look at extra cost and practicalities of taping all the SSMC sessions.

ACTION 27: If agreed, [REDACTED] to create an amendment to the protocol and submit this to MREC.

ACTION 28: [REDACTED] to draft an SOP regarding review of tapes for supervision (how many? how often?), categorisation of competence and treatment differentiation and integrity.

d) GET

- Therapists are all quite inexperienced, so competence is an important issue for GET.
- Timescale is a concern.
- Therapeutic alliance is also not good yet.
- Basic skills and understanding of CFS not good due to inexperience.
- Not enough experience obtained yet with pilot patients.

ACTION 29: All PIs/centre leaders to give additional support on generic skills of engaging patients and more general CFS/ME training, by sitting in on sessions to review skills and from that give further supervision and support to build up confidence.

ACTION 30: All PIs/Treatment leaders to encourage/arrange for therapists to sit in and watch their more experienced PACE therapist colleagues to learn counselling and language skills.

ACTION 31: [REDACTED] to send brief reading material around on Rogerian skills for the therapists and research nurses.

ACTION 32: Treatment leaders to swap tapes and rate the therapists from other disciplines.

ACTION 33: All first wave centre leaders to begin to identify new outpatients from 1st December ready to offer the trial in January (banked patients).

ACTION 34: All PIs/centre leaders to begin a programme for the research nurses for December (after the training) so that they are confident to sell the trial for January. Research nurses should sit in on sessions in December.

10. Patient Clinic leaflet (PCL)

The PCL was reviewed line-by-line, and suggestions for further changes made.

ACTION 35: Suggested PCL changes to be reviewed by [REDACTED] and [REDACTED] and forwarded to [REDACTED] for a final draft.

11. Centre agreements

ACTION 36: [REDACTED] will circulate the centre agreements to the TMG for comments when completed. One will be an institution to institution contract regarding sponsorship and financial arrangements. The other will be a centre leader agreement with the PIs and TMG.

12. Accommodation

A draft Travel and Accommodation policy has been created.

ACTION 37: [REDACTED] will circulate the Travel and Accommodation policy to the TMG for comments when completed.

13. Stationery and other trial tools

a) Headed paper

The decision was taken not to have headed paper printed up with centre addresses as these change too frequently.

ACTION 28: [REDACTED] to review whether the PACE trial centre address should still be included at the bottom of the page, and to advise [REDACTED] so that an order for paper may be placed.

It was decided that compliments slips are now probably an unnecessary excess cost.

[REDACTED] advised the TMG that the Trial Master File is in development and should be ready for collection by each centre at the nurse training day.

b) Case report forms

Costings are currently being made for the production of No Carbon Required (NCR) Case Report Form (CRF) booklets. Some alternative cheaper options were being reviewed.

ACTION 29: █████ and PIs to decide the creation of CRF booklets.

c) Manuals

The issue of how the manuals would be distributed was discussed. Each centre producing their own eases the burden on the PACE trial centre, but removes control over tracking the whereabouts of the manuals.

d) SOPs

The SOPs are currently being written.

14. Training for assessors, recruiters and SSMC doctors 29th November

ACTION 30: All centre leaders to inform █████ of names and numbers of doctors coming on this day.

ACTION 31: █████ to contact Oxford for same.

█████ will lead on SSMC in the afternoon session. Morning session will include training on recruitment, GCP and the trial background.

ACTION 32: █████ to lead on designing this training session.

15. Training for research nurses 29th and 30th November

█████ has agreed to give training on the step test and walking test.

█████ is trying to identify someone at the IoP who might be available to give training on the SCID.

█████ from Cambridge Neurotechnology (the company who make the actigraphy equipment) has confirmed that he can be available on the 30th November to give training to the nurses on actigraphy.

ACTION 33: PIs to design training for research nurses

ACTION 34: █████ to design randomisation training

ACTION 35: █████ and PIs to talk about a second training day on randomisation, SOPs, GCP, TMF and any other issues. To possibly take place on 1st December.

16. Training programme for data managers/secretaries

This is estimated to take place early January with █████ help as █████ will be writing the manual for the database (see Action 16 above).

17. Policy for unsolicited mail

ACTION 36: As agreed with the TSC and DMEC, all staff must forward any such mail to [REDACTED].

ACTION 37: Pls to do further work on the policy for dealing with unsolicited mail and bring this for discussion at a future TMG meeting.

Items 14,15,16, 20,21 & 23 to be moved to a future meeting due to running out of time at this TMG.

18. Date of TMG #12 meeting

1pm to 5pm, Friday, 10th December 2004 in [REDACTED]

4. Date of TMG meetings for 2005

10th February 1pm-5pm

20th April 1pm-5pm

22nd June (*provisional*) 1pm-5pm

14th September 1pm-5pm

17th November 1pm-5pm

[REDACTED]