CENTRE FOR CHILD & ADOLESCENT HEALTH

University of BRISTOL

Centre for Child and Adolescent Health
Hampton House
Cotham Hill
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28th July 2010

REC reference number 10/H0206/32

Dear Mr Ashby,

Thank you for the feedback received from the South West Research Ethics committee after the meeting on the 8th of July 2010. We are grateful for the time spent on this proposal by the Ethics committee which we feel has improved this study.

We have answered the questions raised by the Ethics committee and enclose the documents with tracked changes and with changes accepted so you can easily see what the final documents will look like. A table at the end of this letter lists the documents changed with their new name, version number and date as applicable.

Further information required or clarification required. Qs 3,7,10,14,16 and 17 above should be confirmed and addressed

Q3. If they choose to be interviewed at the hospital will you pay their travel expenses?

Yes, when required

Q 7. Will the researchers and the Lightning people all have CRB checks?

Yes. We have altered the Parent patient information sheet and the Teenager patient information sheet to reflect this. This now has the following section added before the privacy section:

“Does everybody involved in the study have the appropriate police checks?

Yes”

Q 10. It should be made clear in the PIS that confidentiality will be broken if concerns are found with the child’s welfare and t will be reported to the Child Protection Officer at the Trust.

If we have concerns over child protection, we will follow the hospital child protection pathway specified by the Royal National Hospital for Rheumatic Diseases. The pathway varies depending on the nature of the concern and on whether the concern is raised during working hours or out of hours. In some cases, it may be necessary to talk directly with the appropriate on call social worker. We have added the following to the Parent information sheets to cover all eventualities in the section entitled your privacy:

“As with any child being seen in clinic, if we have concerns over your child’s welfare. we may have to break confidentiality In some cases, we may have to discuss your child with another professional such as a social worker or child protection officer.”

I have added the following to the Teenager information sheet:

“If you tell us something that makes us worried about your safety, we may have to discuss this with somebody else as we need to be sure you are safe. This means, what you say would not be kept completely private. We would do the same if you told us something in clinic.”

Question 14. Could there be some 16-17 year olds who are married or employed.

Although our service will provide assessment for young people aged 16 to 18, the service will only see young people in this age range if they are still in school or want to go back to school. Young people who are employed and not in school are offered assessment by the adult service as they are able to offer the appropriate advice about return to work.

Our paediatric service has not previously assessed a married young person who has been at school. If this happened however, we do not believe this would affect the study.

Question 16. Teenagers over 12 years old if competent are able to give their own consent, but all the forms are entitled consent when it should say Assent.

We agree. We have changed the Consent to Assent in all the forms used for those aged under 16 (please see table at the end of this letter for details).

Question 17. The PIS is very muddled, long and complicated some of which the children will struggle through. There is little difference in Adult and Children’s PIS. There should be a specific teenagers PIS and a flow chart would help to make the process clearer.

We have added a patient flow chart to both the Parent PIS and the Teenager PIS.

On the teenagers PIS, in addition to the changes detailed below we have also made the following changes to lower the reading age for younger teenagers: “alternative” to “different”, “opportunity” to “chance” and “observe” to “watch” on page 2; “the daily seminars” to “Each day the course”; on page 3. I have changed “intervention options” to “interventions” on page 3; deleted “intervention” paragraph 5 on page 3,”; changed “approximately” to “about” page 4; changed “interventions” to “sessions” page 4; and “evaluated” to “tested” on page 5, changed “anonymous” to “private” page 6.

We have tried to explain “interventions” the first time it is used by adding “(ways to help)”.

In the paragraph on randomisation (second paragraph page 3) we have added “(in other words, by chance)” after randomly allocated to explain this. We have changed “(in other words by chance)” at the end of the paragraph to “This is the same as rolling a dice”.

The PIS follows the NRES recommended layout and has adopted the NRES recommendations for children. We have also tested the PIS on healthy teenagers who reported that it was clear to read. Members of the patient charity AYME have scrutinised the PIS and also felt it was clear to read.

This may be a difficult study to understand and we have therefore allowed time for both clinicians and the research nurse to go through the PIS with both the young people and their parents to ensure full understanding of the study prior to taking part.

You have also asked for responses to the following:

1. **Further clarification is required on how the young people and parents are to be recruited; when and where will they receive the PIS and how will willingness to participate be obtained.**

In the recruitment section of the protocol, we have changed “Children and their families will be identified ” to “Eligible children and their families will be identified”. We have then clarified that both the children and their parents will be given the patient information sheets by adding “give both the young person and their parents the relevant patient information sheets. The clinician will check that the young person and their family are willing to be contacted by the research nurse and the researcher and will obtain consent …”

In the section on randomisation we have added “the research nurse will ascertain willingness to participate and will check that both the young person and their family understand the study.”

2. **There seems to be some explanations missing from the PIS; young people are asked to consent for schools to be contacted but there is no explanation of how and why this is to be done.**

We have added this sentence to the Parent patient information sheet on p4:

“We will also contact your child’s school at assessment and at each of these follow up time points to find out how much school they are attending.”

We have added this sentence to the teenager patient information sheet on p4:

“We will ask your school about how much you have been at school when we first see you and at follow up.”

3. **It is still unclear how the consent forms are to be used and further clarification is required.**

We have added the following in the Protocol to the paragraph on Ethical issues which discusses the care we have taken to ensure there are rigorous procedures for obtaining further consent/assent:

“In the clinic, the clinician will ask for consent/assent for contact by a research nurse and qualitative researcher from both the young person and their parents. Consent/assent to the study and to randomisation will be obtained by the research nurse after a full explanation of the study when both the young person and the family

have had sufficient opportunity to ask questions. Young people and their families will be given as long as they need before giving consent/assent within the confines of the study. We will then obtain further consent/assent prior to each interview to check that young people and/or their parents continue to be willing to participate. We will also obtain consent/assent prior to recording any interventions from all present."

4. **The title in the study is lost in all the print at the top of the page it needs to be differentiated from the rest.**

We have put extra spaces above and below the title and increased the font size to 16 on both the Parent and the Teenager PIS to help differentiate the title from the rest of the print.

5. **The title of both parent and teenager PIS does not clearly say this is a trial or for which condition. It needs clarification in the heading.**

We have added the following sub heading to both Parent and Teenager PIS:

"Feasibility randomised controlled trial for Chronic Fatigue Syndrome/ME"

6. **The adult version needs shortening.**

We have deleted the following from the adult version:

Page 1, paragraph 1: "it is possible to do a study investigating" and "to do this, we need to know whether young people will take part in a study".

Paragraph 2 "more"; "we are particularly interested in" "of both interventions"

Paragraph 3 "as part of this study" "also try and"

We have changed the paragraph under the title "what we are asking you to do" which describes the interviews to include all three possible interviews by adding "and during the study (on no more than three occasions)…and then "and about your experience of each type of intervention. I have moved "your child will be interviewed at one of these time points for approximately 20 minutes" to this section. This then allows me to delete the first paragraph under Group 1 and Group 2.

Page 4, paragraph 2: I have deleted "to find out more about both interventions"

Page 7, paragraph 2: I have deleted "sometimes during the course of a research study, new information becomes available about the interventions that are being studied. If this happens," and replaced this with "if new information becomes available"

7. **The invitation tells participants which is happening but gives no full description of CFS or ME at the first mention. In the introduction it presumes that they know what current treatment, the Lightning Process and the abbreviations are and although the Lightning Process is explained later it may be appropriate to give a brief outline at this point.**

We have replaced CFS/ME with Chronic Fatigue Syndrome or Myalgic encephalopathy (CFS/ME) in the first sentence on both parent and teenager PIS.

We have moved the description of Specialist Medical care in both PIS from the description of the two arms to page 1. We have also added the sentence “Specialist Medical Care is the current treatment children normally receive if they have CFS/ME. After their assessment, they”…..

The Lightning Process is described at the earliest opportunity after Specialist Medical Care.

8. **Need to explain exclusions under “why has my child been asked to take part?” (is included in the but one paragraph but is better placed under the above heading)**

We have moved the paragraph about exclusions from the “Who should not take part in this study” to the “Why has my child been asked to take part” in the Parent information sheet and done the same move in the information sheet for Teenagers. We have deleted the heading “who should not take part” in both information sheets.

9. **They should be told they are free to withdraw and withdraw their information at any point in the study.**

We agree that we should clarify throughout that parents and children can withdraw at any stage. We have added this to the "consent for interview sheet" (see question 19 below). At the moment, we discuss withdrawing from the study in detail in section 2 of the parent and the teenager information sheet under "what will happen if I don't want to carry on with the study".

We agree that we should clarify the fact that parents and teenagers can withdraw at any point to section one of both the parent and the teenager information sheet and have added this to the section "does my child have to take part".

We have considered carefully the issue of withdrawing information at any point in the study when a participant withdraws. We will accommodate this requirement as much as possible, but there are practical limitations to promising withdrawal of data at any stage of the research. For example, it would not be possible to withdraw information after publication, and withdrawal of qualitative information after analysis would be extremely difficult, if not impossible. This is because once thematic analysis has been performed, we cannot withdraw an individual quote and be sure it hasn't already affected the themes as each quote affects the thematic analysis.

Withdrawal of demographic data would be highly problematic and would threaten the validity of the study. The primary goal is to look at whether the trial is feasible or acceptable. Because the main overall objective is to study is to study recruitment, if we were to withdraw demographic data (which is anonymised at source), we would be unable to achieve our primary goal. This is because we need to compare those that are recruited with those that are not recruited and look at post randomisation drop out.

In addition, this demographic data are currently collected on all children who are seen by the service to enable us to evaluate the service. The North Somerset & South Bristol Research Ethics Committee decided that the collection and analysis of these data was part of service evaluation and as such did not require ethical review by a NHS Research Ethics committee or approval from the NHS R&D office (REC reference number 07/Q2006/48).

We would be happy to withdraw the qualitative information collected at interview on children and parents prior to analysis if they wished us to do so.

We have therefore added the following to the parent information sheet: "Your child can withdraw at any point in the study. Your child can withdraw their information collected at interview at any point in the study before analysis" to the second paragraph under "does my child have to take part."

In the teenager information sheet in the same place I have added: "You can withdraw from the study at any point and if you want us to we will take out the information collected at interview at any point before we carry out data analysis"

10. **It should include possible benefits for parents e.g. may find it helpful to talk to others about their experiences.**

We have added “although some parents may find it helpful to talk to others about their experiences” to the section on “benefits of joining in” on the adult form only.

11. **Needs to explain why they are informing their GP.**

In the parent information sheet in the section “who will know I am taking part in the study” on the last page we have changed “we would like to let your GP know that your child is taking part in the study” to “we think your GP should know about the interventions your child receives”.

In the same section for the teenager information sheet we have added the following: “because they need to know what happens to you”.

12. **Explains privacy/confidentiality well but need to warn potential participants of the situations which may mean that they have to break confidentiality.**

Please see the answer to question 10 on the first page of this letter.

13. **The teenager version needs significant modification for a young audience that starts at age 12 and the information needs to be much more concise. Words/phrases such as intervention, seminar, randomly allocated etc need to be explained or re phrased.**

Please see the response to comment 17 on the first page of this letter.

14. **A flow chart for each group would make clear what is happening and when.**

This has been added.

15. **There is no information of who is conducting the Lightning Groups and where they will be held.**

We have added the following information to the first section on the parent information sheet in the first section about the Lightning Process (page 2):

The course is run by a Lightning Process Practitioner who is trained and licensed to run the course. The courses will be held somewhere near you, either in a clinic or hospital, or in a hotel or community hall.

We have added the following information to the same section of the teenagers information sheet:

“The course is run by a Lightning Process Practitioner who is trained and licensed to run the course. The courses will be held somewhere near you, either in a clinic or hospital, or in a hotel or community hall. Where ever it is held, it will be suitable for the course and for young people your age.”

16. **It is suggested that the PI be broken down into two elements to aid understanding: First stage: the interview to obtain knowledge about what people know about Specialist Medical care and Lightning, and an opportunity to hand out information on the main study. Second stage: the work looking at the two groups**

We have broken down the “What are we asking you to do” section on the PIS for both the teenagers and the parents to two elements and inserted “First stage” to the first paragraph.

We have then added the following before the second stage in the teenagers PIS:

“Second stage: In the second stage you will be part of group 1 which is Specialist Medical Care) or group 2 which is Specialist Medical Care plus the Lightning Process”

In the parental PIS we have added the following:

“Second stage: In the second stage you child will be part of group 1 which is Specialist Medical Care) or group 2 which is Specialist Medical Care plus the Lightning Process.”

17. **Consent for under 16 years needs permission to inform their GP**

We have changed “I know that you will tell my GP…” to “I agree that you will…”

18. **Consent to record intervention – the title is not clear for whom this is intended.**

We have added the following in to the title “ for participants, parents and those delivering interventions”

19. **Teenager consent to interview – 1. Whilst it says that participant can stop the audiotape or ask for the interview to stop without explanation, it does not tell them explicitly that they can withdraw at any time.**

After the sentence on stopping the audiotape, we have added the following: “I know that I can withdraw from this study at any time.”

2. The title does not clarify specifically what age group is included in this. Meant for 16 to 18 years whereas the definition of teenager is anyone older that 12 years.

We have clarified in the title that this is for those aged 12 to 18 by adding (12 to 18) in the title

20. **Teenager consent to study – “I know that my school records will be checked” needs to be replaced with “I agree for my school records to be checked”.**

We have changed “I know” to “I agree”.

21. Child Consent form for evaluation – 1. Needs to be entitled "Assent".

We have changed all the consent forms for those under 16 to Assent in both the title of the file and in the title at the top of the form.

2. I know that my school records will be checked"/"I know that you will tell my GP…" needs to be replaced by "I agree for my school records to be checked. And "I agree that you may inform my GP…"

We have changed "I know" to "agree" in both places

3. Do 13, 14, 15 years olds really want to be called children as title, would it not be better to entitle "assent for under 16 years".

We have changed the title from "Child Consent form" to Assent form for those under 16"

22. Child consent to Contact – 1. Needs to be entitled "Assent". 2. Again do 13,14, and 15 year olds really want to be called children as title, would it not be better to entitle "assent for under 16 years".

We have changed Child consent to contact to Assent to contact for under 16s:

23. All Consents/Assents for under 16years and over 16 years need to include something which allows them to give their permission for their parents/guardian/carer to give their views about them.

We have added the following sentence to the Assent to contact for under 16s, the Assent to study for under 16 year olds; the consent to contact for 16 to 18 year olds and the consent to study for 16 to 18 year olds:

"I agree that you may talk to my parents/guardian/carer about me"

All consents are given overall headings of "CFS/NHS/Paediatrics – specialist help for ME. This is confusing (CFS versus ME) and may not be readily understood by all. (E.g. will everyone know what "paediatrics" means.

This is the title used on letters and information sheets from our service. An explanation is given in the introductory leaflet that is sent to the families prior to the clinic visit. All young people and families recruited will have received clinic letters and the introductory leaflet prior to being recruited to the study.

<u>Training Assessment Form for Participants:</u>

24. Page 4 Q12 asks young people "are you analytical?" This needs further explanation especially for the younger age range.

We have added the following after the word analytical as an explanation.

(do you spend a lot of time questioning and examining things)?

The paragraph afterwards also elaborates on the meaning of the question.

25. **Page 5 states at the top "if you are 18 years or under please ask your parent…and they also agree…to sign the form too". This should state "under 16 years".**

We have changed both the title at the top and the paragraph below on page 5 from under 18 to under 16.

26. **The pages should be numbered**

We have numbered the pages

Health Survey

27. **Some of the activities do not relate to young people (especially for the younger participants) e.g. Q4 pushing a vacuum, bowling, playing golf, lifting or Q5 carrying groceries, Q13 time spent on work, Q22 normal work. This needs to make items more young person focused or add a column to say "never done this".**

Thank you for your thoughts on this. We initially tried to use the CHQ on children (developed for children but not tested head to head with the SF36) with CFS/ME but they told us the activities were not relevant and it did not adequately reflect their disability. We therefore changed to the SF36 on the request of the children in our service and have now used this for 6 years in over 1000 children with CFS/ME. We rarely have missing data on this reflected in our publications.

We understand that changing the SF36 has in the past provoked the threat of legal action and we remain concerned about changing a validated inventory that we have already used extensively on this cohort both clinically and for our previous research. There are risks to interpreting findings and comparing with other published work if we change the inventory.

During this study we will examine young people's views and understanding on completing the SF36 (and other inventories) and will be able to find out if there are issues over the interpretation of the questions. If there are, we intend to use this to apply for further funding to develop a CFS/ME measure of severity.

We would respectfully request that we are allowed to continue to use this well recognised and validated inventory in this group of patients.

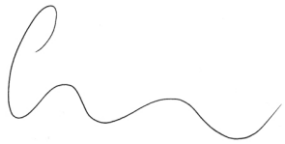
Please find below a table listing the original and revised version numbers and dates of the documentation that has been changed in the order listed your original letter:

Original title	Version	Date	New title	New version	New date
Protocol	5	10 May 2010		v6	July 2010
Phil Parker Training assessment form		20 May 2010		v2	July 2010
Information leaflet for parents	v4	10 May 2010		v5	July 2010

Teenager consent to study	v3	10 May 2010		v4	July 2010
Information leaflet for teenagers	v4	10 May 2010		v5	July 2010
Teenager Consent to interview	v3	10May2010	Teenager (12 to 18) consent/assent to teenager interview	v4	July 2010
Child consent to study	v3	10 May 2010	Assent to study for those under 16	v4	July 2010
Child consent to contact	v3	10 May 2010	Assent to contact for under 16s	v4	July 2010
Consent to record intervention	V3	10 May 2010	Consent/assent to record intervention for participants, parents and those delivering interventions	v4	July 2010
Teenager consent to contact	v3	10 May 2010		v4	July 2010

Thank you again for considering this study and for the Ethics Committee's input in improving this study.

Yours



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