SWAT 27: Remote versus on-site initiation visits

Objective of this SWAT
To investigate the costs and effects of providing on-site initiation visits at trial sites (prior to application for research governance approval) on subsequent set up times, recruitment measures, data collection and costs.

Study area: Recruitment, Data collection, Site set-up times
Sample type: Sites in a Cluster Randomised Trial
Estimated funding level needed: Low

Background
Randomised trials can be problematic and complicated to set up, and often suffer from slow recruitment; limiting the potential for meaningful conclusions to be drawn. A key problem in the setting up phase of trials in the United Kingdom (UK) relates to the delays that can occur before submission for Research and Development (R&D) approval. It is possible that greater contact with recruiting centres in a trial may reduce delays, although this does not appear to improve recruitment rates [1,2]. Preliminary contact with sites recruiting into multi-centre randomised trials in the UK generally takes two forms: initial contact prior to R&D application and site set-up visits after approval has been granted. In the first instance, healthcare professionals at local sites are contacted to discuss the trial rationale and design, and obtain agreement for participation in the study. This initial contact also provides the opportunity to finalise local arrangements and obtain any additional information that may be necessary before submission for R&D approval. While it is necessary to undertake on-site set-up visits after R&D approval to provide training on trial processes and materials and ensure the study will be conducted according to standards of Good Clinical Practice, earlier site initiation can take two forms: face to face on-site initiation visits or remote initiation via email and telephone communications. Both methods have been adopted in trials, but the effect of on-site versus remote initiation visits on time to R&D submission and subsequent patient recruitment is unclear as similarly long time delays have been experienced across studies despite variations in approach.

Interventions and comparators
Intervention 1: Face-to-face on-site initiation visits. Meetings will be arranged to meet the principal investigator (PI), research staff and relevant practitioners at the site to discuss the trial processes and requirements of the site. A site initiation checklist will be used to ensure all important topics are discussed and to standardise discussions across sites. A record of costs associated with on-site visits will be kept using the main trial database, including researchers' time when contacting sites (e.g. telephone, email), visiting sites and travel costs.
Intervention 2: Remote site initiation, using email and telephone communication to discuss trial processes and requirements of the hospital site. This will be undertaken with the PI and research staff and other practitioners where appropriate. As for the on-site group, a site initiation checklist will be used to ensure all important topics are discussed and to standardise discussions across sites. The costs associated with remote site initiation will be estimated by keeping a record of the telephone and email correspondence at each site to estimate how much researchers' time is used.

Index Type: Visit

Method for allocating to intervention or comparator
Randomisation

Outcome measures
Primary: There is no single primary outcome. A range of outcomes will be explored descriptively and by trial group, including
a) Time from first contact to R&D submission
b) Time from first contact to R&D approval
c) Time from first contact to set-up meeting prior to recruitment commencing
Recruitment:
d) Number of eligibility forms returned (estimate of screening activity)
e) Proportion of consenting patients out of eligible patients screened
f) Total number of patients recruited

g) Number of patients recruited across all sites during the period of recruitment of the last site to be set up
h) Time from first contact to time of first recruited patient per site
i) Time from first contact to average time to recruitment per site
j) Time from first contact to time of recruitment of each patient
Data collection:
k) Hospital forms: Proportion returned (after first request and in total)
l) Hospital forms: Time to return
m) Patient questionnaires: Proportion returned (after first request and in total)
n) Patient questionnaires: Time to return
Secondary:

Analysis plans
All analyses will be conducted on an intention to treat basis by including all sites based on the groups they were assigned to at randomisation. All outcomes will be summarised descriptively overall and by allocated group. Group differences and 95% confidence intervals (CI) will be reported. Owing to the small number of anticipated trial centres (around 8 centres per group in the initial version of this SWAT), no formal statistical tests will be undertaken on site-level outcomes. Any patient-level outcomes will be compared between trial groups using appropriate tests for the type of outcome data. Group differences will be summarised descriptively and reported using 95% CI. The statistician will remain blind to the intervention group until all data summaries and results are finalised. Cost and consequences for patient recruitment will be compared. If it is deemed appropriate, an incremental cost per patient will be calculated. Primarily, estimates will be made using the researchers' records of time and costs associated with site initiation in each intervention group, but time associated with site liaison to start recruitment after sites are set up will also be considered.

Possible problems in implementing this SWAT
In order to ensure that the randomised groups are balanced for important characteristics that may impact on a site's ability to set up a site and recruit, minimisation would be used to balance the following factors: 1) whether the site's principal investigator's has previous experience of working on similar multi-centre randomised trials; 2) the site has a Research Nurse in place; and 3) the size of the hospital catchment area.
Within this SWAT, sites will not be informed that they are to be randomised to receive on-site or remote initiation visits. Both approaches are commonly used to set up sites in randomised trials and no negative implications for patients are anticipated because all sites will receive the same amount of training in trial procedures when setting up the site after R&D approval. If a site is randomised to the remote initiation group and the local PI subsequently feels that their site would benefit from face to face contact to discuss the trial, this will take place and the site will remain in the study and be analysed under the assumptions of intention to treat. Recruitment at sites will be monitored on an on-going basis and if the trial is not meeting recruitment targets and monitoring indicates substantial differences in recruitment rates at sites in either intervention group, a decision may be taken to end the SWAT so as not to jeopardise patient recruitment in the main trial.

References
1. Lienard JL, Quinaux E, Fabre-Guillevin E, et al. Impact of on-site initiation visits on patient recruitment and data quality in a randomized trial of adjuvant chemotherapy for breast cancer. Clinical Trials 2006; 3(5): 486-92.
2. Treweek S, Mitchell E, Pitkethly M, et al. Strategies to improve recruitment to randomised controlled trials." Cochrane Database of Systematic Reviews 2010; (4): MR000013.

Publications or presentations of this SWAT design
Comparing two methods of site initiation for centres recruiting patients into a surgical trial (ISRCTN78899574).

Examples of the implementation of this SWAT

People to show as the source of this idea: Laura Jefferson, Stephen Brealey, Liz Cook, Joseph Dias, Caroline Fairhurst, Ada Keding, John Thompson, Nick Taub, Garry Tew and David Torgerson

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