

METHODOLOGY

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Development and evaluation of rapid data-enabled access to routine clinical information to enhance early recruitment to the national clinical platform trial of COVID-19 community treatments

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Abstract

Background: The COVID-19 pandemic has presented unique challenges for rapidly designing, initiating, and delivering therapeutic clinical trials. PRINCIPLE (Platform Randomised Trial of Treatments in the Community for Epidemic and Pandemic Illnesses) is the UK national platform investigating repurposed therapies for COVID-19 treatment of older people in the community at high risk of complications. Standard methods of patient recruitment were failing to meet the required pace and scale of enrolment.

This paper describes the development and appraisal of a near real-time, data-driven, ethical approach for enhancing recruitment in community care by contacting people with a recent COVID-19 positive test result from the central NHS Test and Trace service within approximately 24–48 h of their test result.

Methods: A multi-disciplinary team was formed to solve the technical, ethical, public perception, logistical and information governance issues required to provide a near-real time (approximately within 24–48 h of receiving a positive test) feed of potential trial participants from test result data to the research team. PRINCIPLE was also given unique access to the Summary Care Record (SCR) to ensure safe prescribing, and to enable the trial team to quickly and safely bring consented patients into the trial. A survey of the public was used to understand public perceptions of the use of test data for this proposed methodology.

Results: Prior to establishing the data service, PRINCIPLE registered on average 87 participants per week. This increased by up to 87 additional people registered per week from the test data, contributing to an increase from 1013 recruits to PRINCIPLE at the start of October 2020 to 2802 recruits by 20 December 2020.

Whilst procedural caveats were identified by the public consultation, out of 2639 people contacted by PRINCIPLE following a positive test result, no one raised a concern about being approached.

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Conclusions: This paper describes a novel approach to using near-real time NHS operational data to recruit community-based patients within a few days of presentation with acute illness. This approach increased recruitment and reduced time between positive test and randomisation, allowing more rapid evaluation of treatments and increased safety for participants. End-to-end public and patient involvement in the design of the approach provided evidence to inform information governance decisions.

Trial registration: PRINCIPLE is funded by UK Research and Innovation and the Department of Health and Social Care through the National Institute for Health Research.

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Background

By the 26 November 2020, over 1.6 million people in the UK had tested positive for COVID-19, and 57,896 people had died within 28 days of a positive COVID-19 test result [1]. There were 62 million cases worldwide and 1.45 million deaths [2]. At that time, there were no specific treatments for people with COVID-19 with proven effectiveness suitable for use in the community.

The Platform Randomised trial of INterventions against COVID-19 In older people (PRINCIPLE) [3] was established in March 2020 as an Urgent Public Health, UK-wide National Priority Platform to evaluate the effects of repurposed drugs for people in the community with SARS-CoV-2 infection who are at high risk of complications. The study aims to evaluate whether repurposed medicines speed recovery and reduce the need for hospitalisation and reduce deaths in people with suspected or proven COVID-19. The trial design allows trial arms to be stopped for proven effectiveness, futility or safety reasons, and for arms to be replaced or added. At inception, PRINCIPLE used traditional methods of primary care recruitment through general practices that were opened as study sites, with primary care clinicians checking eligibility and dispensing or prescribing study medications themselves.

Given the uncertain course of the pandemic, a recruitment target was not specified; however, a requirement of approximately 1500 per trial arm was identified. Between 2 April 2020 and 4 October 2020, PRINCIPLE registered 1630 people who were identified as eligible at screening. Of these, 1013 patients were randomised (or “recruited”) over those first 6 months. It was important to develop new approaches that would accelerate recruitment and produce results that would inform care more rapidly.

Recruitment into PRINCIPLE was limited by initially having to set up several hundreds of general medical practices as sites (each with a small patient pool); challenges in dispensing and getting study medications to participants;

efficiently confirming eligibility and safe prescribing in the trial; and discussing possible trial participation with potentially eligible people in a timely way. These steps added time delays to the process that resulted in many potential participants feeling either recovered or being admitted to hospital by the time eligibility was confirmed.

Pre-COVID-19, routine health care data have been used very effectively to identify and recruit eligible participants with common, non-communicable diseases to clinical trials [4–7] and observational cohort studies [8]. In the UK, a systematic review of access to routine data for clinical trials found that most Randomised Control Trials (RCTs) included in the study accessed data through NHS Digital and the most frequently accessed datasets were mortality and hospital visits [9].

With major limitations on access to general practices due to the pandemic, PRINCIPLE recruitment was expanded in July 2020 to include a centralised approach option, where participants could join the trial online or with telephone support, with online consent and central eligibility checks based on data received from participants’ primary care clinicians. Furthermore, an option was added to enable study medications and materials to be couriered to participants’ homes by the research team rather than relying on primary care clinicians.

The aim of this project was to develop an effective and trusted approach to rapidly increase the number of recruits (from a total of 1013 recruits to 3000 recruits) from the community in the UK during the autumn/winter 2020/2021 by using near-real time testing data and for the clinical study team to access NHS Summary Care Records to support safe prescribing.

Methods

Multi-disciplinary team

A multi-disciplinary team was convened by the UK National Core Studies Programmes (Therapeutics; Data

and Connectivity) to solve the technical, ethical, public perception, logistical and information governance questions required to use near-real time data to recruit clinical trial participants.

The initiative was a partnership between the PRINCIPLE investigators and coordinating centre at the University of Oxford, the UK National Core Studies Programmes (Therapeutics; Data and Connectivity), the NHS Digital Information Governance Team, the Information Commissioner’s Office, NHS Test and Trace, the NHS DigiTrials Health Data Research Hub, the Department of Health and Social Care (DHSC) and the Health Data Research UK (HDR UK) Public & Patient Involvement and Engagement Team. An overview of the key programmes and organisations involved is provided in Table 1.

Data and information governance

The project needed to determine whether it was feasible for positive test results to be received by the trial team within 24–48 h of the recipient receiving the result. Any longer would reduce the likelihood of the participant being suitable for the trial (as they may have deteriorated or be approaching recovery by then). The NHS DigiTrials team mapped the data flow and timing from the point of test receipt to the time the data was received within NHS Digital. An overview process map is shown in Fig. 1.

The test result data needed to be sent to PRINCIPLE as identifiable data so that the trial team could verify eligibility and contact eligible candidates. The eligibility criteria for the Trial were:

Anyone experiencing COVID-19 symptoms, which started within the last 14 days may be eligible to join the PRINCIPLE trial if they are aged over 65; or over 50 with an underlying health condition [10].

However, the contact details for people with a positive test supplied to the trial could not be limited to only

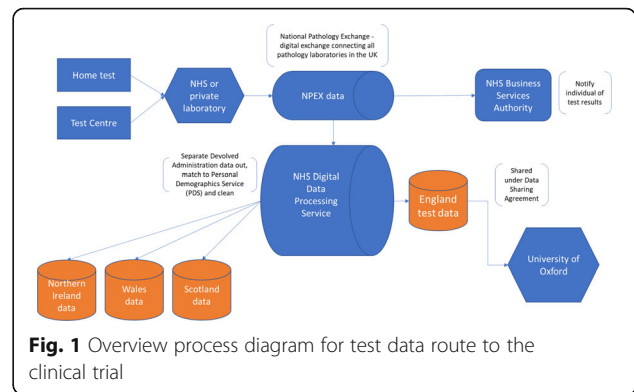


Fig. 1 Overview process diagram for test data route to the clinical trial

those who also had a specified underlying health condition as that information was not provided by NHS Digital. Therefore, the trial received details for some people who were ineligible because they were between the ages of 50 and 64 but did not have an underlying health condition. Thus, many of those contacted could not participate, even although they were symptomatic and had a positive SARS-CoV-2 test. The trial team therefore started to receive contact details for those with recent positive test who were aged 65 and over. For people in this age group, eligibility did not require an underlying co-morbidity, so more of the people contacted were eligible to participate.

During the COVID-19 pandemic, the Secretary of State for Health and Social Care issued NHS Digital with a Notice to require NHS Digital to share confidential patient information with entitled organisations (under Regulation 3(4) of the National Health Service (Control of Patient Information Regulations) 2002 (COPI)) for COVID-19 purposes.

As identifiable data was involved, this required a review of the data sharing and data protection requirements. The Information Commissioner’s Office (ICO)

Table 1 Overview of programmes and organisations involved

| Organisation / programme | Description |
|--|---|
| The National Core Studies (NCS) programme | This programme was established in 2020 and is using health data and research to inform the long-term response to COVID-19 and is accelerating progress in establishing a world-leading health data and research infrastructure for the future. |
| The Clinical Trials Therapeutics NCS | This study was established in 2020 to accelerate delivery of large scale COVID-19 trials, working in partnership with the DHSC Therapeutics Task Force. |
| The Data and Connectivity NCS | This study was established in 2020 to increase the use of data to inform decision makers and catalyse COVID-19 research. The Data and Connectivity NCS is led by HDR UK and the Office for National Statistics. |
| Health Data Research UK (HDR UK) | This institute was established to unite the UK’s health data to enable discoveries that improve people’s lives. By making health data safely available to researchers and innovators, it will be possible to more rapidly develop improved understanding of disease and approaches to prevent, treat and cure them. |
| NHS DigiTrials | This is the Health Data Research hub for data-enabled Clinical Trials and is a partnership between NHS Digital, the University of Oxford Big Data Institute, IBM and Microsoft. |
| The UK’s national COVID-19 testing programme | The UK’s national COVID-19 testing programme generates testing outcome data at an individual level. This data flows from the testing programme (Test & Trace) in England into NHS Digital. By 26 November 2020, there had been nearly 40 million virus tests conducted and over 18,000 positive cases per day recorded in the UK [1]. |

team and NHS Digital Information Governance teams were engaged to review whether the actions constituted direct marketing, whether Privacy and Electronic Communications Regulations (PECR) applied, and clarifications around privacy notices, data sharing and data controllership.

The NHS Digital Information Governance reviews concluded that in the context of a global pandemic an updated privacy notice on the DHSC and NHS Digital websites was the minimum requirement to enable re-contact of people with positive test results. Furthermore, it was important to ensure that the clinical trials team contacted potential candidates after the individual had received the positive test result.

Summary Care Record

The team also applied for access to the Summary Care Record (SCR), to ensure safe prescribing to participants who presented to the trial team. The SCR is a summary for the primary care clinical record for patients in England and includes information on repeat prescribed medication, allergies, long-term conditions, key diagnostic tests and recent consultation notes. It can be accessed remotely by authorised clinicians.

Access to the SCR enabled the team to effectively and efficiently verify the information provided by the individual and to ensure safe prescribing of trial medication. For a patient who has provided consent to join the trial and agreed for their SCR to be accessed, the data is accessed by a clinician to support safe prescribing decisions immediately prior to prescribing medications. The SCR is accessed via Role-Based Access Controls (RBAC) and a role was created for the trial to access the SCR for the duration of the trial.

The application to access SCR to support safe prescribing in the context of this clinical trial was a secondary use. For this reason, SCR access was added to the existing data sharing agreement with the trial to provide a wrapper of contractual controls. It was recognised that this arrangement is different to the existing agreed policy for SCR which has been limited to direct care purposes only. This exception was agreed recognising the high priority of the trial, the compelling reasons put forward by the trial and the very specific set of circumstances of the COVID-19 pandemic. The reasons put forward by the trial included the trial used commonly used drugs where allergies and interactions are known; the trial used common therapeutics; and the need for timely recruitment within a specific clinical pathway.

Prior to the work described in this paper, NHS Digital had not yet shared test result data with any clinical trials organisation for recruitment purposes. Use of the SCR had been limited to direct care purposes and research and clinical trials were specifically excluded. Therefore,

the information governance implications and the public and patient perceptions of doing this were unclear and untested.

Public involvement and engagement

In parallel, a survey with members of the public was developed to understand public perceptions of the proposed approach. The survey was conducted using SurveyMonkey and was publicised through existing HDR UK patient and public networks. Ninety-two patients and members of the public completed the survey.

This method enabled audience reach and allowed individual patients and the public to decide whether they would like to participate depending on their availability and interest. Given the value that direct quotes and insights from respondents can provide, respondents were asked to give consent to the anonymous use of their survey responses. Consent was given by completion of a tick-box within SurveyMonkey, and covered use both within PRINCIPLE and in other work beyond the scope of the project. Each of the issues raised through the governance and the patient and public survey was reviewed and addressed in the design of the data release and recruitment approach.

Implementation approach

The PRINCIPLE team contacted eligible candidates by phone and signposted them to the trial. The approach was tested through batches of data for people aged 50–75 years from NHS Digital to the PRINCIPLE Trial team. Once the data flows were tested, the PRINCIPLE Trial received contact data on 200 people per day aged 50 years plus with positive test results from 13 November 2020.

The majority of the 50 years plus age range did not meet the trial criteria as they did not have the required co-morbidities, so the data export age range was changed to 65–75 years on 24 November 2020.

Initially, people were contacted by phone to ask whether they would be interested in participating in the trial. From the 29 November, the method was changed slightly to also offer support to the participant through the recruitment process during the same call, to include more detail about what participation would involve as well as help in completing the screening form.

From 26 November PRINCIPLE began to receive 300 contacts a day aged 65–75 years from NHS Digital and from 4 December PRINCIPLE received 400 contacts a day.

The tested approach was rolled out with tracked measures of efficiency, effectiveness and patients were asked to provide comments on their experience of the approach.

Data were visualised using Microsoft Excel for Office 365.

Results

Data flow feasibility

Mapping the positive test result data flow from Test and Trace to NHS Digital (NHSD) showed that data could be made available to the trial team within 24–48 h of an individual receiving a positive test result.

Data and information governance

The data governance arrangements were completed within 2 weeks, including data sharing agreements and privacy notice updates. The data sharing agreements between NHS Digital and the University of Oxford were completed by 6 November 2020 enabling PRINCIPLE to receive data from NHSD from 13 November 2020. This rapid turnaround was achieved with intense support provided by HDR UK as part of the COVID-19 National Core Study Data & Connectivity programme [11]. NHS DigiTrials costs for providing this service were covered as part of the COVID-19 National Core Study Data & Connectivity programme.

Recruitment outcomes

Prior to establishing this new data service, the PRINCIPLE trial had registered up to 208 people per week. Once the new data service started, the number of people registered over the period from 16 November to 20 December increased from 3080 to 4092. The registration rate increased from up to 208 people per week to 325 people per week. Over this 5-week period, up to 87 additional people per week were registered from NHSD alone, accounting for up to 31% of the weekly registrations. The registrations by source are shown in Fig. 2.

Some registered patients are subsequently identified as not eligible and are not randomised for recruitment. The number of people recruited to PRINCIPLE increased from 1521 at the start of November to 2802 by 20 December. The recruitment numbers are shown in Table 2.

Table 3 shows the recruitment call outcomes for people contacted using the NHSD test data. 731 people were contacted between 13 November and 24 November 2020, prior to starting the enrolment support. Four people were recruited (0.5%). The majority did not answer their phone (297) and this would line up with some of the responses received in the patient and public survey which suggest “I would certainly be very cautious of a telephone call that did not show the caller number or did not have a regular number.” As one respondent

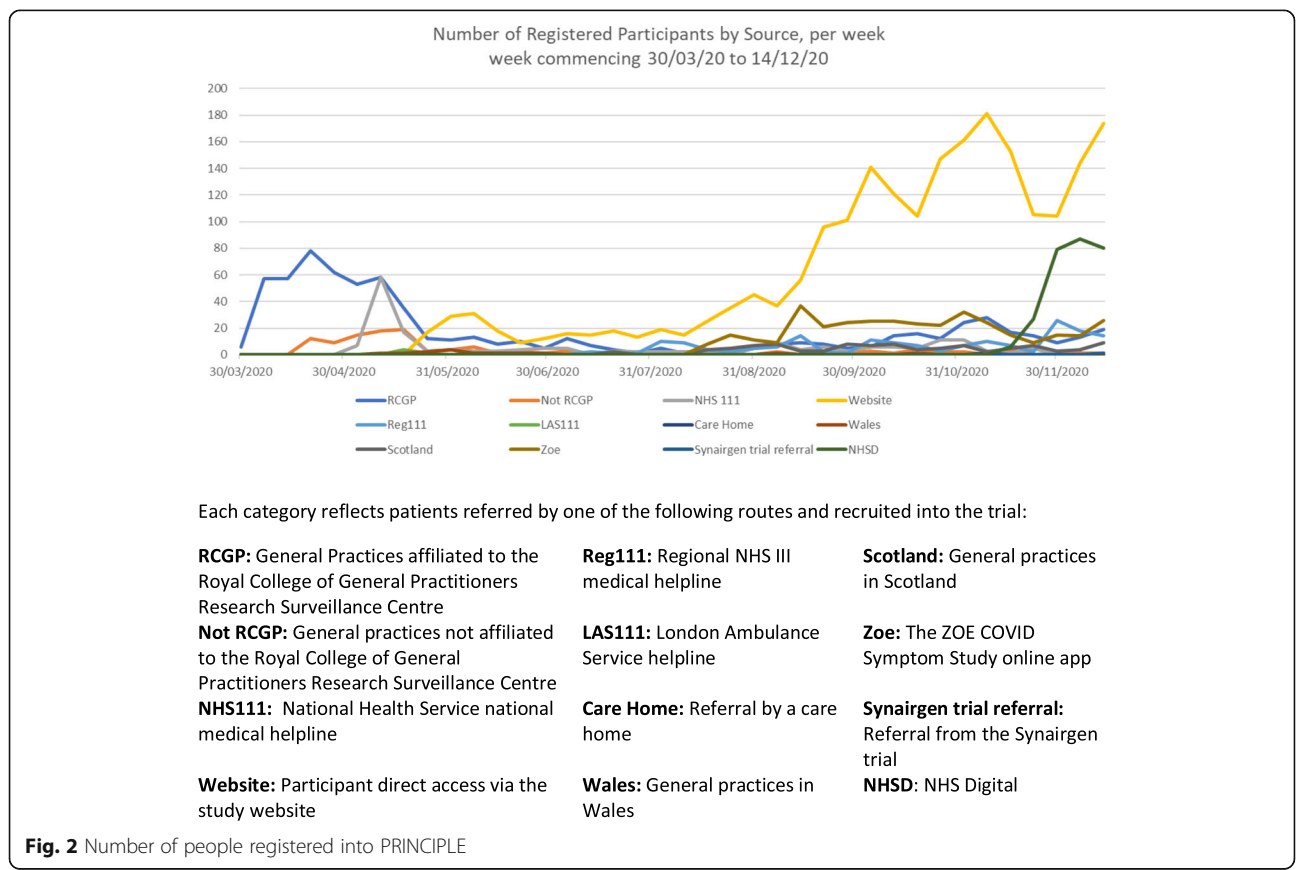


Table 2 Recruitment into PRINCIPLE, number of people

| Date | Total recruitment into PRINCIPLE |
|------------------|----------------------------------|
| 1 October 2020 | 1013 |
| 1 November 2020 | 1521 |
| 1 December 2020 | 2274 |
| 20 December 2020 | 2802 |

suggests “there are too many phone scams going on at the moment so either the phone would not be answered as it is from an unknown number or there would be a lot of trust issues”. Additionally, 123 people requested for information to be emailed to them—responses from the survey indicated this would be to allow people the time to make an informed decision and to feel more comfortable that it is a genuine request as some respondents indicated they would be happy with a phone call “provided it was backed up by an email with background info and someone I could ask questions of after reading the info”.

1908 people were contacted between 25 November and 4 December 2020 and received the enrolment support. Eighty-seven people were recruited (4.6%).

In total, 2639 people were contacted between 13 November and 4 December 2020 using the NHSD test data. Ninety-one people were recruited over the phone and a further 326 requested to receive trial information via email. GPs were then contacted for each individual deciding to participate to verify whether they would be suitable.

Public and patient involvement and engagement

Through established patient and public panels and networks at HDR UK, 92 people provided responses to the patient and public survey within 5 days. This was conducted in advance of establishing the service to

understand what people think they and others would feel about this approach.

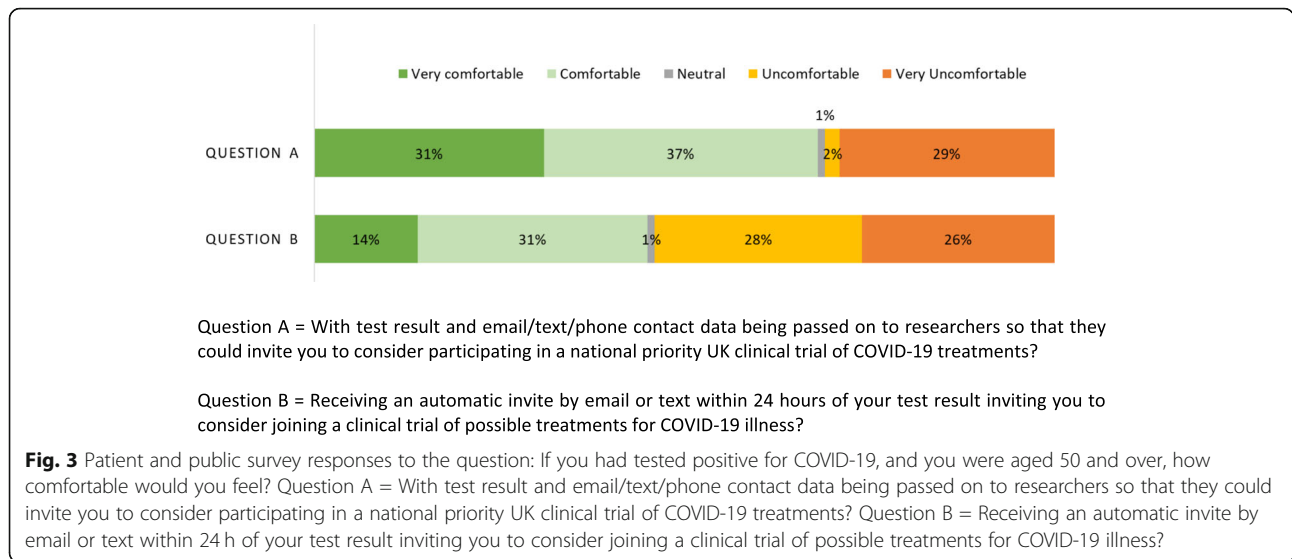
Ninety-seven percent of survey respondents believed the proposed approach would be an ethical use of data and believe “the principle of using the data in this way is certainly acceptable I think, especially considering the scale of the pandemic and the urgency of handling data in this scenario”. Provided all concerns were addressed, respondents were comfortable with receiving the message from the Oxford University team running the clinical trial or NHS as they were seen as trusted voices—“if it were from a non-NHS source, I would want to see sort of official statement from the NHS saying they endorsed it”.

Figure 3 shows that 68% of people would be comfortable or very comfortable with a test result and email/text/phone contact data being passed on to researchers so that they could be invited to consider participating in a national priority UK clinical trial of treatments for COVID-19. Concerns raised were around the fact that “people do not like their details being passed onto third parties without their permission.” These findings were used to improve information provided during the phone call to potential participants to address fears around how the data was obtained and used.

Only 45% of respondents were comfortable or very comfortable with receiving an automatic invite by email or text within 24 h of test result inviting them to consider joining a clinical trial of possible treatments for COVID-19 illness, whereas 54% were uncomfortable or very uncomfortable. Reasons behind the unease of receiving an automatic email related to losing the personal engagement and concern that automation would remove “consideration that these patients and their families maybe stressed and upset”. However, some respondents did believe that an automatic email invite could address concerns around sharing of data as an “automated email

Table 3 Call outcomes (for people identified via the NHSD test data). After 24 November, age range of contacts changed from 50+ to 65–75 years

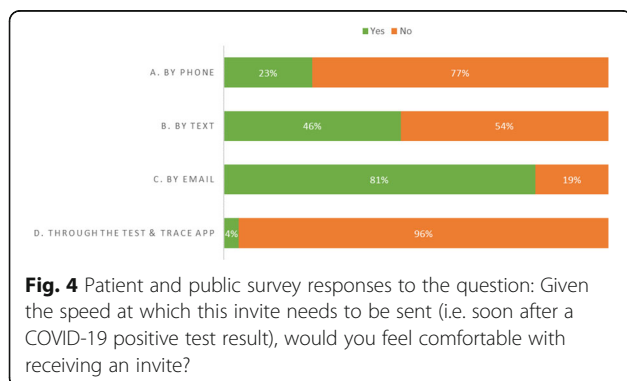
| Call outcomes | 13–24 Nov No. of calls | | 25 Nov–4 Dec No. of calls | | Total No. of calls | |
|---|------------------------|--------|---------------------------|--------|--------------------|--------|
| | n | % | n | % | n | % |
| Interested, information sent | 123 | 16.8% | 203 | 10.6% | 326 | 12.4% |
| Enrolled over the phone | 4 | 0.5% | 87 | 4.6% | 91 | 3.4% |
| Not eligible | 116 | 15.9% | 413 | 21.6% | 529 | 20.0% |
| No answer, left message | 297 | 40.6% | 592 | 31.0% | 889 | 33.7% |
| No answer, unable to leave message | 32 | 4.4% | 147 | 7.7% | 179 | 6.8% |
| Not interested or not wish to take part | 152 | 20.8% | 363 | 19.0% | 515 | 19.5% |
| Hung up, did not wish to be contacted | 0 | 0.0% | 38 | 2.0% | 38 | 1.4% |
| No—other reasons | 7 | 1.0% | 65 | 3.4% | 72 | 2.7% |
| Total | 731 | 100.0% | 1908 | 100.0% | 2639 | 100.0% |



can be explained easier and means that you are hopefully not passing patient information on”.

Figure 4 shows that respondents would be most comfortable with receiving the invitation by email (81% were comfortable) and less comfortable with phone (23% were comfortable) or text (46% were comfortable). They would be least comfortable with receiving the invitation via the NHS Test and Trace app [12] with survey respondents sharing a lack of trust and reliability around the use of the app “a lot of issues with the app are coming up in the various PPI groups and networks I have but also stories in the media. The public don’t trust the app so could then not trust you if that’s how you communicate”.

The sequence of actions was important to responders and shared they “understand speed is of the essence but you need to be a human first”, as they felt that the individual needed to receive their test result and / or “confirm they have test result, ensure they have information/guidance/support needed” before being invited to participate in a clinical trial.



The trial team decided to use phone calls to contact the participants based on their own personal experiences in other primary care trials where texts/emails had yielded fewer recruits than phone calls or face to face trial discussion, and because sending texts or emails to potential participants removed the real-time engagement between study team member and the participant.

Whilst a larger majority of respondents from the patient and public survey were less positive over receiving a phone call, e.g. due to concerns around potential phone scams, the survey results did share some ideas on how to overcome this issue. For example, one respondent shared “I would certainly be very cautious of a telephone call that did not show the caller number or did not have a regular number. They would have to give me some unique information about myself that would only be known to a genuine caller”. The trial team took into account the concerns raised through the patient and public survey about telephone contact and crafted a script to specifically address each of the issues.

The full set of survey responses, including free text comments, is provided in Box 1.

As well as providing insights on public perceptions, the patient and public survey also demonstrated an efficient process to rapidly inform the team’s understanding and test an approach with members of the public through the HDR UK Patient and Public Networks.

Patient experience

Patient experience was recorded for all people contacted and this showed that 38 people out of the 2639 (1.4%) hung up whilst the trial was being explained (Table 3). Furthermore, none of the people contacted raised concerns about being approached following a positive test result. Those who were called could raise concerns

during the phone call itself at any point, including the start of the call where the reason behind the call was explained. Additionally, potential participants were provided contact details for the trial and were able to raise concerns with the trial team outside of the phone call.

Eligibility processes

Access to the SCR was received on 3 December 2020 and became fully operational on 8 December 2020. Prior to using the SCR, it was taking the trial team from 1 to 10 days to confirm participant eligibility by securing the necessary participant data from the participant's GP. This time was predominantly associated with efforts to contact busy GP surgeries.

Use of the SCR enabled the process of confirming participant eligibility by the trial team to be more efficient—requiring less input from participant GPs, reducing the number of study recruiters required in the trial team, hence making it a more efficient process. SCR access led to safe prescribing checks reducing from 1 to 10 days per participant down to 30 min per participant. This reduction in time from screen to confirming eligibility was critical given the urgency of recruiting people soon after diagnosis.

Discussion

Recruitment in distributed settings

By November 2020 there were approximately 200,000 people hospitalised with COVID-19, whereas more than 1.3 million people with COVID-19 remained in community settings in the UK. However, despite there being many more people with COVID-19 in primary rather than secondary settings, recruitment to secondary care clinical trials was significantly higher compared to those in primary care. As a comparison on 28 November 2020 RECOVERY (Randomised Evaluation of COVID-19 Therapy), the national clinical trial to identify treatments that may have been beneficial for people hospitalised with suspected or confirmed COVID-19, had recruited 19,000 participants, approximately 10% of all patients hospitalised with COVID-19. Whereas PRINCIPLE had recruited 2224 participants, approximately 0.15% of all patients diagnosed in the community (however, not all patients with a positive test in the community is at risk of getting complications or within the PRINCIPLE criteria age range).

This paper describes an approach for identifying potentially eligible participants for RCTs, within 24 h of receiving a positive SARS-CoV-2 test result, that achieved important numbers of additional recruits to PRINCIPLE. This approach overcame some of the challenges of clinical trial recruitment in distributed settings.

Recruiting to the national priority community COVID-19 trial using the additional mechanisms of

study team access to test data and SCR data was associated with increased recruitment of people with positive COVID-19 test results in the community setting. The registration rate increased from up to 208 people per week to 325 people per week, with up to 87 people per week from the NHSD test result route, accounting for up to 31% of registrations per week. Over the period of this project, the key changes were the access to the NHSD data and access to the SCR. Other process and protocols remained unchanged.

Patient experience of recruitment

The approach also adds to the collective evidence of patient experience of recruitment using routine healthcare data—an approach being developed by the NHS Digital Trials health data research hub. The patient and public survey and patient experience measures informed the information governance process and sequence of contacting people. Although the patient and public survey, which was conducted prior to establishing the service, indicated that 31% of people would be uncomfortable or very uncomfortable about results being passed onto researchers for this purpose, there were no concerns raised by any of the 2639 people contacted during the actual service. The effectiveness and efficiency of patient and public involvement and engagement through organised groups such as the HDR UK Patient and Public Network contributed to this outcome, and this approach can be built on and developed further to better inform future clinical trials.

Use of the Summary Care Record

Trial clinical team access to the SCR enhances efficiency and safe prescribing. However, the SCR service, prior to this trial, had been limited to direct care only with research purposes specifically excluded. The trial needed to demonstrate a clear and compelling use case for accessing this data in the current pandemic which was considered on its merits including input from an independent panel of experts. Access was allowed under the pandemic COPI powers as secondary use. The SCR webpages were updated to ensure transparency in relation to the access granted.

Further work is required to evaluate which aspects can be replicated for recruitment into clinical trials for other primary care treatments. This work was conducted with English test and with SCR data, further work is also required to extend this approach across all four UK nations.

Wider impacts

Faster identification of people eligible for the PRINCIPLE trial means that more people have the opportunity to contribute to trials of potential treatments

that may reduce deterioration and the need for secondary care treatment. Increased recruitment will also allow more interventions to be evaluated in the trial, with shorter time to results.

The trial only received contact details from NHS Digital for people with a recent positive test who were aged 65 or over, because some people between the ages of 50 and 64 were ineligible if they did not have an underlying health condition. This is a potential limitation of this recruitment route as the patient population received from NHS Digital was skewed toward the higher age range. However, there would have been different skews in other recruitment routes, for example with the Zoe Symptom tracker. This suggests that the study was strengthened by adding to the broad diversity of recruitment sources set out in Fig. 2.

Central recruitment with remote eligibility and courier of study drugs direct to patients' homes allows people from the whole country to be eligible for the trial. Until PRINCIPLE was able to reach out to people in this way, participation in many community trials was limited to those who attended for health care at participating practices. The mechanisms pioneered in this project and that are described in this paper means that research participation could be widened for other urgent public health type trials.

Conclusion

We proposed and then demonstrated a new way of enhancing early recruitment to a clinical trial in a community setting, via access to SARS-CoV-2 test result data and the use of SCR data to ensure efficient and safe prescribing. Potential treatments could therefore be initiated earlier in suitable patients who consented also the recruitment approach could shorten the time to trial results. Furthermore, despite highly effective vaccines, there will be many people who continue to require effective treatments for COVID-19. Therefore, the faster effective treatments can be found, affected people may be able to recover quickly and be hospitalised less often. This novel and efficient approach to an acute condition trial may be an important new methodology for acute incident studies in primary care, which are traditionally more difficult to recruit to than trials in long term conditions.

Abbreviations

COP: Control of Patient Information Regulations; COVID-19: 2019 novel coronavirus; DHSC: Department for Health and Social Care; GP: General Practitioner; HDR UK: Health Data Research UK; ICO: Information Commissioner's Office; LAS: London Ambulance Service; NCS: National Core Study; NHS: National Health Service; NHS 111: NHS urgent medical help service; NHSD: NHS Digital; PECR: Privacy and Electronic Communications Regulations; PRINCIPLE: Platform Randomised Control Trial of Interventions against COVID-19 in older people; RCGP: Royal College of General Practitioners; RCT: Randomised Control Trial; RECOVERY: Randomised Evaluation of COVID-19 Therapy; SCR: Summary Care Record

Supplementary information

The online version contains supplementary material available at <https://doi.org/10.1186/s13063-021-05965-4>.

Additional file 1. Box 1. Patient and Public Perception Survey Responses

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Authors' contributions

SM analysed and interpreted the public survey data. EO analysed and interpreted the recruitment data. CC formed and coordinated the multi-disciplinary study team and was a major contributor in writing the manuscript. All authors read and approved the final manuscript.

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Availability of data and materials

All data generated or analysed during this study are included in this published article

Declarations

Ethics approval and consent to participate

Ethical approval granted by the South Central - Berkshire Research Ethics Committee.

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All participants must provide informed consent prior to enrolment in the trial.

Consent for publication

Not applicable

Competing interests

CCB and FDRH are the co-PIs for PRINCIPLE; CC, DS, SM and AM are employees of Health Data Research UK.

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