

newsletter

Welcome to the Winter 2011-12
edition of the INVOLVE newsletter,
which begins with a few words
from our Chair.

Not if, but when



By **Simon Denegri**,
Chair of INVOLVE

'If you can keep your
head when all about
you are losing theirs...'

So opens Kipling's
poem 'If' as I am sure
you know. Apt words for
our times I would say.

Health and social care is going through a period
of unprecedented reform. The challenges
are immense. These are testing times even
for those of us who have grown a strong
constitution in the face of constant change.

But this is also a time of great opportunity and
for public involvement in particular.

The Government's commitment to health
research funding and the new onus on the
NHS and other providers

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to live up to their responsibilities in research potentially gives us a better than ever foundation for our work. Whether we seize this opportunity is down to us.

With your help INVOLVE is now very close to finalising its strategy for 2012-15.

The message from you has been clear:

‘Be ambitious, push on, just go for it.’

Moreover, not to make complex that which is actually very simple: ‘Putting people first in research.’

But the real difference, the real change, will be made on the ground by you and our colleagues in public involvement. The community is vibrant, energetic and creative. It also has huge stamina. Our task at INVOLVE and with our partners is to harness this into a movement that is single-minded and clear about what we want to achieve.

I prefer to talk about ‘when’ not ‘if’.
Do you agree?

INVOLVE Coordinating Centre news

INVOLVE 2012 conference: call for presentations now open

The eighth biennial INVOLVE conference is being held at the East Midlands Conference Centre, Nottingham, on 13 and 14 November 2012. The conference will bring together members of the public, service users, researchers, research commissioners and representatives of voluntary sector organisations, who share a common interest in public involvement in NHS, public health and social care research.

The conference call for presentations is now open. We are inviting presentations on public involvement in health and social care research that will encourage critical thinking and discussion on the following:

- how people are involved in research

- learning and support
- researching impact
- future directions.

Presentations may take the form of posters, workshops, papers, film, sound recordings, performances and other approaches, as well as speed sessions.

For further information and to complete the call for presentations application form, visit www.profbriefings.co.uk/involve2012

Closing date for applying to do a presentation: Monday 26 March 2012

INVOLVE membership update

Following three selection days in January, we have now successfully appointed our new members and will be adding their details to our website shortly. We were overwhelmed by the high standard of applications and look forward to working with the new members in the coming months.

New INVOLVE strategic plan

Our strategic plan for 2012-15: Putting people first in research will be published shortly. Our strategy sets out the overall direction for our work over the next few years. This will inform the development of our annual priorities as well as the way we work with our partners in the interest of research for public benefit. The plan outlines our vision together with four broad strategic objectives. To:

- lead on public involvement across the National Institute for Health Research
- build and share the evidence base
- develop capacity and capability for public involvement in research
- influence research policy and practice.

We developed the plan following discussion with INVOLVE members, a consultation through our website and networks, and meetings with various stakeholders. Thank you to everyone who participated in the consultation.

INVOLVE website

We have received very positive feedback on our new website and are busy adding further resources to the site. Recent additions include electronic versions of our publications and our 2012 conference pages. Please continue to send us your comments on the site by completing the feedback form www.invo.org.uk/about-involve/keep-in-touch/feedback-form/

Interesting articles and publications

Here are details of three new books focusing on user involvement.

Critical perspectives on user involvement

Edited by Marian Barnes and Phil Cotterell
Published 2012, The Policy Press
ISBN 9781847427502

Drawing on contributions from service users and academic researchers, this book looks at the history and current state of user involvement in health and social care. It considers user movements / groups, and user involvement in services and research. The collection is aimed at students studying health and social care and social work, researchers developing participative research practice, and service users.

Handbook of user involvement in nursing and healthcare research

Elizabeth Morrow, Annette Boaz, Sally Brearley and Fiona Mary Ross
Published 2011, John Wiley and Sons Ltd
ISBN: 9781444334722

This book provides practical advice on service user involvement in nursing and healthcare research. Aimed at anyone working or involved in nursing and healthcare research, it provides a step-by-step guide to the principles and process of involvement, including understanding

the rationale for involvement, designing involvement, working with service users, and evaluating what has been achieved.

Testing treatments: better research for better healthcare (second edition)

Imogen Evans, Hazel Thornton, Iain Chambers and Paul Glasziou
Published 2011, Pinter & Martin Ltd
ISBN 9781905177486

www.testingtreatments.org/new-edition/

Aimed at patients and professionals, Testing treatments presents an argument for better, more reliable, more relevant research, with unbiased or ‘fair’ trials, and explains how patients can work with doctors to achieve this goal. This new edition incorporates some extensive revision and updating.

If you have written or know of any articles or publications relevant to public involvement in research that might be of interest to readers, please contact Helen Hayes at the Coordinating Centre with details:
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Payment for involvement

By Lucy Simons,
INVOLVE Coordinating Centre

Welfare benefit barriers

If you have been grappling with the complexities of receiving or offering payment for involvement in research and how this affects welfare benefits, we hope good news is in store. Baroness Thomas of Winchester, a strong advocate for involvement and easing the welfare benefit barriers that may discourage people contributing, has been looking at the introduction **Continued >>**

of Universal Credit (as proposed in the Welfare Reform Bill). Those of you familiar with the situation will know that legislation in 2009 removed some benefit barriers to involvement, but only where there is a statutory duty to involve the public and service users. The barriers remain in place for involvement in research where there is no statutory duty to involve.

Baroness Thomas submitted an amendment about this to a debate on Universal Credit in the House of Lords on 3 November 2011. The full debate is published in Hansard www.publications.parliament.uk/pa/ld201011/ldhansrd/text/111103-gc0001.htm#11110384000041 (column GC483). This led to the Minister for Welfare Reform, Lord Freud, meeting Baroness Thomas to explore possible solutions to this situation. At the meeting, it was agreed that it is important to avoid situations where benefit claimants might be discouraged from involvement in the field of NHS, public health and social care research because of concerns about the impact on their benefit entitlement. This was followed by commitments to ensure the regulations for Universal Credit would be designed to remove the barriers identified in Baroness Thomas' speech.

We are hugely grateful to Baroness Thomas for pursuing this issue over many years. We hope that the gains she achieved at the end of last year will be followed through with the planned introduction of Universal Credit in 2013.

In the meantime we need to be mindful of these benefit barriers and make sure they are accounted for when setting up systems to pay people when they get actively involved with research.

Mental Health Research Network revised model payment policy for service users and carers

Thomas Kabir, Service Users in Research Coordinator at the National Institute for Health Research (NIHR) Mental Health Research Network (MHRN) in collaboration with Judy

Scott, independent consultant in involvement and benefits, has updated and revised the MHRN model payment policy. Across the MHRN, some regional hubs are hosted by universities and some by NHS Trusts. So Thomas and Judy have developed a model policy for each type of host. The principles of both policies remain consistent but each regional hub of the network can adapt the model policies to the particular procedures relevant to their host organisation.

Thomas and Judy have also produced supporting documents which set out in detail the different conditions for a range of welfare benefits and tips on how best to offer payment and reimburse expenses for people getting involved while receiving benefits. These documents are available through the publications page of the MHRN website www.mhrn.info/pages/publications.html

A patient safety study: reflections

By Sharin Goodchild and Dave Green

Context

Patient safety is a matter of international concern. All healthcare professionals work hard to protect patients from harm, however accidents and mistakes still occur.

The programme of research we are involved in, under the auspices of the Yorkshire Quality and Safety Research (YQSR) Group, focuses on involving patients in aspects of their own safety. There has been little work done in this area that has included patients and healthcare professionals in the development of initiatives to support a patient role in improving patient safety, so this is ground-breaking research.

How the study is set up

The study is divided into four projects:

- **Project one** will develop a patient measure of organisational safety allowing patients to record safety concerns.

■ **Project two** is developing a patient-led safety reporting tool.

■ **Project three** is developing interventions to support patients working collaboratively with healthcare professionals to improve safety and reduce the risk of harm.

■ **Project four** will evaluate a patient-based training programme using patient stories to improve awareness among healthcare professionals.

Organisation and issues

The programme has embedded a patient panel into its overall steering process. This is made up of eight panel members and two co-chairs. Two patient panel members are attached to each of the four projects, with six in the Bradford / Leeds area and two in the Newcastle / Sunderland area. Our own work involves the Newcastle contribution to the research project under Professor Richard Thomson of the Institute of Health and Society, Newcastle University.

The geographical spread of the programme has presented problems in communication. A newsletter and a website have gone some way towards resolving this, although we miss the frequent social contact where, in our experience, sandwiches and copious amounts of caffeine can solve most problems.

In Newcastle, the potential for misunderstanding over roles and status was an issue. We were not part of the initial planning and were unsure of our roles so we would like to have been involved earlier.

Reflections

We bring to the project our experience in industry and the public sector as well as an interest in research and our work as hospital volunteers. This was our first research project and the learning curve on both sides was steep. The entry into a new world of methodology and terminology necessitated having to think oneself into the 'research mindset', which presented a real challenge.

We all brought different skill and experience sets to the project. The influence of a cross section

of people with diverse views leads to robust research, although it is necessary at times to detach oneself from personal experience to see the bigger picture. This requires subtle negotiations, carried out with respect and humour, to ensure that skills and experiences are identified and absorbed into the team. These negotiations are the 'make or break' point for any research team. The most effective team has a mixture of skills and experience and works together to further the objectives of the study. There is a fine balance between tokenism and real patient participation. At Newcastle we feel we got this balance right.

Where we are now

We wrote earlier of thinking oneself into the 'research mindset'. In fact this is no different from the qualities needed to participate in any new enterprise. Our involvement in recruiting patients for the study, analysing focus group scripts, attending conferences and engaging in extensive background reading emphasises the need for professionalism, discipline and commitment and, oh yes, a sense of humour. For us, participation has opened up new horizons. We've been invited on several occasions to give presentations on our experiences and we are exploring our own project, which will feed back into the main study. This will include putting our experiences and the lessons learned into user-friendly terms. We are now aware of the vital role patient-participants play in research and the enormity of the task involved in making partnerships work well. We've come a long way from those very uncertain, tentative beginnings.

www.ncl.ac.uk/ihs/research/project/3852

www.bradfordresearch.nhs.uk/our-research/patient-safety/research-projects-1/

Sharin Goodchild and Dave Green are Patient and Public Involvement (PPI) panel members at the Institute of Health and Society, Newcastle University

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Bridging the gap

By Carol Rhodes

There are numerous articles about patient involvement in research. Does it have an impact on the quality of the research? The jury is still out on this question. INVOLVE's Exploring Impact report found that there were limitations and gaps in the evidence base. Yet some strong and consistent themes emerged from the review, including that public involvement was most frequently reported to benefit the people involved as well as the research participants. I would certainly support this view.

I am a research patient support worker and my role is to bridge the gap between researchers and patients. Is there a gap? Definitely. Researchers, having studied research methods in depth, who are passionately involved in the minutia of their projects (talking the language of academia), who are interested in publishing papers and producing posters for conferences, have to work with Joe Public.

Patients come from different backgrounds, some with little education, others highly educated, both young and old. Some are typical 50-plus white middle class women, but not all. There is a diverse group of people of different educational, ethnic and cultural backgrounds, all linked by the stories they have to tell and the expertise they have gained through their own personal journey of a life changed by illness. They are not interested in dissemination in a publication they will never read, but they are interested in the patient benefit the research may produce.

Then there are the clinicians involved in the trials – doctors and consultants in a privileged position of having gained qualifications in the anatomy and workings of the human body. How can Joe Public add to the knowledge they have gained over many years of hard work and study?



Research user group members

Yes, there is a gap, sometimes a large one, but here at Keele Primary Care Centre, over the last few years all involved have attempted to bridge that gap. Researchers, patients and clinicians have learned from each other to develop a successful research user group. This has taken a lot of hard work and patience from all involved. Problems have been identified and lessons learnt. Patients bring a fresh approach to research projects. Their lack of clinical and research knowledge – their naivety – actually helps the researchers to produce paperwork, such as invitation letters and project summaries, that will easily be understood by the participants of a trial.

There is a line of thought that we should not professionalise patients, but a lone patient, on a steering group for a project or attending a conference as the patient representative, feels that gap greatly and this is where the support is needed. In order to make a worthwhile contribution to the meeting and not be undermined by the presence of professionals, patients need knowledge. They need a glossary explaining research terms in plain English with acronyms explained in full – researchers love their acronyms, patients hate them! They also need a lay summary of the main aims and objectives of the project, not a five-page proposal in research jargon. This is not as easy as it seems. It can take researchers three or four attempts to produce a one-page summary of their project in lay terms.

I love the way this role has increased my vocabulary as a layperson and my understanding of the research process.

My life was changed by illness and my career path altered. Long-term illness can be a negative experience but many patients try to find something positive to take from it. They want to share their experience to help others. Getting involved in research does this – so many of our patient group involved in research on musculoskeletal conditions adopt the phrase: 'Anything I can do to help others, to stop them having to suffer the pain I have.'

Patients always want to see a real patient benefit. I have learned from my involvement with the many research projects conducted here that there isn't always a patient benefit – some projects have no distinguishable results. However, others do and this is where patients' enthusiasm can drive a project and play a large part in disseminating the results, in order to try to get them used in clinical practice. Patients dislike tokenism, they require feedback on the projects, regular updates on how their input has been used, and an explanation of how long a project can take to its completion – sometimes a period of three to five years, much longer than patients anticipate.

This all requires time – my time. Meetings with patients take time to arrange. Patients need refreshment breaks to stretch their aching joints. They also need reserved parking spaces and permits, information on the project to read in advance and meetings at times to suit their needs, not ours. Involving patients can be messy. They may veer the conversation away from the purpose of the meeting or criticise things that cannot be changed, such as validated survey questions, but conversely they can come up with questions for research that only someone who has suffered the condition would think of.

I love my job and I do think patients have a positive impact on the research projects they are involved in. It is not just the research that benefits, but researchers, clinicians, and patients benefit by working together and sharing their individual areas of expertise. We can all learn from each other. Then the results

of the research influenced by patients will benefit patients – a result that everyone can be proud of.

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Patient involvement in combating sight problems

By Karen Bonstein, Ananth Viswanathan and Narciss Okhravi

When discussing the burden of chronic diseases, we often refer to cardiovascular disease, diabetes, chronic respiratory disease, cancer and mental health (Richards 2011) and the impact of eye disease is easily overlooked. However, visual impairment and blindness have wide implications for individuals and families, as well as the UK economy and the NHS as a whole. A report produced by the US National Eye Institute (1998) noted that for older adults 'visual problems have a negative impact on quality of life equivalent to that of life-threatening conditions such as heart disease and cancer'. The Guide Dogs' Cost of Blindness report (2003) illustrated that in England, the annual costs for individuals registered as blind or partially sighted in 2002 ranged from £1.4 to £2.9 billion. The true cost may be four times higher if the assumption is true that only a quarter of visually impaired people are actually registered (www.healthyeyes.org.uk/index.php?id=25).

Globally much effort has recently gone into making the voices of patients heard and involving them in the design of research projects that will answer questions that are important to them. At Moorfields **Continued >>**

Eye Hospital NHS Foundation Trust, building on an active Patient Experience Committee, we engaged with specific patient groups to set up Patient Days focusing on clinical care, research and education. We held two events recently: one for a rare eye disease, Birdshot Uveitis, the other for a common eye disease, Glaucoma. Both diseases are currently incurable, and can often worsen during a patient's lifetime.

What happened at our Patient Days?

The Birdshot Patient Day

The first UK Birdshot Day (involving 126 patients, supporters and healthcare professionals) was set up by a team of staff from four hospitals in the UK and Paris and the Birdshot Uveitis Society (BUS) www.birdshot.org.uk. In consultation with patients, we developed five aims for the event, which were all achieved:

1. to reduce the sense of isolation of patients with this rare disease
2. to raise the profile of the disease in the UK
3. to allow a two-way exchange of information between patients and professionals
4. to help to obtain a better visual outcome for patients
5. to provide a base for research.

The Glaucoma Patient Day

This event, with 296 delegates, focused on clinical care, research and education for patients, carers, students and healthcare professionals. Glaucoma patient advocates formed part of the organising committee. Despite the disease being common, just under half the patients had never met anyone else with glaucoma. We captured patients' stories on video and have since used these for educational purposes.

What happened after the events?

Patients spoke of 'a new sense of hope for the future'.

A five-minute DVD about the Birdshot event was prepared for the Birdshot Uveitis Society and the National Institute for Health Research Biomedical Research Centre for Ophthalmology and can be viewed at www.brcophthalmology.org/Events/BirdshotDay2010.aspx. A DVD of the entire day was sent to all patient participants and healthcare professionals involved in the care of Birdshot patients.

The Birdshot National Research Network (involving patients and healthcare professionals) has been created through the Birdshot Uveitis Society and research is now planned, including a Birdshot Biobank, to improve our approaches to this rare disease.

The Glaucoma event led to 105 patients formally registering an interest in being involved in research design, conduct and dissemination. This invaluable community is already being used by the Moorfields Glaucoma Service to develop new research.

Our work has had national and international impact having been presented at conferences worldwide. The importance and impact of patient involvement in research has become very apparent, leading to new partnerships between clinicians and patients for other eye diseases and for systemic diseases. Our work has also been presented at parliamentary level – both in London and Brussels.

Importantly we have learnt that issues which were concerning clinicians are not always of concern to patients. We now understand that 'unless you ask, you don't actually know'.

Article references available on request.

About the authors

Karen Bonstein is Manager of the National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) for Ophthalmology. Narciss Okhravi and Ananth Viswanathan are Consultant Surgeons at the NIHR BRC for Ophthalmology and were

the Clinical Leads on the Birdshot Patient Day and Glaucoma Patient Day respectively.

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Participants at the first Birdshot Patient Day, September 2010

Making sense of study steering groups: the Approach study

By **John Willmott**

About the project

Approach was a three-year National Institute for Health Research Service Delivery and Organisation (NIHR SDO) funded study on integrated working between care homes for older people and primary care professionals, which has recently been completed. The study was complex in that it had two phases each with two components: in phase one, a systematic review of the research literature and a national care home survey; and in phase two, six care home case studies and a validation meeting to discuss the findings.

How and why I became involved in the project

The University of Hertfordshire Public Involvement in Research (PIR) Group was contacted to see if they knew of anyone who would be interested in taking part in the study. I volunteered as my wife had been in several

different homes for respite care over many years and I felt that my experience with this would be helpful to the study.

My role in the project

Public representation was an integral part of the project at the case study phase and also within the study steering group which met twice a year. I was the University of Hertfordshire PIR Group public representative on the steering group. As a member of the study steering committee, I gave my views as a carer and member of the public on aspects of the study that required public input, for example I gave feedback on summaries of the emerging findings from the systematic review and the survey. I was asked for my opinion on a proposed change to the data collection. I also attended the validation event at which the study findings were fed back to care home experts so that recommendations for the future health care of care home residents could be made to commissioners.

The difference public involvement made to the project

In the care home case studies phase, the study team felt that it might be more appropriate to interview relatives individually rather than in a focus group, as had been planned in the original proposal. The committee was asked to give its opinion on this, and I was happy to agree to this change as I felt it was a much more sensitive approach. This change was subsequently approved by the ethics committee. From my observations of the group, I am confident that the other members saw the benefit of having a lay member on board. They respected my contributions, I had an impact on changing some of the views in the group and I did not feel that my presence as a public representative was tokenistic.

Challenges and difficulties

Researchers took it for granted that all those sitting on steering groups are **Continued >>**

familiar with the role of committees, the way the project operates, who is involved, and how communication is maintained. I commented: “Different people seem to come and go to meetings.” I suggested an organisational chart be devised to describe the structure of the Approach study to include the different management groups, who was involved and how they knitted together. This chart was a valuable tool for me and is now being used in another study on Falls in which I am involved, and would be of value, I am sure, in other studies.

Terminology was also problematic: for example, the word ‘steering’ did not explain the function of the group and eventually I realised it meant ‘advisory’. A big difference in my book! The steering group has now become more aware of the importance of using less jargon when including public representatives and will incorporate this into any future studies.

Advice to others

My advice for researchers is that they should always have in mind the need to use everyday language and be aware of the dreaded acronym.

And for members of the public, if you get the opportunity to contribute to research I would say: “Go for it.” I learned that being prepared to listen at the beginning is preferable to thinking that you can influence everyone immediately. Find your feet, but don’t be afraid to challenge and do it well!

For further information on the Approach study please contact:

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Improving musculoskeletal research in North Bristol through public participation

By **Rachael Goberman-Hill and Amanda Burston**

The need for research in musculoskeletal conditions

Musculoskeletal (muscle and bone) conditions affect millions of people in the UK. They are often very painful and have a great impact on people’s lives. It is crucial that the research community works to understand the best ways to provide healthcare for people with these conditions. At the Musculoskeletal Research Unit at the University of Bristol, we are doing research into the best way of treating musculoskeletal conditions such as osteoarthritis and osteoporosis. Public involvement is helping us to shape this research.

Public involvement in musculoskeletal research

Since July 2010, a group of 11 members of the public has met with researchers every six to eight weeks to discuss research ideas and projects. This group is called PEP-R: the Patient Experience Partnership in Research. Group members bring with them knowledge and experience of living with musculoskeletal conditions.

What does PEP-R do?

A PEP-R session lasts for two hours in the evening. A session usually involves discussion of two projects or ideas, but may include more. Researchers come along to discuss ideas with the group, ranging from very early-stage thoughts about topic areas to projects that are already underway. The group has also had the chance to suggest its own ideas for future research.

Since starting 18 months ago, PEP-R has discussed over 20 projects and ideas including the following:

- An early-stage topic idea was long-term pain after joint surgery. PEP-R identified priority areas for research into improving this pain and researchers are now developing a proposal for a programme of research based on these priorities.
- An example of PEP-R involvement in a project that is already underway is the group’s work with the National Institute for Health Research (NIHR) funded Research Studies into the Orthopaedic Experience (RESTORE) research programme. Working with researchers, PEP-R has provided input into patient information materials, the design of interventions and questions to ask patients in research interviews.

How do sessions work?

Session formats include group discussion, presentations, card-sorting tasks and written answer sheets. It is important for researchers to have a written record of the session, so discussions are recorded on a flip chart or written sheets completed by group members. Material is sent out to group members in advance so that they have the chance to read it beforehand. They have the choice of providing their input verbally during a session, or by telephone or email afterwards. This input is collated and passed onto researchers. A light evening meal in the middle of a PEP-R session keeps everyone going!

Who organises the sessions?

The content of PEP-R sessions is worked out by a planning group. This is made up of researchers, a Communication and Patient and Public Involvement (PPI) Manager and a member of PEP-R.

How are PEP-R members supported?

Amanda, our Patient and Public Involvement (PPI) Coordinator is the key contact person for

PEP-R members. Training in research is built into the sessions and there has also been the chance for PEP-R members to come to the Research Unit during the working day: to visit labs and offices and to discuss equipment. Members regularly receive feedback on the projects they have discussed.

What is the future for PEP-R?

The planning group is currently conducting an evaluation of PEP-R. Group members and researchers are being asked to describe how PEP-R has impacted on them and whether it has met their expectations. Several PEP-R members now sit on steering groups in the Research Unit. We hope that PEP-R is here to stay!

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PEP-R group in action

noticeboard

This is a regular column which can be used to advertise events, initiatives and publications about public involvement in research and development. If you would like to put an item on our noticeboard please contact the Coordinating Centre.

Launch of International Collaboration for Participatory Health Research (ICPHR) website

The ICPHR was established in 2009 to strengthen the role of participatory health research in intervention design and decision-making on health issues. It is open to stakeholders from all countries interested in promoting the dissemination and further development of participatory health research approaches. The ICPHR carries out its work through three cross-cultural, multinational Action Groups. Learn more about the work of the Collaboration, find out how you can get involved with the Action Groups, and sign up for the quarterly newsletter by visiting the new website: www.icphr.org

New Wellcome Trust Sanger Institute survey

A new online survey has just been launched by an ethics team from the Wellcome Trust Sanger Institute to capture public attitudes to sharing genomic results. They hope it will be the largest collection of opinions gathered to date.

Details of the survey project can be found in the press release at www.sanger.ac.uk/about/press/2012/120131.html. The survey itself can be accessed at www.genomethics.org

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INVOLVE is a national advisory body funded by the National Institute for Health Research to support public involvement in NHS, public health and social care research and development. If you would like to receive a copy of the newsletter or find out more about INVOLVE please do contact us.

Deadline for contributions for our next newsletter: **12 March 2012**

If you have any questions on contributing to the newsletter, please contact Paula Davis
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Friendly disclaimer: The views expressed in this newsletter and in any enclosures are those of the authors and not necessarily those of INVOLVE or the National Institute for Health Research. Articles are selected for the sole purpose of stimulating ideas and debate on public involvement in research.