NIHR | Applied Research Collaboration West Midlands

NIHR | Midlands Patient Safety Research Collaboration

Volume 7, Issue 5

ARC West Midlands & Midlands PSRC News Blog

24 October 2025

Wealth and Health. Health and Wealth. A Regress

Prof Richard Lilford, ARC WM Director & Midlands PSRC Co-Director

That wealthy nations are healthier than less wealthy nations is supported by shed loads of data, even though the gradient has diminished sharply over the last three decades. But what about the reverse? Can improving health improve wealth at a population level? This is the topic of a recent article in the *New England Journal of Medicine*.[1] The prominent economist Jeffrey Sachs chaired a WHO commission in 2001 that argued that health is a major driver of population wealth.[2]

Empirical evidence for this thesis is hard to pin down – it is not something that can be trialled experimentally. Historical and cross-country comparisons are so confounded that cause and effect is hard to establish convincingly.

For the ARC WM Director, it is almost inconceivable that there is no positive relationship. This is because it is self-evident that someone with malaria or Tuberculosis will be more productive when they are cured than while suffering the disease. Moreover, there is evidence that good nutrition and hookworm treatment improve children's attendance and concentration at school.[3, 4] The sum of the benefits of inexpensive gains must be positive. And then there are longer term benefits from improved child survival that encourage smaller families of better nurtured children – at least over a couple of generations before the dependency ratio becomes less favourable again.

Quantifying the effect of wealth on health at a population level is impossible – it can be modelled, but the parameter uncertainties are so broad that the model should only be used to explicate mechanisms, not to produce an unverifiable summary statistic.

In the meantime, investors in health services can be reassured that they can add wealth generation to the positive side of the balance sheet, and the above NEJM article is worth a read.

References:

1. Machado S, Kyriopoulos I, Orav EJ, Papanicolas I. Association between Wealth and Mortality in the United States and Europe. *N Engl J Med*. 2025; **392**(13): 1310-9.
2. Sachs JD. Macroeconomics and Health: Investing in Health for Economic Development. *World Health Organization*; 2001.
3. Alaimo K, Olson CM, Frongillo EA. Food insufficiency and American school-aged children's cognitive, academic, and psychosocial development. *Pediatrics*. 2001; **108**: 44–53.
4. Donkoh ET, Berkoh D, Fosu-Gyasi S, et al. Evidence of reduced academic performance among schoolchildren with helminth infection. *Int Health*. 2023; **15**(3): 309-17.

Forum Theatre in Service Design and Patient Decision Aids: A Reflective Exploration

Saba Tariq, Post-doctoral Fellow; Pamela Nayyar, Research Project Manager

I still recall the first time Richard Lilford proposed using theatre within healthcare service design. My response was not immediate excitement, but a blend of curiosity and caution. *Forum Theatre*? In a sector that thrives on protocols, guidelines, and measurable outcomes, the idea felt unusual, even risky.

My professional life has been rooted in research and clinical education, where every new approach must endure the test of peer review. In this environment, good ideas are not enough; they must be supported by evidence, evaluated with precision, and implemented with clear purpose. Yet, the thought of using theatre to explicate the complexities of healthcare stayed with me.

Theatre holds a particular strength as it draws people in and creates a space where emotions, perspectives, and lived experiences meet. I began to ask myself: could this approach go beyond artistic expression? Could it genuinely help shape services that function better and enable patients to make informed choices?

When I began piloting Forum Theatre in maternity care, I quickly understood that introducing something so unconventional in a high-stakes environment is not an easy undertaking. It is creative, yes. It is engaging, certainly. But the question of whether it can truly transform practice remains more complex and perhaps the answer will only emerge over time.

Why Theatre? The Promise

Healthcare decision-making is rarely straightforward. Patients navigate not just medical facts, but personal beliefs, time pressures, and the emotional weight of uncertainty. Traditional communication tools, such as leaflets, consultations, and even decision aids, can be useful, but they often struggle to convey the lived experience behind a choice.

This is where theatre offers something different. Through enactments, role reversals, and freeze-frame interventions, it allows participants to pause, reflect, and re-frame conversations. In service design, it can highlight bottlenecks in the patient journey that might otherwise be invisible. In patient decision aids, it can bring abstract concepts to life illustrating not just what a decision is, but how it feels.

There are precedents, too. Applied theatre has been used effectively in medical education to teach empathy and communication skills.[1] In some healthcare projects, small-scale interventions have engaged marginalised communities in mental health discussions or helped staff reflect on unconscious bias.[2] The literature here is modest but intriguing, suggesting that theatrical methods can open doors to dialogue that conventional tools sometimes fail to unlock.

In my own pilot work, I've seen moments that are hard to ignore. A clinician, watching an enactment of a rushed antenatal consultation,

suddenly recognised how her own phrasing might be perceived as directive rather than supportive. A service user spoke openly about how the performance helped her feel "heard" in a way that traditional focus groups never had. These moments remind me why the idea is worth exploring.

The Reality Check – The Challenges

But here's where my reflective side kicks in: moments are not outcomes. And in healthcare, outcomes matter.

Firstly, not every audience engages in the same way. Some clinicians embrace the opportunity to experiment; others find it contrived or even uncomfortable. Patients may respond differently depending on cultural norms, previous experiences, or simply their mood that day.

Secondly, measuring impact is complex. Theatre excels at sparking insight, but translating that into tangible, measurable change in service design or patient decision-making is another challenge entirely. Did a performance actually lead to better-informed patients? Did it alter the structure of a service? Without robust evaluation, it's easy to overestimate its effect.[3]

Thirdly, context matters. In some settings, the time, resources, and willingness to try something so unconventional may simply not be there. Even with support, integrating theatre into service design requires careful facilitation, clear objectives, and a realistic plan for follow-up.

I've had moments where I questioned whether the outcomes justified the energy spent on organising an enactment. Once, after a performance that I felt was powerful, a participant simply shrugged and said, "*It was interesting, but I'm not sure what I'll do differently.*" That's a humbling reminder that innovation alone doesn't guarantee transformation.

The Middle Ground – Balanced Reflection

So where does that leave us? Somewhere in the middle and that's not a bad place to be.

Theatre is not a magic wand for healthcare service design. But it's also not a gimmick. It is a tool, and in my view, one that can be powerful in the right circumstances, with the right preparation, and the right follow-through.

In our pilot work, the value wasn't in replacing existing methods, but in complementing them. Theatre didn't replace patient surveys, structured interviews, or decision aid prototypes. Instead, it enriched them. It provided texture, nuance, and a safe environment for participants to express things they might never articulate in a survey form.

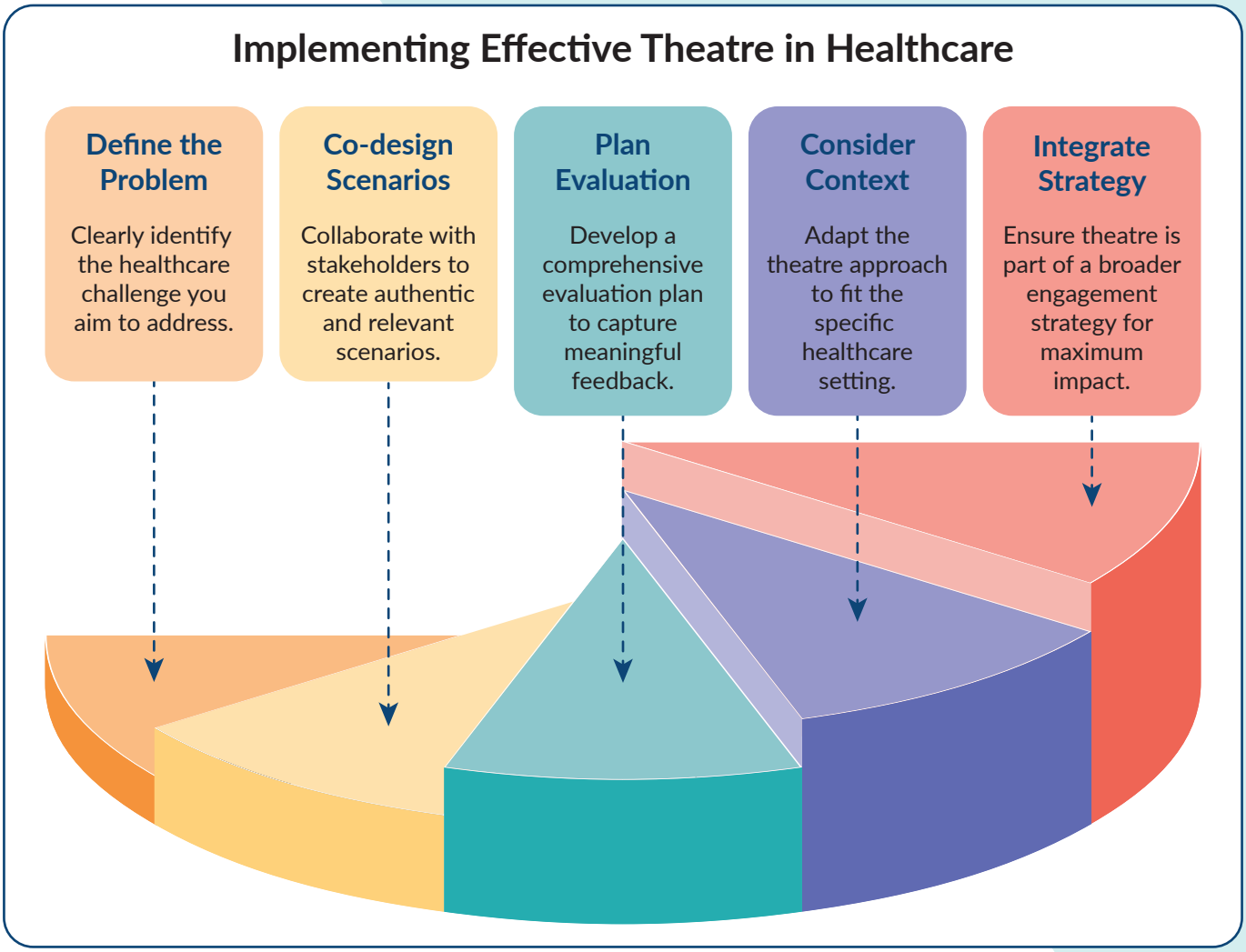
One example stands out. We staged a consultation about induction of labour for a large-for-gestational-age baby. The scene played out as scripted, but then we invited the audience to "freeze" the moment and suggest alternative approaches. This simple pause shifted the dynamic entirely. Clinicians experimented with different tones of voice. Patients challenged medical jargon. The dialogue became more collaborative not because we'd given them new facts, but because we'd created space to try new ways of interacting.

Did this lead to measurable change in patient decision-making? I can't claim it did, at least not yet. But it certainly influenced how participants thought about their roles in those conversations. Sometimes, that's the necessary first step.

Looking Forward – What Experts Should Consider

For those in the field considering theatre as part of service design or designing patient decision aids, we'd suggest a few principles:

- **Start with the 'why':** Be clear about the problem you're trying to solve. Theatre is a means, not an end.
- **Co-design from the start:** Work with patients, clinicians, and facilitators to shape scenarios that are authentic and relevant.
- **Plan for evaluation:** Whether qualitative, quantitative, or mixed methods, ensure you can capture more than just "good feedback."
- **Think about context:** Not every setting will embrace theatre - adapt to the culture, constraints, and readiness of the environment.
- **Integrate, don't isolate:** Theatre works best as part of a broader engagement strategy, not as a standalone event.



If we approach it with humility and curiosity, theatre could become another tool in our collective toolkit for improving healthcare design and patient support. It may not always be the right tool for the task, but still one worth having.

Closing: The Final Note

When I first stepped into this space, I thought I might find a clear answer: yes, theatre works or no, it doesn't. The truth, as is often the case in healthcare, is more nuanced.

Theatre has the potential to change perspectives, spark empathy, and create moments of clarity. But it's not a guarantee. It may not "do the job" in every context, and that's okay. What matters is that we stay open to testing new approaches while holding ourselves accountable to providing evidence and impact. In fact, when we think about why patient decision aids often fall short, three recurring barriers keep emerging: time constraints, limited health literacy, and the constant threat of information overload all of which our theatre approach is designed to tackle head-on.[4]

For me, the real value has been in the conversations that followed the moments when someone said, "I hadn't thought about it that way before." Those are not outcomes you can easily plot on a graph, but they are the seeds of change.

And perhaps that's the point. In a field where we are constantly seeking certainty, theatre reminds us that some of the most important shifts begin with uncertainty and the courage to try.

References:

1. Landry-Wegener BA, Kaniecki T, Gips J, Lebo R, Levine RB. Drama training as a tool to teach medical trainees communication skills: A scoping review. *Acad Med*. 2023; **98**(7): 851-60.
2. Beckett K, Deave T, McBride T, et al. Using Forum Theatre to mobilise knowledge and improve NHS care: the Enhancing Post-injury Psychological Intervention and Care (EPPIC) study. *Evidence & Policy*. 2022; **18**(2): 236-64.
3. Lilford RJ, Nayyar P, Tariq S. Supporting patient choice: Design decision aids or design a service. *NIHR ARC West Midlands and Midlands PSRC News Blog*. 2025; 7(3): 1–3.
4. Tariq S. The three musketeers of patient decision aids: Time constraints, health literacy, and information overload. *NIHR ARC West Midlands and Midlands PSRC News Blog*. 2025; 7(3): 5–7.

Retirement of Professor Sara Kenyon

Christine MacArthur, Kate Jolly

Prof **Sara Kenyon** joined the University of Birmingham and the CLAHRC Birmingham and the Black Country (BBC) (precursor to ARC WM) in 2009, to join the maternity theme, running an RCT of lay support for women with social needs in pregnancy.

In the early 2000s Sara had been a member of the *National Service Framework for Children, Young People and Maternity Services* with Christine MacArthur, the CLAHRC BBC maternity theme lead. Both Sara and Christine were interested in the idea of support for women with social risks. At the time Sara was working at the University of Leicester as a research midwife running a set of ORACLE trials evaluating effects of antibiotics for spontaneous pre-term labour, all of which resulted in Lancet publications. CLAHRC BBC Director Richard Lilford had been on the steering committee for the trials, so when the CLAHRC was funded, and one of the projects was a trial to evaluate lay support workers in maternity care we immediately thought of trying to attract Sara to join us.

As well as the lay workers trial, Sara very quickly engaged with the local maternity services to identify areas for academic input and an obstetrician consultant, Nina Johns at Birmingham Women's Hospital, suggested taking a look at maternity triage as this was a real problem. This led to a hugely successful CLAHRC piece of research and implementation work. For those who are unfamiliar with the topic, when you go to an A&E department you are triaged on arrival so that those most in need get seen quicker. This didn't happen in maternity care, pregnant women attending maternity services were usually seen in the order in which they arrived and no or inadequate tests were done on arrival to check the condition of the baby and the mother. Sara and Nina developed the *Birmingham Symptom Obstetric Triage System (BSOTS),* which ensured that the condition of the baby was properly assessed, as well as the condition of the mother. They were then categorised into risk groups and actions specified for these groups. This was trialled in Birmingham, then three other local maternity units, and is now standard practice in over 120 maternity units in the UK, as well as some in Australia and New Zealand. Sara has done a huge amount to get this change in practice, which is endorsed by the Care Quality Commission as a way of improving the safety of maternity triage.

Sara continued to work in a further CLAHRC (West Midlands) and then led the current ARC WM Maternity theme, leading research and implementation that was relevant to the local services. She has also been a core member of MBRRACE-UK, which is the perinatal and maternity national audit and confidential enquiries, and she has led two successful HTA bids for large maternity trials on induction of labour.

Sara has had a hugely successful career, with many other achievements, in addition to those mentioned above. She was promoted to Professor in 2017, with her inaugural lecture titled '*Great expectations; the unexpected journey of a midwife*'! She has won numerous awards for the BSOTS work and was awarded an MBE for services to maternity research in the King's 2025 New Years Honours List.

We wish Sara a very happy and well-deserved retirement after leaving such an important legacy.

Do the Benefits of Sunlight Outweigh the Risk?

Prof Richard Lilford, ARC WM Director & Midlands PSRC Co-Director

News Blog readers are likely aware that the ARC WM Director has a theory that sunlight is beneficial, net of its effects on Vitamin D production.[1]

I was therefore interested to encounter an article in the Economist providing support for this very theory. The article goes so far as to say that the health advantages outweigh the disadvantage in terms of an increased risk of skin cancer. The latter risk is beyond reasonable doubt.

The Economist article quotes massive observational studies.[2] One included 360,000 British people and found that regular exposure to sunbeds decreases overall mortality by 15%. This corroborates an earlier Swedish study examining exposure to sun and overall mortality.[3]

Sunlight has been shown to stimulate metabolic pathways in addition to its well-known effect on vitamin D production. It encourages production of nitric oxide (which dilates blood vessels and reduces blood pressure) and immune modulators that rid the body of nascent cancer cells.

So the ARC WM Director will aim to avoid sun burn but not sunlight despite a suspicious looking lesion that has arrived on his calf!

References:

1. Lilford RJ. Health Effects of Sunlight: Not Just Vitamin D and Skin Cancer. *NIHR ARC West Midlands and Midlands PSRC News Blog*. 2024; **6**(4): 4.
2. The Economist. The health benefits of sunlight may outweigh the risk of skin cancer. *The Economist*. 17 September 2025.
3. Lindqvist PG, Epstein E, Landin-Olsson M, et al. Avoidance of sun exposure is a risk factor for all-cause mortality: results from the Melanoma in Southern Sweden cohort. *J Intern Med*. 2014; **276**(1): 77-86.

"Science... The Latest Victim in the Culture Wars"

Writing in the Milbank Quarterly, Alan B Cohen (*Editor and Research Professor at Boston University*) argues that the current US administration's actions against diversity, equity, and inclusion (DEI) practices and its cuts to health agency funding have made science a victim of the culture wars. Cohen echoes others, arguing that the common phrase, "*follow the science*," has now backfired, stopping discussion and creating public distrust in advice and directives from US institutions like the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA).

The article cites Aaron Carroll (*CEO and president of AcademyHealth*), who believes that restoring faith in science requires acknowledging its limits and engaging in discussion about policy outcomes. Cohen asserts that the ultimate victim is "truth," which has been exploited by politicians and influencers to spread misinformation.

Several actions by the US government can be seen as evidence of this "assault on science." These actions include the dismissal of members from the CDC's Advisory Committee on Immunization Practices, and the hiring of vaccine sceptics to key government posts. The article also highlights the cancellation of critical mRNA vaccine research contracts, which jeopardises the future development of treatments for cancers and other diseases.

Cohen concludes that such policy decisions demonstrate a disregard for established scientific norms, posing serious threats to public health, and eroding trust in government and healthcare providers.

Sadly, these bad habits have crossed the Atlantic. In your last News Blog we gave an example of the Secretary of State criticising researchers because he did not like their findings [2] (presumably including those from the ARC WM, who had argued against the use of incentive-based performance metrics to drive service improvement, such as in hospitals).[3]

References:

1. Cohen AB. The Ongoing Assault on Science and Truth. *Milbank Q.* 2025; **103**(3): 0903.
2. Lilford RJ. Slow Recovery of Surgical Volumes Post-COVID: Perhaps Time to Stop Beating the Horse! *NIHR ARC West Midlands and PSRC Midlands News Blog*. 2025; 7(3): 8.
3. Lilford R, Chen Y, Sutton M, Hofer T. Hospital league tables, targets, and performance incentives should be used with care. *BMJ* 2025; 389 :e083517.

Diabetes Care Cascade - Improvement Needed Globally

Peter Chilton, Research Fellow ARC WM

The Lancet have recently published a new study using data from the Global Burden of Disease (GBD) Study, this time focussing on diabetes.[1] Diabetes is an increasing challenge in global health, and is estimated to affect 830 million people, most in low- and middle-income countries.[2] This modelling analysis offers the first comprehensive global assessment of the diabetes care cascade from diagnosis to treatment and management. While there have been many improvements over the 20 years analysed (2000-2020), there are also major and persistent gaps in diabetes care that underscores an urgent need for enhanced, targeted strategies globally.

Diagnosis: An estimated 56.7% (95% UI 50.5-63.0) of people aged 15 years and older living with diabetes had a previous diagnosis. This means that the remaining 43.3% of people with diabetes were unaware of their condition, which comes out at an estimated 218 million people with undiagnosed diabetes worldwide.

Treatment: Among those who were diagnosed, the vast majority, 90.6% (87.0-93.6) were on some form of treatment (either insulin or another hypoglycaemic medication). This part of the cascade is where health systems performed best.

Optimal Glycaemic Management: This represents the largest gap in the cascade. Only 42.4% (36.7-49.1) of people on diabetes treatment had optimal glycaemic levels, which is classed as having a fasting plasma glucose (FPG) level of less than 7.2 mmol/L.

Crucially, when considering the entire population living with diabetes, only 21.7% (17.8-26.0) had optimal glycaemic levels on treatment in 2020.

When the authors looked at improvements over the 20 years of the study, they found that global efforts led to increased performance across all components of the cascade, but to varying degrees, with the improvement in glycaemic management lagging significantly. Diagnosis saw the largest absolute increase with 6.8 percentage points; treatment among the diagnosed increased by 6.2 percentage points; while optimal glycaemic management among the treated increased by only 1.5 percentage points. The slow pace of

improvement in glycaemic management signals that simply increasing treatment coverage isn't enough; the quality of diabetes care remains a significant challenge.

The study also exposed substantial disparities across both regions and age groups. For example, diagnosis was highest in high-income regions such as North America (83.2%) and Southern Latin America (79.7%), but considerably lower in central sub-Saharan Africa, where only 16.3% of people with diabetes were diagnosed.

Meanwhile, the largest gaps in diagnosis were found among younger adults (15-39 years), where only a quarter of those with diabetes had been diagnosed. Although the greatest number of undiagnosed individuals were people aged 40–64 years, the poor diagnosis rate for younger adults is a cause for concern, as early onset diabetes is associated with a greater risk of complications.

The findings from the analyses seem to indicate that underdiagnosis and suboptimal glycaemic management are the two most critical barriers to effective diabetes control globally, especially in low- and middle-income countries. To meet global targets, such as the World Health Organization's goal of having 80% of people with diabetes clinically diagnosed by 2030, significant effort is needed. The authors argue that to achieve these aims, targeted interventions must focus on enhanced screening, particularly in low-resource settings and for younger adult populations; and improving quality of care by addressing challenges such as inadequate training of health-care personnel, and high out-of-pocket costs for medicines (like insulin).

Understanding the specific weaknesses in the care cascade will allow policymakers and health professionals to target interventions effectively, reducing the burden of this rapidly more prevalent disease.

References:

1. Stafford LK, Gage A, Xu YY, Conrad M, Barreras Beltran I, Boyko EJ, et al. Global, regional, and national cascades of diabetes care, 2000-2020: diagnosis, treatment, and glycaemic management. *Lancet Diabetes Endocrinol*. 2025: S2213-8587(25)00217-7.
2. World Health Organization. Diabetes. 2025. Accessed 16-Sept-2025.

Quiz

World Menopause Day is October 18th, but other than humans, what mammalian species undergoes menopause?

email your answer to: arcwm@contacts.bham.ac.uk

Answer to previous quiz: Maximilian Oskar Bircher-Benner developed **Bircher Muesli** as an appetiser for patients in his sanatorium. Congratulations to Alan B Cohen, Mark Gabbay and Alan Hargreaves who were first to answer.

Is Regulatory Intervention an Effective Catalyst of Prescribing Behaviour Change?

Christopher Hatton, PhD Student (Acute Care theme Midlands PSRC)

Across Europe, various regulatory bodies are responsible for ensuring that medicines used for the population are safe. Such regulatory bodies include the European Medicines Agency (EMA) and the Medicines and Healthcare products Regulatory Agency (MHRA) in the United Kingdom. Responsibilities differ across jurisdictions, but they are often responsible for granting or refusing market authorisation and mandating changes in usage if safety concerns are identified.

Fluoroquinolones are a class of antibiotic that have been associated with serious, disabling, long-lasting and potentially irreversible adverse reactions affecting multiple body systems, including the musculoskeletal and nervous systems. Within the last ten years, regulatory bodies have attempted to minimise the risk of harm from fluoroquinolones through regulatory intervention.[1] A study published in *Drug Safety* aimed to establish whether regulatory intervention across Europe had resulted in changes in prescribing patterns.[2]

This study utilised routinely collected primary care data from six countries between 2016 and 2021 and used segmented regression to establish whether trend changes in fluoroquinolone prescribing were temporally associated with regulatory intervention. Overall, the incidence of fluoroquinolone prescriptions decreased across most countries. However, the changes observed were inconsistent and there was no clear temporal relationship to regulatory intervention. The authors concluded that regulatory intervention "*did not seem to have relevant effects on fluoroquinolone prescribing in primary care*".

The results and conclusion of the study raise some interesting questions. The authors conclude that there was no relevant effect of regulatory intervention on fluoroquinolone prescribing because there was no clear and obvious temporal relationship. However, the causal pathway between regulatory intervention and behaviour change in this circumstance is likely to be complex and multi-faceted. Behaviour change may arise because of increasing awareness amongst healthcare professionals, local and national guideline changes, or formulary changes within local settings. It is unlikely that all of these processes will be clearly temporally related to the initial intervention.

Further work is needed to understand how regulatory intervention can result in prescribing behaviour change. Ultimately, understanding this relationship will help to align the goals of regulatory intervention with the desired outcomes. In the Midlands PSRC we are seeking to understand how and why prescribing patterns of fluoroquinolones have changed in Birmingham.

References:

1. MHRA. Fluoroquinolone antibiotics: must now only be prescribed when other commonly recommended antibiotics are inappropriate. 2024.
2. Ly NF, Flach C, Lysen TS, et al. Impact of European Union Label Changes for Fluoroquinolone-Containing Medicinal Products for Systemic and Inhalation Use: Post-Referral Prescribing Trends. *Drug Saf*. 2023;**46**(4): 405–16.

Midlands PSRC at the Inaugural SafetyNet Symposium

Sopna Choudhury, Research Programme Manager PSRC Midlands

The Midlands Patient Safety Research Collaboration (PSRC) was delighted to participate in the first-ever *SafetyNet Symposium*, held on 17th October 2025 at the Manchester Central Convention Complex. The event brought together researchers, clinicians, and policymakers as well as patient and public representatives from across the UK to explore the theme of "**Tackling Inequities in Patient Safety**."

Our Programme Manager, Sopna Choudhury, played a key role as a member of the Organising Committee, contributing to the seamless planning and delivery of the event. Research Fellow, Dr Justin Aunger, also represented the Midlands PSRC on the programme planning committee, helping shape the programme and ensuring the inclusion of high-quality, impactful research.

During the symposium, our Pathways and Culture Lead, Dr Arabella Scantlebury, delivered a well-received presentation on "*Inequalities in Access to Respiratory Care*" as part of the Research Impact from the PSRCs session. Her talk sparked meaningful discussion on addressing systemic barriers to equitable care.

The Midlands PSRC team also showcased ten research posters, highlighting the breadth and diversity of our ongoing work across patient safety themes. The posters can be viewed online at: https://psrc-midlands.nihr.ac.uk/nihr-safetynet-symposium-2025/.

We were especially proud that Dr Saba Tariq received the award for *Best Innovation in Patient Safety* for her outstanding poster contribution, a recognition of the team's commitment to creative and practical solutions for safer healthcare (see page 13).

Initial feedback from delegates has been overwhelmingly positive. Attendees praised the organisation, pacing, and accessibility of the event, with many noting how smoothly the day unfolded.

The Midlands PSRC is proud to have contributed to such a successful and inspiring event, helping to strengthen collaboration and share learning across the national patient safety research community.

Latest News and Events

Congratulations: Best Innovation in Patient Safety Award

Congratulations to Dr Saba Tariq, Research Fellow for NIHR Midlands PSRC, who recently won the *Best Innovation in Patient Safety Award* at the national NIHR Safety Net Symposium 2025 in Manchester.

This event saw over 60 posters from the six NIHR PSRCs, showcasing some of the most innovative work in healthcare safety and quality improvement.

Saba's winning poster, "*Using Forumative evaluation of Forum Theatre in Service Design and Patient Decision Aids*," featured a pioneering approach blending performing arts with health service research.

"It's an honour to represent our PSRC and to see creative, human-centred approaches being recognised nationally. This award reinforces my belief that innovation can emerge from the most unexpected spaces even the stage," said Dr Saba Tariq.

ARC WM & Midlands PSRC Seminar Series

Our final seminar of 2025 will take place on **9 December** from 1pm-2pm, led by Dr Kiyah Hurley. Further information will be publicised nearer the date. For details on how to attend, please contact: arcwm@contacts.bham.ac.uk

We regret to announce that the seminar scheduled for 6 November 2025 has been cancelled.

Implementation Science Masterclasses

This masterclass series sees renowned experts showcasing varied case studies on applying implementation science in fields such as health service research, global health and use of AI.

Upcoming Masterclasses:

- **11 November 2025**, 1-2pm, Prof Iestyn Williams - De-implementation.
- 2 December 2025, 1-2pm, Prof Robin Miller - Understanding process.

For further details and to register to attend, please visit: https://implementationscience.wordpress.com/

Latest National NIHR ARC Newsletter

The latest issue of the NIHR ARCs Newsletter is now available at: http://eepurl.com/jlYTXw. Highlights include standardised methods for economic evaluation of implementation strategies; gender bias in AI-driven social care tools used by councils; preventing falls in older adults; and inequalities in health checks for people living with severe mental illness in the UK.

To subscribe to future issues, please visit: https://tinyurl.com/ARCsnewsletter.

Milestone: Six Years of ARCs

This month, the NIHR ARCs turn six years old!

Overall, we have carried out over 3,300 projects, published over 9,000 papers and collaborated with more than 625 partner organisations across the country, including 230 NHS partners, 106 local authorities and 80 universities.

To celebrate this milestone, we have compiled 15 projects of research implementation and impact from across the country, illustrating how our research improves the quality, delivery and efficiency of health and care services, improving outcomes for patients and the public both locally and nationally.

Find out more by reading the newsletter at: http://eepurl.com/jle3CA.

The Role of the CHART in Building Community Research

The NIHR Research Delivery Network are delivering an online research seminar on '**The role of the CHART (Community Healthcare Alliance of Research Trusts) in building community research**' given by Dr. Christine Burt, *Director of Research and Innovation, Birmingham Community Healthcare NHS Foundation Trust*.

(*Please note that this is a change in topic/presenter to that previously advertised.*)

This free event will be held via MS Teams on **Thursday 6 November 2025**, 1-2pm.

For more information, and to register, please visit: https://www.ticketsource.co.uk/wm-rrdn/t-dvylzrx

When Mental Health Care Feels Too Far Away

Researchers from the '*Far Away From Home*' study (based at ARC East Midlands and supported by various ARCs including ARC West Midlands), have spoken directly to young people, families and healthcare staff about their experiences with accessing mental health care that is many miles from their home.

Dr James Roe and Dr Josephine Holland discuss their findings in a recent blog, which also highlights resources aimed at improving admissions. You can read more at: arc-em.nihr.ac.uk/news/when-mental-health-care-feels-too-far-away-what-young-people-are-telling-us.

There is also a webinar taking place on **Wednesday, 6 November 2025** to discuss these resources more and how they can be used. To register, please visit: https://tinyurl.com/sddh48n2.

Creative Arts Improving Wellbeing & Research Involvement

This year, for the ARCs' national webinar series (#ARCseminar), speakers from across the ARCs explored how creative arts can improve both the wellbeing and involvement in research of different communities. Three webinars ran in May, June and July 2025, to great acclaim, with about 700 attendees across the three live events.

You can read more and watch the recordings online at: https://arc-w.nihr.ac.uk/news/the-healing-power-of-creative-arts-2025-national-arcseminar-series/

ICIC26: International Conference on Integrated Care

The 26th International Conference on Integrated Care will take place on **13-15 April 2026** in Birmingham, in partnership with the International Journal of Integrated Care and the University of Birmingham.

The conference will bring together researchers, practitioners, people with lived experience, clinicians and managers from the UK around the world who are engaged in the design and delivery of integrated health and social care. They will explore how integrated care can respond to the needs of diverse people and communities, embrace the skills and knowledge of diverse professionals and practitioners, and develop diverse and innovative interventions which build on the strengths of people and technology.

For more information, please visit: https://integratedcarefoundation.org/events/icic26-26th-international-conference-on-integrated-care

Implementation Conference 2026

Save the date for the next Implementation Conference, which will be held on **25-26 June 2026** in Bristol.

This conference will be focussed on *Inclusive Implementation - making it happen*, and run by ARC West and ARC South West Peninsula, with support from the UK Implementation Society.

Recent Publications

Adeniran K, Akthar M, Bajpai R, Galloway J, Hider SL, Partington R, Muller S, Scott IC. Pain intensity levels and their associations in people with rheumatic diseases in the UK: observational study using British Society for Rheumatology ePROMs data. *Rheumatol Adv Pract*. 2025; **9**(3): rkaf097.

Anderson N, Hughes SE, Aiyegbusi OL, Collis P, Miller R, Calvert M. Patient-Reported Outcomes in Integrated Care: A Frontier of Opportunities and Challenges. *Int J Integr Care*. 2025; **25**(3): 23.

Atkin C, Holland M, Cooksley T, Varia R, Subbe CP, Wilkinson T, Lasserson D, Sapey E Performance against quality indicators in the initial assessment of patients with respiratory infections in acute medicine services. *BMJ Open Respir Res*. 2025; **12**(1): e003207.

Bullock L, Tyler N, Fleming J, Clark EM, Thomas S, Gidlow C, Iglesias-Urrutia CP, Horne R, Bentley I, Hawarden A, Peel N, Gregson CL, Ralston SH, Protheroe J, Lefroy J, Ryan S, O'Neill TW, Mallen C, Jinks C, Paskins Z. The Michael Mason Prize: Development and feasibility testing of a complex intervention to improve adherence to fracture prevention medicine. *Rheumatol*. 2025: keaf413.

Clarke J, Crossland N, Dombrowski S, Hoddinott P, Ingram J, Johnson D, Jolly K, MacArthur C, McKell J, Moss N, Sanders J, Savory N, Taylor B, Thomson G. Experiences of the ABA-Feed Infant Feeding Intervention: A Qualitative Study With Women, Peer Supporters and Coordinators. *Matern Child Nutr*. 2025: e70124.

Clarke J, Thomson G, Crossland N, Dombrowski S, Hoddinott P, Ingram J, Johnson D, MacArthur C, McKell J, Moss N, Sanders J, Savory N, Taylor B, Jolly K; ABA-Feed Study Group. ABA-Feed Infant Feeding Training for Peer Supporters and Coordinators: Development and Mixed-Methods Evaluation. *Matern Child Nutr*. 2025: e70115.

Fisher T, Kingstone T, Shivji NA, Turner K, Chew-Graham CA, Smith HC, Archer C, Bailey J, Evans J, Kessler D, Petersen I, Proctor J, Yu D, Wu P, Silverwood V. Identification of increased risk of perinatal anxiety: a multi-perspective qualitative study. *Br J Gen Pract*. 2025: BJGP.2024.0691.

Kabeya V, Tariq S, Delicate A, Chong H, Aunger J, Naidu H, Dunlop C, Yates D, Muthirulandi A, Muthirulandi A, Lilford R, Sobhy S, Thangaratinam S. Acceptability and use of clinical decision support tools in maternity settings: Systematic review of qualitative studies. *Eur J Obstet Gynecol Reprod Biol*. 2025; **314**: 114718.

Lilford RJ, Watson SI, Chilton PJ. Rethinking induction of labour for LGA fetuses: the Big Baby trial. *Lancet*. 2025; **406**(10512): 1563.

Man R, Morris RK, Magill L, Hughes T, Perry R, Tohill S, Henry N, Kadir B, Macarthur C, Hodgetts Morton V; CHAPTER group. Complications After Childbirth-Related Perineal Trauma up to Six-Weeks Postpartum: A Prospective Cohort Study. *BJOG*. 2025.

Roden-Lui G, Chew-Graham CA, Hard J, Harriott P, King H, Mastrocola E, Walker T. Improving primary care services for imprisoned women with severe mental illness (IP-SIS) Protocol Paper. *NIHR Open Res*. 2025; **5**: 14.

Roydhouse J, Breslin M, Zola A, Basch E, Calvert M, Cella D, Smith ML, Thanarajasingam G, Peipert JD. Patient-Reported Side Effect Bother: Understanding the Value of the Baseline Report. *Patient*. 2025.

Sokhal BS, Matetić A, Protheroe J, Helliwell T, Myint PK, Paul TK, Mallen CD, Mamas MA. Emergency department attendance stratified by cause and frailty status: A national retrospective cohort study. *Geriatr Gerontol Int*. 2025; **25**(10): 1350-8.

Trafford AM, Carr MJ, Ashcroft DM, Chew-Graham CA, Cockcroft E, Cybulski L, Garavini E, Garg S, Hussey L, Kabir T, Kapur N, Temple RK, Webb RT, Mok PL. Temporal trends in primary care-recorded psychiatric diagnoses and psychotropic medication prescribing among children and young people in the UK: a population-based study. *Br J Gen Pract*. 2025' **75**(758): e566-76.

Uthman OA, Court R, Enderby J, Nduka C, Al-Khudairy L, Anjorin S, Mistry H, Melendez-Torres GJ, Taylor-Phillips S, Clarke A. Identifying optimal primary prevention interventions for major cardiovascular disease events and all-cause mortality: a systematic review and hierarchical network meta-analysis of RCTs. *Health Technol Assess*. 2025; **29**(37): 1-65.

Viner A, Deeks O, Nayyar P, Allison J, Murray S, Ainslie K, Cockburn N, Lilford R, Magowan B. The Safe Assessment Form to Evaluate Risks ('SAFER') chart - a clinical practice evaluation study following introduction of electronic risk identification in pregnancies in Scotland. *NIHR Open Res*. 2025; **5**: 37.