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Rationing Treatments: Not Just a Matter for the Health Service

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

Current Rationing Policy

Rationing healthcare is a good thing for this reason: if not rationed, then the opportunity cost cuts in, and so proposed new treatments may displace other, more valuable, care. Explicit rationing of new treatments is the antidote to implicit rationing, say by diluting nurse time or lengthening emergency waiting times. In order to operate a rationing system, a measure of value is needed to place alongside net cost. The measure of value usually used in health economics is a Disability- or Quality-Adjusted Life Year (DALY or QALY). The National Institute for Health and Care Excellence (NICE) appraisal committees use the (net) cost per QALY as their metric of value to the NHS. The indicative NICE threshold is £20k-£30k per QALY. That is the Department of Health and Social Care's best estimate of the threshold beyond which more valuable care would be displaced. This is a coherent and workable theory that has endured for over 20 years. In this article I argue that this perspective, focussed only on health and social care is too narrow. Instead, I believe that the threshold should not only take account of the opportunity cost to the NHS, but should also include effects that play out in the broader economy through the effect of the QALY threshold on the life sciences sector.

Changing the Threshold

It could be argued that NICE sends the correct signal to industry on the grounds that the cost/value cut-off incentivises industry to make medicines that have enough value to justify their costs. But this argument does not work for a number of reasons.

The Case for a Higher Threshold

1. The QALY calculation omits the fact that high prices may last only until the patent expires, after which competitive pressures may reduce real costs. Patents, after all, are a form of subsidy to promote innovation. Therefore, it could be argued that setting the threshold at the opportunity cost purely for the health service partially vitiates patent protection. Such a low monetary value may be insufficient to cover the cost and compensate for the risk of bringing new products to market.

2. Industry is multi-national. If we set the price too low, we find that we are subsidised by countries that are prepared to pay higher prices. This cross-subsidy, where one country can have its industry subsidised by higher prices paid for its products in other countries, is time limited. This is exactly what is happening now in the controversy stoked by US President Donald Trump.

3. The cost of taking a pharmaceutical product to market is enormous. Some people think that drug company profits are excessive, but they discount the risk premium. The typical net profits of 'Big Pharma' have been reported as around 15%.[1] These figures turn largely on a few block-buster products. We need to keep them coming. Big Pharma is valuable to the economy, and a source of innovation, which Joseph Schumpter showed is the power-house of economic growth.

Closing Argument

So, what does all this mean for policy? One possibility would be to inflate the NICE £20k willingness-to-pay threshold for one QALY to a higher figure. The Treasury could help set the threshold because they know how many tax credits are at risk from not doing so. Then again, this country got into terrible shape in the 1960s and 70s by keeping dormant industries alive. But these were loss-making industries that had no innovative competitive advantage. Such is not (yet?) the case for pharmaceuticals.

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Quiz

The Royal Society (*the independent scientific academy of the UK*) was founded on 28th November 1660, but where were they formed?

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

Answer to previous quiz: The only non-human mammalian species that are believed to undergo menopause in the wild are various types of **whales**, such as killer whales, pilot whales and belugas (though recent studies suggest some other mammals *might* if in captivity). Congratulations to Iona Gregory who was first to answer correctly.

Tackling Bullying, Harassment and Abuse in the NHS: A New Cross-SafetyNet Project

Justin Aunger, Midlands PSRC Pathways and Culture Research Fellow

Bullying, harassment and abuse have no place in the NHS. Yet, for decades, these behaviours have affected staff across the health service – and the impact is not felt equally. Black, Asian and ethnic minority staff, who make up almost 30% of the NHS workforce, are significantly more likely to experience bullying and harassment than their White colleagues. [1] The NHS workforce is significantly more diverse than the overall UK population, with around 40% of consultants and 33% of nurses and midwives identifying as being from ethnic minority backgrounds.[2]

Recent data show that in 2023, 89% of NHS hospital trusts reported higher rates of bullying and harassment towards staff of ethnic minority backgrounds compared to White staff. These experiences can lead to stress, sickness absence, and even staff leaving the NHS altogether. Beyond the human cost, this also creates financial strain on the health system through litigation and agency cover.

This not only harms staff wellbeing but also undermines patient safety. For example, staff working in teams where such behaviours are rife may feel unable to report or prevent patient safety incidents.[3] As the NHS becomes increasingly diverse, tackling these inequalities is more urgent than ever.

In June 2025, the NHS Race and Health Observatory launched a tender for interested parties to bid to lead a 16-month programme to start narrowing this gap. We applied from the Midlands PSRC and University of Birmingham with a team comprising Dr Justin Aunger, Dr Jane Ferguson and Dr Ashok Paitnaik, as well as team members at the University of Sheffield (Prof Jeremy Dawson), and the NIHR Yorkshire and Humber Patient Safety Research Collaboration (Dr Olivia Joseph) – and were successful.

What Will the Project Do?

The project has already started as of October 2025. Our research is using a mixed-methods approach, combining large-scale data analysis with in-depth case studies. Here's what that means:

- Analysing NHS Staff Survey data from across England to understand patterns of bullying, harassment and abuse by ethnicity, region and organisation.
- Identifying NHS Trusts that have successfully reduced the gap between ethnic minority and white staff, to learn what works in practice.
- Hearing from staff voices through interviews and focus groups, especially those from ethnic minority backgrounds, to understand lived experience and what actually makes a difference on the ground.
- Exploring organisational culture and leadership, to see how policies and behaviours influence staff experiences.
- Co-producing practical recommendations and resources with staff and stakeholders to help NHS organisations reduce bullying and harassment.

Our Goals

By the end of the project, we aim to:

- Provide clear, evidence-based recommendations for NHS Trusts, Integrated Care Boards and regions.
- Develop achievable improvement targets to hold organisations accountable.
- Share practical tools and guidance to help create safer, fairer workplaces.

How This Connects to Wider PSRC and NIHR Work

This project complements ongoing work within the Pathways and Culture programme of the NIHR Midlands PSRC, which focuses partly on improving safety culture across healthcare settings. We already have another wider project funded by the NIHR focused on interventions for reducing unprofessional behaviours more broadly that is also ongoing. Sharing learnings across both projects, with consideration of inequality their core, will enable an even broader understanding of how such behaviours can be addressed in an NHS context.

This initiative is also a great example of cross-PSRC collaboration via SafetyNet, showcasing the impact of the SafetyNet working groups, particularly those focused on Safety-Equity and Organisational Culture. These groups have been instrumental in forging the connections to enable this proposal to come together. This meant that Justin and the wider team were ready to apply alongside Dr Olivia Joseph, who is the Safety Equity Senior Research Fellow at the Yorkshire & Humber PSRC.

Bullying and harassment are not just disagreements between people – they are patient safety problems. When staff feel unsafe or undervalued, teamwork and communication suffer, and that can put patients at risk. As the NHS becomes increasingly diverse, it is essential that we foster organisations where every member of staff feels respected and supported.

More information about this work can be found in the press release. Please contact Dr Justin Aunger (j.aunger@bham.ac.uk) if you have any questions about the project.

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1. NHS England. NHS Staff Survey Results 2024. 2025.
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A Preposterous Proposal?

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

Again and again I read about conflict between clinical staff and unclear delineation of responsibilities as the root cause of safety incidents in maternity care. One of the first projects I awarded as Director of the Patient Safety Research programme [1] back in 2002 made this observation,[2] and it remains a problem in recent reports, such as the MBRRACE-UK report into maternal and perinatal deaths.[3] The line of tension lies between midwives and obstetricians, and plays out most harmfully in the labour ward.

Numerous remedies have been suggested, including simulations where staff act out their respective roles. However, the most obvious suggestion would be to merge the obstetrics and midwifery professions into a single profession – say '*Maternity Care Provider*' (MCP), with both a medical and traditional midwife route into the profession. The merged training is represented in the Figure.

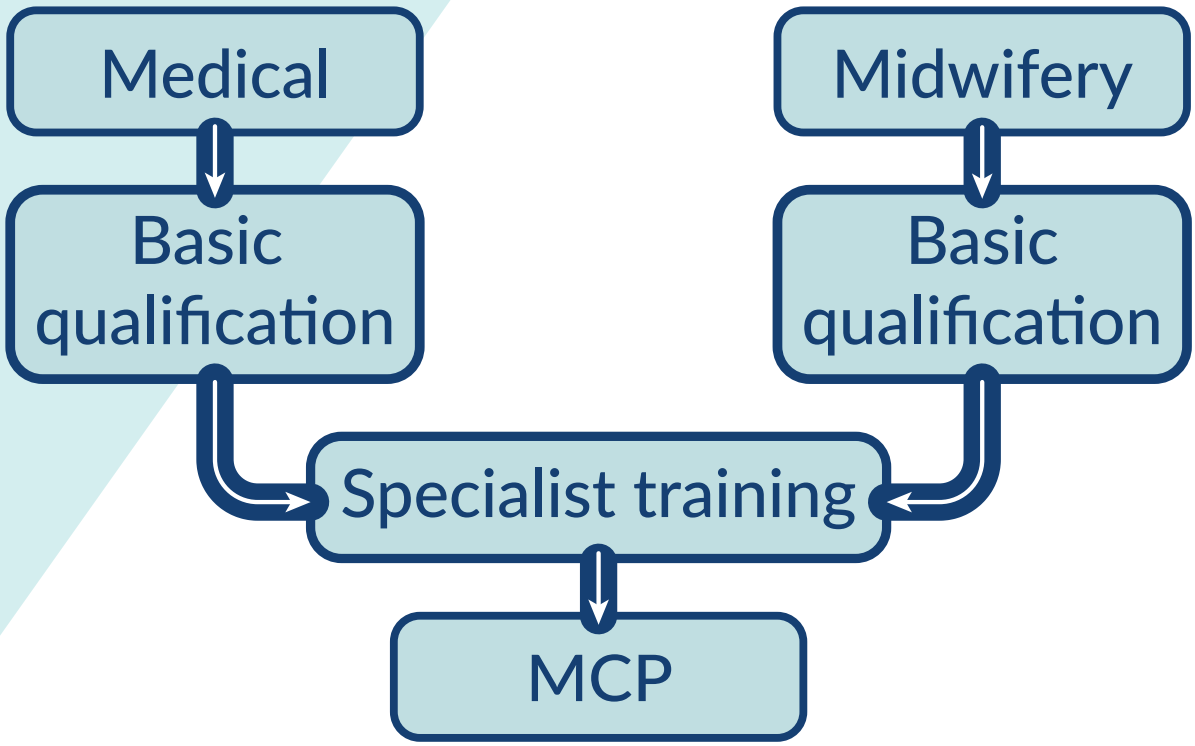

Figure: Routes to Maternity Care Provider (MCP)

This idea may not be as radical as it initially sounds – Swedish intensive care specialists can follow an initial medical or nursing route, for example.

Many organisations have called for closer integration of obstetricians and midwives – the UK report "*Changing Childbirth*" argued that professional boundaries between midwives and obstetricians were a problem.[4] A paper in *Health Policy* suggested that "obstetric-midwifery partnerships" would remedy the problem.[5] Midwives in the UK can be certified to carry out delivery interventions, such as use of forceps/vacuum. The WHO recommended task-sharing. Indeed, the cadre "midwife-obstetrician" already exists in Tanzania and Nepal. Perhaps it is time to give the idea serious consideration in high-income countries. From an emotional point of view I find the idea unappealing given the long and noble history of obstetrics and my professional pride. But that is not enough if care really would improve if the professions fused. The new Maternity Care Providers would be supported by physicians with an interest in medical diseases in pregnancy, and surgeons (perhaps a separate profession of gynaecology) who could carry out large-scale procedures, such as emergency hysterectomies.

It may be a long-time before the professional merger occurs or it may never happen. But I am not the first advocate – Marsden Wagner has also gone the full distance and recommended professional merging.[5]

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Do Local Hospital Waiting Times Change GP Referral Behaviour?

Yixin Wang, Midlands PSRC Pathways and Culture Research Fellow and Statistician

Reducing waiting times has been a long-standing NHS priority and a major policy concern across OECD countries. In cancer care, delays can negatively affect patient experience as well as clinical outcomes. Prolonged waiting times can cause inconvenience, anxiety, and dissatisfaction for patients with suspected cancer, and in some cases may lead to worse health status and poorer treatment outcomes. Waiting times can also influence demand for healthcare services. However, the behavioural response of general practitioners (GPs) to changes in local hospital waiting times remains unclear. Do longer waits discourage referrals, or do they prompt GPs to refer earlier when symptoms are uncertain? Understanding this relationship is essential for designing effective policies.

If waiting times are long, some patients might delay seeking help or opt for private care, reducing the demand for urgent GP referrals. Conversely, long waits could lead GPs to refer patients earlier, particularly when symptoms are ambiguous, potentially increasing demand. These competing mechanisms mean the direction of the effect is theoretically ambiguous. Hayes, et al. investigated whether GP referral behaviour for suspected cancer is sensitive to changes in local waiting times for urgent initial appointments under the two-week wait pathway. [1] The study applied the concept of demand elasticity, defined as the percentage change in referrals associated with a 1% change in waiting times, to quantify responsiveness.

The analysis used annual data from 6,667 GP practices referring to 185 hospitals in England between 2012 and 2018. The outcome was the number of urgent GP referrals for suspected cancer. The key explanatory variable was local hospital waiting times, proxied by the percentage of breaches of the two-week wait target, weighted by each practice's referral patterns. The authors estimated three models: a pooled OLS regression to capture overall correlation; a between-practice estimator to capture cross-sectional differences across practices; and a within-practice fixed-effects estimator to capture how changes in waiting times over time affect referral behaviour within the same practice.

The results showed that in the pooled model, a 10% increase in breach rates was associated with a 4.4% increase in referrals. In the between-practice model, the effect was even larger, at around 12%. However, in the within-practice model, which isolates changes over time within each practice, the effect disappeared. This suggests that practices do not change their referral behaviour when their local waiting times fluctuate. Instead, the observed correlation appears to be driven by structural differences between practices rather than by behavioural responses to waiting time changes.

Further work is needed to deepen understanding of referral dynamics. Future research could incorporate patient-level data to capture individual variation, disaggregate by cancer type given differences in urgency, and use actual waiting times rather than proxy measures. Such work would improve understanding of GP referral behaviour and help inform NHS strategies for managing waiting times and improving cancer pathways.

Reference:

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Eve's Revenge

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

While walking through a game reserve in Mpumalanga Province in South Africa, I asked what would happen should I be bitten by a mamba. I was told that I would be given a tourniquet and then transported to hospital where it would be released. Snakes inject variable amounts of venom when they bite, so paralysis is not inevitable after a bite from a neurotoxic species, such as the mamba or cobra. However, should paralysis (and impending respiratory arrest) ensue, I would be intubated and put on a breathing machine. When asked why I wouldn't be given anti-venom, I was told that it was expensive due to the large volumes required, its short shelf-life, the large range of species involved, and the costs of manufacture.

Those days are (hopefully) now coming to an end. An article in Nature [1] describes a method where, instead of producing one type of anti-venom, a large mammal can be injected with venom from multiple (17 in the article) snake species. The mammalian species used to produce antibodies are the alpaca and llama (both members of the family *Camelidae*). This is because, in these animals, the receptor bearing part of the antibody can be easily separated from the rest of the protein. This means that small, stable molecules with potency against multiple snake species can be produced simultaneously. A point overlooked by the authors – the incidence of serum sickness, caused by antibodies to antibodies, should also be reduced because most of the protein in the antibody molecule has been removed. This is a remarkable achievement, which will save the lives of tens of thousands of people each year.

Reference:

1. Ahmadi S, Burlet NJ, Benard-Valle M, et al. Nanobody-based recombinant antivenom for cobra, mamba and rinkhals bites. *Nature*. 2025: **647**: 716-25.

Hospital At Home*: Is It Really Such a Good Thing?

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

The notion that many people who were previously cared for in hospital could be cared for just as well (or even better) at home is now widely accepted. Indeed, it is a central plank of UK government policy. I want to gently question this idea – it is in danger of becoming something of a trope.

Before laying out my argument, I would like to recount an event – the death of Emperor Hirohito in 1989. After a long and eventful life, the man who signalled the end of World War Two was on multiple organ system support. He was as intensively supported as anyone in the world – perhaps more so if you read the account. Yet he was at home – there in the Imperial Palace. Likewise, King George VI had his pneumonectomy in Buckingham Palace. The point I am making is that anyone can be treated at home up to any intensity; whatever level of intensity required, it can be provided at home. However, it is not. This is for one reason and one reason only – cost.

As a result, we have hospitals that concentrate resources – plant and people that are in close proximity can treat people at much lower cost than when those facilities are scattered over a wide geographical area.

So, the issue of who should be treated where, is an economic one. It is preferable to treat people at home but only up to a point. It might be preferable to pay more to treat more people at home. But again, only up to a point.

In that case, where is the threshold?

The threshold falls where the marginal gain exceeds the value of the opportunity forgone by making that choice.

But how much more expensive is it to treat at home a patient who, in the counter-factual situation, would be tucked up in a hospital bed (where they would be intensively cared for, but nevertheless be at an increased risk of infection, confusion, alienation, dementia and so on)? This expense turns on two things – the relative cost difference and the relative health outcome difference.

Here we need to think of two very different scenarios – hospital at home after early discharge, and hospital at home for people at the point where they would otherwise be referred.

In the second scenario we must expect two things. First, the relative difference in cost between community and hospital is likely to be (much) higher than in the first scenario (of earlier

discharge). Why? Because the intensity of care in much higher when a person is first admitted. This is where hospital specialists make a careful assessment – often many different specialists are involved. This is also when most tests are done and, importantly, where information is transmitted between different care givers. It is also the phase during which observation is most intense. All of these activities can be delivered in the home care counter-factual. However, replicating all the above activities over a geographical area ratchets up the costs. Travel times are also much greater. Surges and troughs in demand mean either that some people will be neglected or that there will be unused capacity.

All the above factors could be quantified by means of time-and-motion methods, but such studies would be very expensive if done properly. And they would tell only half the story. This is because hospital avoidance schemes cause supply-induced demand. In other words, a proportion of people cared for at home would not have been sent to hospital in the counter-factual scenario.[1]

Post-discharge hospital at home is an altogether different kettle of fish. Here the patient has already had the bulk of tests, diagnoses have been made and they have passed the critical phase where rapid deterioration is a real risk. Such patients can be safely monitored and cared for remotely.

What does the evidence say? To summarise a large literature in one phrase – hospital avoidance schemes are more expensive but safe and preferred by patients.[2]

My advice to policy makers is to concentrate on early discharge schemes and use hospitals to provide care for the acutely sick. My research suggests that it is hard to scale-up hospital avoidance schemes.[3] Hospital avoidance has been all the rage for ten years, yet our hospitals are busier than ever with very long waits. It will cost more to reduce pressure by substituting hospital provision with a system to safely avoid hospital admission in the first place.

So I recommend supply-side investments to increase front door capacity in hospitals and facilitate discharge pathways, as they are potentially cost-releasing. Fortunately, ARC WM researchers Sam Watson and Paul Ellis, supported by Alice Turner, are investigating a Birmingham-based initiative to increase hospital at home provision. This is a superb study because it is built around a service, not researcher-based intervention. This makes it much more sustainable and even scalable than an intervention dreamed up by researchers and then implemented with agreement of service managers who do not really feel they own the thing. In other words, opportunistic research promoted by ARC WM.[4] This large study funded by NIHR HS&DR is unusual because it is a cluster RCT and will harvest all its quantitative data from routine sources.

** Some people make a strict distinction between virtual ward and hospital-at-home, which, to me, seems unnecessary.*

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Effect of Caffeine on Atrial Fibrillation Recurrence

Peter Chilton, Research Fellow

A recent study in JAMA looked into whether drinking coffee has an affect on a person's risk of developing a disordered heart rhythm (recurrent atrial fibrillation).[1] This condition affects around 1 in every 45 people in the UK,[2] and has been frequently suggested to be impacted by coffee, though the evidence remains unclear.

Investigators randomised 200 adults who had persistent atrial fibrillation that had been successfully treated with cardioversion (mean age of 69 years, 71% male, across the USA, Canada and Australia) to either consume coffee as normal (around 1 cup per day), or to abstain from coffee and all caffeine-containing products for 6 months. Surprisingly, they found that, while atrial fibrillation returned in 47% of those who were in the coffee consumption group, recurrence was seen in 64% of those in the group who avoided caffeine by 6 months (hazard ratio 0.61 [95% CI, 0.42-0.89], p=0.01). Rate of adverse events, including hospitalisation, heart failure or stroke, were similar between both groups.

There were a number of limitations acknowledged by the authors, including incomplete adherence to caffeine-abstinence among the control group, and whether these results would also apply to higher doses of caffeine, or synthetic products (such as energy drinks). Overall, however, it appears that moderate consumption of coffee may be protective, or at least not harmful, for patients with atrial fibrillation.

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Taking CBT Out of the Clinic and into Society

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

There are shed-loads of studies confirming the effectiveness of CBT (cognitive behavioural therapy) in relieving depression. It is equally effective as medicines,[1] but without the risk of side effects. Depression is common – one-fifth of adolescents (or thereabouts) classify as 'depressed' according to studies. It makes sense then, to go beyond treating cases that present to the health services and screen for depression. The problem arises that are not enough healthcare workers skilled in CBT to meet the demand identified through screening. This problem has been confronted by teaching teachers to provide CBT for 'screen positive' students. A study in West Africa [2] has shown that it is possible to teach the teachers, and that this can result in improved mental health outcomes for screen positive students.

But why stop there? Screening is not an accurate process to identify depression and a person's mood changes from time-to-time, as we all experience. There is therefore a strong argument to deploy CBT across groups of people, rather than sub-groups who have been identified by screening. In essence, I advocate a 'psycho-prophylactic' approach, previously mentioned in your News Blog.[3]

An interesting example I heard about recently took the form of a CBT module subtly built into a computer game. I do not know whether this imaginative adaptation was evaluated formally, but it does exemplify the concept of embedding CBT in normal life. The trials of teacher-led CBT are informative, because they show that CBT is effective when delivered to groups not just individuals. I would be interested in feedback on this idea in terms of likely value and feasibility.

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Patient Safety Incident Reporting Systems and Huddle-Based Reporting Practices

Naureen Ali, Midlands PSRC Pathways and Culture Research Associate

Unsafe practices continue to cause harm to patients all around the world despite advances in medical care. According to studies, about 10% of individuals suffer injury while obtaining medical care, which results in more than 3 million fatalities every year.[1] Robust, evidence-based ways for investigating and tackling patient safety issues are needed, as up to 40% of damages in primary and outpatient care are avoidable.[2] Common factors that can negatively harm patients include medication errors, risky surgical procedures, infections linked to healthcare, pressure sores, diagnostic errors, falls, patient misidentification, unsafe blood transfusions, and venous thromboembolism. [1,3]

In this blog, we will shed a light on key approaches to better understanding and learning from patient safety incidents, from structured incident reporting systems to proactive huddle-based reporting practices.

Patient Safety Incident Reporting Systems

Healthcare workers can record safety events, near-misses, or unfavourable incidents using incident reporting systems, which are organised platforms. These systems enable organisations to:

- determine recurrent harm patterns
- examine the underlying causes of errors
- implement corrective measures into action
- track improvements over time

According to research, well-designed reporting systems lessen avoidable harm by facilitating evidence-based policy changes, encouraging a culture of transparency, while providing actionable insights.[1,4]

However, success of these systems can be dependent on organisational culture. For example, staff may be reluctant to report incidents because they are unsure of what qualifies as a reportable event, fear of being blamed, or being unsure what will happen in response. Clear direction, non-punitive policies, and leadership support are needed to overcome these obstacles. Healthcare organisations can proactively prevent adverse incidents and continuously improve safety procedures by promoting reporting.

Huddle-Based Reporting Practices

Safety huddles are a kind of proactive briefing method conducted by healthcare personnel to collaborate, exchange information, and increase awareness of safety concerns in healthcare settings.[5] These occur within a short time frame after a patient safety incident with the closely involved staff and those responsible for implementing measures to reduce the likelihood of such an event happening again. Safety huddles in healthcare settings include a circle-like arrangement to protect participants from distractions and ensure focused and efficient communication.[5] These brief, focused stand-up meetings have the potential to improve healthcare by fostering a shared understanding of contemporary clinical scenarios and enabling effective, collaborative information sharing.[6]

According to the *Joint Commission Centre for Transforming Healthcare*, 80% of major medical errors are caused by a lack of communication between healthcare staff.[5] The *Improvement Academy's Huddle Up for Safer Healthcare (HUSH)* programme demonstrates that safety huddles improve communication, culture and reduce preventable harm. With 5–10% of hospitalised patients in high-income countries experiencing harm, huddles help teams address falls, pressure ulcers, violence, and other safety concerns.[7] By 2023, over 400 teams were routinely huddling, and an evaluation of 92 wards showed strong adoption, with 83% of staff reporting they would miss huddles if they stopped. Concept analyses highlight five core attributes of effective huddles: structured communication; interdisciplinary collaboration; time-bound goal-oriented design; proactive risk prediction; and contextual adaptability, emphasising that leadership support, psychological safety, and dedicated resources are key to sustaining their impact.[7]

Huddle-based reporting practices offer a practical way to strengthen safety culture by creating regular space for teams to connect, reflect and discuss risk. Because safety culture can feel nebulous, huddles help link the what of the work with the how teams work together. Evidence shows that safety huddles helped prevent over 6,000 falls and saved an estimated £15 million, with further improvements seen in pressure ulcers, deteriorating patients and mental health safety issues.[8] These examples support the wider message of the toolkit: that culture shifts when teams intentionally focus on their interactions, build psychological safety and value all contributions. Research shows that the effectiveness of interventions such as huddles depends as much on the social relationships within teams as on the tools themselves, reinforcing the need to nurture both.[8]

Safety huddles function as brief, real-time interventions that enable healthcare teams to detect risks, enhance communication, and respond promptly to patient safety issues. In contrast, formal reporting and investigation mechanisms provide a longitudinal perspective, facilitating the systematic analysis of incidents and the implementation of organisational-level corrective measures. These two approaches can be synergistic, with huddles generating immediate insights that inform broader safety and quality improvement initiatives. Nevertheless, the processes through which information from huddles is integrated into formal reporting systems, and how this interaction unfolds in practice, remain poorly understood.[9]

Building on these insights, our work at the NIHR Midlands Patient Safety Research Centre (PSRC) aims to address the gaps identified in the literature and practice of safety huddles. Specifically, we are launching a project to explore the mechanisms through which huddles influence patient safety culture within UK healthcare settings, and how information from these real-time interventions interacts with formal reporting and organisational learning systems. By examining these dynamics, our study aims to generate practical insights to optimise the design, implementation, and integration of huddles, ultimately enhancing teamwork, communication, and patient safety outcomes.

[NB. References on next page.]

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Remembering Professor Tim Draycott

Hsu Chong, Consultant in Maternal & Fetal Medicine

We at the West Midlands PSRC and ARC West Midlands are deeply saddened by the sudden death of **Prof Timothy Draycott**. Our deepest condolences are with his family.

Prof Draycott was an impactful advocate for Women's Health and patient safety. His work championed teamworking and the training package for obstetric emergencies that he introduced, PROMPT, continues to be transformative, reaching maternity providers globally. He has inspired a great many into obstetrics and gynaecology, research and medical education.

Way back when Richard Lilford was running the Department of Health and Social Care *Patient Safety Commissioning Programme* for the then CMO Liam Donaldson, Tim and his colleague Bryony Strachan won a grant to evaluate a promising programme to improve management of emergency birth. Richard put himself forward as a trainee and there was no doubt that, notwithstanding his self-proclaimed expertise as an *accoucheur*, his skill was not as great as he thought. He would have really benefited from the programme had he remained in clinical practice. The rest is history. Tim's programme has since swept across UK and beyond our shores. It has proven effective and saved thousands of babies and parents.

Prof Draycott was one of those people with whom just a 5-minute interaction would result in an inner shift in yourself as an individual, because he made you believe in what was possible. Kind, encouraging and patient-centred, he leaves behind a legacy of people who will continue to champion women's health, encourage the next generation of clinicians, midwives and academics because Tim has shown us change is possible.

Members, Fellows and Trainees of the Royal College of Obstetricians & Gynaecologists are invited to share their memories, condolences and reflections on their memoriam page.

Intergeneration Community Building for Better Wellbeing

The potential benefits and ethical drivers to put neighbourhoods and communities at the centre of designing and delivering support has long been recognised in public policy and practice. For example, within public health, building on local community assets is vital for a more preventative and holistic approach which addressed structural health inequalities, and within social care, strengths-based working is embedded in legislation to promote individual and family wellbeing. Despite this emphasis, there are limited examples of successful and sustained community development in action in recent times, particularly those which are holistic (i.e. not related to the priorities of a discrete policy area) and driven by local people (i.e. not developed by agencies with limited opportunity for genuine co-production).

To explore the opportunities and challenges of community wellbeing, ARC WM have undertaken a study of stakeholder perspectives of an intergenerational approach to working with communities. Together We Can (TWC) is a long-term project in the Firs and Bromford area of Birmingham. Funded by the National Lottery Community Fund and Big Local, TWC supports neighbours to work together to make their local area a place where people feel welcome, connected, and able to flourish. TWC is not primarily about delivering specific projects or services. Instead, staff walk alongside neighbours, helping people to connect, belong and take part, so that long-lasting local change is done with and by the community, not for them. TWC creates welcoming spaces, groups, and events where people can meet others, share what they know and love, and support one another.

Stakeholders within the public and voluntary sector saw TWC as a community- based partnership which has considerable value to local people and to their work as agencies. Benefits for the community included being: connected (through engaging people peer-support and inclusive events), welcomed (through safe spaces for new arrivals and those in a time of crisis), belonging (through creating pride in the people and environment of the estate), celebrated (recognising 'unsung heroes' and volunteering) and supported (through responding to practical need and facilitating access to advice and guidance). TWC was seen to assist other agencies to more effectively carry out their work through providing access to the community, having a good understanding of the interests and aspirations of local people, and increasing uptake of services and support which is available.

For more information, please read the report (PDF) or contact Prof Robin Miller, University of Birmingham (r.s.miller@bham.ac.uk).

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.

The final masterclass of 2025 will take place on **2 December 2025**, 1-2pm, with Prof Robin Miller on the topic of '*Understanding process*'.

Next year will start with a masterclass from Dr Arabella Scantlebury on '*Evidence versus experience: the clash of the surgeons*', to be given on 28 January 2026, 1-2pm.

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

Collectively Common: The Devastating Impact of Rare Kidney Diseases in the UK

Kidney disease is a public health emergency costing the UK economy an estimated £7 billion annually. Rare kidney diseases consist of over 150 distinct conditions. Although individually affecting fewer than 1 in 2,000 people, it is estimated that, overall, these rare diseases affect over 160,000 people in the UK. The annual NHS cost for dialysis is approximately £263 million. Kidney Research UK (KRUK) recently commissioned a report, titled 'Collectively common: the devastating impact of rare kidney diseases in the UK'.

Prof Lee Aiyegbusi (Theme 1, Long-term conditions) was one of the leading UK experts who contributed to and provided insights for this report, which was launched at the KRUK 'Driving Discoveries' conference in September 2025. The report outlines issues including significant diagnosis delays, inconsistent care and long waits for new treatments, with children in particular left at greater risk of medical, educational, and economic disruption. It also provides 14 recommendations to enhance diagnosis, clinical trials, and encourage multistakeholder commitment to investment in research and care services.

In November, Lee participated in a parliamentary roundtable hosted by Stuart Andrew MP at Westminster where the report and its recommendations were discussed extensively with members of parliament.

Latest National NIHR ARC Newsletter

The latest issue of the NIHR ARCs Newsletter is now available at: http://eepurl.com/jqAaM6. Highlights include details of comprehensive guidance for care planning in English care homes; resources to improve admissions to mental health units for young people; and guidance to support clinicians working with young people in mental health services.

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

ARC Advent Campaign

During December the national ARC social media account (NIHRARCs) will be running a daily ARC Advent campaign on X and BlueSky featuring posts of the most popular ARC stories of 2025 from across all the ARCs. You can follow #ARCAdvent on X or BlueSky until 25 December.

Develop Your Coaching Skills with NIHR

NIHR's latest e-learning module aims to help you have more impactful conversations to unlock performance and foster a learning culture. This includes: identifying coaching mindset principles; building coaching skills into daily interactions; and role-modelling best practice coaching behaviours.

There are 15 modules currently available on NIHR Learn that cover the latest leadership tools and will enable you to reflect on and practise new approaches. You can access them on demand and each module takes around 40 minutes to complete.

Find out more at: https://learn.nihr.ac.uk/course/view.php?id=1126 (sign-up required).

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

2026 Postdoctoral Event - Manchester

Save the date for the third postdoctoral event, which will be held on Thursday **29th January 2026**, at Kings House Conference Centre, Manchester. The theme is "*Thriving in Transition*". (Event open to final year PhD students and Postdoctoral researchers.)

Further information to follow.

Recent Publications

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