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ARC West Midlands News Blog





Health Financing in Sub-Saharan Africa: the Story of a Bandwagon

Richard Lilford, ARC WM Director

The 1980s, were something of a watershed for healthcare in sub-Saharan Africa. On the demand side, the AIDS epidemic was wreaking havoc. There were also severe problems on the supply side. Many African countries were performing poorly economically under totalitarian and corrupt governments. Investments from the International Monetary Fund and the World Bank were not resulting in the anticipated enhanced economic performance that would enable them to be repaid. It was against this backdrop that the [Bamako Initiative](#) was adopted in 1987.

The intellectual basis for this initiative lay in the rising prominence given to community financing. The idea was to harness the productive capacity of communities through initiatives such as micro-finance and loan syndicates. The backdrop also included waxing interest in community self-help,[1] for example through women's groups.

In the particular case of the Bamako Initiative, the idea was to raise funds for primary health care through the sale of drugs at a profit. The initiative was strongly supported by the WHO and

UNICEF. In 1989, Paul Garner wrote an article in the BMJ,[2] expressing some doubts about the initiative. Then, in 1993, Barbara McPake and colleagues wrote an influential article describing their evaluation of the initiative based on five case studies.[3] The article was nuanced and fell well short of a ringing endorsement of the initiative. However, in 2003 Knippenberg and colleagues wrote an article concluding that the initiative had led to “improvements in the access, availability, affordability and utilization of professional health services... for the average population and for poorest groups”. [4] However, opinion changed and in 2019, [Robert Yates](#), Director of the Global Health Programme and Executive Director of the Centre for Universal Health at Chatham House, wrote an article saying that it is time to bury the Bamako Initiative.[5] What went wrong?

First, a rereading of Knippenberg's article suggests that he and his colleagues likely over-interpreted the data in claiming cause and effect. They documented declining mortality in a number of countries that were part of the initiative, but without controls. This was the era of great improvement in child and infant

mortality, driven by vaccination, malaria prophylaxis, improved detection and correction of malnutrition, improved breast-feeding rates, and improved management of diarrhoea. Mortality was improving all over the world, and in the absence of contemporaneous controls I suspect that Knippenberg was describing a temporal trend. Of course, this does not disprove the initiative, but Mali, the very country where the initiative began, has now scrapped the system. The general climate has also changed, and micro-finance is no longer seen as a magic bullet.[6]

The trend now is, quite rightly, geared towards achieving universal health coverage. In other words, it is no longer believed that communities can be the sole architects of their own salvation. It is important, however, that we do not throw out the baby with the bath water. People were initially hubristic about grassroots and community initiatives. It is also important to avoid hubris regarding universal healthcare; a paper by myself, Celia Brown, and Frances Griffiths in the *BMJ Global Health*, shows that there simply is not enough money in LMICs to provide adequate state funded care, even at the primary level, and even if the proportion of government spending on health care was to rise.[7]

Meanwhile the [Abdul Latif Jameel Poverty Action Lab](#) has shown that a number of micro-initiatives can produce positive impact, [earning Nobel prizes](#) for Banerjee, Duflo and Kremer, the architects of the initiative. We are evaluating the effectiveness and sustainability of self-help groups in Nepal, India and Nigeria under funding from an NIHR RIGHT grant ([#NIHR200132](#)). We think a combined bottom-up and top-down approach is the best way forward; increase universal health care as fast as possible while not ignoring other sources of finance, such as saving syndicates. Meanwhile, we have made another discovery as part of our work on slum health.[8] Medicines are by far the largest primary health care cost for poor people in cities, greatly exceeding the cost of consultations [*paper forthcoming*].

Is it possible that as countries try to expand universal health care, facilities use public money to cover the costs of consultations, but make up for a shortfall in government funds by a charge on drugs? In that case, the Bamako Initiative is coming back in, but by the back door!

I would very much welcome comments and corrections from people more expert than myself, and continue the debate in these pages.

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Iterative Approaches to Intervention Development



*Charlotte Woodcock, Nicola Cornwall, Julie Ashworth, Christian Mallen, Clare Jinks
(Keele University - ARC WM Theme 1, Long-Term Conditions)*

Using robust methodology across the whole intervention development and evaluation pathway helps to give interventions the best chance of being effective and implemented, and of being acceptable to patients (and their families) and those working in health and social care. Although approaches to definitive evaluation are well established (e.g., randomised controlled trials), strategies to evaluate initial or prototype interventions are perhaps less well known. As we eagerly await publication of the updated MRC guidance on developing and evaluation of complex interventions,[1] we can look towards recent advances in the field of intervention development. For example, a taxonomy of approaches to intervention development and guidance for intervention developers have emerged from the INDEX Study.[2,3] These publications are helpful in shining a light on how intervention developers can approach early phases of development and testing.

Iteration is a key feature of initial intervention evaluation and involves “*doing something again and again, usually to improve it*” ([Cambridge Dictionary, 2021](#)). O’Cathain et al.,[3] recommend that “*once an early version or prototype of the intervention is available, it can be refined (sometimes called optimised) using a series of rapid iterations where each iteration includes an assessment of how acceptable, feasible and engaging the intervention is, leading to cycles of refinements*” (p8). Iterative working is required in person-based approaches to intervention development [4] as part of a rigorous process for eliciting and analysing the views of a wide range of users, and developers of e-health interventions often describe this stage in the evaluation pathway as user testing.[5] Intervention developers may choose different methods to achieve iterative testing and evaluation, including discussion and feedback with stakeholders, qualitative and quantitative research. At ARC WM we have used in-practice testing and cycles of think aloud interviews in our research programme that aims to develop and test a new clinical pharmacist led review for patients prescribed opioid medicines for chronic pain.

In the UK, it is estimated that 43% of the adult population experience persistent non-cancer pain, also known as chronic pain,[6] many of whom are prescribed opioids.[7] The latest NICE guideline for the assessment and management of persistent pain does not recommend opioids for the treatment of chronic primary pain.[8] This recommendation follows a lack of research evidence for the long-term benefits of opioids and growing evidence of adverse side effects and long-term risks (e.g., addiction, overdose). A regular review is therefore recommended for patients prescribed long-term opioids to assess treatment efficacy and, where appropriate, to support patients to gradually taper their opioid dose.

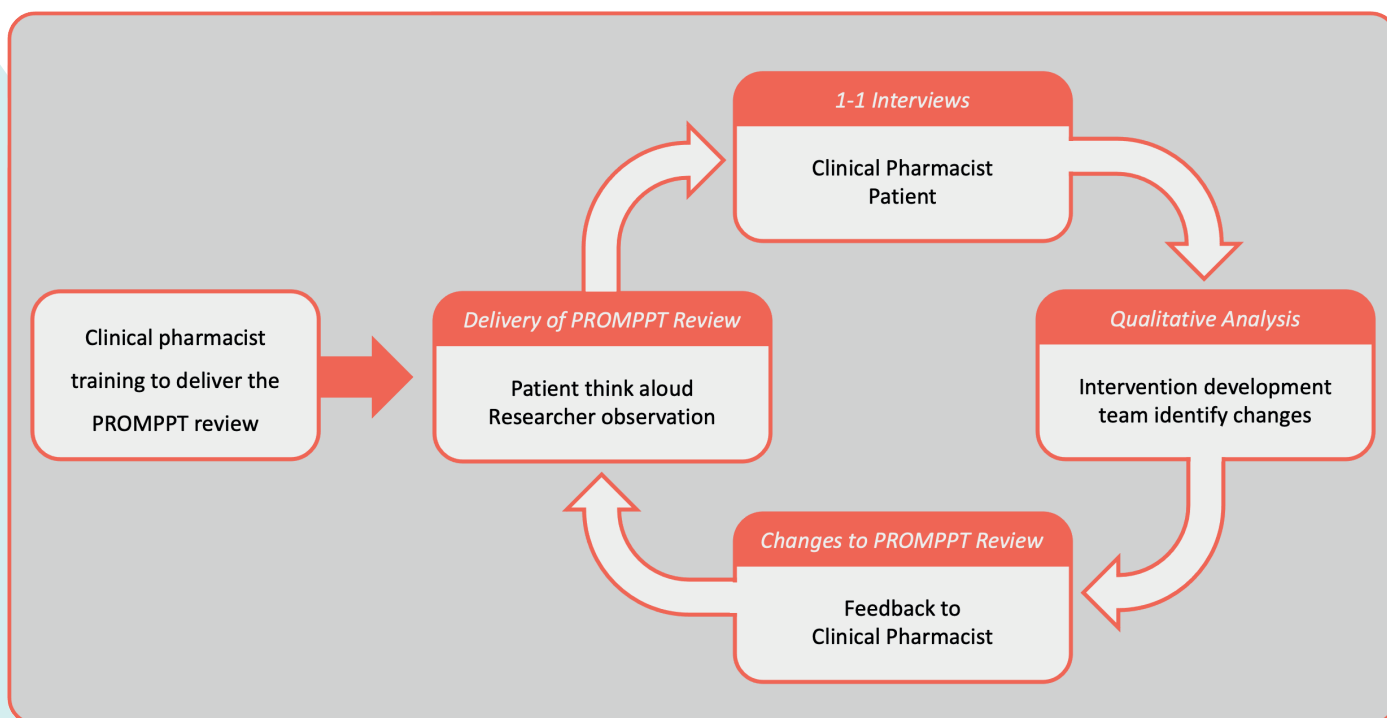
In 2019, the NIHR awarded £2.4 million to Keele University to fund a 5-year programme of research to develop and evaluate a pharmacist-led primary care intervention (**P**roactive clinical **R**eview of patients taking **O**pioid **M**edicines long-term for persistent **P**ain led by clinical **P**harmacists in primary care **T**eams: PROMPPT) to address opioid overprescribing. The project team, led by Professor Christian Mallen (CI) and Dr Julie Ashworth (PI), adopted an iterative person-centred approach to intervention design. The first year of the programme was dedicated to initial phases of conception and planning (e.g., evidence synthesis, stakeholder meetings, patient and public involvement, interviews and focus groups with patients, general practitioners, and clinical pharmacists, as well as an online patient discussion forum), designing and creating (e.g., development of intervention components and resources along with an accompanying training programme), and initial refinement (i.e., in-practice testing). [3]

In-practice testing provides an opportunity to evaluate an intervention with a small sample before progressing to costlier phases of a research programme, such as formal feasibility testing or a definitive randomised controlled trial (RCT). The method adds to any simulation or patient involvement activities, and allows for immediate and obvious problems with feasibility and acceptability to be identified, as developers work with patients and practitioners in near similar conditions to those planned for subsequent stages of evaluation.

What we did:

For PROMPPT, three clinical pharmacists based in three primary care centres in the West Midlands agreed to take part in the in-practice testing. The pharmacists attended a half day of face-to-face training at Keele University to learn about the components of the PROMPPT review and its person-centred guiding principles. The training included simulated pain management consultations with members of Keele's PPIE group. Ethical approval was required as the in-practice testing was located in NHS settings and we used think-aloud qualitative interviews that yielded research data.

We undertook iterative cycles of delivery, data collection, reflection, and revision of the pain review. In total, 13 patients participated, with two of these patients attending a follow-up appointment, meaning 15 consultations were conducted overall. Patients were asked to think-aloud during the review by saying out loud any thoughts or feelings that come up during the review. Every pain management review was audio-recorded and observed by two qualitative researchers. Immediately following each review, the patient and clinical pharmacists were interviewed by one of the observing researchers. Data from each phase of in-practice testing was combined with researcher reflections and pointed to aspects that worked well as well as highlighting areas needing revision.



What We Found

The results of the in-practice testing are due to be published in future. We gained insights into how the patient facing documentation was received and used (invite letter, pre-review pain concern form and patient resource leaflet). We identified further work was needed to help all practice staff understand and support the pain management review. We also realised clinical pharmacists needed more support to make appropriate referrals and deal with a wide range of issues that crop up whilst also keeping a focus on pain. We recognised some processes could be streamlined to help keep the review to under 30 minutes. We saw how there was a lack of clarity about the need for follow-up consultations.

What Next

Findings from the in-practice testing were discussed with the intervention and training development teams. Areas for refinement were presented to the PROMPPT stakeholder group of clinical pharmacists, general practitioners, general practice managers, practice nurses, a health psychologist, an addiction specialist, a clinical psychologist, specialist pain physiotherapists, and a representative from the PROMPPT PPIE group. Key actions for

refinement were prioritised through stakeholder discussions whilst also considering wider implementation issues to inform a single-armed feasibility study to test the acceptability and credibility of the pain management review. The project is currently undertaking feasibility testing in a small number of practices in the East and West Midlands. We continue to take an iterative approach to assessing the pain management review and adapting it to recent restrictions imposed by the COVID-19 pandemic.

Our approach has required significant time and resources including two qualitative researchers, three clinical pharmacists, 13 patients, clinical research network and practice staff. In addition, other research team members developed and delivered a prototype training programme for clinical pharmacists and engaged with stakeholders. Some may question the rationale for spending time and resources on this type of early evaluation work. Robust strategies for intervention development do take time and need to be planned and properly funded. Identifying obvious problems and possible solutions before conducting expensive feasibility studies or RCTs has potential to save time and money in the longer term by preventing evaluation of sub-optimal interventions or trial processes.

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The H@H Research Project

Hong Chen, Research Fellow; Dan Lasserson, Professor of Acute Ambulatory Care (University of Warwick - ARC WM Theme 2, Acute Care Interfaces)



How to utilise the potential of Hospital at Home services to deliver more acute non-COVID and COVID care outside of hospital

Background

Hospital at Home (H@H) is a service that provides acute and subacute care by healthcare professionals in private or care homes for a condition that would otherwise require acute hospital inpatient care.[1] It treats people with a wide range of conditions in a variety of contexts, with its particular interest in the provision of services for older people living with frailty. You can see features of H@H and how it differs from other home-based health services at the [UK Hospital at Home Society's website](#).

There are significant challenges in meeting the acute healthcare needs of our population during waves of the COVID-19 pandemic. Emergency Departments, acute medical units and intensive care units can reach capacity limits, which has

implications for hospital function (including reducing elective surgical care), staff well-being and results in delays to assessment and treatment. This research project aims to understand how the current provision of H@H can support delivery of certain hospital-level care processes in community settings. It will produce practice and policy-relevant evidence to inform how H@H can contribute to system recovery and resilience- through delivering more acute non-COVID and COVID care for newly or already vulnerable, home-bound groups outside of hospital.

The H@H project is rapid COVID-related research funded by NIHR Policy Research Programme through its Recovery, Renewal, Reset funding call, and is led by the University of Warwick.

What Will H@H Achieve?

Aiming for person-centred care, H@H provides multi-disciplinary, coordinated care in the home, working with patients and carers and interfacing with existing acute and also community-based health and social care services.[1] It is therefore inherently complex, with multiple, interacting strands of activities/interventions delivered by different professionals at multiple levels, through complex relationships and interactions within and across professional and organizational boundaries.[2] Flexibility and adaptability to individual needs/circumstances and local contexts are its strength which entails variations in the service model.[3,4]

The project will produce some urgently needed evidence to inform policymakers on how to scale up H@H, including ‘core ingredients’ of H@H that can be adapted to individual needs/circumstances and local contexts to formulate ‘local recipes’; some baseline data about access, capacity, process of care, costs and savings of the existing H@H services in the UK; and implementation lessons during the pandemic. The project will also create a single data set that captures activity, complexity and outcomes from the UK services.

What Will the Team Do?

The research team will first undertake a rapid review to develop a theory of change for H@H programme. Then virtual stakeholder consultations will be held with multidisciplinary team members and service leads/managers of H@H services to capture lessons learnt during the pandemic, and to refine and update the theory. The team will also conduct a UK H@H baseline survey to assess the current H@H provision in the UK, and undertake comparative cost analysis, including estimation of implementation costs and contingent costs. At the end of the project, results from the above components will be used to create and define a core data set for a national data registry.

Impact & the Future

The project will run from April 2021 to March 2022. This research initiative will contribute to meeting a major challenge faced by the Department of Health and Social Care during the pandemic and beyond: providing personalised acute care for older people living with frailty. The team will produce practice and policy-relevant evidence on H@H including its impact on patients and their carers, acute healthcare delivery providers, social care providers and other community services. The findings will be set within the context of the NHS Long Term Plan for ‘Ageing well’. We will share findings with policymakers, service planners/commissioners, practitioners, researchers, and the public using social media, workshops and publications.

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The First Early Career Opportunities Day About Goals and Time Management: ARC WM Training and Development Group Event

*Kelly Ann Schmidtke (University of Warwick); Sarah Muller (Keele University);
Laura Kudrna (University of Birmingham); Phil Simmons (University of Warwick);
Aileen Clarke (ARC WM Lead for Research Capacity Development)*

Introduction

Who are early career researchers (ECRs)? Many definitions of ECR serve bureaucratic functions that may undermine the more nuanced nature of this term, e.g., [a person being within five years of receiving a PhD](#). More nuanced definitions describe early career research as a “[stage](#)” that researchers move through as they progress to self-lead research projects. While this nuance allows for longer periods of growth, it may increase confusion and stagnation. Becoming an independent researcher with a unique voice may at times feel isolating. “[We \[ARC WM’s early career researchers\] are not alone](#)”, but until we are purposely brought together, we may not realise this.

On 17th June 2021, ARC WM held our first ECR event online. The purpose of the event was to support ECRs across ARC WM. [The planning committee included researchers](#) across all of our partner institutions, including Sarah Muller

at Keele University, Laura Kudrna at the University of Birmingham, and Kelly Schmidtke at the University of Warwick. The committee was led by Prof Aileen Clarke, with Phil Simmons providing additional administrative support.

We aimed to:

- identify early career researchers associated with NIHR ARC WM;
- run a fun event to allow networking for ECRs;
- consider our goals and time management in the context of early career research;
- generate aims for future ECR events.

Identifying ECRs

The planning committee considered lists of employees associated with ARC WM. People with job titles below the level of “senior lecturer” were invited. People above this level were also invited if the planning committee believed they might want to attend (aiming to over-recruit).

We wanted people to [self-define](#) their career stage. Additional early career researchers were invited who were not directly employed by ARC WM, but who were associated with our ARC, e.g., public health specialists in training.

Discuss goals and time management

The event included two breakout room activities and a guest presentation.

Activity 1: Setting Objectives.

Laura Kudrna introduced the first activity, called “Getting Objectives”, by asking attendees to think about what goals they would like to achieve in the next year – shorter-term goals. Then Laura asked attendees to share why they choose those goals in their breakout rooms. This activity was meant to empower attendees to collaboratively consider factors, within and outside of work, that influence the goals they set.

Activity 2: Future Planning.

Aileen Clarke introduced the second activity, called “Future Planning”, by asking attendees to imagine what they will have achieved in 5 to 10 years – longer-term goals. Aileen invited attendees to write a mini-biography (‘my story, my narrative, where do I want to be) like the ones displayed on book covers. Attendees shared their biographies in their breakout rooms. This activity was designed to support attendees discover and articulate their own goals and to recognize similarities across their goals.

Presentation: Talk on Time and Attention Management.

[Ashley Willians](#), assistant professor at Harvard Business School, gave a presentation on time and attention management. Her research investigates whether and how intangible incentives affect employee motivation and well-being. The presentation was packed with fascinating research. Some highlights include:

- Ashley asked attendees to consider what words they associated with the word “time”.

Many of our proposed words were negative, e.g., “running” or “deadlines”.

- Her research showed that 80% of working-age US adults consider themselves ‘time poor’.
- She explained how our understanding of time and our satisfaction with life is influenced by how we allocate our attentional resources.
- She talked about how to resist societal pressure (being busy is a status symbol) and how to change our focus to make more use of our time.
- Mantras included ‘find time,’ ‘negotiate for more time,’ ‘re-frame time,’ ‘time for happiness’.
- One interesting section dealt with how the shift to hybrid working and working at home during the pandemic has left some employees unable to disengage from their work.
- In addition to sharing her exceptional research, Ashley put forward strategies we could use to reallocate our attention and reclaim time, e.g., [scheduling in time for small talk around meetings](#), [creating a ritual activity to mark when the workday begins and ends](#), and [focusing on the most important rather the most urgent daily tasks](#).

Aims for future events

Near the end of the event, Sara Muller asked attendees how we could support their future career ambitions. We used an online Padlet to anonymously collate ideas for future early career researcher events. There were requests for skills-based support around “getting papers published” and having “the right sort of confidence and assertiveness at meetings”. Several comments were specifically around obtaining and managing grant funding: “How to get a fellowship?” and “How do research budgets work?” There were questions around careers after the current ARC-funded posts. Specifically, whether methodological or disease-specific

skills are more valuable, and whether individuals should attain teaching qualifications. Attendees would also like to see more “inspiring talks”, and to do research that “makes a difference to patients and policy”.

Reflections on the workshop

The planning committee met after the event to pick out priority areas early career researchers wanted to explore over the next year. We identified five thematic areas that we believe we can support moving forward: Publishing, Assertiveness, Small Grants, Budgets, and Asserting Research Independence.

Over the next year, the committee will host bi-monthly meetings around each theme. All early career researchers who attended the current event will be invited to these meetings, and we encourage other people who identify as ECRs to attend. In this sense, these meetings will serve two purposes. First, we will offer support for expressed needs. Second, we will develop our community of ECRs and in so doing empower them to learn, share, and help each other. In addition to these meetings, we will host the second ECR Opportunities Day next year about diversity in research career paths.

Conclusions

The event was very successful. There were 21 attendees across all partner institutions. We were also happy to see attendees across varying levels of career progression, from PhDs to Assistant Professors. We have clearly started to build a network of early career researchers and the planning committee has a wealth of ideas to take forward.

ARC WM Quiz

Pica pica is the scientific name for the common magpie. Pica is also the name of a psychological disorder, but what is it characterised by?

email your answer to: ARCWM@warwick.ac.uk



Answer to previous quiz: The condition St Vitus’ dance is also known as Sydenham’s Chorea or Chorea Minor, and is characterised by rapid and uncoordinated jerking movements of the face, hands and feet.

Congratulations to Mark Gabbay who was first to answer correctly.

Comparison of the Results of Trials vs Real Life Use: an Example Based on Trials of Nudge Theory

Richard Lilford, ARC WM Director

I am grateful to ARC WM News Blog reader Gus Hamilton for drawing my attention to this interesting paper from the National Bureau of Economic Research in the USA.[1]

This paper compares academic trials of nudge theory with trials of the same nudge interventions carried out on a larger scale by Nudge Units in the United States. The latter provide access to a repository of no less than 126 randomised trials covering nearly 24 million people.

The effect size in the academic trials was 8.7 percentage points, representing a 33% (relative risk ratio) increase in the take up of the desired behaviour in intervention versus control participants. However, in the larger Nudge Unit trials, the percentage point improvement was only 1.4%, representing an increase of only 8% in relative risk ratio. Indeed, the latter is more in line with an RCT carried out by ARC WM looking at nudge theory to improve uptake of the influenza vaccine involving over 8,000 frontline staff.[2] In fact, our trial produced a point estimate of no effect within very narrow confidence intervals.

The Nudge Unit trials were, on average, over ten times larger than the academic trials, thereby representing intervention at scale. In fact, after controlling for sample size, some of the differences between the academic and Nudge Unit trials disappears.

The report covers the entirety of Nudge Unit trials, leaving no room for publication bias. However, there was some evidence of discontinuity in the distribution of the [t-statistics](#) in the non-Nudge Unit trials, suggesting some publication or lack of submission bias. This worrying finding of publication bias, broadly defined, in the academic literature is of concern and somewhat

at variance with recent findings from ARC WM researchers in the health service literature.[3]

The Nudge Unit trials tended to have less intensive interventions, for example with less direct contact, and also to have longer time horizons. Controlling for this feature also removed a significant portion of the difference in results between academic and Nudge Unit trials.

This is a monumental study running to 73 pages, including much detailed statistical analysis. It is certainly interesting and provocative. It also adds further support for an opinion frequently expressed in this News Blog; we consistently argue for more evaluation of real-world interventions implemented by the service, rather than specific implementation science interventions, implemented largely by academics operating in an acquiescent service.

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Harmonious Professional Relationships Are Not Just a Matter of Good Manners; They Save Lives

Richard Lilford, ARC WM Director

When I was in frontline clinical practice, I generally enjoyed harmonious relationships with my colleagues. I got on well with anaesthetists, image specialists and, perhaps especially, my paediatric colleagues. Every now and then I would encounter friction. I even went on a course on how to handle difficult people (or some such title). I confess it – the course helped me manage a rather rebarbative colleague with whom I had a piquant relationship. I learned from role play never to rise to the bait. Ask questions – the act of conjuring an answer requires mental effort that deflects some of the hostility. But it should not come to that. Civility is too important.

It's not just to make the workplace more convivial; good working relationships save lives. I advise on a grant regarding managing post-operative crises run by Prof Peter McCulloch, while my colleague Prof Russell Mannion has just [won an HS&DR grant to study the topic](#). I thank Russell for the following references showing that hostile working relationships actually endanger patients, especially in a crisis.[1-3]

Cooper and colleagues looked at surgery outcomes of 13,653 patients, and found that those who were operated on by surgeons who had received a higher number of reports from co-workers about their unprofessional behaviour were at a significantly increased risk of complications ($p < 0.001$).[1] A multi-centre RCT by Katz, et al. showed that anaesthetists who took part in a simulated scenario featuring a 'rude' surgeon, scored lower on all performance metrics measured compared to those using a

standard scenario.[2] These metrics included vigilance, diagnosis, communication and patient management. Meanwhile, a study by Riskin, et al. involved 39 neonatal ICU teams attending simulation workshops where they were exposed to neutral performance statements, or rude statements from the patients' mother. Analyses showed that the rudeness affected both diagnostic and intervention performance, as well as on patient care processes within the team, such as information sharing and communication.[3]



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The Effect of Remote Working on Worker Productivity

Richard Lilford, ARC WM Director

The ARC WM director finds home working very hard due to lengthy and uncertain lines of communication. He believes that he must work much harder to achieve the same result when he is dislocated from the office. One of the ARC WM Director's relatives, by contrast, rather enjoys working from home and perceives no adverse effect on his productivity, or that of his team. Doubtless, remote working affects different people differently. But what is the effect on average?

Gibbs, Mengel and Siemroth have collected extensive data on this point,^[1] based on routine data collected by software installed on computers of over 10,000 employees. Do remote workers spend more time working? The answer is yes; working hours increase by an average of 30% and time spent working outside normal office hours increases by 18%. Did productivity increase? No, there was no increase overall and productivity per working hour fell. So, where did the extra hours go? The increase in time spent in meetings exceeded even the increase in total

working hours. That is to say, the time spent focused on individual tasks actually decreased.

These results seem to confirm the Director's observations. Remote working increases transaction time. It is much less satisfying or enjoyable; have you ever tried cracking a joke on video call? And hybrid working needs to be carefully coordinated among staff, otherwise those working remotely transfer stress and work to those in the office.

Previous research was based on call centres, where work involves repetitive tasks and minimal worker interaction. Where the work is more complex, for example applied health research or management consultancy, remote working seems severely constraining.

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Telemedicine for Outpatient Care

Peter Chilton, Research Fellow

It is safe to say that the COVID-19 pandemic has caused an unparalleled level of disruption, particularly within healthcare. As a result of this there has been a movement towards embracing telemedicine, something which we have talked about previously in this News Blog.^{[1][2]} One form of healthcare in particular, outpatient (or ambulatory) care, has seen a definitive shift towards telemedicine.

A study in the JAMA Health Forum ^[3] used a recent audit of outpatient care in the US from 2018 to 2020 and aimed to determine which conditions and diagnoses were the most common to be evaluated through telemedicine, as opposed to managed face-to-face in office-based care; and whether there has been a change in the balance of issues (short-term, long-term or preventive needs) being addressed.

They found that use of telemedicine increased significantly during the early stages of the pandemic (and office-based correspondingly decreased), before a slight decrease and then a levelling off at a rate higher than prior to the pandemic. Analyses showed that telemedicine was more commonly used for established

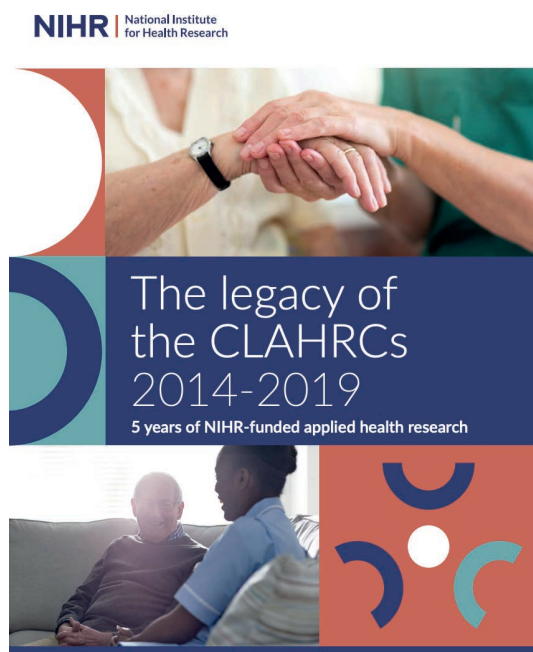
patients, as opposed to new visits; and that telemedicine was used substantially more for psychiatric or behavioural treatments, as opposed to preventive care. The authors suggest that this association is likely due to an increased demand for such services as a result of the pandemic, as well as the suitability of psychiatric and behavioural treatments for telephone or video-based interactions.

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Latest News and Events

NIHR CLAHRC Legacy Document, 2014-19



The NIHR have recently released a legacy document bringing together highlights from across the NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRCs), which became Applied Research Collaborations (ARCs) in October 2019. It showcases achievements from five years of collaborative applied health and care research, including two case studies from CLAHRC West Midlands: the BSOTS programme, a triage system for maternity units; and our refinement of rapid response and stepped-wedge cluster randomised controlled trials.

It can be read at: arc-wm.nihr.ac.uk/impact/clahrc_legacy.pdf

From 2008 to 2019 the NIHR CLAHRCs brought together patients and the public, NHS service providers and commissioners, universities, local authorities, charities and voluntary sector organisations to work on projects that improve people's health and the delivery of care across England. This document demonstrates how our impact is enhanced by working closely with our partners.

Case studies are presented by priority theme, including children and young people, early detection and prevention, managing long term conditions and emergency care and acute illness.

Dr Louise Wood CBE, co-lead NIHR, Director of Science, Research and Evidence at the Department of Health and Social Care, said:

"The NIHR CLAHRCs increased the country's applied health and care research capacity and capability, making this a key strength of the NIHR. These case studies are a fantastic demonstration of the CLAHRCs' impact on improving services and outcomes for patients and the public, across a wide range of priority areas. Our Applied Research Collaborations continue to build on this legacy."

National NIHR ARC Newsletter

The July issue of the national NIHR ARC newsletter is now [available online](#), with details on research plans into the National Priority Area of Healthy Ageing, Dementia and Frailty; and the first COVID-19 End-of-Life Care model. There are also details of a number of upcoming online events.

To subscribe to future issues, please visit: <https://tinyurl.com/ARCSnewsletter>.



ARC National Priority for Adult Social Care and Social Work Publishes Report on Involving People with Lived Experience

In the same week that the NIHR published its long-awaited report on [Public Involvement in Social Care Research](#), ARC West Midlands published its report, '[Equal Access to the Knowledge Table](#)', which shares findings from a scoping exercise to understand more about how service users, carers and public contributors shape social care research across the ARC landscape.

Recommendations from the report will be used to inform approaches to involvement in the [National Priority for Adult Social Care and Social Work](#), which is led by ARC Kent, Surrey & Sussex (KSS).

The full report can be accessed at: arc-wm.nihr.ac.uk/research/social-care/co-production/adult-social-care-research-arcwm.pdf.

Heart Failure and Hospital Readmissions

Research by authors from ARC East Midlands and ARC West Midlands recently won the **Nurse Investigator Award** at the '*Heart Failure 2021*' congress, hosted by the Heart Failure Association of the European Society of Cardiology. This paper by Dr Claire Lawson and colleagues looked at trends in 30-day hospital readmissions following initial hospitalisation for heart failure and found an increase in readmission

rates over the last 16 years, with a greater impact on those who are less affluent and those who belong to an ethnic minority group. The article is available at: Lawson C, Crothers H, Remsing S, Squire I, Zaccardi F, Davies M, Bernhardt L, Reeves K, Lilford R, Khunti K. [Trends in 30-day readmissions following hospitalisation for heart failure by sex, socioeconomic status and ethnicity](#). *EClinicalMedicine*. 2021; **38**: 101008.

Involving the Public in Research:

Upcoming Retirement of the INVOLVE Website

The NIHR Centre for Engagement and Dissemination took over from NIHR INVOLVE in April 2020. The National Institute of Health Research retired the INVOLVE website on 28 June 2021.

Many resources developed by NIHR INVOLVE have been [updated and relaunched in April](#)

2021, and can be found on [Learning for Involvement](#). The remainder of resources that were produced during the lifetime of INVOLVE can still be accessed by their original links. If you would like a list of all the resources that were available through the NIHR INVOLVE website, you can contact the Centre for Engagement and Dissemination: ced@nihr.ac.uk.

Recent Publications

- Aiyegbusi OL, Hughes SE, Turner G, Rivera SC, McMullan C, Chandan JS, Haroon S, Price G, Davies EH, Nirantharakumar K, Sapey E, Calvert MJ; TLC Study Group. [Symptoms, complications and management of long COVID: a review](#). *J R Soc Med*. 2021.
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