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1 Liberating Time in the NHS

3 Sharing Ideas and Solutions to Delays in the Induction of Labour Process

6 One-to-One Coaching Improves Cardiologists' Communication Style

7 The Lancet: a Curious Journal

8 Article on Medical School Selection, With One Glaring Hole

Workforce & Productivity Measures 9

ARC WM Quiz 10

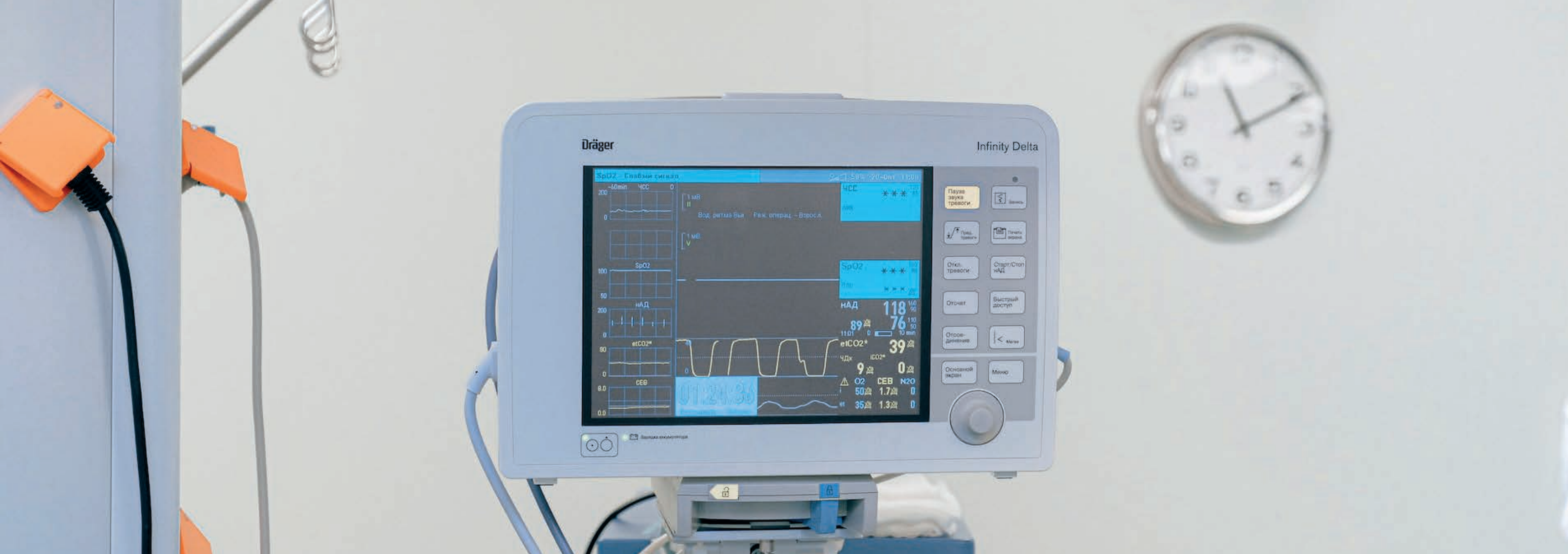
Interventions with Human-Centred Design to Improve Well-Being 11

News & Events 12

Recent Publications 15

ARC West Midlands News Blog

10 May 2023



Liberating Time in the NHS

Richard Lilford, ARC WM Director

A recent (25th March) issue of the BMJ included a set of well-written, editorial length articles on pressures in the NHS – especially acute care in community and hospital settings.[1]

Abstracting from these vivid accounts of what it is like on the front-line, I identified one pervasive issue: the issue of time. There is just not enough time to do all that is required. And here is the rub – the aspect of care that tends to get sacrificed in the interests of time is communication with patients. To take a good history, fully explain options in care, elicit feelings and answer concerns takes time – often a lot of time. What is the point of providing decision aids for use in consultations if the process has to be rushed? Minna Johansson, writing from Sweden, states that, averaged across the population, people spend 20-30 minutes per year with a doctor. She cites this as a limitation on screening for diseases like colon cancer.[2] In short, there is just not enough time to do all the things that need to be done.

So, when we think about health service policy, we should start with the resource from which other resources flow – **TIME**. Making most efficient use of time is precisely what High Volume, Low Complexity surgical hubs are designed to address.[3]

Of course, deploying more staff is the obvious way to create more time, but the UK cannot afford many more staff, and even if it could, ratcheting up supply is a long-term process.

Is there anything else we can do to liberate time? Yes, operations research can be deployed to maximise efficiency by improving processes and making them more efficient. The management philosophy called 'lean' service design is heavily predicated on removing unnecessary inefficiency and duplication.[4] Then there is waste. The current re-validation process for doctors has never been evaluated, and seems a procedure-based waste of time. And regulation and inspection visits to facilities. It is time that the Care Quality Commission (CQC) was itself evaluated – how reproducible are its inspections? How much value do they offer? And let's reduce the number of organisations that carry out inspections – why, for example, does the Litigation Authority conduct inspections when the CQC already does the job?

And as for IT systems – they burden practitioners with collection of data that have nothing to do with concerns for the patient under consultation. We should audit IT systems and strip away ***ALL*** data entry requirements that are not required for the care of an individual patient. If the information is crucial for quality control / management of the service, then pay someone else to collect it. Intrusive data collection procedures are a major cause of doctor stress, burnout and early retirement – see Robert Wachter's book.[5]

Can any more be done? Yes. I have written before about IKEA-style, do-it-yourself, health.[6] This is health that relies on the patient's own assets. Obviously, this cannot be used for all patients, such as those who are frail or those with dementia. But for many, much of the work could be done outside the consulting room. Shared decision-making is great, but many people supplied with the right information by a decision aid are perfectly capable of making up their own mind. And history-taking – I showed over 40 years ago that patients can provide their own histories through branching computer algorithms.[7-10] Considerable efficiency gains could be achieved by giving patients an opportunity to enter their own data, and of course Boolean (or more fancy) algorithms running in the background could provide clinical prompts / action suggestions. That said, action suggestions should be stripped back to reduce cognitive load on clinicians – too many safety features are unsafe. Indeed, to strive for perfection is to land even further from it.[11]

So here is my message to policymakers. Think 'time' and then work from there. Whenever a new procedure, algorithm or routine is proposed, be prepared to answer the question – what can be given up so that this can happen?

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Sharing ideas and Solutions to Delays in the Induction of Labour Process

Dr Magdalena Skrybant, ARC WM PPIE Lead (University of Birmingham)
Prof Sara Kenyon, Professor of Evidence Based Maternity Care (University of Birmingham)

ARC WM Hosts First National Group to Share Improvements Around the Process of Induction of Labour

Induction of Labour – Increasing demands on maternity services

After nine months, the wait for a new baby can be an exciting but also anxious time. Parents hope, most of all, for a safe delivery. Induction of labour (IOL) is usually offered to women when the risks to mother and/or baby are believed to be greater when the pregnancy is prolonged, rather than the risks associated with a scheduled birth.[1,2] Labour Inductions can be offered to women at any stage of the pregnancy, but are most common when the pregnancy is at term. Rates of women undergoing IOL globally have been rising over past decades, particularly in high-income countries.[3-5] In the United Kingdom rates of women experiencing IOL were approximately 20% in 2009-10, increasing to 29% in 2016-17, and 33% in 2021-22.[6]

Reasons for this rise in labour inductions are complex. Increased maternal age and obesity; advances in antepartum foetal monitoring and management practices; and growing evidence for at-risk maternal groups demonstrating improved outcomes with IOL, are all contributing factors to increasing numbers of labour inductions.[7-9] In the UK, this increase has added significant pressure to the maternity system; inductions usually take longer than spontaneous labour and women need more monitoring. Combined with severe shortages in midwifery and medical staffing, this has led maternity service leaders to raise concerns over current IOL practices.[10] Most recently, the Ockenden Report highlighted how current IOL pathways have impacted on patient safety and care quality.[11]

From Understanding the Problem to Finding a Solution

To understand local policies and practices for IOL, ARC WM's Maternity Theme led a national survey. The findings, currently submitted for publication, not only highlight substantial variation in induction rates, processes and policies across UK Maternity Services, but also showed that delays were common and a cause for safety concerns.

Professor Sara Kenyon, ARC WM's Maternity Theme Lead, presented the survey findings at the British Intrapartum Care Society (BICS) meeting in September 2022. Beginning with reflections from a woman who had experienced IOL, the session, 'Improving Induction of Labour', not only highlighted issues identified in the survey, but sparked contributions from BICS members about local solutions to address issues. Discussions spilled over into breaks and networking sessions and demonstrated a real appetite to share local quality improvement work to address current shortcomings in IOL Pathways.

Sharing Best Practice – a National Workshop

ARC WM was eager to capitalise on momentum from the BICS Conference and offered to lead a national event. The purpose of the event was to provide a space where clinicians could come together and share examples of local strategies implemented to address challenges associated with IOL. Maternity units from across the UK were contacted to submit quality improvement work to be discussed within this national workshop. The response was overwhelming, demonstrating the drive and commitment of staff in maternity units to deliver the best quality of care for women undergoing IOL. To ensure a range of contributions and maximise the workshop potential, participants were selected based on area (England, Scotland and Northern Ireland), region, size, induction rate and area the quality improvement work was undertaken in.

The workshop took place at the University of Birmingham on 23 January 2023, with 58 people attending, including representatives from the Royal College of Obstetricians and Gynaecologists, Royal College of Midwifery, BICS, regional obstetricians, and obstetricians and midwifery leads from 40 maternity units from across the UK. Importantly, the workshop included public representatives to share personal experiences and ground local quality improvement work with women's views and expectations.

Improving Induction of Labour: 5 Key Themes

Quality improvement work, submitted by all trusts who attended, was divided in to five key themes:

- Improving women's experiences within the IOL process.
- Developing tools to support informed consent for IOL.
- Prioritising women within the IOL queue.
- Reducing delays within the IOL process.
- Using technology to support the IOL pathway.

Workshop participants were divided into groups and invited to share projects in a table-top discussion format. Each table had a facilitator, a time and note taker, and a public contributor. Eight clinicians on each table each presented a brief summary of their project. The table then selected three projects to be shared with the whole group.

There was a real 'buzz' in the room, with people keen to share their own work – highlighting challenges as well as facilitators to implementing ideas – and opportunities to ask questions, take notes and, importantly, exchange contact information to follow-up on conversations. In addition to sharing ideas, participants were generous in sharing documents and templates, preventing the re-invention of wheels that were already in motion and running smoothly. Feedback from the participants was very positive with many commenting on the value of getting together and sharing their local solutions. Professor Kenyon commented: '*This was a great opportunity for the ARC WM to bring together people to share ideas and solutions they have developed which may help others, and ultimately improve the experience of Induction of Labour for others- it was a very positive meeting.*'

The Start of a Journey

ARC WM is currently producing a summary document, sharing the quality improvement work chosen by the national group that provided key solutions across each of the five themes. The aim of this document is twofold: firstly, to share details of quality improvement projects; and secondly, to highlight both barriers and facilitators to improving the Induction of Labour Process. The document, which will be available on the BICS website, will present options for Maternity Units to consider that may be of local benefit to improve their current Induction of Labour practices.

A further legacy from the workshop is a series of events, where people with a shared commitment to improving IOL can continue to share and learn. Since the initial event, the following have been planned, facilitated by ARC WM, to bring the community together:

- 20 February – Methods of IOL, Prof Andrew Weeks (University of Liverpool)
- 1 March and 21 March – Induction of labour on BadgerNet, Nikki Farmer (IOL co-ordinator at Birmingham Women's and Children's Hospital)
- 19 April – QI for beginners, Jacqui Lawrie (University of Edinburgh)
- 11 May – Outpatient IOL, Mairead Black & Linda Stewart (Aberdeen Maternity Unit)
- 2 June – National IOL data, Asma Khalil (Obstetric Lead of the National Maternity and Perinatal Audit)

Following the successful workshop in January, ARC WM is currently discussing plans for a future event. In addition to providing opportunities to share success stories and capture learnings, there will be opportunities to plan how this important network can continue.

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One-to-One Coaching Improves Cardiologists' Communication Style

Richard Lilford, ARC WM Director

A randomised trial of personal coaching was recently reported in JAMA Internal Medicine.[1] The authors claim that this is the first such study, and that previous studies have been small, non-randomised and lacking in objective assessment.

Cardiologists were chosen as the treatment group. How did the authors persuade well-paid, busy, heart specialists to take part? They paid them $200. Patients were also paid for their time but at a lower rate of $20. Only 40 cardiologists took part, along with 240 patients. A minimisation programme was used to maximise the balance of cardiologist characteristics across intervention and control groups.

Intervention cardiologists received three one-to-one instruction sessions on communication skills instruction. The basic curriculum was similar to that which we teach our medical students; establish eye contact, introduce yourself, ask open questions, gently test the patient's grasp of essential points by encouraging 'playback', and so on. The educational model was based on strength-based practice, experiential learning, and feedback. Cardiologists audio recorded conversations with patients. They then went through these with the coach and provided self-criticism or self-praise. When the intervention was complete in the intervention arm, patient encounters were recorded from both the intervention and control arms.

Third party coding was used and, interestingly, the researchers who coded the encounters achieved excellent reliability, with a correlation coefficient of over 80%. Encounters were objectively coded based on cardiologist behaviours, and global ratings of communication for warmth and respect. Patient outcomes were recorded in terms of interpersonal processes, trust, and a care measure. Physician outcomes were burnout (using a validated scale) and feedback on the intervention.

Intervention cardiologists were objectively more likely to make empathetic statements, and to ask open questions than control cardiologists. Their patients also perceived empathy to a greater extent than patients of control cardiologists. As in previous studies, the authors were unable to study differences in patient ratings because of ceiling effects.

There exist a great number of decision rules and decision support programmes. According to these authors, however, much less work has been done on actually improving clinician communication performance. I was surprised the authors registered positive effects with a trial of only 40 cardiologists.

The NIHR Midlands Patient Safety Research Collaboration will work with our ARC West Midlands to improve communication in a maternity context, with special reference to presenting probabilistic information. This JAMA paper will be a useful reference as we design our detailed protocol.

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The Lancet: A Curious Journal

Richard Lilford, ARC WM Director

Has anyone noticed something strange about the Lancet? There is a massive dissonance or disconnect between their news items, Series and Commissions on the one hand, and the scientific articles it includes, on the other hand.

Take the March 25 issue, for example. The Editorial covers the fascinating topic of the commercial determinants of health.[1] The World Report covers Pope Francis and his influence on health affairs,[2] along with the health consequences of crowd-control weapons.[3] Then what do we find in the scientific section? A couple of double-blind, randomised, placebo-controlled phase 3 trials of a biological agent in systemic lupus.[4, 5]

The Lancet has a staggeringly high journal impact factor of 202.7 and, yes, large clinical trials attract large numbers of citations. But individual trial results apply to small, sometimes tiny, proportions of the general population, and the head-to-head methodology is bog-standard and requires little ingenuity. Generic or pervasive problems in health services and policy are seldom resolved by trials, even when they are feasible. To be clear, I am not taking Richard Horton (editor-in-chief) to task for the dissonance between the scientific part of the Lancet and the generically interesting part. After all, he is doing exactly what I would do if I were editor of the Lancet! I too would publish the interesting stuff in the news and the clinical trials in the scientific section.

But this takes me back to our last news blog, where I complained about the slant towards intellectually trivial, but practically actionable and impactful, trials at the expense of research, which tries to tackle much bigger issues affecting health and welfare, such as methods to promote population health.[6]

It is up to policy-makers, to level the playing field, and to reduce the impetus to show immediate impact and high citations. Items selected for your News Blog are heavily slanted towards those that are intellectually interesting and generically important, rather than single medical effectiveness studies.

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A Good Article on Medical School Selection, But With One Glaring Hole

Richard Lilford, ARC WM Director

I was broadly in strong agreement with the main idea of a recent article by Humphrey, et al. in the March edition of JAMA.[1]

The thrust of the article is that medical school rankings are not only meaningless, but a disservice to both the public and the schools themselves. Summary rankings of institutions, schools and hospitals included, is rapidly going out of fashion. At least I hope it is!

However, the authors state that "*[there] is strong evidence that medical schools can identify the individuals who possess the attributes… to be successful future physicians through holistic review practices.*" In fact, the systematic review that I carried out with colleagues in 2007 showed that tests for empathy do not correlate with subsequent practice of patient-centred care.[2] Furthermore, ARC WM collaborator, Celia Brown, and colleagues showed that tests of non-cognitive skills do not predict subsequent safe practice. Interestingly, academic performance does correlate with these 'non-cognitive' skills/attributes.[3] The authors provide no evidence for the effectiveness of so-called holistic assessment, and such evidence as I am aware of, points to a conclusion opposite to their claim. But I will publish a retraction if I am wrong.

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Workforce and Productivity Measures

Paul Bird, Head of Programme Delivery for ARC WM

We keep hearing in the news that the United Kingdom is facing a productivity challenge [1] backed by a range of data.[2] During one of our regular team meetings, our ARC WM Director expressed an interest in trying to use existing data to take some comparative measures of productivity between organisations and professionals. As is often the case, we quickly moved on to a discussion of the art of the possible versus the art of the practical.

Our Director was of course right; there is a myriad of routinely collected NHS data which could be drawn on. However, having been involved in a number of local and national schemes to do something similar whilst working for the NHS, I was aware of some significant pitfalls.

There are inherent structural issues around collecting such data. One national programme I worked on some years ago combined Hospital Episode Statistic (HES) data with survey data completed by the organisation around the resources available for that particular specialty or service. Even when taking a sensible combined approach many issues in the data became apparent. For instance, when looking at outpatient clinics not all consultants will have registrar support available to them. This will hopefully be reflected in the clinic rules for their sessions but it is not always immediately apparent in consultant level data and can give misleading impressions around productivity and clinic throughput. Also, some 'miscellaneous' activity is often set up under the clinical lead by default. For example, I remember there was no capacity to record nurse led activity at one point in time, but these still needed to be booked, recorded and charged for. Consequently, all the nurse led clinics for placing Peripherally Inserted Central Catheters (PICC lines) were set up under the name of the consultant who was service lead for the area. Whilst the service manager for an area is likely to know this, an independent observer of the data would not, and so when these local peculiarities are scaled up to organisational level, results can become distorted and misleading.

Often, we have re-purposed clinical systems (such as radiotherapy or radiology software systems) designed for the delivery of technical services, to report on administrative data they were not intended to collect (such as waiting times or referral sources). This means these systems are often not integrated to other key software systems such as the hospital Patient Administration System (PAS) and therefore hold conflicting or incomplete data.

For example, during a project concerned with productivity and efficiency, we worked with theatre teams to increase the utilisation of operating theatres; one of the most high-cost resources in a hospital. When we examined the data held on the local theatre software system we discovered that 'late starts' were the main causes of under-utilisation of theatre capacity. This led to loss of theatre time and sometimes the cancellation of elective surgery cases. Over 90% of the time late starts were attributed to late arrival of surgeons. We shared this data with the surgeons to see if we could improve the processes around start times and got a surprise – as did the surgeons! The problem was mis-attributed on the system. The people responsible for data entry simply clicked on 'surgeon late' as a default

option. All other options, apart from 'surgeon late', such as 'patient not ready' or 'equipment not available" would be the 'fault' of the theatre team. So naturally the chance to apportion blame elsewhere without recrimination was too good to turn down! Simply by connecting data sources and making them more visible we were able to record much more accurate data and found a multitude of reasons for 'late starts', and then could work to address the problems they identified.

Whilst it remains a challenging area to study in the English NHS at present, we would like to hear from international colleagues if they have examples of successful studies that have been undertaken in different or more unified administrative systems.

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ARC WM Quiz

This week saw the coronation of King Charles III, but which UK monarch had to postpone their coronation due to appendicitis?

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

Answer to previous quiz: The term anthropocene, referring to the time during which humans have had a substantial impact on our planet, was first coined by Eugene F. Stoermer and later re-invented and popularised by Paul J Crutzen.

Congratulations to those who answered correctly.

Interventions with Human-Centred Design to Improve Well-Being

Peter Chilton, Research Fellow

Healthcare workers in the NHS and around the world are suffering from declining mental health, made worse by the COVID-19 pandemic. In the latest NHS Staff Survey, 44.8% of all staff reported that work-related stress had left them unwell in the previous 12 months,[1] while the latest data from NHS Digital (covering November 2022) recorded 24% of all NHS sickness absences being due to anxiety, stress and/or depression.[2] On their own these figures are a cause for concern, but a recent systematic review and meta-analysis showed a significant association between physician burnout and an increase in patient safety incidents.[3]

The authors of a recent Viewpoint in JAMA argue that interventions that aim to improve care quality and safety in healthcare can unintentionally make it harder to deliver high-quality care.[4] They cite increases in clinician workload (cognitive and physical), negative impacts on work-life balance, and frustration from false positives from electronic alerting systems, to name a few. Instead, they argue that human-centred and participatory design methodologies can provide a solution for improving clinician well-being, while also not impacting on patient safety. Such designs aim to take the experiences of all people involved into account, creating solutions that balance all the competing needs and desires. The most important thing to consider for interventions is to engage with and get participation from all key partners, including the clinicians themselves. This promotes both innovation effectiveness and clinician buy-in, potentially providing simple solutions that reduce burden and are responsive to their needs. The authors hope that taking such an approach can lead to restoring clinicians' well-being and improving care quality for patients.

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MRes in Health Sciences Opportunity

NIHR ARC West Midlands is offering an MSc (by Research) in Health Sciences for 12 months (or 24 months if part time) for:

Ethnic variations in access to treatment for eating disorders in multicultural England, with special focus on young people.

This will be supervised by Dr Helena Tuomainen, Dr Sagar Jilka, Dr Sheryllin McNeil (BWC FTB)

As part of the project, the successful applicant will take part in regular cohort activities where they will receive training in research integrity, science communication and critical appraisal of the literature.

Details on the project can be found at: warwick.ac.uk/fac/sci/med/study/researchdegrees/researchdegrees/health/arcwm_ed_projectdetails_march23.pdf

For more information on the MSc please visit: https://warwick.ac.uk/fac/sci/med/study/researchdegrees/researchdegrees/health/ or contact Helena.tuomainen@warwick.ac.uk.

The deadline for applications is **Thursday 11 May 2023**, with interviews likely to take place on Friday 26 May 2023.

NIHR Shape the Future #BePartofResearch

On 1 May, the NIHR launched their latest Be Part of Research campaign, '*Shape the Future*', celebrating the NIHR's role in the success and innovation of the NHS, saving lives and money. More information on the campaign can be found at: nihr.ac.uk/explore-nihr/campaigns/nhs-75/ This includes some examples of improvements in patient care, as well as pioneering techniques made possible by research. You can also sign up to #BePartofResearch and take part in a wide range of health and care research at nearby locations (bepartofresearch.nihr.ac.uk).

Latest National NIHR ARC Newsletter

The latest issue of the national NIHR ARC newsletter is now available online at http://eepurl.com/ionbQ2

This issue includes how social media may impact adolescent mental health; a support programme with and for nursing teams; and a report identifying unmet needs of stroke survivors and carers.

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

Race Equality Framework Blog

The NIHR have published a blog on the Race Equality Framework, for which both University Hospitals Birmingham and Keele University were pilot sites. The blog, "*Why research inclusion leads to better outcomes: An Asian women's perspective,*" features reflections from public contributors on why this work matters to them, and why it should matter to organisations. It is available at: nihr.ac.uk/blog/why-research-inclusion-leads-to-better-outcomes-an-asian-womens-perspective/33175.

Leading Lights Lecture - Prof Amy Grove

Prof Amy Grove, part of our Public Health theme, is presenting at Warwick Medical School's Leading Lights programme on '*Surgical research and researching surgery: collective wisdom and collective blindness.*' The lecture will take place on **Wednesday 14 June, 12:00pm**, both online and in-person.

Students, alumni, members of the public and University colleagues are invited to attend these lectures to find out more about the work undertaken in Warwick Medical School.

For more information, and to register, please visit: warwick.ac.uk/fac/sci/med/news/eventscal/inaugural/amygrove/

National Webinar Series: Mental Health in Our Modern World

Registration for the cross-ARCs national webinar series on *Mental Health in Our Modern World* is now live. This is a series of three webinars looking at mental health in the context of some of the most topical themes of our times.

- Wed 17 May: Mental Health & World Crises.
- Wed 21 June: Mental Health & Social Inclusion (*including a talk from Prof Domenico Giacco, from our Youth Mental Health theme, on improving access and experience of care of people from minority ethnic groups*).
- Wed 12 July: Young People's Mental Health.

For more information, and to book these free webinars, please visit: eventbrite.com/cc/nihr-arcs-national-webinars-mental-health-1960809

HSR UK Conference 2023

The 16th HSR UK Annual Conference will be held at the University of Birmingham and online on **4-6 July 2023**.

The planned conference programme is now available showcasing the promotion of health services research in policy and practice.

Registration is now open, with Early Bird fees available until 8 April. (*A limited number of complimentary spaces are available to patients, carers and public contributors.*)

For more information, please visit: https://t.co/9Wd6JP8Lri.

Applied Research Leadership Academy

NIHR ARC South London's Applied Research Leadership Academy was launched in 2022 as a place for health and social care professionals, researchers, public involvement members and PhD students from across ARC to come together to learn leadership skills and build their research careers.

Following highly positive feedback from participants this **free course will now be open to all ARCs in 2024**. The course is delivered online with weekly sessions over six months and includes: lectures, action learning sets, and a mentorship session. It is led by Prof Cilla Harries, ARC South London's deputy theme lead for capacity building/training.

Read more about the current course at: arc-sl.nihr.ac.uk/events-training/events-training/nihr-arc-south-london-applied-research-leadership-academy and register your interest for 2024 at: qualtrics.kcl.ac.uk/jfe/form/SV_0J9hRHcgCwta0Gq.

PEP-OA Project Osteoarthritis Video

Researchers part-funded by our Long-term Conditions theme, based at the Keele Impact Accelerator Unit, have produced a video for patients with osteoarthritis, describing what it is and what patients can do to help themselves. The Royal Wolverhampton Primary Clinical Network has put the animation on the GP waiting room screens at their nine practices. The video is available on YouTube at: https://youtu.be/6iz78WMm-Lo

National Dementia Research Fellows Launch Event

The national cohort of ARC Dementia Research (Dem Comm) Fellows recently came together to mark the opening of the Dem Comm programme at the University of Southampton. The two year programme will see researchers from universities across England supported to become the research leaders of the future as part of a £7.5 million pound investment by the NIHR and Alzheimer's Society. NIHR ARC Wessex have published a report, available at: arc-wx.nihr.ac.uk/post/countrywide-arc-dementia-research-teams-starts-work.

UK & Ireland Implementation Science Research Conference

The deadline to submit abstracts for the Implementation Science Research Conference has been extended to **Tuesday 16 May**. This hybrid conference will be held on 13 & 14 July at the University of Limerick and online. This year's theme is: Sustaining health and public services in an uncertain future: what role for implementation science?

To find out more and submit an Abstract, please visit: arc-sl.nihr.ac.uk/events-training/events-training/6th-uk-and-ireland-implementation-science-research-conference-2023

Recent Publications

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