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ARC West Midlands News Blog

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Reflections of an ARC Director 3: How Can ARCs Deliver on Their Manifold Objectives?

Richard Lilford, ARC WM Director

Introduction

The story is told of a head of the NIHR who, while visiting a seaside town, was aghast to hear that local health service managers were blissfully unaware of their regional ARC. In this, the third article in the series, I examine the scale and hence potential reach of an ARC, and gently ask whether too much is expected of an ARC; there is always a risk that if jam is spread too thinly, then its impact will be diminished. I also ask how ARCs can be configured to maximise impact when so much is expected of them.

Let's Do the Maths

When follow-on grants for which ARCs are uniquely eligible are added to the £9m core grant, the total quantum of an ARC grant is about £2m per year. This is a sturdy number from a researcher point of view. However, the total planned spending for the Department of Health and Social Care in England is £190 billion in 2021/22. The 15 ARCs will receive around £30m over that time; ARCs thus receive 0.016% of the NHS budget. To put this another way, ARCs receive little more than one six-thousandth the total health and social care budget. Perhaps it is not that surprising, after all, that managers in the seaside town had not heard of ARCs. So let us see what ARCs are required to deliver in return for £2m per annum.

Coverage of Health & Social Care Organisations

Applicants for ARCs are instructed to engage with the full range of NHS and Social Care organisations. This is a fine aim, and ARC WM has extensive links with organisations of all types. However, a reality check is in order. We have previously mapped the health and social care organisations across the West Midlands.[1] At that time there were 27 Provider Organisations, 24 Primary Care Federations, 14 local authorities, numerous regional bodies (such as Public Health England, Health Education England, the West Midlands Combined Authority, and our AHSN partner), and 12 Health & Wellbeing Boards. The West Midlands region is home to six Integrated Care Systems. This amounts to over 80 NHS and Social Care organisations. It is not logistically possible to have detailed interactions or collaborative projects with all potential regional partners. And that is before we come over 11,000 voluntary sector organisations, over 100,000 small- and medium-sized enterprises, and 11 universities.

Maximising Impact

So how can an ARC maximise geographical impact and meet the reasonable expectations of services?

A distinction can be drawn between organisations that contribute co-funding (and with whom we therefore engage in collaborative projects), organisations we consult so that their particular

needs can be taken into account in setting ARC priorities, and organisations who may benefit from our findings and dissemination activities.

In ARC WM we have a four-pronged strategy:

1. Continue collaboration with organisations with whom we have an established relationship and from whom we receive co-funding, accepting that these partnerships will evolve over time.

2. Reach out to organisations that represent provider types, such as Health & Wellbeing Boards, and Association for Directors of Adult Social Care. This is a strategy to maximise impact among the large number of organisations listed above, given the logistic challenges of interacting with each and every institution. Previously we engaged with Sustainability & Transferability Partnerships, and increasingly, we are engaging with the successor organisations of STPs, Integrated Care Services. Relationships with the latter are crucial since they are statutory organisations with responsibility for regional budgets, which they have the power to flex. They also have oversight of hospitals, communities and interfaces in care.

3. Communicate via social media and our monthly ARC WM News Blog and Twitter feed.

4. Perhaps above all, join forces with other NIHR infrastructure. In West Midlands this includes other centre grants, such as our Biomedical Research Centre and Schools of Public Health, Social Care and Primary Care. We are actively working on mechanisms to strengthen collaboration so that together we can achieve greater impact. We will return to this point below.

Geographic Coverage

I sense that ARCs are going to be increasingly called on to widen geographic coverage to include areas so far little affected by research – seaside towns, for example. Let me disclaim at once that I entirely applaud this policy. The reason I am a strong supporter of such a policy is that it is economically efficient. To create a centre of excellence is quite easy. The communist USSR was quite capable of creating Sputnik, nuclear bombs and even a world-leading eye disease centre. The problem for the Soviet Union was that it could not spread such excellence. Likewise, the problem with the NHS is not that it cannot create excellence – the problem lies in massive variations, for example in use of digital technologies, across the service. There are thus good reasons to support a policy of multi-focal excellence. A particular issue for ARCs going forward relates to the latest crop of new medical schools where students are no less deserving of scientific opportunities. In theory then, there are good (indeed excellent) arguments for ARCs to expand geographically and follow centrifugal policies. But this takes us back to the analogy of jam spread on toast – the zeal to do everything can lead to achieving little.

Topic Coverage

The ARC application form requires applicants to specify research themes. Deciding how many and what themes to include is, necessarily, a topic for much debate and negotiation when bringing an application together. In our first CLAHRC we had nine themes, dropping to six in the second CLAHRC. In the ARC we originally specified six (four substantive and two cross-cutting), but added two further themes (social care and public health) when our funding was made conditional on strengthening these two topics. At eight themes, that amounts to £1m per theme or £200k per year (allowing £1m for administration and other cross-theme activities). What can £200,000 per year buy? Two research fellows, a PhD and some senior investigator

time. If geographical coverage is to widen, the number of service partners to increase, and new medical schools to be embraced, then that seems to be an argument to rationalise the number of themes going forward.

There is another issue to be considered in theme selection. If themes are based on clinical conditions, two problems arise. First, this leaves the majority of topics uncovered. For example, a four theme ARC may prioritise cardiovascular disease, mental health, musculo-skeletal disease, and maternity. But then what about neurological disease, skin disease, child health and orthopaedic surgery? Second, specialising in a segment of the medical nosology risks solipsism, whereas ARCs are more about shared learning across conditions and contexts. So, from my perspective there is a compelling case for generic themes, such as chronic disease, long-term care and acute disease, or community care, acute care and interfaces in care. The knowledge expertise in ARCs is generic; behavioural psychology; organisational, sociology and epidemiology, rather than specialist-based. I make an exception of mental health, which is pervasive across all of clinical practice – specialist and generalist.

Broad Range of ARC Activities

The requirements of an ARC are considerable – they are certainly not just to do research. ARC applicants must specify what they will do to strengthen UK competitiveness and industry; how (beyond simply learning by doing) they are going to strengthen capacity (in both academia and the services); how they are engaging under-served communities; working with public and patients; and supporting equality in diversity.

In summary, a lot is expected of ARCs for about £2m per year; cover health and service organisation; ensure geographic reach; engage with diverse communities; include a number of themes; build capacity; strengthen the supply-side of the economy; engage with the public and communities promoting diversity.

Squaring the Circle

ARC funding has not increased from the time of the first round of CLAHRCs and demands have increased. The ARC request for applications specified that not all NIHR / Health & Social Care priorities should be prioritised by each ARC, but when we took that literally we were asked to strengthened Public Health and Social Care – something we have actually had great pleasure in doing. Nevertheless, my first request to commissioners is to ask them to pull back from heaping ever more requirements onto a fixed budget. That said, the NIHR is itself under great pressure to meet national policy objectives embracing all those listed above. I understand this imperative all too well, having myself worked as a senior civil servant. So ARCs will need to develop their own strategies to thrive in a political world.

A perennial difficulty for ARCs is how to strike a balance between reaching out to service stakeholders while avoiding 'over-promising' and thereby generating demand that can't be satisfied. Another is to specify deliverable projects while maintaining capacity to respond to new needs and opportunities as they arise. These are nice problems to have, but it is important to plan ahead and maintain capacity to respond. At the limit some CLAHRCs ran an internal bidding system. This enabled the CLAHRC to remain responsive, but the policy has serious drawbacks. First, it makes capacity development hard because money is moved from one set of researchers to another, so it has limited power to build careers. Second, it is extremely inefficient as it involves a bidding process inside a bidding process. Third, to make it fair and transparent, the process requires time which vitiates the possibilities to respond rapidly and conduct opportunistic research, as I will describe in the following article in this series. In ARC WM we try to address this problem of flexibility by appointing a team with fairly generic skills in subjects cognate to Service Delivery research (first article in the series [2]), and then maintain

capacity to flex this human resource across the most propitious projects.

A small number of themes allows greater geographic reach, since each theme could afford to locate researchers in more than one place. I think this is preferable to small themes concentrated in one place – e.g. mental health, University of Warwick; maternity care, University of Birmingham. If themes are small in number, it may be preferable to make them generic rather than condition specific. For example, hospital care, social & community care, and interfaces in care, rather than maternity, old age, musculo-skeletal, etc. As stated, an advantage of a more generic approach is that no condition or disease is thereby excluded.

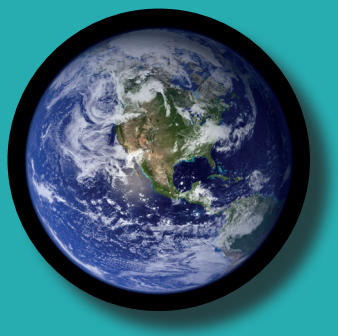
Perhaps the most important point to make is that many ARC functions are shared with other NIHR infrastructure. Therefore, the ARC does not need to shoulder all responsibility for outreach to diverse groups, capacity development, methodology support, etc. By combining forces with the university infrastructure and other NIHR capacity the sum can genuinely be greater than its parts. To put this another way, the time is propitious to develop a combined policy, integrating these numerous functions across the NIHR infrastructure in local health and social care economies. That way, when it comes to completing an application form, applicants can describe the combined policy and identify the particular activities that their Centre or School will contribute. This policy aligns well with 'One NIHR' principles currently promoted by the Department of Health and Social Care.

References:

1. Bird P. Engaging with Engagement. *NIHR CLAHRC WM News Blog*. 15 Feb 2019.
2. Lilford RJ. Reflections of an ARC Director: Overview. *NIHR ARC WM News Blog*. 2022; 4(2): 1-2.

ARC WM Quiz

Earth Day is an annual event held on 22 April to show support for environmental protection - but in what year was it first celebrated?



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

Answer to previous quiz: The **Sorites paradox** is the inability to define the moment when something moves from one state to another when the two states lie on a continuum.
For example, when removing a grain of sand from a heap, when exactly does it stop being a heap?
Congratulations to those who answered correctly.

Strengths-Based Practice in Adult Social Care During COVID-19: Insights From Practice Reviews in the West Midlands

Sharanya Mahesh, Research Fellow University of Birmingham

The COVID-19 pandemic has had an unprecedented impact on adult social care services. With the enforced closure of services, such as day centres in the community, and the emergence of new priorities due to the pandemic, local authorities have been required to introduce and adapt to new ways of working so that they continued to support people meaningfully.

Working with the West Midlands Association of Directors of Adult Social Services (WM ADASS), the Social Care theme of ARC WM have produced a report examining the impact of the pandemic on strengths-based practice. Document analysis on nine practice reviews undertaken between October 2020 and September 2021 form the basis of the report. Since their introduction, practice reviews have become an integral part of the peer challenge programmes led by the WM ADASS. Analysis of the reviews highlighted some positive and negative impacts on strengths-based working, and also brought to light the impact of the pandemic on staff who were at the forefront of demonstrating strengths-based practice.

Summary of the Main Findings

The reviews highlighted that the pandemic accelerated the implementation of systemic and practice-related plans of local authorities. Some authorities reported that their IT plans were implemented at a much faster pace than they would have usually been, as they were both integral in supporting remote working, and also enabled practitioners to provide continuous support to people. While some of the changes implemented were already in the planning pipeline of local authorities, other changes may have been forced upon them to keep up with the demands of the pandemic. Local authorities reported that practitioners had to identify and work with a range of different community organisations due to the closure of regular day services. The benefit of this new engagement was that local authorities were able to continue to signpost people meaningfully, while also recognising that 'regular day services' that were offered prior to the pandemic were not always the best fit for all people.

During the pandemic there was little to no face-to-face contact with people other than in emergency situations, which may have restricted the extent to which practitioners were able to demonstrate strengths-based practice. The reliance on technology and other family members to gather information was challenging, but equally seemed to shift the focus on risk assessments or safeguarding rather than considering the strengths, aspirations and desires of people. The pandemic has posed many challenges for practitioners, mainly due to remote working but also due to the changes with how they engage with people. Practitioners reported that they felt anxious and isolated, but managers and senior leaders seem to have been instrumental in providing continuous support to practitioners. However, the reviews consistently highlighted the resilience demonstrated by staff and more notably their skills to find creative solutions and adapt to changes.

The full article is available at: https://arc-wm.nihr.ac.uk/social-care/report_on_sbp_and_covid_-19_-_final_version.pdf

Another Trial of Orthopaedic Treatments for Acute Injury Seems to Favour the Conservative Arm

Richard Lilford, ARC WM Director

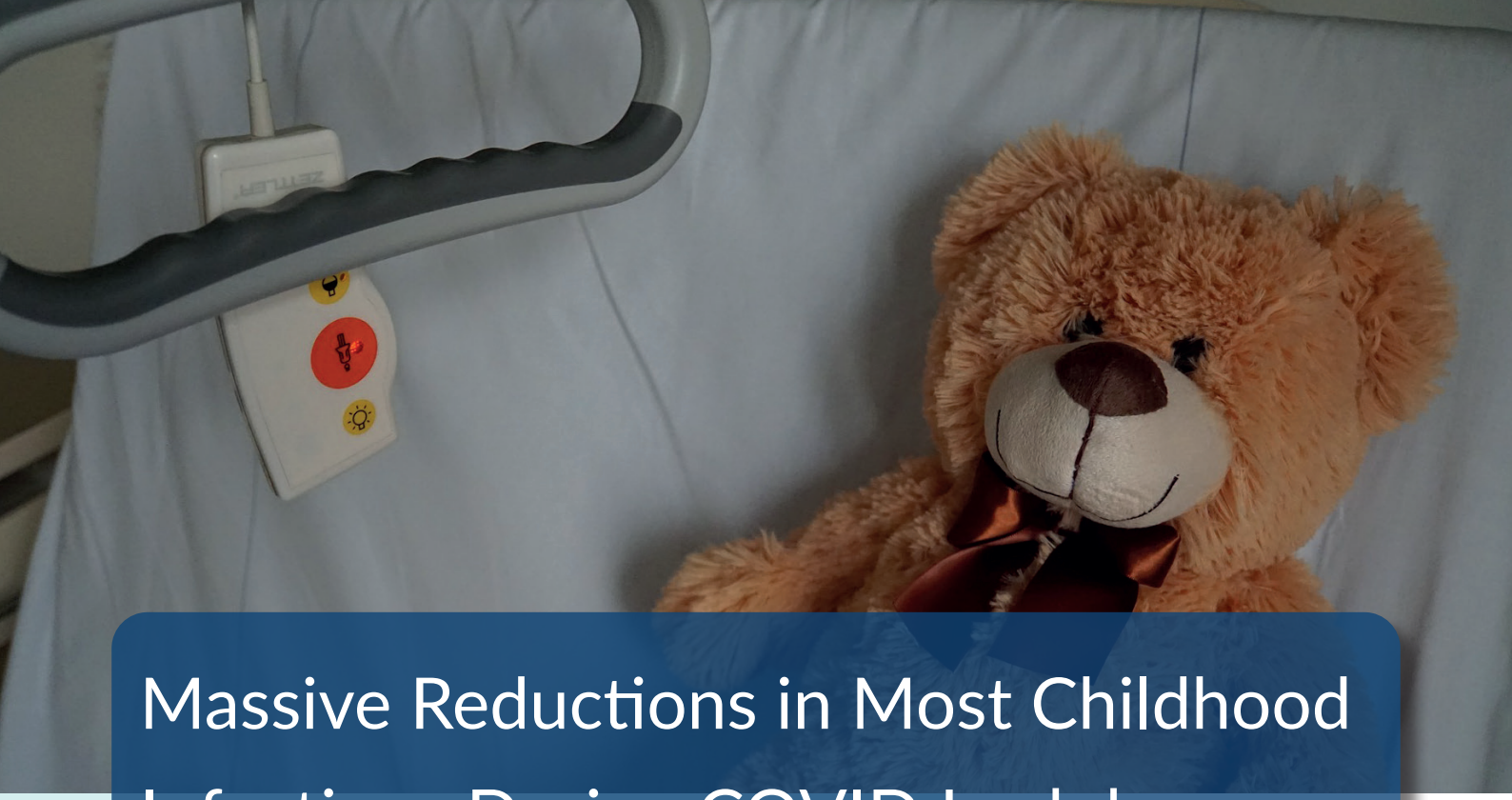
News blog readers know that the ARC WM Director is a fan of orthopaedic trials because orthopaedic surgery is so commonly performed and because the outcomes can be obtained over relatively short time spans. [1, 2] Recently, our ARC WM has published research on the update of the results of trials of orthopaedic treatments for fractures of various sorts.[3] In all three of the trials studied in this paper, the more conservative treatment was non-inferior to more invasive surgical interventions.

Now another study has been published comparing metal fixation with a K wire versus use of a cast in the very common injury of fracture of the distal radius.[4] And again the findings favour the more conservative treatment. There was no difference in function or pain between the two procedures, but one in eight of patients treated conservatively were prescribed surgical fixation at a later date because the bones were poorly aligned.

Our previous study showed that publication of the trial results did not affect uptake of the findings, although in two of the three trials a change in practice anticipated the trial findings. It will be interesting to track the use of K wires versus a cast in distal radius fractures.

References:

1. Lilford RJ. Why the CLAHRC WM Director Loves Orthopaedic Trials. *NIHR CLAHRC WM News Blog*. 23 February 2018.
2. Lilford RJ. Most Frequently Performed Orthopaedic Operations Are at Best Unproven, at Worst Useless. *NIHR ARC WM News Blog*. 2021; **3**(10): 10.
3. Reeves K, Chan S, Marsh A, et al. Implementation of research evidence in orthopaedics: a tale of three trials. *BMJ Qual Saf*. 2020; **29**(5): 374-81.
4. Costa ML, Achten J, Ooms A, et al. Surgical fixation with K-wires versus casting in adults with fracture of distal radius: DRAFFT2 multicentre randomised clinical trial. *BMJ*. 2022; **376** :e068041.



Massive Reductions in Most Childhood Infections During COVID Lockdown

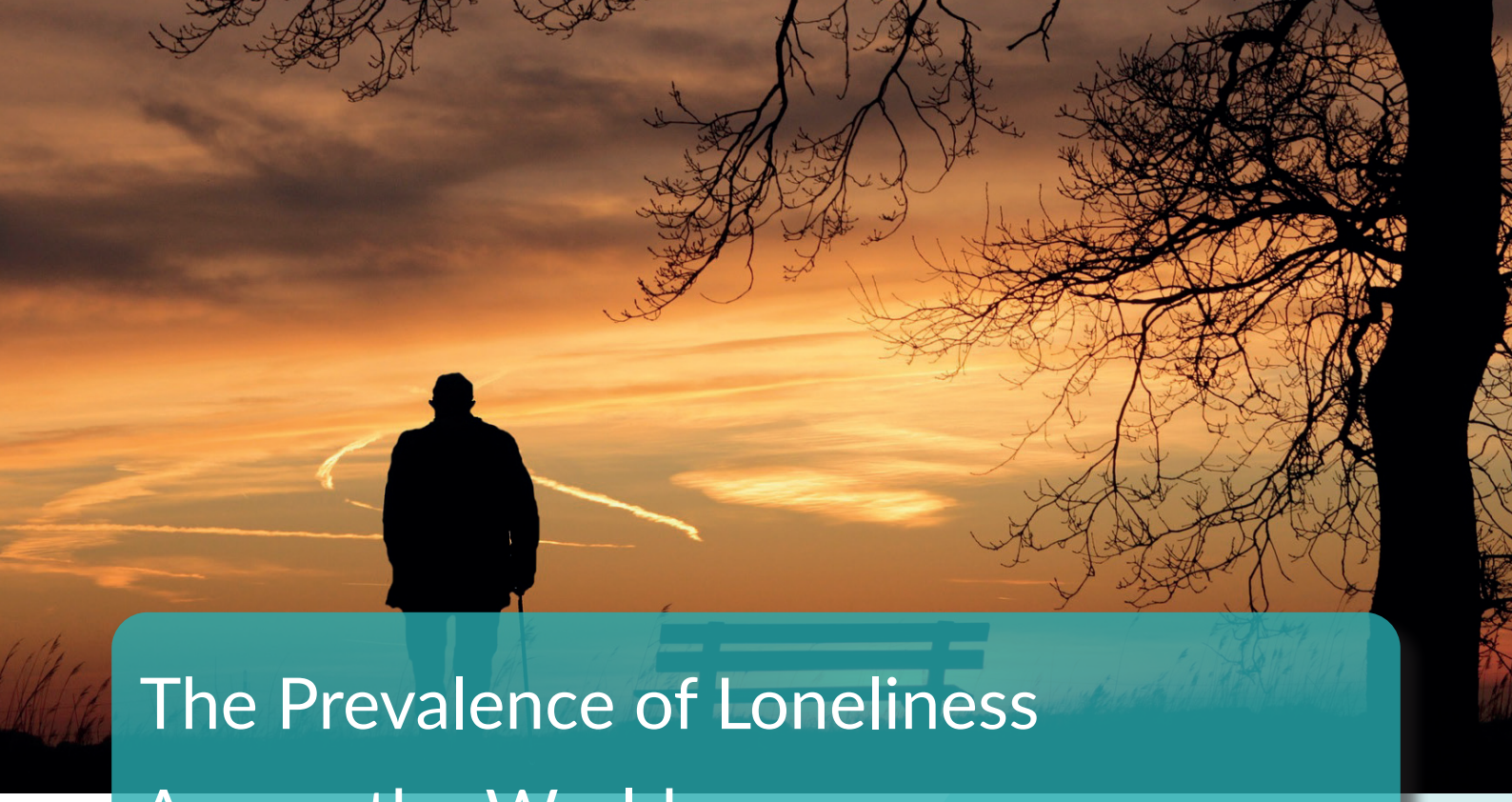
Richard Lilford, ARC WM Director

An interesting paper in the March issue of BMJ examined the effect of COVID surges on various types of childhood infections that were of sufficient severity to warrant hospital treatment.[1] The study was based on hospital episode statistics (HES) data. The reduction affected both bacterial and viral infections, with the greatest reductions, of 90% or more, being seen in influenza and measles. Only one of the 19 conditions examined, pyelonephritis, did not show a reduced incidence.

The authors attribute the findings to a range of conditions, such as school closures. The authors point out that some of the reduction observed might have been the result of greater reluctance to send people to hospital during the pandemic. It will be interesting to track infection rates further into the future.

Reference:

1. Kadambari S, Goldacre R, Morris E, Goldacre M J, Pollard A J. Indirect effects of the covid-19 pandemic on childhood infection in England: population based observational study. *BMJ*. 2022; **376**: e067519.



The Prevalence of Loneliness Across the World

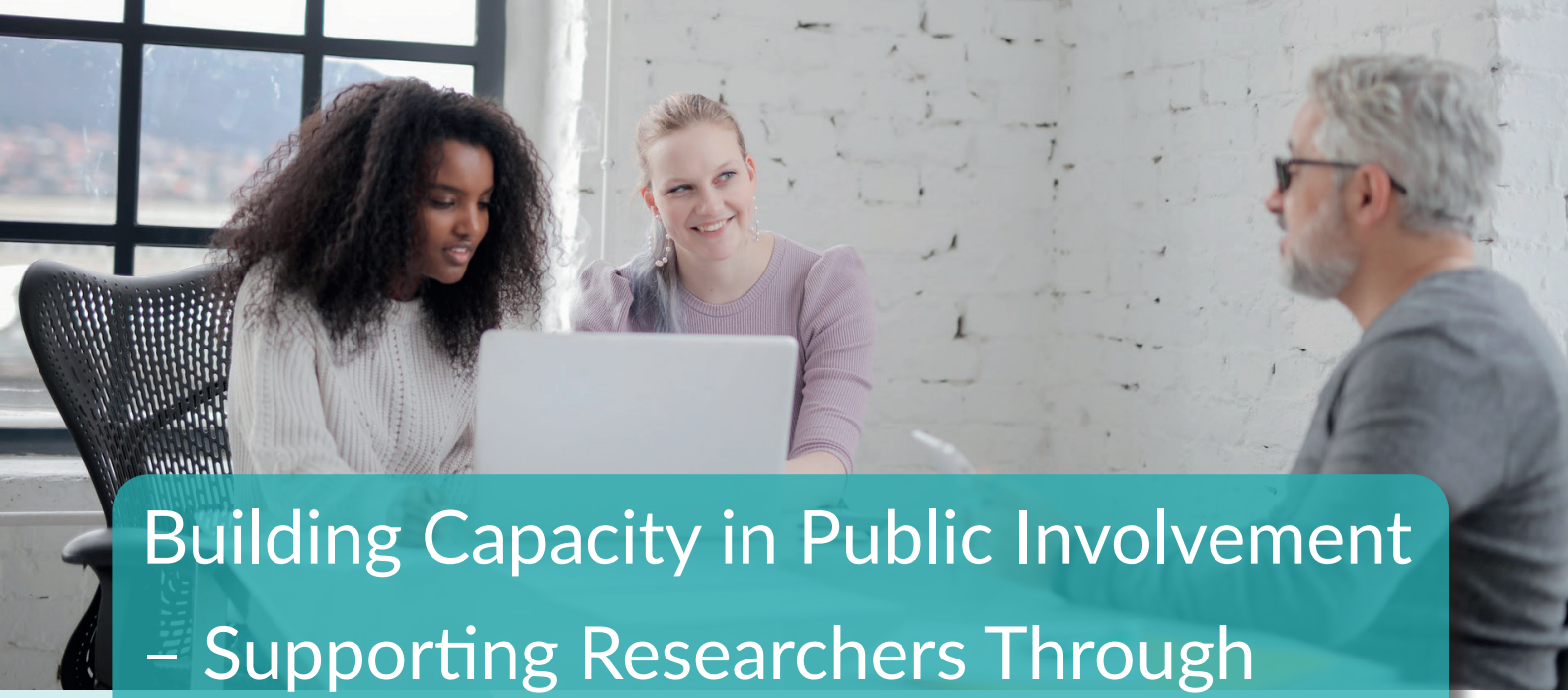
Richard Lilford, ARC WM Director

The ARC WM Director discussed the issue of loneliness in one of the first news blogs just over eight years ago.[1] Now the BMJ reports a systematic review of the prevalence of loneliness across 113 countries.[2] Most of the usable studies came from Europe. The prevalence goes up with age, as one might expect. The prevalence is highest in eastern Europe and, perhaps surprisingly, lowest in northern Europe. The prevalence for people over the age of 60 is about 5% in the north versus nearly 10% in the east of the continent.

Loneliness is associated with reduced mental and physical health but the directions of causality are not clear cut. The authors make the good point that loneliness is an inadequately researched determinant and outcome of health.

References:

1. Lilford RJ. Encouraging Elderly People to Lead Independent Lives: Bad Idea? *NIHR CLAHRC WM News Blog*. 16 April 2014.
2. Surkalim DL, Luo M, Eres R, et al. The prevalence of loneliness across 113 countries: systematic review and meta-analysis. *BMJ*. 2022; **376** :e067068.



Building Capacity in Public Involvement – Supporting Researchers Through Drop-In Sessions

Magdalena Skrybant, PPIE Lead

A key aim for any NIHR-funded centre is to develop capacity and skills in health and social care research. Public involvement and engagement is no exception. ARC WM's Public Involvement Team are keen to share knowledge on public involvement with the ARC WM community (and beyond) to support continual improvement of public involvement practices. Delivering regular Drop-In Sessions is just one way we support researchers and clinicians to gain knowledge and develop skills in Public Involvement and Engagement.

From Small Acorns...

The Drop-In Sessions had humble beginnings. When I first started in my role as Public Involvement Lead in the NIHR CLAHRC WM I was approached by researchers and clinicians outside our Centre who wanted to learn more about public involvement. I realised a 'gap in the market', and so I offered to meet people in a café: we'd chat all things public involvement over a cup of tea.

It wasn't long before I was joined by colleagues in Birmingham – other PPI Leads – from our host Trust (University Hospitals Birmingham), NIHR Birmingham Biomedical Research Centre (Birmingham BRC) and NIHR Surgical Reconstruction and Microbiology Research Centre (SRMRC). This is consistent with our policy of integration with other NIHR infrastructures - see our leading article.

Word about the drop-in sessions soon spread, and the *ad hoc* 'chats' became a much more professional outfit. Out went the scribbled notes and advice to '*Google xx resource*'; in came a marketing campaign, twice monthly sessions, feedback forms, and with clear signposting to those 'go to' resources, and evaluation forms.

All Change During the Pandemic

When we went into lockdown, we were forced to change our ways of working. Face-to-face drop-ins came to an abrupt halt, so we changed our ways of working to offer virtual sessions. During COVID, many researchers wanted advice on how to do public involvement virtually – twice monthly sessions increased to weekly sessions for a period to meet the demand. The new

virtual sessions were a definite hit: researchers didn't have to 'hang around' waiting for their slot, and because we invited researchers to tell us what they wanted to chat to us about, we had opportunities to do our own research before the session.

How Do the Drop-In Sessions Run?

Our Drop-In Sessions are informal and we invite researchers to bring any topic to the virtual table. We are very non-judgemental, and we want to provide support to anyone at any stage of their PPI journey. Whilst we don't guarantee to have all the answers, more often than not we are able to signpost to a resource or have a contact in our networks that can help.

Whilst every session is different, and you never quite know how a session will unfold, certain features of the Drop-Ins are fixed:

- Each Drop-In Session is 2 hours. There are 3 slots per session, and each slot is 30 minutes.
- Researchers need to book a slot in advance. Before attending, they complete a short form, telling us about themselves and what they want to discuss.
- Two PPI Leads take the Session. One PPI Lead 'leads' the discussion whilst the other takes notes and 'chips in' whenever relevant. Having a note-taker means the researcher can focus on the discussion rather than worry about noting everything down.
- After the session, the researcher is sent the Drop-In Form, with notes from the discussion and signposting to key resources that will help them on their PPI journey.
- We invite researchers to complete evaluation forms. In addition to helping us improve the Drop-In Sessions, it helps us capture the impact of Drop-In Sessions (e.g. a researcher shaping a bid with public involvement following advice from the Sessions).

Added Benefits From Drop-In Sessions

In addition to sharing knowledge of public involvement with researchers – either from the evidence base or tacit knowledge gained through planning and delivering public involvement – the Drop-In Sessions also support capacity development for PPI Leads. For me, at least, whenever I do a Drop-In 'every day is a school day' and I learn so much by thinking about public involvement in areas outside my comfort zone of applied health and social care. I also gain so much from co-delivering the Drop-In Sessions with Public Involvement Leads from other NIHR Centres – everyone has different approaches to public involvement, and it's great to share best practices and ideas with local colleagues.

Who Can Attend?

Priority is given to researchers from Birmingham and the West Midlands, although we have supported researchers from further afield. The process is simple: researchers book a slot on one of our sessions and just turn up.

We have just confirmed dates for the next few months (*starting with sessions on 3 May and 19 May*) and we advertise sessions through our Institute comms teams and on websites. You can find out more about our upcoming sessions at: arc-wm.nihr.ac.uk/ppie/resources/ppie_drop-in_may-july_2022.pdf and you can book a slot by contacting: ppi@contacts.bham.ac.uk

How One Trail Blazer Stopped the Thalidomide Disaster from Affecting North America: *The Story of Dr Frances Oldham Kelsey*

Philip Simmons, ARC WM Project Administrator

Born in British Columbia, Canada on 24th of July 1914, Frances Kelsey was a true trailblazer. In 1935 she gained a master's degree in science, followed by a PhD in pharmacology in 1938. During World War Two she was investigating cures for malaria while working at the University of Chicago; it was this research that created an interest as to how drugs could be passed from the mother to the foetus via the placenta. Following the war, she continued to study at the University of Chicago and was awarded a medical degree in 1950.

During the following decade Dr Kelsey worked in a variety of roles; from an editorial associate for the American Medical Association journal, to teaching pharmacology and being a practising GP. In 1960 she was offered a position with the US Food & Drugs Agency (FDA) and became a part of a small team of staff reviewing applications to market new drugs within the USA.

One of her first assignments was to review a drug called Kevadon (better known as Thalidomide), a sedative and painkiller specifically marketed at pregnant women suffering with morning sickness.

The drug had already received approval in 20 European and African countries, and the company (Merrell) had copious amounts of the drug ready for shipment to the US. In fact, 2.5 million samples had already been sent to over 1,000 American doctors in anticipation of FDA approval.

Upon reviewing the application, Dr Kelsey was astonished that no clinical trials had ever been completed and so asked for more information. The information was duly supplied, but complaints were made to her managers that she was an "*unreasonable bureaucrat, stubborn and fussy*" who was wreaking havoc with their marketing timetable.

Conducting further research, Dr Kelsey found a study indicating problems with the drug. She warned Merrell, but they dismissed her evidence as "inconclusive" and pressed for quick approval. Dr Kelsey refused, advising that the risk assessment was poor, using anecdotal testimony in place of clinical data. She was also dismayed that no trials had been conducted on pregnant animals to see if the drug could cross the placenta.

This battle, with unrelenting pressure from the drugs company, took 19 months, with FDA approval being demanded by Merrell and denied by Dr Kelsey six times. This was at a time when FDA drug reviews had to be finished within 60 days, after which approval of the drug would become automatic.

Eventually Dr Kelsey's stance was vindicated as evidence from Europe showed that Thalidomide was the cause of severe foetal deformities. In the UK alone at least 2,000 children have been born with deformities characteristic of Thalidomide.

Following this, Congress voted unanimously to strengthen drug regulation, with companies required to demonstrate that new drugs worked and that any adverse reactions should be reported. For her actions in preventing Thalidomide from reaching the market in the USA Dr Kelsey was presented with the President's Award for Distinguished Federal Civilian Service by President John F Kennedy in 1962.

National Institute for Health Research (NIHR) Name Change

In order to emphasise its enduring commitment to social care research, the NIHR has officially changed its name to the '**National Institute for Health and Care Research**'. *The acronym 'NIHR' will remain unchanged.*

Prof. Lucy Chappell, Chief Executive of the NIHR, said: "At NIHR, we believe that funding and supporting research that expands and strengthens the way that social care is provided is one of the most important ways to improve standards of care for people who need it. We want to support the incredible work being done on the ground by both paid and unpaid carers . . . Our history of investment in social care research already tells a strong story, and today's concrete plans to further fund and support such research are a clear affirmation of our commitment to this vital part of the health and care sector."

More information on this change can be found at: nihr.ac.uk/news/nihr-changes-name-to-emphasise-long-term-commitment-to-social-care-research/30309.

Inaugural Lecture - Prof Richard Lilford

ARC WM Director Prof Richard Lilford will be giving his inaugural lecture at the University of Birmingham on **Wednesday 1 June 2022, 16:30-17:30**. The lecture will look back over Prof Lilford's fifty year career, along with the changing views as to what counts as medical knowledge, and why current statistical philosophy is a poor guide to the design and analysis of trials.

Professor Lilford will offer views on alternatives to hypothesis tests and their implications, such as designating a 'primary' outcome, dichotomising outcomes and the risible practice of insisting that trials can only go ahead if they are adequately 'powered'. He will argue that trials based on informative Bayesian approaches and causal pathway analysis are a better guide for clinical and policy decisions than the current methodological cannon.

To register, please visit: birmingham.ac.uk/university/colleges/mds/events/2022/01/richard-lilford-registration.aspx.

Inaugural Lecture - Prof Robin Miller

As part of the University of Birmingham's Inaugural Lecture series, Prof Robin Miller (ARC WM Social Care theme lead), along with Prof Catherine Mangan, are discussing tales from ten years of collaborative working in public sector and academia.

They will offer a candid reflection of the realities of professional and organisational collaboration and why so often leaders miss opportunities to improve health, care, and wider outcomes for society. They will also share what they believe is required to embed these practices across organisations and systems and how academia can play its role and make a stronger contribution.

The lecture will take place on **Monday 6 June 2022, 18:00-19:00** in Birmingham, but will also be available to attend virtually over Zoom. For more information, and to register, please visit: birmingham.ac.uk/university/colleges/socsci/events/inaugural-lectures/2022/we-are-still-standing.aspx.

Your Thoughts On *Reflections of an ARC Director*

I enjoyed your reflections on CLAHRCs/ARCs and particularly the comment on the nonsense of expecting NHS resources to be under the control of the ARC Director. This has never happened because of NHS system expectations of how core commissioned funding streams should be managed - a point that does not appear to have been understood by the NIHR senior team.

-- Prof Gary Ford, Oxford AHSN

I enjoyed reading your reflections on the role of ARCs in research and implementation. You very nicely connected the IOM aims with Donabedian's model and with formative and summative evaluation

--Alan B. Cohen, Questrom School of Business, Boston University

National NIHR ARC Impacts - Special Edition

To celebrate the halfway point of the ARCs funding, each of the 15 ARCs has showcased a story of research implementation and impact. These illustrate how ARC research improves the quality, delivery and efficiency of health and care services, improving outcomes for patients and the public both locally and nationally. Please click here to find out more.

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

Opportunities to Engage with Research Event

The NIHR Clinical Research Network (CRN) West Midlands are hosting a face-to-face event to provide opportunities to engage with research and help further health and social care research careers. The event will take place on **Wednesday 4 May 2022**, from 09:00-16:45 at Edgbaston Cricket Ground.

To register, and view the agenda, please visit: eventbrite.co.uk/e/opportunities-to-engage-with-research-in-your-health-social-care-career-registration-203658617407.

NIHR Academy Mentoring Programme

The NIHR Academy Mentoring Programme is now open for expressions of interest from colleagues wishing to join the programme as a mentor or mentee.

More information about the programme can be found online. The deadline for expressions of interest is 5pm on **Monday 9 May 2022**.

Job Opportunity - National ARC Comms Manager

University Hospitals Bristol and Weston NHS Foundation Trust are recruiting for an ARC National Communications Manager to join the NIHR ARCs network. The primary role would be to promote the work of NIHR ARCs to a wide range of targeted audiences, with responsibility for planning and implementing communications projects. For more information, and to apply, please visit: https://bit.ly/3uzFRXf.

The deadline for applications is **Monday 2 May 2022**.

Recent Publications

Atkin C, Knight T, Cooksley T, Holland M, Subbe C, Kennedy A, Varia R, Lasserson D. Society for Acute Medicine Benchmarking Audit 2021 (SAMBA21): assessing national performance of acute medicine services. *Acute Med*. 2022; **21**(1): 19-26.

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