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NIHR CLAHRC West Midlands News Blog

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NHS National Institute for Health Research

Welcome to the latest issue of your NIHR CLAHRC West Midlands News Blog.

In the latest issue of our News Blog we argue that high-income countries should reduce the size of the medical work force, while low-income countries need less doctors than they think. We feature a a guest blog from CLAHRC WM Co-Director Tom Marshall, who takes a sceptical look at mass screening for pre-diabetes. We also summarise articles dealing with the health of politicians; the latest Dr Foster Unit article on the weekend effect; the idea of defensive medicine; and the health of the world. Unusually we also discuss a book - Bob Wachter's influential discussion of the trials and tribulations of digital health.

Further, we bring you a PPI update; the latest news; profile Giovanni Radialli; highlight upcoming events; feature some recent Tweets; and have our CLAHRC WM Quiz. Finally, we list some of our latest publications.

We hope that you find these posts of interest, and we welcome any comments. You can find previous issues of our News Blog here.

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Director's Blog

How Many Doctors Do We Really Need?

In a previous post we blogged about the changing nature of medical practice: the influences of regulation, guidelines, sub-specialisation, and patient expectations. We mentioned skills substitution, whereby less experienced staff take on tasks previously carried out by doctors. We also mentioned the role of Information Technology, but shied away from discussing the implications for medical manpower. However, it seems important to ask whether Information Technology could reduce the need for medical input by increasing the scope for skill substitution. Some patients have complex needs or vague symptoms, and such patients we assume will need to be seen by someone with deep medical knowledge to underpin professional judgements, and to provide patients with such an informed account of the probable causes of their illness and the risks and benefits of viable options. But much of medicine is rather algorithmic. A patient presents with back pain – follow the guidelines and refer the patient if any 'red flags' appear, for example. Many of the criteria for referral and treatment are specified in guidelines. Meanwhile, computers increasingly find abnormal patterns in a patient's data that the doctor has overlooked. Work in CLAHRC WM shows that many patients do not receive indicated medicines. [1] Health promotion can be delivered by nurse and routine follow-up cases triaged by Physician Assistants. A technician can be trained to perform many surgical operations, such as hernia repair and varicose vein removals, and Physician Assistants already administer anaesthetics safely in many parts of the world.[2] Surely we should re-define medicine to cover the cognitively demanding aspect of care and those where judgements must be made under considerable uncertainty.

In the USA they talk about "people working up to their license". What they mean is

that it is inefficient for people to work for extended periods at cognitive or skill levels well below those they have attained by virtue of their intellect and education. Working way below the level is not only inefficient, but deeply frustrating for the clinician involved, predisposing them to burn out. Use doctors to doctor, not to fill in forms and perform routine surgical operations.

We conclude by suggesting that there is a case for re-engineering medical care or at least articulating a forward vision. The next step is some careful modelling, informed by experts, to map patterns of practice, assign tasks to cognitive categories, and calculate manpower configurations that are both safe and economical. Such a process would likely identify a more specific, cognitively elite role for expensive personnel who have trained for 15 years to obtain their license. In turn, this may suggest that less people of this type will be needed in the future.

While high-income countries should address the question "*how much should we reduce the medical workforce, if at all?*", low-income countries face the reciprocal question, "*by how much should we increase the medical work-force?*" Countries such as Kenya have only two doctors per 10,000 population, compared to 28 in the UK, and 25 in the United States.[3] Much of the shortfall is covered by other cadres, especially medical officers (who work independently), and nurses. Health personnel are strongly buttressed by community health workers, a type of health worker that we have discussed in previous posts.[4] [5] Information Technology is unsurprisingly very under-developed in low-income countries, although telemedicine is increasingly used. It is particularly difficult to attract doctors to work in rural areas, and there is the perennial issue of the medical brain drain. The time is thus propitious to consider carefully the human resource needs not just of high-, but also of low- and middle-income countries, and consider how these may be affected by improving Information Technology infrastructure.

-- Richard Lilford, CLAHRC WM Director

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CLAHRC WM Quiz

There is currently an outbreak of the Zika virus across Latin America, but where is Zika, after which it is named?

Email CLAHRC WM your answer.

Answer to our previous quiz: The smallpox vaccine also **protects against HIV**. It is thought to do this by interfering with the replication process of the virus. Epidemiological consequences may have been quite large since small pox vaccine was withdrawn shortly before the HIV epidemic took hold.

Congratulations to Jo Sartori who was first to answer correctly.

Guest Blog

Screening That Dare Not Speak its Name

-- Prof Tom Marshall, CLAHRC WM Co-Director

We are about to embark on a mass screening programme to prevent diabetes: but we will not call it screening.

Every hour sees the number of diabetics in England increase by 13. Surely something must be done. An evidence base feeds a seductive narrative. Type-2 diabetes does not develop overnight; it disproportionately affects the old, the overweight, South Asians. Those about to develop diabetes have tell-tale laboratory test results: raised glycosylated haemoglobin levels (indicating persistently raised glucose), impaired glucose tolerance. These days we even have a name for this: pre-diabetes. There is good evidence that intervention to change physical activity and diet prevents about a third from developing diabetes.[1] Prevention is highly cost-effective.[2] Hey presto! The solution is obvious. We do blood tests on people at high risk of diabetes. We find those at high risk. We offer intervention. In essence this is the National Diabetes Prevention Programme.[3] Pilot projects are under way across England, including Birmingham. Before they have finished there are plans to roll the project out across the country.

As Henry Menken once said “For every complex problem there is an answer that is clear, simple, and wrong.” The scale of the problem is overwhelming. About one in ten adults is pre-diabetic. The evidence for diabetes prevention involved intensive

lifestyle intervention lasting from one to six years and was delivered by health professionals. The NHS thin-gruel will be shorter and delivered by health trainers. This might work. But it would be nice to know before spending millions on the programme.

But the bigger problem is practical. While frantically trying to identify more pre-diabetics, the National Diabetes Prevention Programme simply can't even cope with the existing burden. Most pilot projects can only offer intensive lifestyle intervention to a minority of pre-diabetics: 200 of 6,000 in Bradford; maybe up to 1,500 of 13,000 in South Birmingham. Public health services face further funding restrictions just as we are identifying more pre-diabetics. One option is to offer the remaining pre-diabetic population less costly alternatives, but it is less clear that weight loss programmes prevent diabetes.[4] Even weight loss programmes have a cost. Would handing out leaflets work?

In all but name, this is a screening programme. But it won't be called screening because that would subject the programme to the scrutiny of the National Screening Committee. One of their criteria for assessing screening programmes is revealing: "Adequate staffing and facilities for testing, diagnosis, treatment and programme management should be available prior to the commencement of the screening programme."[5] Nobody use the "s" word.

-- Tom Marshall, CLAHRC WM Co-Director

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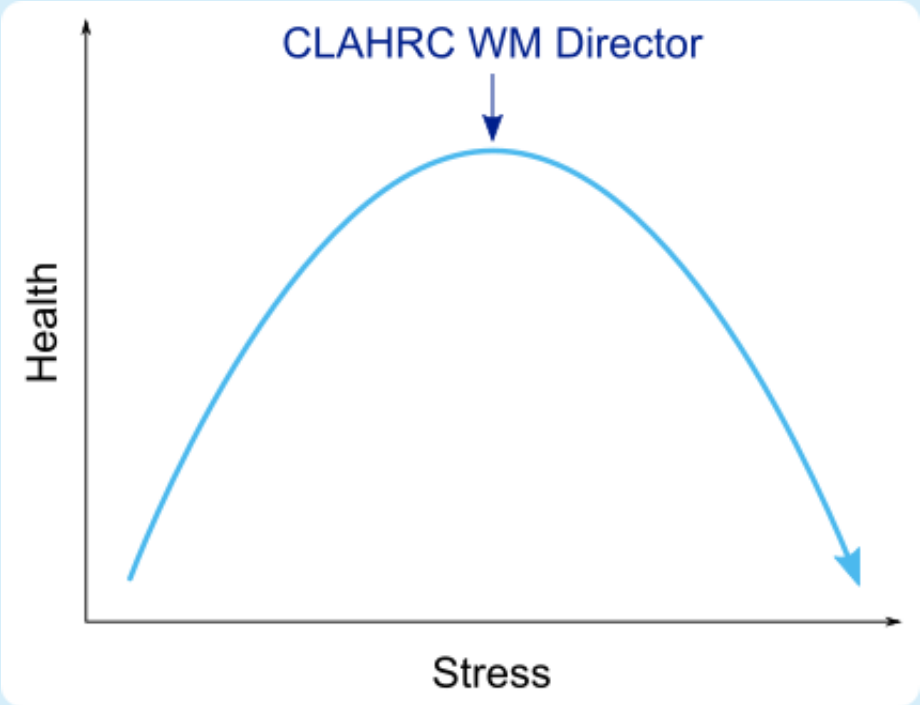
Director's Choice - From the Journals

Who Does Better with Respect to Health:
the Winner of High Political Office or the Gallant Loser?

Every so often the CLAHRC WM Director reads an article and says, "*By Jupiter, why didn't I think of doing that?*" Such an article compared the life expectations of the winners and runners up of 297 national elections across 17 countries.[1] From the Whitehall studies one might have concluded that the winner takes all – the feel-good factor of being a winner in life's race would presage a longer life-span. Not so. The winners on average live a full 2.7 years *less* than the losers – a larger effect size than many of the unhealthy behaviours we tackle in public health. US Presidents are known to have the same life expectancy as the general US population, but given

their high social class they should live longer. So the stress of high office really might be bad for health. The CLAHRC WM Director posits an inverted U-shaped stress curve:



-- Richard Lilford, CLAHRC WM Director

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Reference

The Latest Dr Foster Unit Article on the Weekend Effect

More on the weekend effect – this time concerning the CLAHRC WM Director's speciality, obstetrics. This was another large database study,[1] with an impressive 1.3 million deliveries from the English National Health Service database. The weekend effect is the difference in outcomes from weekend admissions versus weekday admissions. However, the main study finding was that "*the perinatal mortality rate was 7.3 per 1000 babies delivered at weekends, 0.9 per 1000 higher than for weekdays (adjusted odds ratio 1.07, 95% confidence interval 1.02 to 1.13)*". But look at the figure and the rate was even higher on a Thursday, and Wednesday and Thursday combined would yield a similar increase over the mean. Granted, weekend was an *a priori* hypothesis and Thursday was not, but that does not mean we should ignore the observation – the babies who died were not aware of this 'rule of the game' in frequentist statistics. The authors make the usual mistake of enumerating preventable deaths on the basis of 'cause and effect' assumption. They came up with 770 per year.

By the time the CLAHRC WM Director received the print version of the BMJ, 36 critical comments had already been posted online.

Reinhart and Rogoff made their data of factors associated with economic depressions available to other scientists [2] – the CLAHRC WM Director assumes that Palmer and colleagues will also make their data available for re-analysis?

-- Richard Lilford, CLAHRC WM Director

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References

Calling All Doctors. And Lawyers. And Politicians

The idea of defensive medicine is that ordering lots of tests, admitting patients and making referrals will reduce the risk of being sued, even when there is a low probability that the activity will be beneficial. In obstetrics it is well known that the clinician is much more likely to be sued for not doing, than for doing, a Caesarean section.

But what about general medicine – is it true that defensive medicine works in its own terms, i.e. that it will reduce the risk of medical litigation? Resource use by physicians is a proxy for defensive medicine. So, is there a correlation between physician spending and litigation risk?

STOP AND THINK – WHAT IS YOUR GUESS?

NOW READ ON.

Well, the answer (and it was *not* what the CLAHRC WM Director guessed) is that there is a strong *negative* correlation between spending on extra activities and the risk of litigation.[1]

This is a spectacular record linkage study – in this case data from Florida hospitals and data from the Florida Office of Insurance Regulation. Doctors were compared within speciality after risk-adjustment for patient severity. To avoid the possibility of reverse causality, expenditure in one calendar year was correlated with incidence of litigation in the following year, it having been established that expenditure patterns within clinicians are highly correlated across time epochs. The study also replicated the well-known negative correlation between Caesarean section rate and risk of a malpractice claim.

So it's not just how well you communicate with patients that determines your litigation risk, but how defensive your practice is. Why is this? Do patients get a sense that you have taken the complaint seriously when you have done the things that consume the resources? Or do they sense that their chances of successful litigations are reduced? Or is the extra-expenditure effective in reducing adverse events? The policy implications turn on the mechanisms by which higher expenditure translates to lower claims. For instance, if activity reduces the probability of a misdiagnosis, then defensive practice is not really defensive – it is clinically effective and quite possibly cost-effective because it has the potential to reduce the costs of both adverse events

and litigation. On the other hand, if the (negative) correlation is an artefact of patient perception, then education may be the way forward. From the point of view of the clinician, the implications are pretty obvious, whatever the mechanism.

-- Richard Lilford, CLAHRC WM Director

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Reference

An Extraordinary Collaborative Effort:
Disability Adjusted Life Years (DALYs) for 306 Countries

Last fortnight's blog post featured a synopsis of the mighty Global Burden of Disease Study on life years lost across different countries and across the world over time due to different diseases. A subsequent paper has recently been published in the Lancet that uses a standardised framework and method to estimate summary measures of health loss expressed as DALYs and Health Life Expectancy.[1] Health loss was estimated for 306 diseases/conditions across 188 countries at regular intervals between 1990 and 2013. Headline messages from this 46 page study are as follows:

1. Worldwide life expectancy rose by 6.2 years (from 65 to 71 years) over the 23 years of the study.
2. Age-standardised DALYs fell by a mighty 27%.
3. Indicators (total DALYs and age-specific DALYs) improved dramatically for communicable diseases; and for maternal, neonatal and nutritional diseases.
4. Age-adjusted DALYs have also declined for non-communicable disease – a surprise?
5. Some communicable diseases (notably leishmaniasis and dengue) bucked the trend for communicable diseases as a whole and registered a recent *increase* in DALYs. The CLAHRC WM Director questions the finding regarding leishmaniasis - he suspects that visceral leishmaniasis, at least, is declining.
6. The greatest causes of DALYs were ischaemic heart disease, pneumonia, stroke, spinal pain, and road injuries. The CLAHRC WM Director suspects that mental illness is underestimated in this study?
7. Leading causes of DALYs are highly variable across countries.
8. Progress has been most rapid in the latter part of the survey period thanks to major reductions in HIV/AIDS and malaria, along with maternal, neonatal and nutritional disorders.
9. DALY rates for neoplasms and cardiovascular disease are minimally related to socio-economic status except that risk for cardiovascular disease drops at the very highest economic level.

The health of the world's population really has improved and to quite a dramatic degree. This has happened even in countries that have not prospered economically. The GBD study is a remarkable achievement, up there with the human genome

project. It shows that science is a massive public good, and is a stark vindication of Enlightenment values and investment in research.

-- Richard Lilford, CLAHRC WM Director

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A Book for a Change

The CLAHRC WM Director finds himself on an expert working group established to advise the Secretary of State for Health – Jeremy Hunt – on future strategy for Information Technology in the English NHS. The group is chaired by a famous American Physician and West Coast Professor, Bob Wachter. Word has it that the said Wachter was identified as a candidate to chair the working group on the basis of his recent book – 'The Digital Doctor'.[1] So the CLAHRC WM Director thought he had better read it. It arrived in the post today and we shall report on it further in due course. But a quick glance at the first few chapters indicate that it is extremely well-written and researched. News Blog readers will know that the CLAHRC WM Director is obsessed with the doctor-patient relationship [2] [3] – the basis for the whole of medical practice. Wachter says that health care was slow to computerise, but there have been recent examples of a rush to make up for lost time on both sides of the Atlantic. And in this haste the precious doctor-patient relationship has been side-lined. Indeed, the possibility that this could happen was studied formally by the CLAHRC WM Director no less than three decades ago.[4] It now appears to be happening on an epic scale. But we can't go back – like the great white shark, we must keep moving forward to find the best way to use technology. Sometimes paper may be best, as discussed in a previous blog. Anyway, the CLAHRC WM Director shall keep reading and report back to you. In the meantime, consider ordering a copy for yourself.

-- Richard Lilford, CLAHRC WM Director

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Patient and Public Involvement

Citizen Member for Funding Panel

Do you have an interest in improving services in a range of health care issues across the West Midlands? The West Midlands Strategic Clinical Networks have one-off funding available to support NHS Improvement Projects across the West Midlands. They have an exciting opportunity for a lay individual who has high awareness of current healthcare issues and of the needs of the West Midlands population to be a

member of the review panel. For more information and to express an interest, please visit: http://bit.ly/1QnTNcx
Closing date: **Monday 1 February, 5pm**

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News

First Inter-CLAHRC Health Economics for Service Delivery Research workshop

On the 20th January 2016, CLAHRC WM hosted the first inter-CLAHRC Health Economics for Service Delivery Research workshop at Kings College London's Strand Campus. The event aimed to allow CLAHRCs to share their plans and activities in developing the methodology of health economics for service delivery research, and highlight any particular challenges and methodological issues.

The group was welcomed by chair John de Pury (Assistant Director of Policy at Universities UK), and each CLAHRC was given the opportunity to present their current activities and outline the advances and challenges they have come across. Following this, Prof Richard Lilford (Director of CLAHRC West Midlands) led group discussions on the key domains that emerged from these presentations, including practical problems, such as identifying costs and statistical issues; conceptualising the problem, defining both the intervention and the alternative, boundary effects and modelling; epistemology, including context and complexity; and update and dissemination issues, i.e. what do decision-makers need in order to make a decision.

John de Pury summarised the discussions and the group identified a number of ways to move forward with the health economics for service delivery research, including organising a symposium on the subject with a possible output, and creating a network or working group to refine the domains and establish a plan to move forward.

-- Hannah Dodd

CLAHRC work featured on Cochrane homepage

Work by members of CLAHRC WM Theme 3 has recently been featured on the homepage of the Cochrane Library – Dietary fibre for the primary prevention of cardiovascular disease. The authors (Hartley, May, Loveman, Colquitt, Rees) found that there was a beneficial reduction in total cholesterol and LDL ('bad') cholesterol, and diastolic blood pressure with increased fibre intake. The full paper can be read online.

NIHR Parliamentary Day

Minister for Life Sciences, George Freeman MP, hosted the first NIHR Parliamentary Day in Westminster recently. MPs and Peers were invited to learn about the world-class research funded and supported by the NIHR, and how the NIHR have transformed the research environment in England over the last ten years. For more information, visit: http://eepurl.com/bNeEYD

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Personality of the Issue

Giovanni Radaelli

Dr Giovanni Radaelli is a Research Fellow at Warwick Business School and works for CLAHRC WM Theme 5: Implementation and Organisational Studies. Giovanni obtained his PhD in Management, Economics and Industrial Engineering at the Politecnico di Milano (Italy). His thesis studied the strategic and institutional role of generalist middle managers engaged with the diffusion of integrated care pathways in 14 Italian hospitals. His main research interests relate to change and development in professional organizations, with a specific focus on how healthcare professionals and managers engage with interdisciplinary collaborations to introduce radical innovations. In the past, Giovanni was involved in various national and European projects, contributing to the impact assessment of e-Health systems for risk prevention and management in 4 Hospitals in Italy, England and Finland (EU project: ReMINE); to the impact assessment of e-Health systems for patient activation (EU project: Palante); to study the implementation of a new tele-monitoring system for patients with chronic heart failure (National project: Nuove Reti Sanitarie); and to study the antecedents of knowledge sharing behaviors in 6 Italian Hospice & Palliative Care Organizations. In early 2014, Giovanni joined the University of Warwick. In CLAHRC WM projects, he undertakes qualitative research on the translation of evidence into new roles, services and technologies. Giovanni is currently conducting research on:

- The development of a new clinical service for patients with complex symptoms
- The implementation of ‘advanced nurse practitioners’ in mental health
- The diffusion of a personal health records in primary and secondary care
- The design and implementation of a new Mental Health Service for Children and Young Adults aged 0-25 in Birmingham Children Hospital

All qualitative research encompasses interviews, non-participant observations; and other instruments of longitudinal analysis and grounded theory. Methodologically, while embedded in traditional research methods, Giovanni has a strong interest in exploring new modes of research, and particularly collaborative research methodologies (Mode 2). Giovanni also contributes to the course “Healthcare Management” for Master students in biomedical engineering at Politecnico di Milano; and has lectured in Bachelor courses of Business Administration; and MBA courses on health technology assessment.

Outside of work, Giovanni enjoys football, American sports, stand-up comedy, long walks, Frank Zappa, hard rock and jazz fusion.

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Selected Replies

Re: Improving Services: Professional Responsibility for Organisational Failure

Lessons from another industry?

In the 1960s and early 1970s, the rate of commercial aircraft accidents (defined as those involving planes with a capacity of more than 19 passengers) was rising inexorably. The main reason was due to the growth in traffic. Revenue passenger miles had grown threefold in a decade. In 1972 there were 41 accidents worldwide, with a death toll of 2,300. The industry was on course for one headline-making crash per week. This was seen as unacceptable. No amount of statistical interpretation and manipulation of the data was going to offset the negative perceptions thus created.

Seventy-percent of accidents were attributed to human error. Therefore it appeared that the focus had to be on the people. However, the aviation industry was already highly regulated. Personnel were then, and still are, carefully selected and extensively trained. They are given regular refresher courses. Procedures are fully documented. Accidents are investigated thoroughly and lessons disseminated. Despite all of these measures, extremely capable, highly professional people kept making fatal mistakes. Furthermore, these mistakes were invariably fatal to the people making them. It is difficult to think of a greater motivation to be error free.

If we fast forward to the present day the picture is different. Every year since 2000, the number of accidents has been at, or below, 15 per annum, with a low of six. Fatalities have averaged 600. (2014 was the worst year, mainly due to 537 being killed in the two Malaysian Airlines accidents.) In simple terms, there has been a three to fourfold improvement in safety. This has been achieved against a nine fold growth in traffic in the last 40 years.

It is important to understand the reasons behind such a dramatic change. How much credit should go to the frontline professionals, and how much to management? The manager does not fly the plane. The manager does not wield the scalpel. If the pilot shuts down the wrong engine (as happened at Kegworth in 1989) there is nothing that anyone in the management hierarchy can do about it. The individual must always expect to be held responsible for the consequences of their actions. This applies to the cleaner as much as the consultant. However, responsibility for organisational failure must lie with the people who design the organisation. As the Captain of the Boeing 737-400 plane that crashed at Kegworth said, "*We made a mistake — we both made mistakes — but the question we would like answered is why we made those mistakes*."

It is not enough to rely on the superb professionalism and dedication of front line staff. Members of staff should find it easy for to make the right calls. The Japanese call this *poka-yoke*, or mistake proofing. The actions of the crew at Kegworth would have been correct for all earlier models of the Boeing 737, but not the very latest one that they were flying. Ensuring that the crew were aware of the model differences, and the reasons for them, would have made a big difference to the outcome. That is a management issue.

Controlled Flight into Terrain (CFiT) (allowing a perfectly serviceable plane to crash into the ground) was the cause of a number of accidents over a long period. Improving the training of the crew could have been the solution. Indeed this approach was tried for many years. Installation of a Ground Proximity Warning System (GPWS) was the more robust solution. The crews have been given the tools that reduce the possibility of making a mistake. That is a management issue.

One way in which the aviation industry connects individual responsibility with the necessity for management oversight is through a system called CHIRP (Confidential Human Factors Incident Reporting Protocol). CHIRP was established in 1982 to enable people in the aviation industry to report matters of concern in a structured manner. The rail industry followed suit in 1996 and the maritime industry in 2003. Almost every fatal accident enquiry uncovered a series of near misses (sometimes literal, sometimes metaphorical) that took place beforehand. CHIRP captures information on these incidents and enables system improvements to be made. (Examples include an issue with a maintenance procedure being undertaken in the middle of the night, and application of the working time directive.) Individuals are

encouraged to report potential problems. However, it is up to management to implement changes to working practices across the organisation.

Should a Director be held accountable for *organisational* failure? Absolutely. There is a big clue in the job title. The Director's job is to provide direction. A Director is a system architect. A Director has to design a system, to create a structure, which is fit for purpose under any reasonably foreseeable circumstance. If all of the people within that system are highly motivated, superbly trained, and willing to 'go the extra mile' then there will be the benefit of significant resilience.

English law has something to say on this matter. In 1987, the ferry Herald of Free Enterprise capsized, causing the death of 193 people. The immediate cause of the tragedy was the failure of the assistant boatswain to close the bow doors. Seven people involved at the company were charged with gross negligence. The operating company was charged with corporate manslaughter. However, the Judge directed the jury to acquit the company and the five most senior individual defendants. The defence of the senior people, was, in essence, that they were too remote from daily working practices to be accountable. It did, however, set a precedent that corporate manslaughter is legally admissible in English courts. It was not until 1993 that an accident took place that led to a Director being jailed following a conviction for Corporate Manslaughter. This was the Lyme bay canoeing tragedy that took place in 1993 where four teenagers died. The company in question was very small. The Director was intimately involved in all aspects of its operation. The Corporate Manslaughter and Corporate Homicide Act (2007) (in force from April 2008) was introduced to clarify the law. Since then, 16 prosecutions have reached the courts. The first of these related to an accident that took place in September 2008.

Therefore, whether we like it or not, Directors are responsible for corporate failings.

-- Mr Keith Stanley, SME Engagement Manager R&D, University Hospitals Birmingham

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Events

4 Feb 2016
A Pain App a Day Keeps the Doctor Away Workshop
Britannia Stadium, Stoke-on-Trent

The West Midlands AHSN Person-Centred Care Theme are hosting a one-day workshop to bring attendees up to date with the new trend in patients using their mobile phones, and how it can improve patient care.

For more information, please click here. To book a place please contact Emily

Brayford on e.c.brayford@keele.ac.uk

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11 Feb 2016
Primary Care Consultations - harnessing patient engagement in tricky long-term conditions: obesity, malnutrition and health
thestudio, Birmingham

The West Midlands AHSN Person-Centred Care Theme are hosting a one-day workshop for clinicians, commissioners and providers who use motivational interviewing in their consultations. This hands-on workshop will cover behaviour change theory techniques, as well as provide access to e-learning sessions, training resources and an interactive workbook from the RCGP.

For more information, please click here. To book a place please contact Emily Brayford on e.c.brayford@keele.ac.uk

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23 Feb 2016
Patients Bereaved by Suicide (PABBS) Workshop
Britannia Stadium, Stoke-on-Trent

The West Midlands AHSN Person-Centred Care Theme are hosting a one-day workshop to offer health professionals an opportunity to build their confidence and skills in caring for those bereaved by suicide.

For more information, please click here. To book a place please contact Emily Brayford on e.c.brayford@keele.ac.uk

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24 Feb 2016
ePrescribing: Looking to the Future
Royal College of General Practitioners, London

The Centre for Research on Families and Relationships (CRFR) are holding an event on ePrescribing, from implementation and adoption to organisational transformation and patient benefits, which will look forward from 5 years of ePrescribing research. There will be discussions focussing on lessons learned and implications for the NHS, and maximising benefits and realising returns on investment through technologies. International experts include Prof David Bates (Harvard Medical School), and Prof Denis Protti (University of Victoria).

For more information, and to book a place, please click here.

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06 April 2016
CAT in a Day
Primary Care Sciences Building, Keele University

Health Professionals working with patients with musculo-skeletal disease are invited to attend a CAT in a day workshop - '*Your Clinical Question Answered in a Day*' - at Keele University. The workshop will be focused around exercise and is free to attend, but places are limited. To secure a place, please contact Emily Brayford on e.c.brayford@keele.ac.uk by 31 March 2016.

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Fortnight's Publications

Castle DJ, Singh SP. Early Intervention in psychosis: still the 'best buy?' *Br J Psychiatry*. 2015; **207**(4): 288-92.

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Kuo CF, Grainge MJ, Mallen C, Zhang W, Doherty M. Impact of gout on the risk of atrial fibrillation. *Rheumatol*. 2015. [ePub].

Østerås N, Jordan KP, Clausen B, et al. Self-reported quality care for knee osteoarthritis: comparisons across Denmark, Norway, Portugal and the UK. *RMD Open*. 2015; **1**(1): e000136.

Taylor-Phillips S, Freeman K, Geppert J, et al. Accuracy of Non-Invasive Prenatal Testing using Cell Free DNA for Detection of Down, Edwards and Patau Syndromes: A Systematic Review and Meta-Analysis. *BMJ Open.* 2016; **6**: e010002.

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Tweets

A new guide 2 public involvement in research by @ParkinsonsUK will be useful 4 ALL researchers: simondenegri.com #ppiprimer PI RT
28 Jan 2016 @SDenegri

CALL OPEN: The DH Policy Research Programme is inviting applications in two policy evaluation areas. Find out more ow.ly/XAKpL
27 Jan 2016 @OfficialNIHR

@WMHINet @wmahsn Great presentations today at the WMHIN annual conference including STarT Back tool. pic.twitter.com/DR94RYAMWa

26 Jan 2016 @CLAHRC_WM

Great networking & learning opportunity at #Healthcare #Innovation Showcase East Mids @CLAHRC_EM on 25 Feb: bit.ly/1LqrRNU

22 Jan 2016 @CLAHRC_WM

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