Commissioning Brief (11/1022)
Call for proposals: Demand management for planned care
Closing date: 1.00pm on 15 September 2011

1. Introduction

Like other advanced health systems, the NHS is facing substantial increases in activity and costs and rising demands for planned hospital care. Different strategies have been put in place to contain demand – from referral management centres, providing a filter between referring general practitioner and hospital, to reviews by hospital specialists to authorise referrals and divert patients to appropriate teams. These organisational initiatives have not been well evaluated. The SDO programme wishes to fund robust assessments of demand management interventions for elective care, to complement a recent call for research on unplanned hospital admissions. This should provide evidence for local managers to make informed decisions about tactics to manage demand for planned care.

This paper briefly sets out the background to this topic and what is known from existing evidence in Section 2, with main topic areas for new research outlined in Section 3. There is also a description of the scope for this call, clarifying those areas which will not be considered for funding. Section 4 of this call for proposals offers general guidance to applicants on what makes for a successful application to the SDO programme, while section 5 sets out our expectations in relation to research outputs and knowledge mobilisation, and section 6 explains how applications are assessed and selected. Please note that sections 4 and 5 of this call for proposals providing the SDO programme's general guidance on research applications and knowledge mobilisation have been extensively revised and researchers are advised to note the changes.

The NIHR Service Delivery and Organisation programme is funded by the NIHR, with contributions from NISCHR in Wales. Researchers from Scotland and Northern Ireland should contact NETSCC to discuss their eligibility to apply.

The NIHR SDO programme improves health outcomes for people by:

- Commissioning research and producing research evidence that improves practice in relation to the organisation and delivery of health care, and

- Building research capability and capacity amongst those who manage, organise and deliver services – improving their understanding of the research literature and how to use research evidence.

The primary audience for SDO commissioned research is decision makers in the NHS in England and Wales – particularly managers and leaders in NHS organisations. We focus our research commissioning on topics and areas where we think research evidence can make a significant contribution to improving decision making, and so to improving the organisation and delivery of healthcare to patients.

Further information on the NIHR SDO programme, including a list of past, current and recently commissioned projects, can be found on the SDO website: www.sdo.nihr.ac.uk

2. Background to this call

2.1 Research need

A key role for commissioners is to ensure fair access to planned (non-emergency) care. This poses challenges given increased demand for services due to an ageing population, changing patterns of ill-health and higher public expectations. Planned care includes all elective surgery (inpatient and day case) as well as outpatient activity. However, most surgery would be preceded by an outpatient appointment (or pre-operative assessment) and so, in practice, the crucial interface is between general practitioner (or other referring professional) and hospital outpatient services.

Over 9 million referrals are made for planned care each year at a cost of over £15 billion and this has risen year on year (HES 2010). At the same time, evidence suggests that a substantial proportion of elective care may be unnecessary – one national clinical audit suggesting that around a third of all cancer outpatient referrals were not needed (Patel 2000). Many local organisations have been given blanket target reductions for elective activity (for instance, 5% reduction in outpatient referrals). Many strategies have been developed to achieve this, but not all have firm grounding in evidence.

Historically, demand has been managed through the gatekeeper role of the general practitioner (as in the Netherlands and now increasingly adopted by countries such as the US, France and Germany which previously allowed patients direct access to specialists) and through the waiting list. This has changed in recent years, as national targets have led to reductions in waiting times and public expectations have reduced the acceptability of reliance on waiting lists as a mechanism to manage demand. Greater emphasis has been placed on the role of GP as gatekeeper, although evidence shows substantial and unexplained variation in referral patterns (O'Donnell 2000) suggesting differential thresholds for accessing acute care.

As a result of this, some commissioners have put in place different mechanisms to manage demand for planned care. These range from structured referral protocols to referral management centres. These all aim to improve referral quality and also to manage exposure to acute care costs. This is important, since once a referral has been made, the subsequent costs and processes of care are largely driven by decisions made in the acute care provider. It is worth noting too that, although numbers are smaller, consultant-to-consultant referral has increased at double the rate (39%) of that of GPs to hospital specialists (19%) over the last five years (Kings Fund 2010). Within the healthcare system, there is a need to get the first referral right.

2.2 Existing literature

This call relates to research to assess initiatives to contain or manage demand for elective hospital care. The area is broad and complex and spans a number of areas. To understand current state of knowledge, it may be helpful to consider three key areas of activity; interventions aimed at general practitioners; interventions aimed at hospital specialists or at the interface; and organisational interventions to manage demand.

2.3 Interventions aimed at general practitioners

Mechanisms to manage demand and improve the appropriateness of the initial referral include referral thresholds, appropriateness criteria and specific interventions such as structured referral sheets. Although the notion of appropriate referral rates may itself be

contested, there are interesting initiatives in other countries to develop standardised set of criteria as a way of ensuring greater consistency across referring clinicians. These include the New Zealand priority criteria developed through iterative processes with clinicians and others for a number of elective surgical procedures, from cataracts to knee replacements (Hadom 1997).Other interventions at the point of referral include human barriers, such as seeking second opinion in-house from another practitioner before onward referral. Systematic reviews of evidence on interventions to reduce outpatient referrals from primary to secondary care (Grimshaw 2005 and Akabari 2008) concluded that passive mechanisms such as referral guidelines were less effective than other interventions such as structured referral sheets and educational outreach by specialists to influence referral behaviour.

Given this body of knowledge, commentators have noted "it is surprising that more attention is not given to strategies of proven value in reducing outpatient demand." A few robust studies have been published which are grounded in what is known of implementation science and evidence of what works, such as a fairly recent multi-faceted trial to improve the appropriateness of referrals for stroke prevention (Wright 2006), but these are rare.

In recent years, there has been interest in the use of GPs with specialist interest running clinics, although an SDO-funded study (Rosen 2006) did not find evidence of reduced referral rates in assessment of four clinics in dermatology and musculoskeletal conditions. Other studies showed benefits in clinics led by GPs with specialist interests, although not necessarily cost savings (Salisbury 2005).

Other initiatives directed at GPs include giving them direct access to hospital diagnostic tests and services, without prior consultant approval in an outpatient clinic. Studies suggest impact in reducing hospital workload by direct access schemes in areas such as urology and bowel problems (Roland 2006), although these are often under-used by GPs. However, authors noted the variable quality of the limited studies on this, completed before 2000, so further work may be helpful in this area.

There have been limited attempts to reduce inappropriate referrals by financial incentives (for instance, through GP contractual mechanisms). Although there is little evidence, concerns have been expressed about deterring appropriate as well as inappropriate referrals in unselected raising of thresholds (Roland 2007).

2.4 Interventions aimed at specialists or at the interface

As well as changes within primary care, other mechanisms have been developed in secondary care to provide barriers to inappropriate referrals. These include pre-authorisation or clinical review mechanisms, feedback to general practitioners from hospital specialists on the appropriateness of referrals (Elwyn 2007) and referrals to teams rather than specialists, so that hospitals can divert patients to the most appropriate member of the team. It is worth noting that learning from other countries, such as Health Maintenance Organisations in the US (Ham 2010), emphasise that managing demand for secondary care cannot be controlled through tweaking primary care demand mechanisms alone.

These interventions to `screen' referrals by hospital specialists may also be directed to fellow specialists (consultant-to-consultant referrals) as well as general practitioners.

Other innovations include the use of teleconferencing or e-consultation as a form of triage (as opposed to wider e-health initiatives), whereby the GP seeks the opinion of the specialist before referral to reduce the number of inappropriate referrals. Although small studies have been undertaken in this country, such as electronic consultation for chronic kidney disease (Stoves 2009) or email triage for neurology (Patterson 2010), larger trials may be helpful.

Other important studies include interventions to reduce unnecessary outpatient follow-up in hospitals, such as patient-initiated review or open access clinics where patients can see a specialist according to their need, assessed with promising results in some clinical areas such as rheumatoid arthritis (Hewlett 2005).

2.5 Organisational interventions to divert or manage referrals

As well as referral guidelines for individual clinicians, some organisations have introduced initiatives such as **referral management centres**. The idea behind referral management centres is that they provide a central form of intelligence (including sometimes dedicated clinicians funded by the commissioner) to assess, monitor and direct patients to the best place of treatment. This might mean diverting patients to services which are under-used by referring clinicians or more cost-effective than existing alternatives. An example might be sending patients who need specialist GI endoscopy to dedicated units rather than the nearest general service at the local hospital. Schemes vary from particular initiatives to direct patients within a specialty (such as orthopaedics) to routine vetting and management of all routine and non-emergency referrals. Many localities have adopted referral management centres, sometimes as part of `choose and book' schemes. It is difficult to know how many formal referral management centres exist - a survey in 2007 indicated that 10% of localities had referral management centres and this is likely to have increased in the last few years (Kings Fund 2010).

Critics have concerns that they might pose an intermediate layer with little benefit or undermine the expertise of the general practitioner as referral agent. There has been little formal evaluation of the impact of such initiatives (Davies and Elwyn 2006), other than a limited review of seven Welsh pilot sites (CRG Research/University of Cardiff 2007).

A related but parallel initiative to divert patients to more appropriate forms of care is the development of **clinical triage or assessment services**. These are centralised triage systems for particular specialised services. These include diversion of patients to alternatives to hospital – for instance, to GPs with a specialist interest in dermatology (Salisbury 2005) or community-based musculoskeletal clinics with specialist physiotherapists (Akbari 2008). These intermediate services may treat low risk patients and make limited referrals of more complex patients to hospital specialist care. Although findings suggest such initiatives can result in improved quality and access, many of these schemes have been developed with additional money, so it is difficult to estimate impact on reducing demand for planned secondary care. In effect, these may supplement rather than substitute for secondary care services.

This call builds on an earlier scoping review commissioned by the NIHR SDO programme in 2005 on outpatient services and primary care (Roland 2006). This authoritative review generated debate and usefully identified some gaps in the evidence, which is partially addressed by this call. The NIHR SDO programme has funded the following relevant studies:

08/1518/082: Outpatient services and primary care: a scoping review of research into strategies for improving outpatient effectiveness and efficiency (Roland)
http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1518-082

08/1210/034: Evaluation of a primary care dermatology service (Salisbury)
http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1210-034

08/1210/035: A study of general practitioner specialist clinics to evaluate their impact on access to specialist care, costs and patient and clinician satisfaction (Rosen) http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1210-035

08/1304/045: The development and implementation of diagnosis and treatment centres as an organisational innovation (Bate) http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1304-045

08/1304/046: Evaluating innovations in the delivery and organisation of gastroenterology services (Williams) http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1304-046

08/1310/071: Evaluation of the Threshold Assessment Grid (TAG) to improve access from primary care to mental health services (Slade) http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1310-071

08/1310/072: The REFER project – Realistic Effective Facilitation of Elective Referral: an assessment of current use of referral tools for referral from primary to secondary care for elective surgical assessment and design of new tools(Van der Meulen) http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1310-072

Other related (although not directly relevant) work within NIHR includes projects funded by the Health Service Research programme on equity of access (for instance on cardiac services); some related projects funded by the Programme Grants for Applied Research on access to services (for instance, mental health services) and programmes funded by the Policy Research Programme on health reform evaluation and on commissioning and healthcare. Note too that the Policy Research Programme has funded a major evaluation (led by Professor Newman) of the Whole Systems Demonstrator project, which is due to report shortly and a stream of work on technologies to support self-care, which may be relevant to this area.

3. Remit of this call: main topic areas identified

Managers and clinicians face increasing pressure to bear down on rising activity in planned care and various mechanisms have been introduced to achieve this. Little is known about what works, in what combination, and there is a dearth of well-designed robust studies to test and evaluate interventions to manage demand. There is also useful learning from other health systems which face similar problems in rising demand.

There is scope for larger primary research studies, including possible pragmatic trials of service innovations. However, these types of studies are vulnerable to policy and practice change in the fast-moving world of healthcare. Service models and incentive structures may change over the lifetime of a major study. Care will be needed to design studies which will stand the test of time and remain relevant to clinical leaders and managers in three to five years time.

Particular areas of research need have been identified within the following three themes:

3.1 Interventions aimed at general practitioners

3.2 Interventions aimed at specialists and the interface

3.3 Organisational interventions to manage or divert referrals

The areas and themes outlined below are **indicative** of the wider aims and purpose of this call for proposals, and are not exclusive. Proposals for research which are not explicitly aligned with one of these areas or themes but which are consistent with the overall aims of this call for organisational research into elective care management are welcomed.

It should also be noted that research needs have been divided into three areas in order to provide a reasonable framework in a complex field. In practice, it may be useful to study combination of interventions across these areas, providing clusters of innovation to manage demand. These might include a range of initiatives targeted at clinicians in primary and secondary care, together with organisational arrangements to contain referrals. Such studies would be welcome, although the effect of individual interventions may be difficult to isolate and care will be needed in the study design in order to generate evidence from one locality which has wider relevance to the service.

3.1 Interventions aimed at general practitioners

Given the paucity of well-designed studies using best knowledge of implementation science, prospective studies – which could combine a number of proven effective strategies – to evaluate the impact of primary care-based interventions to reduce demand for planned care would be helpful. This could draw on health service research, such as the recent multi-faceted trial of practice-based interventions on stroke prevention, which included use of referral guidelines, educational initiatives aimed at GPs and feedback. Other areas might include evaluation of impact of structured referral sheets or use of referral thresholds for particular specialties and learning from other countries. The Roland 2006 review on outpatient services and primary care identified two particular areas which showed promise but where further research is needed. The first is the use of GPs with specialist interest to substitute (rather than complement) secondary care. The models of care provided by GPs with specialist interest vary greatly and it is not yet clear which reduce demand on hospitals or are cost-effective. The second research area identified in the Roland review was the use of in-house `second opinion' (peer review) by a second GP before referral, which appeared effective from the very small evidence base (one study at time of review).

In summary, new research could include:

- Primary research to evaluate impact of primary care-based interventions to improve the quality of referrals, either singly (such as referral sheets) or used in combination (referral guidelines and education)
- Primary research to compare the use of `second opinion' within practice before onward referral and impact on referral rates and costs
- Primary research to extend direct access to a wide range of tests and services
- Primary research to evaluate the cost-effectiveness of using GPs with specialist interest to substitute for secondary care
- Evidence synthesis of interventions developed in other countries to manage demand, focused on referring clinicians, such as the New Zealand referral thresholds and others

3.2 Interventions aimed at specialists and the interface

Evaluations are needed of the impact of interventions directed at specialists, such as clinical review before accepting patients with or without feedback to the referring clinician (GP or consultant colleague). There have been small-scale studies of local developments to manage demand through e-consultation (or e-opinion), where GPs consult by telephone or email with hospital specialists before referring patients. Larger studies would be useful,

which used measures to assess changes in inappropriate referrals as part of prospective research to evaluate the impact of such interventions on activity and costs.

Specific studies on re-design of outpatient services to reduce (inappropriate) referrals would also be welcome. These include larger studies to evaluate patient-initiated review or open access clinics and the impact on activity, costs and outcome.

In summary, new research could include:

- Primary research to evaluate interventions aimed at specialists to improve the appropriateness of referrals, such as clinical review, pre-authorisation or e-opinion
- Primary research to evaluate the impact of patient-initiated review in managing demand for outpatient services (while maintaining quality)
- Evidence synthesis of existing learning from other countries on any of the initiatives directed at specialists or at the interface between general practitioners and specialists to manage demand

3.3 Organisational interventions to manage or divert referrals

Research is needed to evaluate the effectiveness and cost-effectiveness of referral management centres in reducing (inappropriate) referrals for planned care. Some work may be needed to map current services across England and Wales, since these vary greatly, from small-scale email filters to referral diversion centres with dedicated clinical input and from single specialties to all elective referrals. The greatest interest though is in studies to assess the impact of referral management centres. This should probably take the form of before-after studies, using some form of quasi-experimental design – such as interrupted time series – in areas where such centres were introduced. Other methods, such as comparative analysis using secondary data, may also be considered although since many areas have adopted some form of referral management centre, it may be difficult to provide adequate controls.

More evaluation studies are also needed of clinical triage and assessment services. Many of these have been developed for particular specialties. The evidence base is therefore dispersed in `silos' of specialty-specific literature. It would be helpful to draw out the learning from these interventions in a single review focused on impact of such schemes in reducing activity (across the whole system) and costs, as well as access and patient acceptability alongside primary research evaluating the impact of such initiatives.

In summary, new research could include:

- Studies to map referral management centres in England and Wales and quasi-experimental studies to assess the impact of particular centres in avoiding inappropriate referrals
- Studies to consider parallel organisational initiatives in other countries (or in other settings, such as independent healthcare)
- Studies to evaluate clinical triage and assessment services and also synthesise evidence of impact across specialties

Scope

This call asks researchers to submit applications for organisational research relevant to managing demand for planned care. There are a number of related fields of work, which

are being considered separately or funded elsewhere. For this call, research which will **not** be funded includes: qualitative research on decision-making by individual clinicians; telecare and telehealth initiatives (in general); and models of intermediate care, including hospital at home and virtual ward schemes.

Applicants should also consider the generalisability of studies to the wider health service. Although bids focused on a particular specialty or clinical setting may be supported, applicants would need to demonstrate how the innovation or organisational feature could be replicated in other areas. Every application should have a strong health service research or evaluation component and provide learning on effective demand management strategies for clinical leaders and managers in the wider service.

Research also needs to fit the remit of the NIHR SDO programme. This focuses on evaluating local models of service delivery and interventions which have the potential to improve service effectiveness, efficiency and productivity. It does not fund studies which evaluate national policy or research or those with a wholly clinical focus, since these fall within other funding streams.

4. General guidance for applicants

NB: This is general guidance and not all the sections will apply to the specific call

Our main concern is to commission research which is well designed; will be effectively carried out by the research team; will provide findings which meet the needs of the NIHR SDO programme and the NHS management and leadership community it serves; and will be used to improve health services. With these aims in mind, we offer the following general guidance to applicants. We do not prescribe or prohibit particular approaches to research, but we encourage applicants to take account of this guidance in their project proposals, and point out that the SDO Panels and Commissioning Board will take account of this guidance when they assess and select proposals.

Research team makeup and expertise

Our key concern is that projects should have a research team with the right skills to undertake the research. It is important that the team has the necessary expertise, but is not so large that project management will be difficult. Projects are likely to use a team with significant input from diverse disciplines appropriate to the content and methods of the project. All applicants need to show that they will commit appropriate time and effort to the project, and the use of large teams of applicants with little or no apparent time commitment to the project is discouraged. Full proposals should make it clear what responsibilities and roles will be fulfilled within the project by each team member.

The chief investigator or principal applicant should generally be the person who has contributed most to the intellectual and practical development of the proposal, and who will take lead responsibility for its implementation. This is not necessarily the most senior investigator in the research team. Where the principal applicant has a limited past track record in holding grants, we will look for evidence that they will be supported and mentored by more experienced co-applicants.

NHS management engagement

Our key concern is that NHS managers should be directly engaged or involved with SDO research projects because this will produce research that is more closely grounded in and reflective of their concerns and makes the subsequent uptake and application of research findings more likely.

We particularly welcome project proposals in which an NHS manager is formally part of the project team as a co-applicant, and in which they (and/or other NHS managers) play a significant part in the project. Their contribution may be to facilitate or enable research access to organisations, to be directly involved in research fieldwork, to comment on and contribute to emerging findings, and to be involved in knowledge mobilisation (see below). We think that direct NHS management involvement in proposals of this kind shows commitment to and support for the research from the NHS organisations involved. The time of NHS manager(s) as co-applicants can be costed into the proposal, as part of the Research Costs.

There are other ways in which NHS management support for the proposed research can be demonstrated, such as co-opting managers to project advisory or steering groups, the inclusion with full proposals of a letter or statement of support from senior leaders in relevant NHS organisations.

Gains for the service

Not all research will individually result in potential savings or direct gains for the service. However it may lead to a better understanding of organisations, systems or services and contribute to that body of knowledge. Where it is appropriate, studies should include a cost-effectiveness component with a view to helping managers and service providers make decisions and identify potential for savings. As a publicly funded programme in a time of restraint, researchers should look to demonstrate potential savings and gains for the service, where appropriate. This includes setting out in broad terms the likely impact and implications of this work for the wider service at outline stage.

Research methods

Our key concern is that the research proposed is well designed, will be well conducted, and will add to knowledge in the area. It is not our intention here to specify particular research methods, but to highlight areas where we have found common weaknesses in the past.

Proposals need to make proper use of relevant theory and of the findings in the existing literature to frame their research questions. Although at outline stage, comprehensive referencing is not required, illustrative sources and indication of the grounding in a body of literature should be given. Theoretical, descriptive evaluations, proposals which appear not to be informed by the existing literature and projects which appear to replicate rather than add to existing research are unlikely to be funded. Research questions need to be very clearly stated and framed – in terms which are sufficiently detailed and specific. This includes a clear description of the intervention which is being assessed (where relevant) and articulating the objectives and aims of the research.

The research methods proposed must be appropriate to the nature of the research questions, and to the theoretical framework for the project. It is important that the proposal makes a clear link between the research questions and the intended empirical approach and fieldwork, showing what data will be gathered and how it will be used. The approach to data analysis must be clearly explained. The proposal needs to show that the research team has considered and addressed the logistics and practical realities of undertaking the research – gaining ethical and research governance approval, securing access, recruitment, data collection and management, etc. Studies should be realistically costed to take account of these activities. Where trial methodology is proposed, researchers would be advised to have got input from local trial taken advice from their local clinical trials unit or officer.

Researchers should be mindful of the need for generaliseability of results and the relevance of the outputs for the service as a whole. This may affect the study design – for instance, single case studies are only likely to be supported only exceptionally.

The plan of investigation should set out clearly and in some detail the proposed methodology. It should include a Gantt chart or project timetable showing clearly the planned dates of different project phases and of project outputs.

Public involvement
It is a core concern of the SDO programme that all commissioned projects should pay appropriate attention to the needs and experiences of all relevant stakeholders (including local communities, individual members of the public, users of services, carers and minority ethnic communities as well as healthcare practitioners and managers) during the design, execution and communication of the research. Proposed projects should be explicit in describing their arrangements for public and patient involvement and in communicating how the proposed work has potential implications for service delivery that could lead to enhanced public and community engagement. The application includes a section for the non-expert and care should be given to 'pitching' the proposal at a public audience, avoiding jargon and explaining clearly the expected benefits of the research.

Research governance
Applicants should show that they understand and that their proposal complies with the Research Governance Framework for the NHS. Successful applicants will be required to provide proof of research ethics committee approval for their project, if it is required, before funding commences. The project plan should take realistic account of the time required to secure ethics and governance approval.

Costs and value for money
Project costs will be carefully scrutinised and must always be well justified and demonstrate value for money. NIHR programmes currently fund Higher Education Institutions (HEI) at a maximum of 80% of Full Economic Cost (except for equipment over £50,000 – 100%). For non-HEI institutions, NIHR may fund 100% of costs. However, the NIHR SDO programme reserves the right to award a grant for less than this maximum and for less than the amount sought by applicants.

5. Research outputs and knowledge mobilisation

Our key concern is to ensure that projects funded by the SDO programme are designed from the outset to produce useful, timely and relevant research findings which are then used. Experience suggests that this is most likely if researchers collaborate with NHS managers throughout the life of a project, and aim to produce a variety of research outputs – not just a final report and one or more papers for academic peer reviewed journals.

All full proposals submitted to the SDO programme must include a detailed section on research outputs and knowledge mobilisation in the full plan of investigation which is attached to the proposal when it is submitted. We would expect to see that section and the project plan detailing the outputs and knowledge mobilisation activities which are planned across the life of the project, and the resources section of the proposal showing that sufficient resources have been allocated within the project budget to undertake these knowledge mobilisation activities. In general terms, all projects which are longer than 12 months are expected to produce some interim outputs during the life of the project as well as those at the end of the project.

The outputs and knowledge mobilisation activities shown in the project proposal are likely to include some or all of the following:

- A final and full research report detailing all the work undertaken and supporting technical appendices (up to a maximum 50,000 words), an abstract and an executive summary (up to 2000 words). This is a required output. The executive summary must be focused on results/findings and suitable for use separately from the report as a briefing for NHS managers. Care should be given to using appropriate language and tone, so that results are compelling and clear. The report must use the layout template provided. Following scientific peer review and editing/revision, the report will be made available on the SDO programme website. This is a required output from all projects.

- A set of PowerPoint slides (up to 10 maximum) which present the main findings from the research and are designed for use by the research team or others in disseminating the research findings to the NHS. The slides must use the template provided. They will be made available alongside the report on the SDO programme website. This is a required output from all projects.

- Journal papers for appropriate academic peer reviewed journals, designed to ensure the research forms part of the scientific literature and is available to other researchers.

- Articles for professional journals which are read by the NHS management community and which will be helpful in raising wider awareness of the research findings.

- Seminars, workshops, conferences or other interactive events at which the research team will present and discuss the research and its findings with NHS managers

- Guidelines, toolkits, measurement instruments or other practical methods or systems designed to enable NHS managers to use the research findings in practice. We are looking for practical, innovative ideas – such as questions arising from the research that non-executive directors could raise at Board meetings or similar.

This list is illustrative rather than comprehensive, and we will welcome project proposals which include other forms of output and knowledge mobilisation activities. All projects are encouraged to collaborate in knowledge mobilisation with the SDO Network, which is hosted by the NHS Confederation and exists to enable managers to improve and develop the services they manage by facilitating their access to and use of the latest health services research. (http://www.nhsconfed.org/networks/sdonet/Pages/SDONetwork.aspx).

6. Process for proposal selection

The NIHR Service Delivery and Organisation programme is funded by the NIHR, with contributions from NISCHR in Wales. Researchers from Scotland and Northern Ireland should contact NETSCC to discuss their eligibility to apply.

Whilst we have not set a maximum duration or cost for projects, value for money will be scrutinised and all costs must be justified. Applicants should be aware that changes of costs between outline and full proposal will have to be fully explained, and we therefore encourage applicants to be as realistic as possible when costing their outline proposals. Realistic costs are also very important at commissioning as the SDO programme does not normally accept requests for variations to contracts for additional time or funding once projects have been contracted.

Applications for this call will be assessed in two stages. Firstly, outline proposals will be sought. Once remit and competitiveness checks[1] have been made, they will then be reviewed by the Priority Areas Panel. The primary criterion against which the Panel assesses outline proposals is that of **NHS need for the research** – in other words, whether the proposed research will be useful to research users in the NHS, and is likely to contribute to improving decision making. It will use four main criteria to make this judgement:

- Relevance of the proposed research to the themes set out in this call for proposals
- Relevance of the proposed research to the needs, interests and current and future challenges for the management community in the NHS.
- Likelihood that the proposed research will produce findings which are timely, useful to and capable of application by the management community in the NHS
- Likelihood that the proposed research will promote the greater engagement between the academic research community and the health management community in the NHS, and will encourage development of links between academic institutions and NHS organisations.

Applicants whose proposals are shortlisted will be asked to develop a full proposal for assessment by the SDO Commissioning Board meeting. This board's primary concern is the **quality of the proposed research**. It uses two main criteria to make this judgement:

- Scientific rigour and quality of the proposed research, and the expertise and track record of the research team.

- Value for money of the proposed research, taking into account the overall cost and the scale, scope and duration of the work involved.

7. Application process and timetable

Should you have any questions or require any further clarification please refer to the NETSCC FAQs at http:\\www.sdo.nihr.ac.uk/faqsnetscc.html, if the answer to your question cannot be found please email your query to sdofund@southampton.ac.uk with the reference number (11/1022) and title for the call for proposals as the email header. Applicants should be aware that while every effort will be made to respond to enquiries in a timely fashion, **these should be received at least two weeks before the call closing date.**

The process of commissioning will be in **two stages** and applicants should submit **outline proposals** via the SDO website by **1pm** on 15 **September 2011**. No late proposals will be considered. No paper-based only submissions will be considered.

Applicants will be notified of the outcome of their outline application in November 2011.

Shortlisted applicants will be invited to submit a full proposal via the SDO website (a link will be sent to shortlisted applicants). Applicants will be notified of the outcome of their full proposal application in April 2012. Please note that these dates may be subject to change.

[1] '***Non-Competitive***' means that a proposal is not of a *sufficiently high* standard to be taken forward for further assessment in comparison with other proposals received and funded by the SDO programme because it has little or no realistic prospect of funding. This may be because of scientific quality, cost, scale/duration, or the makeup of the project team.

Transparency agenda

In line with the government's transparency agenda, any contract resulting from this tender may be published in its entirety to the general public. Further information on the transparency agenda is at:

http://transparency.number10.gov.uk/
http://www.ogc.gov.uk/policy_and_standards_framework_transparency.asp
http://www.contractsfinder.businesslink.gov.uk/

References

Akbari A, Mayhew A, Al-Alawi MA, Grimshaw J, Winkens R, Glidewell E, Pritchard C, Thomas R, Fraser C (2008). 'Interventions to improve outpatient referrals from primary care to secondary care (Cochrane Review)'. *Cochrane Database of Systematic Reviews*, issue 4, article CD005471

CRG Research/Cardiff University (2007). *Referral Management Pilots In Wales – Follow UpReview. Final Report*. Cardiff: National Leadership and Innovation Agency for Healthcare. http://www.wales.nhs.uk/sites3/Documents/484/NLIAHRMPReviewweb2.pdf

Davies M, Elwyn G. Referral management centres: promising innovations or Trojan horses? BMJ 2006. 332: 844-6

Elwyn G, Owen D, Roberts L, Wareham K, Duane P, Allison M, Sykes A (2007). 'Influencing referral practice using feedback of adherence to NICE guidelines: a quality improvement report for dyspepsia'. *Quality and Safety in Health Care;* 16 (1); 67-70.

Faulkner A, Mills N, Bainton D, Baxter K, Kinnersley P, Peters T, et al. *A systematic review of the effect of primary care-based service innovations on quality and patterns of referral to specialist secondary care. Br J Gen Pract 2003; 53:878-84*

Grimshaw JM, Winkens RAG, Shirran L, Cunningham C, Mayhew A, Thomas R, et al *. Interventions to improve outpatient referrals from primary care to secondary care. Cochrane Database Syst Rev 2005;3: CD005471*

Hadom DC, Holmes AC (1997). The New Zealand priority criteria project. Part 1: the overview. BMJ 1997;314:131.

Ham C (2010). *GP Budget Holding: Lessons from across the pond and from the NHS*. Health
Services Management Centre Policy Paper 7. Birmingham: Health Services Management Centre, Birmingham University

Hewlett, S., Kirwan, J., Pollock, J., Mirtchell, K., Hehir, M., Blair, P.S., Memel, D., Perry, M.G. (2005). Patient initiated outpatient follow up in rheumatoid arthritis: six year randomised controlled trial. BMJ 2005;330;171-177

Hospital Episodes Statistics (2010). *Main specialty by age group for all outpatient attendances: All genders* The NHS Information Centre, Hospital Episode Statistics for England. Outpatient statistics, 2004-05; 2006-07; 2008-09

Kings Fund (2010). Referral management: lessons for success. Imison I, Naylor C. Kings Fund, London

O'Donnell CA. Variation in GP referral rates: what can we learn from the literature? **Family Practice** 2000; **17:** 462–471.

Patel RS, Smith DC, Reid I (2000). 'One stop breast clinics – victims of their own success? A prospective audit of referrals to a specialist breast clinic'. *European Journal of Surgical Oncology*, vol 26, no 5, pp 452–4.

Roland MO, McDonald R, Sibbald B (2006). Outpatient Services and Primary Care: A scoping review of research into strategies for improving outpatient effectiveness and efficiency. A report to the NHS Service Delivery and Organisation R&D Programme from the National Primary Care Research and Development Centre and Centre for Public Policy and Management of the University of Manchester.

Rosen R, Jones R, Tomlin Z, Cavanagh M(2005). Evaluation of General Practitioners with Specialist Interests: Access, Cost, Evaluation and Satisfaction with Services. London: NHS Service Delivery and Organisation Research and Development Programme

Salisbury C, Noble A, Horrocks S, Crosby Z, Harrison V, Coast J, de Berker D, Peters T (2005). 'Evaluation of a general practitioner with special interest service for dermatology: a randomised controlled trial'. *British Medical Journal;* 331;7530:1441–6.

Sibbald B, McDonald R, Roland M (2007). 'Shifting care from hospitals to the community: a review of the evidence on quality and efficiency'. *Journal of Health Services Research and Policy*; 12 (2); 110–17.

Stoves J, Connolly J, Cheung CK, Grange A, Rhodes P, O'Donoghue D et al (2010). Electronic consultation as an alternative to hospital referral for patients with chronic kidney disease: a novel application for networked electronic health records to improve the accessibility and efficiency of healthcare. *Qual Saf Health Care qshc.2009.038984Published Online First: 16 June 2010 doi:10.1136/qshc.2009.038984*

Wright J, Harrison S, McGeorge M, Patterson C, Russell I, Russell D, Small N, Taylor M, Walsh M, Warren E, Young J (2006). 'Improving the management and referral of patients with transient ischaemic attacks: a change strategy for a health community'. *Quality and Safety in Health Care; 15(1): 9-12.*