

Research Brief (12/5003)

Call for proposals:

Research to test new forms of acute medical care for frail elderly patients – how best to deliver Comprehensive Geriatric Assessment (CGA) hospital-wide in a cost-effective way?

Closing date: 1.00pm on 17 May 2012

1. Introduction

Research to test new forms of acute medical care for frail elderly patients – how best to deliver CGA hospital-wide in a cost-effective way?

In this call, the NIHR Health Service and Delivery Research (HS&DR) programme wishes to fund ambitious, high quality studies to help managers and clinical leaders to make informed decisions about how best to organise services for frail older people in hospitals. There is now good evidence that structured assessment linked to coordinated, geriatric-specific care provide better outcomes for patients. However, it is not clear how best to deliver these processes across a hospital in a cost-effective way. Studies are needed to test different models of care, using robust designs to deliver answers for those managing services. A number of uncertainties are raised in this brief around how best to deliver services hospital-wide; applicants are asked to address one or more of these questions in proposed studies.

There is potential for service changes in this area to have similar effect on patient outcomes as the reorganisation of stroke services, creating an exciting window for high-impact research. Given the importance of this topic, the questions in this call are likely to be best answered by a small number of substantive studies which are designed to provide robust evidence across the service.

This brief describes the problem and existing research which addresses some of the issues in section 2. Section 3 identifies particular gaps, with an outline of what research we would like to commission. The following sections (4-6) give general guidance to applicants to maximise success, expectations on research outputs and knowledge mobilisation (with updated guidance) and criteria for assessment.

HS&DR Programme

The NIHR Health Services and Delivery Research (HS&DR) programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services, including costs and outcomes in order to improve health and health services. It is focused on research to support decisions by frontline managers and clinical leaders on the appropriateness, quality and cost-effectiveness of care. The HS&DR programme will also promote the effective dissemination of research, engage NHS decision makers in commissioning new research and help build capacity to use and apply evidence among decision makers and in NHS organisations.

It is a new programme which came into effect in January 2012 building on the strengths of two previous NIHR research programmes – the Service Delivery and Organisation (SDO)

and Health Service Research (HSR) programmes. This is the first commissioned call of the new programme.

The NIHR Health Services and Delivery Research programme is funded by the NIHR, with contributions from NISCHR in Wales and CSO in Scotland.

The programme operates two funding streams (this call is under the commissioned workstream); Health Services Research (Researcher-led) and Healthcare Delivery Research (Commissioned). Researchers in England and Wales are eligible to apply for funding from either workstream under this programme. Researchers in Scotland may apply to the Health Services Research workstream but are not eligible to respond to the Healthcare Delivery Research workstream and should contact the CSO to discuss funding opportunities for HDR type research. Researchers in Northern Ireland should contact NETSCC to discuss their eligibility to apply.

2. Background to this call

2.1 Service need

Older people account for a bigger proportion of NHS hospital activity every year, with the number treated growing at a much faster rate over the last decade compared to any other age group (NHS Information Centre). Hospital stays in England involving patients aged 75 and over rose by two thirds in the last decade compared to the overall growth rate of 41 per cent from latest Hospital Episode Statistics (HES) data up to 2010/11.

The majority of people admitted to hospital as emergency patients are over 65 years. Their needs are different from younger patients and yet services and systems are not structured to take account of that. Older people tend to have longer lengths of stay, with non-specific presentations (such as falls, confusion or immobility) and with complex needs. They are likely to have multiple co-morbidities and medication regimens. Services are under pressure, as the rise in demand for acute admissions has been accompanied by a decline in the number of acute hospital beds and greater use of early supported discharge schemes.

Because of the ageing population, demands on the service and evidence of poor quality, there is growing appreciation of the need for comprehensive interventions aimed to improve care for older patients in hospital. Of particular interest is the group of frail older people – although the concept of frailty is used loosely to cover a range of different conditions in older people, including general debility (Poltawski 2011). There is little evidence from the UK on what works – paradoxically, since geriatrics is more established as a specialty in this country (e.g. Harari 2007).

Policy, research and regulators have highlighted deficiencies in the current management of older people in hospitals. Uneven standards of care led to the development of a National Service Framework for older people in 2001 which included recommendations for more patient-centred hospital care. Descriptive research from the NIHR SDO programme has highlighted variation in care delivered to older people on general wards (<http://www.sdo.nihr.ac.uk/projlisting.php?srtid=19>). More recently, a targeted inspection programme of a hundred hospitals in 2011 by the Care Quality Commission showed that 20/100 failed basic standards of dignity and nutrition (CQC 2011). One key finding of the report was the inconsistency of care, even within single organisations – with adjacent wards demonstrating very different standards of care.

Knowledge of poor practice has led to efforts to improve the assessment and care planning for older people in hospitals. The process which has developed over the last twenty years to provide specialist, organised and coordinated geriatric care through structured assessment and care planning is known as comprehensive geriatric assessment (CGA). CGA has been defined as a "multidimensional interdisciplinary diagnostic process focused on determining a frail elderly person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long term follow up" (Rubenstein 1991). Key components include co-ordinated multidisciplinary assessment; geriatric medicine expertise; identification of medical, physical, social and psychological problems (and support from informal carers); and the formation of a plan of care including appropriate rehabilitation.

Despite evidence for processes that lead to better outcomes for such patients, these are not applied consistently throughout the NHS.

2.2 Research need

There is now good evidence that use of CGA carried out early in an admission provides substantive benefits to patients over care as usual. A Cochrane review published in June 2011 (Ellis 2011) provides authoritative evidence of the benefits of CGA. This is based on a meta-analysis of 22 trials, with more than 10,000 patients. The review shows a clear and significant improvement in the chances of a patient being alive and in their own home at up to a year after an emergency hospital admission if they receive co-ordinated specialist services. This effect is consistently seen from trials of geriatric wards where patients are admitted to a dedicated ward area and receive care from a specialist multidisciplinary team. This effect was not clearly seen where patients remained in a general ward and received assessment from a visiting specialist multi-disciplinary team.

But CGA is not applied consistently throughout the NHS. There are many different forms of specialist care for the frail elderly, with different configurations depending on local context. This includes different forms of services at the interface between hospital and community and different ways of accessing specialist input. Although the focus of this call is largely on the hospital, there are opportunities to consider ways of optimising services across the system. Ellis noted that the strength of evidence for the benefits of CGA is similar to that which prompted reorganisation of stroke care. It is possible that changes to service improvement in the acute care of older people could have similar impact to that achieved by concerted effort on delivery of stroke care, in line with evidence on what works.

A recent overview of all hospital-wide interventions (Bakker 2011) to improve care for frail older people noted the heterogeneity of approaches and the lack of good quality evidence on what works in terms of service delivery models. It noted the lack of literature on hospital-wide interventions, although many individual components had a reasonable level of evidence. An exception is a very small-scale pilot pre-post evaluation study of a hospital-wide intervention (Harari 2007) for delivering early CGA to older medical inpatients leading to targeted geriatric intervention. High-risk patients were either rapidly transferred to geriatric wards or case managed on general medicine wards. These kinds of initiatives warrant further testing on a more rigorous scale.

2.3 Relevant work from NIHR Health Service and Delivery Research portfolio

Most relevant work funded by the SDO programme comes from a commissioned SDO workstream on older people. Particularly relevant studies include:

08/1809/227 Better mental health care for older people in general hospitals (Gladman).

08/1809/228 Understanding and improving transitions of older people: a user and carer centred approach (Glasby).

08/1819/218 2 dignity in practice: an exploration of the care of older adults in acute NHS trusts (Tadd).

08/1819/222 Inpatient care for people with dementia: implications for patient-centred care (Schneider).

Other relevant work has been funded on the effectiveness of interprofessional working (08/1819/214 Nancarrow) and delivery of stroke services (08/1819/219 Harris).

Particularly relevant to the issue of best way of delivering complex interventions is a recently commissioned work comparing configurations and models of stroke care (10/1009/09 Fulop).

[Note – NIHR Policy Research Programme commissioned sixteen studies as part of a programme on Older Peoples Use of Services (OPUS) from 2002-2007 to evaluate aspects of the NSF on older people. A summary report of these findings was published in 2008 - <http://prp.dh.gov.uk/2011/10/20/health-and-care-services-for-older-people-overview/>.]

3. Remit of this call: main topic areas identified

3.1. Research gaps

There is good evidence on the effectiveness of CGA in improving outcomes for frail older people in hospital. However, there is little information for the manager about how best to deliver this in a cost-effective way. There is a tension between the need to process patients rapidly through acute medical units (length of stay usually less than one day) and the time required to deliver a specialist geriatric assessment, which is a key component of CGA. Given the costs of delivering this well, evidence is needed to support decisions about who receives CGA, how this is organised, and whether quicker, leaner models using CGA principles can be applied to a greater number of patients. A key feature of this research call is that it applies to the whole hospital as a system and not constrained to particular clinical specialties or departments.

What currently happens?

There are some uncertainties about defining CGA which have in common specialist assessment coupled with longer term care planning. We do not know what forms of CGA are used and how they are implemented across hospitals in different parts of the country.

Who to benefit?

Around CGA itself, which is not always tightly defined, there are many areas of uncertainty. Given limited resources and the costs of this intervention, who would best benefit from this? How would they be identified? Current models vary from age-specific (such as over-85s); needs-based (for instance, focusing on falls, confusion or other presenting conditions); or focused on service use (risk of emergency admission, such as used for identifying patients for virtual wards or community matron initiatives).

How and when?

Different studies have looked at different acute care timelines, comparing hyperacute (within 24 hours of admission) to standard acute care. Current evidence is unclear on which forms of CGA are most appropriate to which setting, for instance what works for acute or post-acute care and how this might be delivered hospital-wide. At the front end, decisions to admit are often made by the most junior medical staff, although evidence suggests benefits in early access to a senior geriatrician and a multi-disciplinary team capable of performing CGA and its interventions. The benefits of different models – such as dedicated wards admitting direct from emergency department or admitting patients later in their hospital stay is not known. Other questions relate to the comparative effectiveness of general medical admission units, age-related admission units and frailty specific units at the ‘front end’ of the hospital. These include different siting of professional staff, such as geriatricians working in emergency departments or acute medical admission units to lead on CGA delivery.

Where – alternative specialist-led care outside hospital?

Although this call focuses on organisational research around the hospital, there has been increasing interest in the possibilities of providing specialist care for frail elderly (through CGA processes) in hospital at home schemes and other forms of intermediate care. These are an alternative to hospital admission, but specialist-led (rather than primary care-led). Evidence to date indicate that hospital at home services may be as safe and cheaper than admission to acute care (Shepperd 2008). Although there were few frail elderly included in the studies reviewed, and inpatient care may not have been using ‘gold standard’ CGA, there are potentials for studies which compare the use of CGA in hospital and hospital-at-home settings.

Other places have looked at strengthening specialist input in the community, with different rapid access models from home to specialists and in-reach services by geriatricians to care home settings. Interestingly, some places have appointed geriatric interface teams (British Geriatrics Society 2010) working part-time in hospital admissions and part-time in the community to improve admission and care decisions across the system.

Who to deliver?

Optimal team composition is also unknown, with questions around skill and grade-mix associated with good outcomes. The review by Ellis suggested that key to most trials is the role of a senior physician with experience in geriatric medicine, specialist nurse, physiotherapist, occupational therapist and social worker. There are questions however about the team leader role, as some studies have focused on the use of a clinical nurse specialist leading an interdisciplinary team in a dedicated unit (Tucker 2003) and other forms of nurse-led units. Overall, there are still questions around the cost-effectiveness of different team profiles, including acceptability to patients and carers.

Extending CGA to wider groups?

Another question is whether there are benefits to extending the use of CGA – for instance, the benefits of early CGA screening followed by rapid transfer to geriatric wards or case management on acute medical wards. This mirrors recent calls (Kings Fund 2011) slightly paradoxically for virtual wards within hospital i.e. coordinated case management approach for frail older people who may be under the care of different medical and surgical sub-specialties. There is a need to understand how to reduce movement around wards and identify accountable clinical leads for the care of the individual patient with complex needs.

Another general area might be use of CGA for pre-operative assessment of frail elderly. A recent NCEPOD report, based on a large (800+) observational study of patients over 80 who died within a month of surgery, found that only 38% of them received adequate care and made recommendations for better perioperative care for the elderly, including involvement of more senior doctors (geriatricians) in pre-assessment before surgery.

Leaner, tailored CGA?

Components of successful CGA include holistic assessment from a geriatrician and multidisciplinary team and treatment plan, with care on a dedicated ward. This requires considerable resources to do properly. There are questions about whether some of the principles of CGA can be extended to a wider population and delivered in leaner ways. This might include use of new and emerging technologies to take CGA to places previously not reached. Novel approaches include virtual assessments, or use of pervasive monitoring technologies to inform rapid assessment and so on. Overall, research is needed to help organisations construct robust step-down models of CGA across a whole hospital.

3.2 Call for research

Current evidence strongly suggests that ward-based comprehensive geriatric assessment should now be considered the evidence-based standard of care for the frail older in-patient. However, there are some uncertainties about how best to deliver this. As Ellis notes, “Future research should potentially focus on evaluating the differences between trials of CGA to improve understanding of the mode of effectiveness of this diverse intervention.” (Ellis 2011).

Ambitious studies are needed to identify how best to deliver CGA in a cost-effective way in acute hospitals. These should test elements of the key questions identified above in terms of existing research gaps. There are many unanswered questions about how best to organise care for all frail hospitalised older patients and maximise capacity, given that most hospitals will have only one or two dedicated geriatric wards. How can current capacity be used to best effect? Indeed, the delivery of CGA raises wider questions about the role of small-medium district general hospitals and the impact on workforce (sub-specialism, rotas) in rising to the challenge of optimal care for frail elderly people.

Particular and interrelated questions relate to who receives CGA (and who would benefit best from hospital admission); workforce to deliver CGA; whether the principles of CGA can be extended to a wider population or in quicker, leaner ways and to create a robust step-down model of care. Applicants should design studies to test one or more of the questions identified in this brief, focused on hospital-wide interventions and delivery of care.

Substantial funds are available for studies which would reduce service uncertainties in this area. We are not prescriptive about what methods are selected, but would like to fund studies likely to have the highest impact in strengthening the evidence base on how to organise hospital services for frail elderly patients. Care should be paid to making the findings as generalisable as possible, while acknowledging the importance of context in complex interventions such as this. Study designs are likely to require early piloting stages and include sufficient flexibility to allow changes to be made during the course of the intervention (Bakker 2011).

Applicants should consider best practice in evaluation of complex interventions (Craig 2008), which highlight the benefits of experimental and quasi-experimental designs. This might for instance include multicentre cluster trials of interventions, if contextual factors specific to each site could be controlled for adequately. Quasi-experimental techniques such as interrupted time-series and before-after testing may be considered. In each case, these

intervention studies would need to be accompanied by robust process evaluation and qualitative methods to provide insight into the context and mechanisms for success, as well as acceptability to staff and patients.

All studies should have a strong economic component and range of service, resource and effectiveness measures in the study design. Care should be given in study design to identify appropriate measures of resource use, given the complexity of service interventions which may cross care settings. For instance, length of stay as a secondary outcome measure should be combined with analysis of service use in other parts of the system.

Evaluations of interventions within one site should consider carefully how to increase generalisability of findings.

An additional useful output from this call, over and above evidence of impact of different models, would be guidance for hospital providers on how to evaluate local services for frail older people in hospitals. This would include discussion of strengths and weaknesses of different types of routine data and measures to assess the impact of local initiatives.

3.3 Out of scope

This call does not ask for research specific to end of life care or dementia care, as these were both subject of recent invitations for research. However, it is recognised that some interventions may include components of these aspects of care, such as transitions to palliative care or care for dementia patients on general care of elderly wards.

This call relates largely to the effectiveness of different modes of care delivery, in terms of how services are organised. These will feature different ways of deploying staff and elements of service re-design. Such studies would include outcome measures of quality and patient experience, as well as costs and impact on service parameters such as length of stay and readmission rates, in line with MRC guidelines on evaluation of complex interventions (Craig 2008). However, it does not invite research with an exclusively clinical or therapeutic focus. That is, a study would not be eligible where the only outcomes were functional patient outcomes, without considering the impact of service delivery on costs, resource use, length of stay, readmissions and other service measures.

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 HS&DR 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 HS&DR HDR Panel 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 HS&DR 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 HS&DR 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 HS&DR programme reserves the right to award a grant for less than this maximum and for less than the amount sought by applicants.

5. Research output dissemination and knowledge mobilisation and transfer activities

Our key concern is to ensure that projects funded by the HS&DR 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 HS&DR 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 HS&DR 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 HS&DR 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 dissemination and knowledge mobilisation and transfer activities.

6. Process for proposal selection

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 HS&DR 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 checks¹ have been made, they will then be reviewed by the HS&DR Healthcare Delivery Research (HDR) 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 HS&DR HDR Commissioning Board. This board's primary concern will be the **quality of the proposed research**. It will use 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 [HS&DR programme - FAQs](#), if the answer to your question cannot be found please email your query to hsdrinfo@soton.ac.uk with the reference number (12/5003) 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**

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 HS&DR 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.

proposals via the HS&DR website by **1pm** on **17 May 2012**. 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 **July 2012**.

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

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/>

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