Commissioning Brief
15/145 - Use of GPs in and alongside emergency departments
Closing date: 17 December 2015 (two stage – outline to full)

1. Remit of this call: main topic areas identified

Research is needed on different models of incorporating GPs into and alongside EDs with the aim of reducing the burden on EDs and the staff who work there, and providing an effective, efficient, safe service for patients.

Emergency departments (EDs) in the UK are currently facing major challenges in terms of capacity and staffing levels. Demand for ED services is rising for both urgent and emergency health problems. One of the recommendations from a joint report from the Royal College of Emergency Medicine, Royal College of Paediatrics and Child Health, Royal College of Physicians, and Royal College of Surgeons, is that every emergency department should have a co-located primary care out-of-hours facility. These may, or may not, include a substantial GP presence. It is the specific contribution of GPs to secondary care and the contribution to the wider urgent and emergency systems that are of interest. There is a body of evidence showing around 20% of attendees could potentially be treated by GPs associated with EDs, but there is a lack of evidence on the most appropriate target group of patients for these services, model of service organisation within the wider urgent and emergency care systems, and the budget cost to providers and to commissioners of placing GPs within or associated with EDs. There is also a body of opinion that this is not an effective use of GPs' time and skill, and that they are used more effectively in their communities.

Several areas of research need have been identified for this call, and researchers are encouraged to address at least the first three foci, with one or more service models in a single proposal, with a comparison model:

i. Evaluation of service models of GPs in and alongside EDs.

Three main operational models have previously been identified by the Primary Care Foundation, as outlined in their report in 2010. These models, and emerging variants, require evaluation:

- GP service located alongside or next to the emergency department;
- GPs working at the front of the department screening attendees and either treating or diverting to other places – effectively acting as a filter;
- GP services fully integrated into a joint operation covering the whole range of primary care and emergency services.

The development of a taxonomy of the models that identifies the target group of patients served, the place of the models within the wider urgent and non urgent care systems, and their associated resource implications is required.

Evaluation of one or more models in depth and with a rigorous design is required. This could include comparison to models without GP input associated with ED. Outcomes should include process of care variables (such as wait times), healthcare use (such as diagnostic tests, re consultation), and adverse effects. Process evaluation may include understanding how the generalist GP way of working within or alongside ED could lead to differences in resource use/outcome. Identification of

which patient groups are served, the place of the models within the wider urgent and emergency care systems, and the associated resource implications of the models to the healthcare system is required.

There is scope for evaluation of interventions which seek to optimise one or more models for sub groups of patients. For example, measuring the impact on healthcare usage by specific sub-groups of patients (such as homeless people, walk-in- patients, or those consulting with healthcare issues believed to be more appropriately managed by the local primary care services) and of making available decision aids and information on services in a locality.

ii. Impact on wider system

Changes to ED and primary care services are impacted by and impact on the wider urgent and emergency care system in which the service is provided. This should also be evaluated to include the effect on patient waits, and healthcare use, and cost to commissioners and providers within the local healthcare system.

iii. Impact on patient experience and patient safety

Patient experience should include measures that reflect what service users regard as important to the quality of their care in the specific services described in (i), as well as the other services involved in managing the episode of care, and their perspectives on advice on self-care, redirection of referral, and on the management of similar or related health issues. Patient safety might include adverse events, morbidity and mortality.

iv. Impact on GP and ED human resource indicators

This should include turnover, absence, job satisfaction, stress and well-being of the GP and ED workforce. Elaboration of the skill-mix and competences of staff working as GPs in these services will also be important to understand as will the implications for resourcing these services in future. The impact on the skills and support and input to training of secondary care staff in ED by GPs could also be evaluated.

2. Scope

Preferably studies will be based on comparative evidence; although challenging, experimental design should also be considered.

3. Purpose of call

There is a shortage of GPs so evidence on effective use of their skills is timely and important. In addition, the topic of effectiveness of service models in use of GPs in EDs is timely and important given concern about burden on EDs and staff who work there, as well as being an important part of inter organisational configurations of urgent and emergency systems of health and social care within communities. The cost to commissioners of these services is often embedded in the wider healthcare system, so making evidence based commissioning decisions about the use of GPs in or associated with ED services needs to be made more transparent. The impact of these models on patients' experience and outcomes, and on the GP workforce is also important. Given the timeliness of the call, consideration should be given to offering actionable interim findings.

Further information on the background to this call, including knowledge gaps and relevant research is given in supporting information.

4. Notes to Applicants

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 NIHR HS&DR programme is funded by the NIHR, with contributions from NISCHR in Wales, the HSC R&D Division, Public Health Agency in Northern Ireland, and case by case contributions from the CSO in Scotland.

The programme operates two funding streams; researcher-led and commissioned. Researchers in England, Wales and Northern Ireland are eligible to apply for funding from either workstream under this programme. Researchers in Scotland may apply to the researcher-led workstream but are not eligible to respond to the commissioned workstream and should contact the CSO to discuss funding opportunities for healthcare delivery-type research

5. Application process and timetable

This call for proposals should be read alongside further supporting information and general guidance from the HS&DR programme on applications.

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 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 HS&DR website by **1pm** on **17 December 2015**. All proposals will initially be checked for remit and competitiveness[1]. 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 March 2016.

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 October 2016. Please note that these dates may be subject to change.

6. 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.contractsfinder.businesslink.gov.uk/

[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