Health Services and Delivery Research Programme

NHS National Institute for Health Research

Commissioning Brief
14/195 - Medical generalists (in hospital)
Closing date: 18 Dec 2014 (two stage – outline to full)

1. Remit of this call: main topic areas identified

It is increasingly recognised that hospitals are not well set up to care for people with multiple medical conditions and needs. Typical patients are frail older people who may present in a non-specific manner with a complex set of illnesses. After admission, they may be under the care of different specialists in different wards. The same fragmentation is seen in outpatient care, where patients with complex and overlapping needs are making multiple visits to separate clinics. Medical care has become increasingly specialised, with almost thirty sub-specialties within medicine. This makes sense given the need for doctors to keep pace with rapid changes in technology, knowledge and treatment but may not be in the best interests of patients, particularly those with complex needs.

In recognition of these problems, a new role has developed in the US called the hospitalist. Emerging evidence suggests that hospitalist care reduced average cost and length of stay for complex patients. In this country, similar care is provided by different kinds of hospital-based general doctors – physicians trained in general internal medicine alongside their particular subspecialty (such as chest medicine or cardiology) and geriatricians with expertise in the care of older people. There has also been a welcome revival of the acute physician role and growth of acute medical units to improve hospital admissions. But commentators have noted the limits of the UK model. Unlike their US counterparts who stay with the patient throughout the hospital spell, the acute physician cares for acutely unwell patients only for the first 48-72 hours of care, but then transfers them to a particular specialty. There is thus potential for fragmented and poorly coordinated care for patients with complex needs – in outpatient settings, as well as inpatient care. There are also not enough physicians or geriatricians to meet current demands. Despite recent renewed interest in the role of general physician, this has become less popular given increased service requirements and workload, greater out of hours demands and lower status and prestige compared with specialist counterparts.

The role of generalist and specialist featured in recent national professional debate with the Royal College of Physicians launching the Futures Hospital Commission in 2013. This called for new forms of care, from medical divisions to acute hubs, with a greater role for the acute physician beyond acute medical units to medical and surgical wards.

Not enough is known about the effectiveness and cost-effectiveness of different forms of medical generalism in hospitals. Robust studies are needed which combine methods to understand different models and their impact on patient care, performance and processes.

Researchers should build on related work in the HS&DR portfolio, including studies on specialist cover 24/7, comprehensive geriatric assessment in hospitals, case management and new models of integrated care for people with longterm conditions.

Two particular areas have been identified as priority areas of research need:

i. Models of providing generalist care in hospitals

More research is needed to test assumptions about the best way of providing patient-centred medical care to patients. This cannot be seen in isolation – renewed interest in the medical generalist is paralleled by similar debates on the role of specialist nurses as case managers in hospital and community settings and multidisciplinary teams providing continuity of care. Robust studies are needed to evaluate the implications and impact of extending the acute physician role beyond the acute medical unit. There are other ways in which this could happen. Some have argued for multi-disciplinary teams, similar to virtual wards in the community but within the hospital, who care for complex patients through hospital stay to discharge. Other options include an extended role for specialists supporting general medicine across hospital wards and into the community or, conversely, for the general practitioner following their patients into hospitals. In the outpatient setting, one-stop shops, rapid assessment or hot clinics have developed to provide more integrated specialist-led care for patients with multiple conditions. Evaluations of all models need careful design to allow for context - for instance, levels of intermediate and social care provision outside hospital will impact on process measures like readmission rates or length of stay. These are complex interventions, but attempts should be made to examine cost-effectiveness of new models.

Although the focus is mainly on hospital care, the role of medical generalists at the interface between hospital and community – for instance, in admission avoidance schemes (such as virtual wards), new community consultant roles or complex care ambulatory units is also relevant. Research should consider the impact on the wider hospital as well as the particular unit or cohort of patients being studied. The wider context of intermediate and social care provision will also be important if using measures of effectiveness like length of stay or readmission rates. Learning from other countries, building on useful comparative research with the United States, would be useful to understand different organisational models (similar to acute hubs) and configurations and how they have impacted on performance and outcomes. Organisational context is important and studies should consider important differences in how the generalist role in small hospitals as opposed to large teaching centres are also worth studying.

ii. Professional identities and working practice

Organisational and social science research has provided useful insights into changing scope of practice, professional identities, status and culture among different staff groups. A shift to greater generalism has implications for training, career path and reward systems in medicine as well as impact on how care is organised across a hospital, including seven-day working. HS&DR funded studies on clinical leaders, medical managers and particular roles such as the clinical director or the ward sister have given insights into the motivations, priorities, legitimacy and identity of different staff groups. More research is needed to understand the particular requirements, challenges, training and organisational support required for new generalist roles in line with current and future workforce demands. This will include the way in which medical generalists could work with and through others to provide coordinated, patient-centred care.

2. Purpose of call

The suggestion for developing a general practitioner role in hospital outpatient services was made by a patient representative. This was discussed further at a workshop for clinical leaders, managers, patients and researchers who linked the question to debates about the hospitalist in acute care and better ways of caring for people with multi-morbidities in hospital. The majority of inpatients now are elderly, with multiple and complex conditions. Hospital care is organised largely by specialty; acute physicians and geriatricians provide some form of holistic care but this is limited. At present there is little evidence to support different ways of organising general medical care for people with multiple morbidities in

hospital and beyond. Research is needed to test different ways of integrating generalist and specialist care for patients in the hospital setting.

3. 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

4. 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 **18 December 2014**. 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 Mar 2015.

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 Aug 2015. Please note that these dates may be subject to change.

5. 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