Commissioning Brief (11/1025)
Call for proposals: Improving clinical productivity
Closing date: 1.00pm on 15 December 2011

1. Introduction

The NHS is facing unprecedented challenges, with increasing demands in a climate of financial pressure. The focus for managers is ensuring that quality and safety are not compromised while achieving savings of £20 billion over the next four years. It is recognised that substantial improvements can only be brought about by addressing the productivity of clinical systems and processes, including the causes and consequences of variations in performance and the methods for reducing or eliminating waste and ineffective care. These include various interventions around supply side efficiencies (for instance, appropriate means of reducing inpatient stays); demand management (such as reviewing thresholds for treatment); and measures to enhance clinical productivity, which is the subject of this brief.

This brief provides background and an outline of the research needs of the service in this area. Only proposals with a focus on understanding and improving clinical productivity will be considered for this call. Note that terms such as productivity and performance are sometimes contested and have not always been clearly defined. This is why an important part of this call aims to commission research on variation in productivity and what it means. We want also to commission research which adds to the evidence on the effectiveness of different initiatives designed to help NHS staff to deliver more for less.

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

Staff costs account for more than half of NHS expenditure and 70% of provider costs. Over half of the workforce is clinical (NHS Information Centre 2011) and so measures to change the way in which clinical staff work is key to achieving efficiency targets. There appears to

be substantial variation in what clinical staff do – for instance, figures from the NHS Institute of Innovation and Improvement (NHS Institute 2010) show a five-fold difference in the episodes of care provided by medical consultants. In the last ten years, levers such as nationally negotiated contracts for medical consultants and general practitioners have attempted to shape workload more directly, but the impact on clinical productivity appears to be limited (National Audit Office 2007, 2008) although other important changes need to be taken into account, such as restrictions to junior doctor hours. For nursing and other staff, similar differences are cited – for instance, a small study suggested three-fold difference in patients seen by health visitors studies (e.g. Malone 2007) have been carried out to describe and measure productivity levels of pharmacists (headcount by number of prescriptions dispensed). At a national level, initiatives like Agenda for Change have attempted to ensure greater consistency in terms of skillmix and clinical activity.

Other drivers to enhance clinical productivity are high staff sickness rates and use of agency staff. On average, NHS staff take eleven days off sick each year which is 1.3 days higher than the public sector average and 4.6 days more than the private sector (Kings Fund 2010). There are links between staff absenteeism and use of bank, agency and locum staff for medical and nursing cover, which is seen as a growing issue in terms of costs and quality. Sickness absence has been estimated to cost the NHS £1 billion (NHS Employers 2010) and a national target has been set for the NHS to reduce agency costs by 45% by 2013/14.

Workforce patterns are often historic rather than rational or strategic. The weakness of much workforce planning has been noted and a recent Kings Fund report reviewing workforce strategies noted that only half had clear plans to drive improvements in productivity (Kings Fund 2009).

Overall then there is evidence of variation in productivity of clinical staff and pressing need to maximise use of this resource. This is becoming more urgent due to other trends in the labour force, such as reduced working hours, workforce ageing, restrictions in nurse registration and increasing demands on the service.

2.2 Existing literature

Research in this area is limited and there are few evidence-based initiatives focused on productivity. However, there is evidence in a number of related fields such as skillmix, deployment of staff, clinical teamworking and other areas. These are briefly reviewed below, as well as the small evidence base on clinical workforce productivity initiatives directly relevant to this brief.

Understanding variation in productivity

National bodies (NHS Institute) have shown variation in patients seen by medical staff. Although some of this may be due to differences in specialty, acuity of patients and other activity, evidence suggests marked variation in medical activity, even after adjusting for case mix (Bloor 2004). More studies could be done to understand the real level of variation in and between medical specialties, using careful methodology to allow for confounding factors. This includes recognition of the increasingly complex nature of workload in a health system – for instance, the role of secondary specialists in supporting general practitioners and others in chronic disease management (with reduced direct patient contact). For nursing and other staff, similar differences are cited in acute and community care – for instance, a small-scale review by the Health Services Journal suggested a three-fold difference in patients seen by health visitors (HSJ 2009). Again, more robust research would be helpful to understand this better, particularly in areas such as community and mental health nursing. Careful work is needed to allow for the portfolio nature of senior clinical manager roles in assessing

productivity. Little high quality work has been undertaken on productivity in allied health professions.

Organisational features, leadership and clinical productivity

Some researchers have attempted to identify some of the organisational and institutional features which may be associated with high-performing workforces. For instance, one US study some time ago (focused on nursing performance) identified organizational-level elements which appeared to be associated with high levels of performance, including participative management, professional development opportunities and relatively flat hierarchies with few supervisors as well as relatively high organizational status of nursing (Aiken 1994).

However, a wider review by Sheaff (2004) cautioned against any easy predictors of success, noting that the literature suggests few, if any, simple organisational levers that can be pulled to influence organisational performance. The review noted that there is no consistent or strong relationship between performance and organisational size, ownership, leadership style, contractual arrangements for staff or economic environment (competition, performance management).

Current research also emphasizes the importance of leadership at a clinical team level – whether it be a clinical director or ward manager. For instance, Patterson's work on organisational performance and quality of acute care emphasises the key identity of clinical unit or team in fostering cultural change. There is a substantial body of national and international evidence on clinicians as managers and clinical leadership (for example, Marnoch 2000 and Greener 2011). It may be possible to build on this evidence to understand the features of high-performing (productive) clinical teams which could be generalized to others.

Improvement initiatives to enhance patient flow

There is a well-established evidence base of organisational/management theory and practice to improve patient throughput and flow, in matching workforce supply to patterns of demand. In the health service, it is increasingly recognised that modern services require more than allotting fixed staff numbers to units. Improvement techniques have been used for instance in predicting peak times and matching staffing levels in different contexts, from emergency department (Higginson 2011) to general practice (Salisbury 2007). These have been linked to national drivers to improve access to services – for instance, in achieving higher levels of same-day appointments in general practice. Salisbury's evaluation showed that interventions to enhance access were able to offer patients appointments slightly more quickly than control practices, with no evidence of any decrease in continuity of care or difference in the increase in practice workload. However, benefits were lower than expected and there was little evidence of improvement techniques extending to other aspects of practice activity.

Broader nursing-focused improvement schemes have also been popular in recent years. The most high-profile of these is the national productivity series by the NHS Institute on ways of releasing time for clinical staff on the wards (Productive Ward) and making better use of theatres (Productive Theatre). Although to date there is limited evidence of impact, stakeholder analysis (National Nursing Research Institute 2010) suggests high levels of engagement and support from frontline staff.

Workforce interventions to increase efficiency and flexibility

Service managers have focused on initiatives to reduce reliance on temporary and agency clinical staff. This has led to initiatives such as electronic rostering (or e-rostering), where managers can deploy staff more flexibly, although not all trusts appear to be making use of such tools (NHS Employers 2007). Indeed, there is widespread evidence of inflexibility in traditional ward rota systems/contracting and considerable scope for improvement in many areas. Some trusts have experimented with flexible/variable shifts, self-rostering, term-time hours/contracts and annualised hours. Other initiatives include Hospital at Night and other 24/7 projects to deliver better quality and productivity at all hours (including use of technologies such as iBleep to allow for better coordination/deployment of junior doctors and others). However, few of these initiatives have been subject to rigorous evaluation.

An interesting exception is the evaluation of a radical change of working practice at a specialist children's' hospital to accommodate restrictions in junior doctor hours (Cass 2003). Changes included overhaul of the team to be led by a clinical site practitioner (experienced intensive care nurse), reduction of number and tiers of doctors working overnight and increased cross-specialty cover. Although a single-site experiment, this suggests the kind of new ways of working which may warrant further assessment.

An earlier SDO-funded study (Elliott 2003) looked at the effect of local labour market factors on the delivery of services. One finding was that in shortage areas, or to increase productivity, some organisations had pooled clinical services including specialist diagnostic services. However, few such partnership initiatives have been rigorously evaluated.

Another related theme is skill flexibility, using multi-skilled workers who can flex from different roles as the work requires. In non-health fields (Bhattachary 2005), studies have shown the contribution of skill flexibility on firm performance and cost-efficiencies. There have been few studies in this vein applied to the health context.

The changing pattern of the workforce, including the feminisation of the medical profession, has led to shifts in working practice (such as increasing number of part-time partners or salaried staff in general practice). As an employer, the NHS has invested effort in encouraging return to work of skilled clinical staff after maternity breaks and introduced more flexible working. However, there are few research studies evaluating the effectiveness of these or impact in shortage areas.

Impact of new workforce roles, skillmix and substitution

There is a substantial literature on nursing workforce planning and workload measurement systems, as identified by an SDO-funded study in 2003 by Carr-Hill. This was reinforced by a more recent international review (Dubois and Singh 2009) which noted the dominance of studies on nursing workload, including studies attempting to identify optimal staffing levels against measures of quality and safety (such as adverse events) and wider literature on skillmix.

In terms of productivity, a key question is whether certain tasks and activities could be performed by less expensive parts of the workforce. A comprehensive review (Sibbald 2004) found a paucity of evidence on changing workforce, especially on the cost-effectiveness of substitution of roles across the team. This was confirmed by a more recent review (Laurant 2010) which noted the lack of evidence, especially for non-nursing staff. What studies exist suggest that substitution is acceptable to patients and provides equivalent or even better patient outcomes. However, the effect on healthcare costs appears mixed – savings depend on context and the specific nature of role revision.

More recent evidence has attempted to identify ways of increasing productivity by considering skillmix as distinct from staff grades and types. This includes role enhancement – giving extended responsibilities to existing staff in new and flexible roles. In the NHS, these include nurse consultant roles, surgical and physician assistants (ref Drennan), emergency care practitioners (ref Mason report) as well as changes in medical demarcation (for instance, GPs with specialist interest in areas such as dermatology). It also includes roles in allied health professions, clinical scientific staff and others. The SDO programme has already funded substantive projects on some of these new roles and further research would need to build on and complement these studies.

Another aspect of role enhancement is the development of new *generic* roles for staff – from the case worker (usually qualified nursing staff taking on care planning role for patients with multiple and chronic conditions, such as the frail elderly) to general `navigator' or care coordination role of a support worker. These may span health and social services and limited evidence suggests there may be impact in reducing the number of visits by different professionals in areas such as rehabilitation support (Stanmore 2006). Overall though there is little evidence on the impact of some of these new and emerging roles on productivity.

Historic patterns and professional roles – sometimes known as `scope-of-practice' –, as well as regulation, have sometimes limited the flexing of activities and tasks between and within professional groups. Methods of reimbursement may play a part in encouraging more flexibility – for instance, the introduction in Australia of payment to integrated health care teams as opposed to fee-for-service type compensation for individual clinicians (Dubois and Singh 2009). In this country, the model of payment in general practice (with the practice as the economic unit) has perhaps contributed to expanded roles for some nurses in prescribing or running chronic disease clinics (Laurant 2005), although evidence of impact on productivity is still limited.

Impact of incentives on productivity

Wider work on financial incentives is relevant here. There is a body of knowledge in areas such as performance-related pay in health care and incentives in medical contracts. The largest evaluation in this country is underway of the introduction of US-style pay for performance incentives in one region in England (ref Ruth McDonald). This ambitious evaluation will not report until 2014 and should be of interest to managers, given assessments in the US which suggest impact on costs per case and other efficiency measures by rewarding high-performing clinicians.

A recently concluded SDO-funded study of incentives in a range of primary care services (through national quality targets and contracting) concluded that these provided powerful levers for higher levels of incentivised activity in general practice, community pharmacy and dentistry. They also noted unintended consequences (including `tick box' approaches to aspects of care) and underlined the fact that implementation of such schemes is highly dependent on their context (ref – Tickle study). There are other important questions about the impact of local incentive schemes – for instance, whether these should be focused on the individual, team or unit – which may bear further examination.

2.3 Selected relevant work from the SDO portfolio includes:

Published:

Carr-Hill R. The potential for improving the effectiveness of the workforce in secondary care: what is the evidence? 08/1319/051

Elliott R. The impact of local labour market factors on the organizational and delivery of health services. 08/1319/052

Mason S. A multi-centre community intervention trial to evaluate the clinical and cost-effectiveness of emergency care practitioners. 08/1519/98

Salisbury C. An evaluation of enhanced access in general practice. 08/1310/070

Salisbury C. Evaluation of a primary care dermatology service. 08/1210/034

Tickle M. The impact of incentives on primary care professionals. 08/1618/158

Ongoing:

Drennan V, Gage M, Brearley S. Investigating the contribution of physician assistants to primary care in England. 08/1808/236

Ham C. Models of medical leadership and their effectiveness: an exploratory study. 08/1808/236

McDonald R, Roland M, Peckham S. Evaluation of the advancing quality pay for performance programme in the NHS North West. 08/1809/250

3. Remit of this call: main topic areas identified

There are few high quality studies evaluating the impact of different skillmix and staffing arrangements on productivity. Evidence (mainly from the acute sector) suggest substantial variations in the deployment of staff working in the same specialties, inflexibilities in traditional staff rota systems (especially on the wards) and considerable scope for improvement in many areas. New roles and ways of working are emerging, but few have been rigorously evaluated. Studies have been criticised for their descriptive focus, poor design, with many restricted to single sites and small samples limiting their external validity. Initiatives to enhance productivity, such as flexible working arrangements and new kinds of rostering, have not always been assessed. To date, research has not established clear links between organisational forms, incentives and measures of effectiveness and performance.

Evidence from non-health sectors and other countries is under-used. Although highly contingent on context, learning from wider management and organisational practice and of successes in enhancing clinical productivity in other countries may help our knowledge of what works.

This call is designed to support managers in their pressing task of meeting efficiency targets. There should be a focus on cost-effectiveness studies and, where appropriate, identifying scope for cash-releasing initiatives in the NHS.

Particular areas of research need have been identified within the following six themes. **These are indicative of the wider research aims of this call and are not exclusive.** Proposals for high quality health services research which are not explicitly aligned with one of these themes but address ways of enhancing clinical productivity in the NHS will be considered, as long as they have productivity as a central focus of their project. Overall, the need is for actionable findings which will help managers meet the demanding challenges of doing more for less, without compromising quality.

3.1 Understanding variation in clinical productivity

Although there appears to be substantive differences between clinical staff in patients seen and other workload measures, more high quality research is needed to identify the true extent of variation. This would include work to understand factors which need to be taken into account in order to make meaningful comparisons. This work would include medical, nursing and allied professions across all settings, focused on areas (such as community) which have perhaps been less well studied.

3.2 Organisational features, leadership and clinical productivity

Previous research has not been able to identify clear relationship between different organisational forms and productivity. But it may be helpful to look at high-performing clinical teams or wards to understand better what works and why. This might take the form of case study/observational research on purposively sampled clinical teams. It would also be important to identify those organisational features which support high-performing teams. Imaginative uses of secondary data to assess the relationship between work unit and productivity would be welcome, together with tools that might be used by managers. This might also include methodological work on defining and standardising measures of clinical activity and productivity, such as routine measures of ward-based activity (noted by Patterson as absent), as a foundation for future studies and benchmarking.

3.3 Improvement initiatives to enhance patient flow

Interesting work has been carried out in health, using improvement science and other techniques to match capacity to demand and improve patient flow. This includes work on advanced access in general practice (where practices profile demand and match to doctor and nurse slots) and studies of patient flow, staffing and throughput in emergency departments. These initiatives aim to make best use of staff, seeing more patients within existing resources. Further work could be done to extend to other clinical areas and to build on existing work in urgent care and general practice. High quality research is needed to understand better peaks and troughs of demand and how this might be met by a range of staff, including `whole system' service re-designs to unpack true nature of demand and how it might be met.

3.4 Evaluation of workforce interventions to improve clinical productivity

Managers need to know which tools and interventions are effective in enhancing the efficiency and productivity of clinical teams, for instance reducing sickness absence. This would include evaluations of workforce interventions such as staff rotas, electronic rostering, flexible working practices and impact on efficiency and quality. Other initiatives worth evaluating include sharing of clinical services across provider organisations and staff pooling. The impact of initiatives to engage staff in improving productivity is also not well known. Evidence from non-health settings, including human resource practices in other public and private services, would be helpful here.

3.5 Impact of new workforce roles on productivity

There have been few high quality studies examining the impact of new workforce roles or enhanced roles on productivity, controlling appropriately for confounding factors. Rigorous evaluations are needed comparing the relative cost-effectiveness of alternative skill mix combinations and assessing new roles, such as non-medical practitioners with a particular focus on the impact on productivity. This could include studies of generic workers and the impact of skill flexibility on performance.

3.6 Impact of incentive schemes on productivity

Research is needed to build on previous evidence on the relationship between reward and performance. Particular focus could be given to the impact of incentives on individual, team and unit. The emphasis would be on assessing local reward systems for clinical frontline staff, rather than national contracts or payment systems, and impact on performance and productivity.

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 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.

Merger of SDO/HSR programme – Health Services and Delivery Research (HS&DR) programme

Although the SDO programme will merge with the HSR programme from 1 January 2012 to become the Health Services and Deliver Research (HS&DR) programme, the remit and oversight of applications to this call will remain unchanged.

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 HS&DR Healthcare Delivery Research (HDR) Panel. The primary criterion against which the Panel assesses outline proposals is that of **NHS need for the**

[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.

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 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 (11/1025) 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 **15th December 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 February 2012.

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 August 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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