

A Message from the Programme Director No 1. December 2006

There was a very substantial response to the first call for applications in the newly established RfPB Programme. More than 650 people registered an initial interest in submitting proposals with around half of these converting that interest to a full proposal in time for their applications to be considered in the first competition. There were marked differences in the response across the 10 English regions - London producing the highest number.

The topics which applicants wished to study were very diverse, as were the research designs and techniques of data collection and analysis. This, of course, is exactly as it should be for a responsive mode programme. It was especially heartening to see good numbers of proposals coming forward on the management of long-term conditions, on mental health and on public health topics. Many of you had expressed fears that areas such as these would struggle to find a place. So far at least, this has not proved to be the case – although we cannot yet know how the pattern will take shape once the Regional Funding Committees have met and the successful proposals are known (mid February). It was pleasing also to see how many proposals had been planned in collaboration with patients. The move from research ‘on’ patients to research ‘with’ patients is not right for every study, but it will, I suspect, produce some of our most innovative projects.

Now that the first set of proposals has gone to peer review, I can respond to a number of questions more fully.

‘What is the preliminary scrutiny stage and why has it been introduced?’

All full applications in each of the ten regions in England are seen by a preliminary scrutiny committee. This is a subgroup of the main Regional Funding Committee, with members drawn from different disciplinary backgrounds. Their task is to determine whether the proposals should go for peer review. Guidance instructs them in particular to focus on:

- whether the proposal is in scope for the programme
- whether it makes a clear case for patient benefit
- whether on the face of it there are obvious difficulties in the design and methodology
- whether the administrative rules of the scheme have been followed.

Although subgroup members will not necessarily be specialists in areas under consideration, comments that they make on potential duplication will be drawn to the attention of peer reviewers.

This preliminary stage is vital for several reasons. First, we must identify proposals which are outside the remit of this particular Programme and would be better directed either to another funding strand in the NIHR or elsewhere. Secondly, we need to

utilise the time of peer reviewers in the most efficient way possible (more on this below). I take the view that even where numbers of applications are not high, in the interests of efficient use of public and peer resources, and of consistency of approach and standards across the country, this preliminary stage should be carried out. The scale and logistics of a national Programme such as this are further considerations. At current rates of application and with a target of two peer reviewers and one lay reviewer for each proposal, at least 3,000 people each year would need to be approached to add this new reviewing task to their workloads.

‘Can you explain further the reasons for rejection at this first stage?’

Rejection on ‘scope’

This has been the most common and the most significant cause of rejection in this first round. RfPB is an *applied* research programme and from the outset, I was aware that we would have a real challenge in developing and then promoting a shared understanding of its scope. The key phrases in the Guidance to Applicants are **‘research that arises from daily practice’** and research that has a **‘demonstrable impact on the health or health care of users of the service’**. In many cases, the reason for rejection was that applicants were seeking to answer more basic research questions. The Programme is looking for research that is a contribution to practice as well as a contribution to knowledge. Research that is ‘near market’ is one way of putting it; research that ‘closes the loop’ is perhaps another.

One set of fears has not been realised. The term ‘patient benefit’ has been interpreted, as we emphasised that it should be, to include health benefit as well as health service benefit. Public health and health promotion have clearly figured as topic areas in the applications now going forward for review. But here too, the basic/applied distinction has to come into play. Studies which are solely epidemiological – which map services or demographic characteristics without closing that loop into practice have been questioned for their relevance.

Failure to make a convincing case for patient benefit

Committees, both at the preliminary stage and later, will quite rightly ask questions about the likely outcomes of the research. If the sole outcome is a journal article – then the goal is research that adds to knowledge rather than also to practice. However worthwhile that addition to knowledge might be, it is likely to be out of scope for this Programme, especially if it will be many years before patient benefit can be demonstrated. Those projects which have gone forward to peer review have on the whole been ones with practical and tangible outcomes - projects, for example, that develop a novel patient information and participation resource, that run a clinic in a different way demonstrating cost savings and patient satisfaction, that refine a screening tool and seek to demonstrate quantifiable benefits to staff and patients.

An inadequate research design

Some people believe that questions of research design should be left to peer reviewers who are subject area specialists. In essence, I agree. Committee members taking part in preliminary scrutiny are warned that they are *not* acting as peer reviewers and that even where they do have the requisite knowledge and skill, it would not be appropriate for them to take a definitive view in the context of a preliminary scrutiny.

However, at least one member of the sift committee is there to represent methodological competence and others will bring their experience and understanding of standards from different disciplinary areas. If this experienced group is persuaded that peer reviewers would be certain to recommend rejection (for example, the methods do not cohere, they are not adequately justified or clearly have a fatal flaw), then they have the discretion to decide against allowing the proposal to go forward. Committees at this stage are warned again that this is not peer reviewing – they should not, for example, be discussing the track record of applicants. I would encourage applicants who find this box ticked on their feedback letter to discuss amongst colleagues or perhaps approach a RDSU for specific critiques and suggestions on methodology and research design (see www.national-rdsu.org.uk).

4. Rejection on administrative grounds

Proposals which are over budget in terms of the rules of the Programme or which are for periods longer than the specified 36 months will be rejected. If mandatory fields on the application form are not completed, again the proposal will not be considered. But we do have a human face. A missing telephone number or a couple of extra noughts in error on the total sum requested will prompt us to get you to put it right. We had a real dilemma when a small group of applicants failed to press the final submit button and thus had not submitted on time. If we accepted it we would be opening the door to late submissions. However during competition 1 we agreed to be more lenient as this was a new programme and accept these applications. We have done some additional redesign work to make this requirement more prominent and consequently will not accept applications in competition 2 that fail to complete the application process as required.

There is more on these and other issues in the ‘Frequently Asked Questions’ posted on the website. We are updating the FAQs regularly – often in response to queries we have received.

Some people have asked ‘can I resubmit?’ The strict answer is no. This will be true for proposals that fall at the peer review stage as well as those that have been ruled out at preliminary scrutiny. But you are free to submit a new proposal, starting with a new Registration of Interest (ROI). The application might be entirely new or it might be a modification of a previous proposal. In the latter case, you should take account of the feedback we have been able to provide and seek advice, for example, from your local RDSU or from your immediate colleagues.

Having now seen the applications for the first round I would like to offer some tips which may be helpful to applicants

- DO remember that your proposal, before it gets to peer review by experts in your field, needs to make sense to a very diverse audience, including researchers, practitioners, and patients and members of the public. All of these people must be able to appreciate its potential.
- DO demonstrate explicitly that your proposal is ‘in scope’ and that it will lead in a timely and direct way to patient benefit. This may seem obvious, but it is surprising how often such points are taken for granted.

- DO check that you are within the eligibility rules. (There are already several FAQs on this topic and with our update policy it will always be worth checking whether there is something there that covers your case).
- DON'T hesitate to make use of the CCF helpline. It is not just for technical problems. Several people have used it to test out whether a particular topic is in scope. In those cases where we can clearly say no, much time and effort is saved. Often, however, our advice is to be sure to make the case for patient benefit, demonstrate that the research will make a difference to practice in the short to medium term and build dissemination and action strategies into the project.

What more are we doing within the Programme to help you? Chairs and committee members have already been accepting speaking engagements where we can give potential applicants a chance to ask more questions. We will be briefing RDSUs just as soon as possible and developing these messages and amending guidance in light of experience. CCF is happy to hear from you about ways in which we can improve and your comments are brought to my attention. A new programme always has teething troubles. I was particularly pleased to hear the Director of R&D say about the whole NIHR effort – ‘we will make mistakes – but we will listen and we will change’.

I am planning some work in this first year to see if, despite its necessary breadth and open-endedness, we can provide more clarification on scope with some specific examples. A proposal, for example, to explore aetiology or to identify and examine disease markers might well be out of scope, whereas a proposal to develop, apply, adjust and evaluate a diagnostic tool that builds on an existing evidence base might be in scope. We are never going to be able to give an exhaustive list of what is in scope, not least because RfPB is a responsive Programme and we deserve to be surprised by what it is that those in touch with daily practice see as relevant to service improvement in the NHS. There is room too for some pilot work, which gives more flexibility (see the FAQ on this).

We have already made adjustments to the process and we will continue to do so as experience grows. However, we are still in the very first funding round and the time for major change is not yet.