Greater Essex Health Determinants Research Collaboration: Business Plan

1. This document sets out our delivery plan for a Health Determinants Research Collaboration (HDRC) in the area covered by Essex County Council, Southend, and Thurrock Councils. We call this area Greater Essex (GE).

2. The plan has been prepared by Essex County Council (ECC), Southend City Council (SCC), Thurrock Council (TC), University of Essex (UoE) and Anglia Ruskin University (ARU). It has been reshaped in several fundamental ways to reflect feedback from previous submissions to NIHR funding calls, and lessons learned from a further year of joint work across our organisations. It is supported by GE's Integrated Care Boards and public service agencies and partnerships across GE (see letters accompanying this Business Plan).

Section 1: Background and rationale – the case for the GE HDRC

3. There are stark health inequalities across GE. The difference in life expectancy between our most and least deprived wards is c.16 years for women and c.22 years for men (Office for Health Improvement & Disparities (OHID), 2022). These inequalities reflect communities' economic and educational opportunities, and their living conditions – the wider determinants of health (WDH) (ECC, 2021a; Marmot et al., 2020).

4. Prior to COVID, life expectancy improvements had stalled across the poorest GE areas (Office for National Statistics, 2021), the pandemic and subsequent economic crisis have exposed the most disadvantaged groups of the population to further pressures such as school closures, unemployment and lost income (ECC, 2021b). All these factors will impact on long-term health outcomes, particularly in GE's most deprived places and among vulnerable groups (British Academy, 2021).

5. For this reason, GE councils have put the WDH at the centre of their plans for change (ECC, 2021c; Thurrock, 2022; Southend 2021). Securing change is not easy. No single organisation can make progress by working alone. GE is too large, diverse and complex. Places across GE differ in their history, culture, geo-political relationships, and in the intersection of the WDH (ECC, 2021a). This presents challenges for policy-makers working across GE. Addressing the WDH in each place requires a unique package of action, co-ordinated across multiple agencies, and tailored to reflect local needs and circumstances.

6. GE's 1.9m people are spread across urban, rural and coastal communities, fast-growing cities, historic market towns and 1950s New Towns. The most acute deprivation, and the worst health outcomes, are found in:

    a. coastal towns such as **Southend-on-Sea**, where 23% of the population (40,800 residents) live in areas among the most deprived 20% in England; **Canvey Island**, or **Harwich** and **Clacton**, where 31% (44,000 residents) live in areas of acute deprivation;

    b. larger towns such as **Colchester** and **Tilbury**, with 18,700 (10%) and 16,400 (12%) residents, respectively, living in areas of acute deprivation; and

    c. purpose built new towns of the 1950s such as **Basildon** and **Harlow** where over 45,000 residents live in areas of acute deprivation (MHCLG, 2019).

7. GE's public services are the most complex in England, combining single and two-tier local government. Partners include two unitary councils, one county council and twelve district councils. There are three Integrated Care Systems (ICSs). No two organisations work on the same geography and only the Police & Fire Commissioner/services work across all of GE.

8. This means the levers to affect the WDH are spread across a network of agencies with separate mandates, accountability structures and business pressures. This creates challenges in defining shared priorities and aligning partners behind specific interventions.

9. This complexity magnifies the need for rigorous, high-quality research that commands the attention of decision-makers. We see a vital role for the GE HDRC, and the research it will carry out, in delivering a step-change in capability and culture that will help us:
    a. bring partners together to develop a shared understanding of need and of the key issues affecting the WDH within the region;
    b. inform decisions on strategy, determine the interventions that will be most effective in tackling key issues and evaluate the impact of these measures; and
    c. work with residents to define programmes of action that reflect their lived experience and enable them to inform and shape solutions.

10. **The GE HDRC will help its host councils to 'cut through' this complexity, providing a platform for sustained improvement in health outcomes in those parts of GE where they are at their poorest (see paragraph 6), and embedding a research-positive culture in GE.** Current research capability is not sufficient to realise this step change. Although our councils have a relatively mature approach to quantifying and understanding needs, our research capability to inform policy choices and undertake evaluation is less well developed.

11. There are, however, assets upon which we can build. These include:
    a. **Effective partnership governance:** GE has a set of mature structures through which senior leaders from different partners work collectively to shape policy. These include the Essex Partners Board; Essex Chief Executives Forum; the Association of South Essex Local Authorities; Essex Leaders & Chief Executives and our Health & Wellbeing Boards. Each is supported by a secretariat, and a multi-partner working group coordinates business across key forums (Essex Partners, 2020a).
    b. **Deep links with local universities:** ECC, Southend and Thurrock councils have a track record of working with local universities. This has included establishing shared posts including the creation of a 'Chief Scientific Advisor' position between ECC and UoE and the secondment of council employees into ARU research programmes; funding collaborative PhD studentships; working through 'challenge labs' to focus research on public service problems and co-investing in Innovation Hubs; and linking public health research with practice through the East of England Population Research Hub. Most recently, local authority (LA) partners, ARU and UoE worked together to deliver the Essex Renewal Project (Essex Partners, 2023) an independent commission examining the changing risks and opportunities stemming from the COVID-19 pandemic and subsequent crises.
    c. **Essex Centre for Data Analytics (ECDA):** GE partners have previously invested in a system-level analytics infrastructure, creating ECDA. This is a partnership venture between local government, Essex Police and the UoE, focused on data sharing and the use of data science to inform the planning and targeting of key services (Essex Partners, 2020b). The lessons learned in creating ECDA have informed the plan for the GE HDRC.
    d. **Public engagement:** Councils, higher education partners and Healthwatch Organisation are committed to working with communities to co-produce research and to shape services based on lived experience. They have each invested separately in infrastructure to support this. This includes the UoE's Service User Reference Group; ARU's Public Involvement Network, ECC Residents Panel (3000+ members); Southend's 'Community Voices' framework and Thurrock's Collaborative Communities Framework - Involving residents in the decisions that affect their lives, using co-design and co-production

methods. The HDRC will be able to use this infrastructure, and partners' existing links to hard-to-reach communities, to recruit members of a Citizens Involvement Forum to ensure that their voices are embedded in HDRC activity.

Section 2: Aims, objectives and measures of success

12. The HDRC's overall aim is to improve health outcomes – to increase life expectancy, quality of life and to reduce health inequalities, focusing on those places where health outcomes are poorest. Achieving this will require us to better understand the effectiveness of measures to tackle underlying social and economic challenges affecting local communities:
    a. limited **access to high-value employment** in coastal towns;
    b. **geographical isolation** in coastal and rural areas;
    c. **poor housing conditions** in urban estates and in GE New Towns;
    d. increasing levels of **housing insecurity**;
    e. **poor access to community assets** and services, including access to green/blue space;
    f. **higher levels of crime** in key towns; and
    g. inter-generational **cycles of low educational** attainment, **low adults skills** levels and **low aspiration.**

13. The HDRC will work across a complex system to bring partners together through the use of rigorous, high-quality research. This will be led by a Delivery Team, hosted by ECC, and working to a programme shaped in dialogue with public service partners and communities. In establishing this team our objectives are to:
    a. build the capability necessary to develop and deliver a research and evaluation programme that speaks to GE's strategic priorities; and
    b. drive a sustained culture change by:
        i. placing the use of research evidence at the heart of our approach to system-wide working;
        ii. developing the capability of employees and political leaders' to undertake and use research evidence; and
        iii. increasing senior leaders' engagement with research and evaluation, and seeking new and innovative ways to translate findings into action with local stakeholders.

14. We will assess the success of the GE HDRC based on:
    a. **Health outcomes and inequalities:** the HDRC's research will improve outcomes in those parts of GE where they are poorest, reducing health inequalities.
    b. **Decision-making:** the HDRC's work will drive change in the way decisions are taken, with political leaders seeking scrutiny of the evidence before implementing changes, ensuring new research is commissioned where the evidence does not exist.
    c. **Wider stakeholder's knowledge and behaviours:** the HDRC will change the way partners' understand the value of research, increasing their appetite for, and trust in, research findings - unlocking further investments of time, energy and money in research activity.

15. We will assess our impact on health outcomes and inequalities by developing impact case studies. Using quantitative and qualitative techniques, we will explore how HDRC research findings have impacted local policy decisions.

16. We will measure our impact on decision-making and stakeholders through an annual survey of senior politicians and officers and through follow-up interviews with a sample of respondents. This will provide data to inform key performance indicators on issues such as:

    a. stakeholders' demand for, and trust in, local research;
    b. changing perceptions of the value of research;
    c. use of HDRC/other research in decision-making;
    d. stakeholders' skill and confidence in using research evidence;
    e. their awareness of HDRC's work/outputs; and,
    f. views on the value of the HDRC.

    We will undertake a baseline assessment within six months of launching the HDRC.

17. We will assess our delivery progress with reference to the milestones, set out in Section 6, for each phase of the HDRC's implementation. We will also evaluate and improve the quality and impact of HDRC work within specific delivery programmes. This will include driving up levels of public involvement in our research programme using the UK Standards for Public Involvement (NIHR et al, 2019) as a framework for evaluation, and tracking equality, diversity and inclusion (EDI) data to ensure that our research is inclusive. It will also mean undertaking before and after assessments with members/ officers / public representatives supported through our capability development programme, and evaluating the reach and impact of particular communications and dissemination strategies.

Section 3: How the HDRC will operate

18. To do this, we will establish a core team to deliver the work of the HDRC (the HDRC Delivery team). In order to maximise the value of NIHR investment, we propose that the delivery team be hosted within ECC allowing it to build on ECC's existing research systems/processes and resources including:

    a. routes to engage the public (e.g. ECC's 3,000+ strong residents panel; regular resident surveys);
    b. access to a suite of research tools, platforms and datasets;
    c. established information and research governance, and ethical assurance process;
    d. robust policies on equalities, safeguarding, and lone-worker issues;
    e. established mechanisms for commissioning research where this is necessary; and
    f. access to library and journal subscriptions.

19. This hosting arrangement will also ensure that the HDRC benefits from ECC's role as a 'backbone' organisation - convening many of the strategic partnerships whose views will shape the HDRC programme.

20. GE's universities have also aligned senior academic capacity to support the work of the HDRC. UoE and ARU have agreed to:

    a. align four academics (two per institution) to the work of the HDRC. These academics, identified based on their expertise and experience, will provide leadership to HDRC workstreams and guidance to the collaboration overall. They will work 20% to the NIHR grant and bring insights from their wider work to strengthen research in GE;
    b. provide also access to a wider community of experts and pool of expertise beyond these work-stream leads. In this way UoE and ARU have pledged to provide much more than the time of a senior academic researchers; and

c. make places available for research-active council officers on their CPD programmes and other advanced courses. These would be made available for free or at discounted rates when filled via the HDRC programme.

The HDRC Resources, Leadership and Management

21. The HDRC delivery team will comprise a team of 20 people (c.12 FTE). An organogram is provided separately. Membership of the team is as follows:

    a. **Researchers** (6 FTEs – all to be recruited upon confirmation of award). These researchers will work in a matrix-model across each of the HDRC's four research workstreams (see section 5) to make the best use of their skills and enable flexibility to reflect peaks and troughs in workload. The HDRC researchers will:

        i. deliver a portfolio of primary and secondary research projects, supporting academic, and LA practitioner leads and HDRC Fellows, and working to a programme agreed with the Leadership Board;

        ii. develop research outputs – working with the Communications and Public Involvement leads to disseminate findings in ways that connects with key audiences;

        iii. develop applications for research funding to help broaden the work of the HDRC and sustain its work beyond the Year 5; and

        iv. support the Capability Programme Lead to facilitate knowledge transfer across GE.

22. A further three posts (2.2 FTE) will be created to oversee the HDRC's key programmes (see section 5 for detail). All will be recruited upon confirmation of award:

    a. **Communications and Engagement Manager** (1 FTE - to be recruited upon confirmation of award). The role holder will lead the delivery of the Communications and Engagement programme, working with communications and engagement teams across HDRC partners. The role holder will drive collaboration, engagement and behaviour change across our key audiences (see para 75). They will lead on the development of the GE HDRC's brand, support work to disseminate research findings with impact, and secure advocates for the HDRC's work. They will directly manage the HDRC digital communications assets and channels and its events & conferences. They will also oversee the management of the Citizens Involvement Forum.

    b. **Capability Programme Manager** (1 FTE - to be recruited upon confirmation of award). The role holder will lead delivery of the GE HDRC's Capability Development programme. This will involve identifying opportunities to draw in new research funding and providing advice and guidance to researchers as they develop bids. It will also involve developing the research capability across GE by sign-posting and funding continuous professional development for those involved in research; establishing a new community of practice for researchers, and working with colleagues to support 'outreach' activity with senior stakeholders and the public – building their understanding of research and its value.

    c. Julia Carr will act as the HDRC's Public Involvement Lead (0.2 FTE). Julia will and champion and share expertise on Patient and Public involvement (PPI) across the HDRC. She will lead engagement with the Citizens Involvement Forum and lead on the PI work programme, including participant training and outreach activity required to make this a successful and influential. Julie will ensure that the voice of residents is embedded in the HDRC's key programmes. Julia will enable the dissemination of research findings amongst the public, and secure public advocates for the HDRC's work.

23. Leadership of the HDRC delivery team will be provided by:

a. **Alastair Gordon will act as HDRC Director (0.5 FTE).** He will provide strategic leadership to the HDRC, overseeing resources, governance and management structures and leading work to maximising influence with decision-makers and to embed a research culture within the host councils. He will hold overall responsibility for the delivery of the HDRC's programmes and the evaluation of/ reporting on the HDRC's work. Alastair will do this alongside his current role as ECC's Head of Profession: Research and Citizen Insight. In this role Alastair leads ECC's in-house research function and public health Business Intelligence and evaluation teams. As Head of Profession, he leads on the development of ECC's broader research capabilities. Combining these roles will ensure that the HDRC can exploit synergies and amplify ECC's existing insight work, as well as ensuring that the HDRC has seamless access to ECC's existing research infrastructure, policies and processes.

b. **HDRC Implementation Lead (1 FTE – to be recruited).** The role holder will provide operational leadership across the HDRC's programmes and line management to key HDRC staff, including its pool of researchers. They will also lead delivery of the HDRC's overall Research programme. This will mean ensuring that projects are resourced and progress in line with agreed schedules; that all projects pass through ECC's research governance process, are ethical and meet aspirations for public involvement.

24. To strengthen the work of the HDRC Director to support a sustained culture change with the host councils he will sit on the Leadership teams for ECC's Public Health function and its Policy Unit, with direct lines into ECC's Director of Public Health and its Director of Policy – both of whom sit on the council's Corporate Leadership Team (its most senior officer board). This will help ensure that the HDRC has:

    a. immediate access to expert advice on issues relating to public health and the WDH. Collaboration with colleagues on the Public Health Leadership team will help ensure that the direction of HDRC programmes support wider public health objectives and reflect ongoing developments in policy, practice and local delivery; and

    b. immediate input into work on ECC's corporate strategy, political engagement, equality, diversity and inclusion work and its work to convene the strategic partnerships whose views will shape the HDRC programme and through which HDRC outputs will influence partners' decisions (this includes the various partnership forums set out at para 11a).

25. Leadership for the HDRC's research workstreams will be provided by senior academic colleagues, from the University of Essex and Anglia Ruskin University. These 'academic leads' have been identified based on their skills, specialisms and networks. They will be seconded on a part-time basis to ECC (0.2 FTE). The HDRC's 'Academic Leads' will:

    a. work with senior practitioners from within the local authority and HDRC Fellows (see section 5), to guide the work of HDRC researchers;

    b. work with the HDRC Director to define workstream scope of and agree research questions;

    c. ensure that research meets the highest standards and is informed by wider academic research and networks;

    d. develop research outputs – working with the Comms manager and PPI Lead to disseminate these effectively amongst key audiences;

    e. develop further applications for research funding; and

    f. work with teams and decision-makers across GE to facilitate knowledge transfer, drawing on their wider regional and networks as appropriate.

    The Academic leads engaged in the GE HDRC are as follows:

26. **Professor Lee Smith** will be the academic lead on the environmental determinants of health workstream (see section 5). He is Professor of Public Health at Anglia Ruskin University. Lee has published extensively in public health and epidemiology (650+ peer-reviewed manuscripts in leading academic journals). He holds/ has held in excess of £5,000,000 in research funding. Notable studies Lee has contributed to in relation to environmental factors in public health include: The Impact of Constructing Non-motorised Networks and Evaluating Changes in Travel (EPSRC funded); The Active Buildings Study (NIHR funded). Lee has significant experience in working in large multi-sector networks. For example, he is the UK lead on the Horizon 2020 funded study Cancerless. The Cancerless consortium includes academics, NGOs, charities and local authorities. Lee also leads the ARU Wellbeing Research and Innovation Network that includes private organisations and several NHS Trusts. He supervises many early career researchers and PhD students and has vast experience in managing multi-sector collaborations.

27. **Professor Matt Fossey** will be the academic lead for the education workstream. He is Professor of Public Services Research, Director of the Veterans and Families Institute for Military Social Research (est. 2014) and co-Director of the Centre for Military Women's Research (est.2022). Prior to academia he spent most of his career in Local Government, NHS and the DHSC. Matt has worked on the front line as a mental health social worker, graduating to national service improvement roles (NHS Modernisation Agency) before working at the DH as the Deputy Director of the Improving Access to Psychological Therapies (IAPT) workstream, where he was responsible for the equalities impact assessment of the programme. He has worked with national charities and think tanks on the development of policy and the delivery of research to inform the evidence base for improved service delivery. This has included a diverse portfolio including liaison psychiatry delivery; how children communicate with parents who are serving in the RN; sexual violence in the military (where he is co-chair of the NATO research group); and improving services for vulnerable military service leavers. His work is widely cited and used to inform policy and practice.

28. **Professor Matteo Richiardi** will be the academic lead on the economic determinants of health workstream. He is Professor of Economics and Director of the Centre for Microsimulation and Policy Analysis at the University of Essex. In 2018-2020 he was Director of EUROMOD at the University of Essex, overseeing the EUROMOD tax-benefit model for the EU-28 Member States, and its transfer to the European Commission. Prior to joining the University of Essex he worked at the Department for Social Policy and Intervention at the University of Oxford, collaborating to the Employment, Equity and Growth Programme at the Institute for New Economic Thinking and to the Oxford Martin Programme on Inequality and Prosperity. He is a labour economist and has more than 20 years of experience in microsimulation modelling. He is collaborating with epidemiologists and statisticians to study – among other things – the long-term effects of the Covid-19 pandemic, the socio-economic determinants of health outcomes, the care economy and the role of the demand and supply of care over the life cycle.

29. **Professor Ewen Speed** will be the academic lead on the vulnerability workstream. He is Professor of Medical Sociology at the University of Essex and Implementation lead in the Inclusive Involvement in Research for Practice Led Health and Social Care research theme within the National Institute of Health Research East of England Applied Research Collaboration. He is also a founding director of the Health and Care Research Service which has undertaken over 30 evaluations of local authority projects and interventions. He is a medical sociologist with a clear track profile in researching issues around health inequalities from the perspective of inclusive participation and involvement, He has more than 20 years of experience in these areas. He is currently working on an NIHR funded project looking at issues of access to health services for Gypsy, Roma and Traveller groups within the east of England. He recently completed an ESRC project looking at the impact of COVID19 on

voluntary action across the devolved jurisdictions in the UK. He has also published extensively on participatory methods, as well as research on participation and policy in the context of the NHS in England.

30. In addition to the academic lead, each of the HDRC's four research workstreams will benefit from the strategic guidance of a **senior local authority practitioner**. These senior officers will be drawn from the relevant council service areas to work alongside the academic colleagues. Their role will be to ensure that the research that is planned, delivered, and for which funding is sought, is aligned with local priorities, and adds value by informing professional practice and political decisions. They will provide advice and guidance on navigating relationships, framing outputs to share with decision-makers and on the dissemination for findings. We have identified the following senior officers who will play this role across the research workstreams:
    a. **Environmental** determinants of health: Tom Day, Head of Energy and Low Carbon and John Meehan, Head of Sustainability (Green Space/Air Quality);
    b. **Education factors affecting health:** Claire Kershaw, Director of Education
    c. **Economic factors:** Mark Doran, ECC, Director of Sustainable Growth;
    d. **Vulnerability:** Chris Martin, Director of Commissioning and Policy (Children & families)

31. With the exception of the academic leads, all members of the HDRC delivery team will be subject to ECC's established line management, performance management and supervision arrangements. Academic leads will retain line management and supervision arrangements determined by their university. The wider support to the HDRC delivery team, including Financial, Legal and HR support, will be provided by ECC.

The HDRC Governance

32. The work of the delivery team will be overseen by the HDRC's multi-partner governance structure. An organogram showing this structure is provided separately.

33. The **HDRC Leadership Board** plays the central role in HDRC Governance. The Board is the focal point for decision-making and HDRC sponsorship. The board brings together Directors of Public Health with representatives of universities, district council Chief Executives, the NHS, VCFS and members of the public to:
    a. agree the focus/scope of HDRC activity, including the content of its research programme and the questions to be explored through this;
    b. steer the development and delivery of both the Capacity Development and Communications, and Engagement programmes;
    c. champion the outputs of the HDRC's work – advocating its value across GE's strategic and thematic partnership networks; and
    d. unblock issues that might affect the successful delivery of the HDRC's objectives (e.g. researchers' access to data or partners engagement in workshops and events); and champion the work of the HDRC across the system.

34. In developing and defining the GE HDRC's research programme, the delivery team will gather views from across GE existing strategic and thematic partnerships. These partnerships may include, but may not be limited to, Health and Wellbeing Boards; Health and Care Alliances; Essex Partners Board, and the Essex Chief Executive's Forum. Engagement with these partnerships will be vital if the HDRC's work is to influence decisions and if research collaboration is to be embedded within GE over the long-term. Although not part of the HDRC governance structure, these partnerships should be regarded as core consultees. The Board

will wish to ensure that the decisions it makes on the work of the HDRC are informed by consultation with these wider partnership bodies.

35. Both the Leadership Board, and the delivery team, will benefit from input from the **HDRC Advisory Group.** This group will bring together academic advisors, public health specialists and local authority officers and representatives of the public who have been recruited to support the HDRC. This group will be independent of the delivery team and will provide advice, support and constructive challenge on its work. It will also provide independent assurance to the Leadership Board that the HDRC's research is useful, aligned to local priorities, high-quality, and reflective of our aspirations around public involvement. Members of this Advisory Group may also be invited to join ad hoc panels to consider the ethical approval of projects (see section 5).

36. All partners supporting this bid are committed to ensuring that the composition of the Leadership Board and Advisory Board reflects the highest standards in terms of equality, diversity and inclusion.

37. The final elements of the GE HDRC's governance structure reflects our commitment to public involvement. We will establish a **Citizens Involvement Forum (CIF)** – a group of public representatives who have agreed to support the HDRC's work on an ongoing basis

Section 4: Resident Involvement and Equality, Diversity & Inclusion (EDI)

38. Our proposals reflect input received from residents and we are committed to involving the public in the HDRC at all levels through the CIF. Our aim is to ensure that residents become confident to play a full role as partners in the HDRC. CIF members will play a role in:

    a. **setting the direction for the HDRC** - resident representatives will sit on the HDRC's Leadership Board alongside Directors of Public Health, senior officials from universities and NHS bodies and voluntary sector colleagues. They will play a direct and equal role in decisions on the HDRC's strategic direction, its research programme (including the questions to be explored), its communications activity and its work to build capability.

    b. **Shaping and challenging HDRC practice** – CIF members will be invited to sit on the HDRC's Advisory Group. These representatives will gather views from wider CIF members and provide advice and challenge to the Delivery team how research might better reflect aspirations around public involvement, and what can be done to improve public involvement on an ongoing basis.

    c. **shaping primary research projects, research funding bids and the strategy for disseminating findings to lay audiences.** At an operational level, CIF members will bring insight from lived experience to the HDRC Delivery team through a series of face-to-face meetings, online workshops and pop-up surveys. Resident input will steer the development of research projects and bids – e.g. informing strategies for engaging specific groups, cohorts and communities. There may also be opportunities for deeper involvement with residents taking on the role of a co-researcher on specific projects.

       CIF members will also be invited to support the HDRC's engagement work - helping the team to ensure that events, publications and research outputs are accessible to lay audiences. It may involve attending HDRC seminars, events and conferences; reviewing and/or co-producing reports, presentations, newsletters or blogs before publication.

    d. **helping the HDRC to promote EDI.** CIF members will be recruited to ensure the overall membership of the forum reflects those groups which are 'seldom heard' and too often excluded from research and policy making. It will also include representatives from voluntary and community sector who work with these groups. The CIF will therefore

support the HDRC team in applying a 'health inequalities' lens when scoping, designing, conducting or disseminating research or evaluation.

e. **informing evaluation of the HDRC.** We will invite views from residents on the value added through the work of the HDRC.

All members of the public who support the HDRC will be remunerated in line with NIHR's guidelines for the reward and recognition of public contributors.

39. It will include issuing invitations to members of partners' existing networks and involvement panels (e.g. existing PPI groups and resident panels). The recruitment of hard-to-reach and 'seldom heard' groups will be led by Julia Carr (HDRC PPI Lead) and will involve:
    a. discussions on the role of the CIF with trusted community networks (Foodbanks, churches, etc), and with known hard-to-reach individuals and groups;
    b. monthly face-to-face outreach and awareness raising activities in various locations across GE. These will include activities to build residents' confidence to play a part in the CIF, to build understanding of the value of research and public involvement (i.e. 'This is what we are doing and why we want you involved'). Following resident feedback, events will be held in both urban and rural areas to ease concerns about access and travel costs.

40. To support participants interested in joining the CIF, we will:
    a. develop an induction for CIF Members and linking them with ongoing training opportunities available from existing sources to support their ongoing engagement. This will include using resources from the NIHR's Centre for Engagement and Dissemination (e.g. the Learning for Involvement platform) and NIHR public communications and engagement work (e.g. the Be Part of Research Campaign).
    b. provide guidance and advisory support to CIF Members, this will be channelled through our PPI lead but will also include linking those who are new to research with more experienced members of the CIF through informal mentorships.

41. We propose to hold an Annual Showcase to recognise the role of Public Voice in research and to advocate for the CIF and its role in the HDRC. Following feedback from public representatives this will be held as a touring roadshow reaching communities across Essex, rather than at a single fixed location.

42. Within the HDRC team, the PPI Lead will hold specific responsibility for championing the involvement of residents. The Implementation Lead will hold specific responsibility for championing EDI and the role of the HDRC in addressing health inequalities. These colleagues will lead the development of a Resident Involvement and EDI strategy – co-producing this with members of CIF. We will also embed our commitment to resident involvement and EDI within the delivery team's operations:
    a. all members of the team will have objectives around resident involvement, EDI and health inequalities reflected in their annual performance plans;
    b. we will roll out training on to all team members on how to embed resident involvement in research and on EDI. We will use the NIHR's PPI Resources for Applicants (NIHR, 2019) as a basis for this. EDI training will include use of the Inclusive Research e-learning module (UoM, 2021) as well as the NIHR Research Design Service Equality, Diversity and Inclusion Toolkit (NIHR 2022) to help staff and researchers understand how inclusive research contributes to health equity and how to ensure EDI in all aspects of their work;
    c. we will audit all proposed research and evaluation projects prior to their being approved for delivery.

Section 5: Our Delivery Programmes

43. The HDRC will develop/deliver three complementary programmes which, taken together, will drive a sustained culture change. Our commitment to residents involvement (set out in section 4) runs throughout these programmes. The programmes will focus on:

    a. **Research:** delivering collaborative research projects and advancing bids for funding to enable further research aligned to local priorities;

    b. **Capability development:** developing the capability of our employees and our executive and political leaders to undertake and use research evidence; and

    c. **Communications and engagement:** increasing senior leaders' understanding of and engagement with research and evaluation, and effectively communicating findings to influence local stakeholder action.

    Research

44. The HDRC's research programme will focus on:

    a. **delivering collaborative research projects**: the HDRC delivery team will work in partnership with district councils, public service partners and members of the community to undertake high-quality research on local priority issues. Our collaborative approach will maximise the opportunity to ensure that research informs responses to local challenges around the WDH; and

    b. **developing bids for funding to enable the delivery of further projects aligned to local needs**. This will mean collaborating with a broader network of academic researchers and preparing bids to organisations including the NIHR, UK Research Councils, government departments and charitable foundations etc. This will be vital in ensuring that the HDRC can deliver an influential and impactful research programme in years one to five, and in ensuring it can sustain its work beyond this period.

45. The Research Programme will have a strong focus on 'place'. GE's cities, towns and villages differ markedly in their social, economic and environmental circumstances. Distinctive sub-cultures exist in each place. The HDRC will not, therefore, focus its research across the whole GE by default. Rather, it will prioritise research in those areas of GE where health outcomes are poorest – coastal towns in Tendring district, Canvey Island, estates in Colchester, Basildon, Harlow, Southend-On-Sea and Thurrock. This will ensure that the work of the HDRC is focused on a smaller number of localities with the greatest need and not spread thinly across the area as a whole.

46. In developing research, the HDRC will balance the desire to produce transferrable insights that can shape policy and practice across GE and other areas of the UK, against the need to ensure that research is rooted in the material circumstances that characterise GE's different towns and cities. Part of our strategy to address this will be to:

    a. ensure that all projects work with local stakeholders to identify the economic, geographical and social factors that shape research findings; and

    b. share research findings in ways that engage audiences in dialogue around how the issues and interventions examined in parts of GE might play out in other areas.

    This approach will be vital in ensuring that lessons can be generalised and applied in appropriate ways in other places.

47. Research will be progressed through **four** mutually re-enforcing research workstreams, scoped to encompass the key factors influencing health outcomes in GE's most challenged communities (see para 12) and the factors set out in the OHID WDH Framework (OHID,

2023). These workstreams have also been shaped to enable the HDRC to engage effectively with the different 'tribes' and professional groups that make up the local government workforce. The workstreams, and illustrative examples of the sorts of issues they might explore, are set out below:

a. **Economic and labour market factors** affecting health. This workstream would provide a natural point of engage for economic development and regeneration professionals. Under this workstream, the delivery team might explore issues around:
   - the effectiveness of different policies in promoting good quality employment opportunities in coastal communities such as Clacton and Southend;
   - the health and wellbeing implications of the cost-of-living crisis on 'at-risk' populations and how local policy can mitigate these impacts; or
   - the evidence on how local authorities can maximise the health and wellbeing benefits of major investments like Freeports (there are two in Greater Essex) or nationally significant infrastructure investments (11 planned in Greater Essex).

b. **Environmental factors** affecting health. This workstream would provide a natural point of engagement for spatial planning, urban design and environmental service professionals. Under this workstream the delivery team might explore issues around:
   - the health and wellbeing impacts of office-to-residential conversions concentrated in Greater Essex's 20th Century New Towns (i.e. Harlow and Basildon);
   - the effectiveness of local planning and licencing policy in influencing local food provision; or
   - inequalities in access to green and blue space for recreation and the impacts on physical activity.

c. **Educational factors** affecting health. Engaging with educational professionals across schools, colleges; HEIs, and examining:
   - the factors influencing the low levels of participation in higher education amongst Essex children in receipt of free-school-meals;
   - the effectiveness of strategies to attract and retain high quality teaching staff in deprived communities.

d. **Vulnerabilities** affecting health: engaging with children and adults social services, health partners and with police service colleagues through the Essex's Violence and Vulnerability Unit. This workstream might examine:
   - the experiences of victims of domestic abuse in accessing support from local services;
   - the extent to which living in deprived communities is a predictor of unmet mental health need or over-diagnosis; and
   - effective strategies for tackling loneliness and social isolation amongst different 'at-risk' demographic groups.

As outlined in Section 3, each workstream will be led by a senior academic from one of our HEI partners (an 'academic' lead), and steered by an identified senior practitioner from the relevant council service area. The workstreams will also be supported by a HDRC Fellow (a 'future leader' identified from Essex, Southend and Thurrock councils – see section 5) and researchers from within the HDRC delivery team.

48. To ensure that each workstream focuses its energies on the priority issues within these places, the HDRC will undertake collaborative workshops in each of our 'priority places' to build a shared understanding of health outcomes and inequalities in each place; the social, economic and environmental drivers of these outcomes; and the programmes and

interventions being put in place to tackle these outcomes. We envisage that these workshops would include:

a. officers from the relevant local authority;
b. officials from the relevant Integrated Care Partnerships;
c. academic researcher beyond the HDRC delivery team;
d. representatives of Healthwatch organisations;
e. elected politicians;
f. representatives of the voluntary, community and faith sector; and
g. members of the public drawn from the CIF.

49. These workshops would be supported by:
    a. a review of existing data and insight on the WDH across GE, drawing on existing Joint Strategic Needs Assessments, published data and local administrative datasets. The HDRC will use these sources to identify areas where further research is required;
    b. a rapid review of existing evidence on the impacts that different factors can have on health outcomes, drawing on academic literature as well as studies and evaluations conducted elsewhere;
    c. wider engagement with local partners through existing forums for collaboration (e.g. Health and Care Alliances) and professional groups (e.g. Essex Housing Officers).

50. The Research programme will also benefit from collaboration with wider partners, including:
    a. **the East of England Population Health Research Hub (EoEPResH).** The EoEPResH brings together representatives of the main research universities of the East of England, local public health systems and OHID. Its purpose is to bring these communities together to influence how research is shaped and informed by priorities from local populations as seen by the public health leads in those communities. Across the East of England university landscape there are highly complementary relevant academic skill sets, and cross regional investments include East of England ARC, and School for Public Health membership (Cambridge) that provide avenues to responsive funding. The EoEPResH has agreed to work with the GE HDRC, and to provide it with a route to draw in wider academic experience to collaborate on future bids and to share insights to shape its work to deliver research projects.
    b. **Research and Enterprise Offices within University of Essex and Anglia Ruskin Universities.** HDRC Researchers will work with colleagues in these teams to identify potential funding opportunities. We will also work with the new NIHR Research Support Service to ensure that HDRC Researchers, and wider members of the delivery team receive the support they need to develop compelling and competitive research grant applications. The delivery team will make use of the existing infrastructure in the LAs as well academic institutions on pre- and post-award management.

51. These inputs will help the teams on each HDRC workstream to scope out the high-level research questions that will guide the research they deliver and the funding bids they prepare. The Research team will prepare a draft four-year programme that can be refined through iterative discussions with local stakeholders and members of the HDRC's multi-partner Leadership Board. This programme will then be subject to a informal consultation with partners and public representatives. Following this consultation, the Leadership Board will take final decisions on the adoption of the research programme. This programme will be subject to annual reviews, informed with input from residents and partners.

52. Projects within the HDRC research programme will not duplicate existing work to understand the health needs of local populations and communities. The scope of the programme will be informed by local councils' Joint Strategic Needs Assessment processes, but HDRC projects will **focus primarily on identifying and evaluating effective practice in addressing the WDH within the local context**. In this way, by focusing on "what works" the work of the HDRC will inform the selection, design and evaluation of local interventions to affect change.

53. All projects within the HDRC's research programme will be carried out in accordance with the UK Policy Framework for Health and Social Care Research, the relevant research and development policies in ECC as well as each of the universities. This will help ensure that the rights, dignity, safety and wellbeing of all those involved in research can be protected. It will also helps to protect the reputation of ECC and the HDRC.

54. The HDRC delivery team will use ECC's existing research governance framework. Researchers will use a decision toolkit based on the Medical Research Council and Health Research Authority toolkit (HRA, 2020) to help them to decide the type of ethics approval required for their work, as some studies may require HRA approval, for example where a study is looking at changes in specific health outcomes as a result of addressing wider determinants of health. However, other studies will not require approval via this route. For studies that require ECC approval only, the research proposals will be risk assessed by ECC's in-house research function (which is separate to the HDRC delivery team). This team will assess the proposal's implications on beneficence, nonmaleficence, autonomy, justice, confidentiality, anonymity, conflict of interests and data protection. While projects assessed as 'low risk' will be allowed to proceed, those assessed as 'medium risk' or 'high risk' will be offered advice and guidance. This may involve convening ad hoc panels to provide guidance in line with the UK Policy Framework for Health and Social Care Research, Good Clinical Practice and all relevant internal research governance frameworks. Researchers will only be allowed to proceed when approval has been obtained and all concerns have been addressed.

Capability development

55. This programme focuses on developing our employees and our executive and political leaders to undertake research and use evidence in decision-making. The programme has been shaped to support ECC's strategic commitment to work in a way that is "insight and evidence led" (ECC, 2021c), and to help enable with the council's future transformation aspirations, seeking to become a council that is "systemically informed and driven by data and insight - a council therefore, that understands its communities, cohorts and places well" (Jones, 2022). The programme will focus on developing the understanding and skills of key individuals, and on creating a supportive environment.

56. Our work on skills development will focus on the groups set out below. We recognise that securing the engagement of busy council officers will be challenging. These HDRC Delivery Team will therefore dedicate resources to identifying and engaging with these groups:

    a. **Research active employees:** extending opportunities for Continued Professional Development (CPD) and providing support to researchers in navigating the range of opportunities available. We can confidently identify research active employees within the host councils through pre-existing internal networks.

    b. **Research curious employees**: extending opportunities to develop research skills and experience and encouraging collaboration with local research teams. We will identify 'research curious' employees through internal communication and outreach activity, and through the councils' employee appraisal processes and the development discussion that employees have with their line managers. Incorporating specific development goals around research skills into employees objectives will help drive engagement with research activity and strengthen research culture.

c. **Future leaders** – we will engage them directly in research activity, encouraging a mindset that prizes the role that research and evidence plays in good decision-making. Again, we will identify and secure engagement from future leaders through a combination of internal communications and outreach, the annual appraisal/ development plan process and by drawing on the sponsorship of the HDRC's most senior advocates: our Directors of Public Health, Directors of Policy, Chief Executives and Cabinet Members. Using their profile and influence we will communicate the value of research emphasising the importance of these skills to aspiring leaders and the central role that they will play in realising our councils' strategic objectives.

d. **Members of the public** – building confidence among public representatives to better enable them to take part in research and support the HDRC's work.

57. The key actions we will take to support these groups and build capability are as follows:

For research active and research curious employees:

58. We will compile publish and maintain a **prospectus of high-quality CPD** and research training and development activities. This will include training on effective Patient and Public Involvement. The preparation of this prospectus reflects the principle that we should maximise the value of existing researcher development programmes before looking to commission new local solutions. We would expect this prospectus to include programmes and Fellowships offered by organisations such as the NIHR and the Health Foundation, as well as provision made available through local universities.

59. As well as cataloguing provision, the prospectus would be designed to provide the information, advice and guidance necessary to help those using it to navigate the complex range of CPD opportunities available. It would also make clear where existing provision would be suitable for those with more limited research experience, as well as for those with deeper expertise. The prospectus will be published via the HDRC's website.

60. Work to develop this prospectus will benefit from the HDRC's partnership with EoEPResH. The prospectus will use build on work that the EoEPResH have done to understand and map the availability of research training and development opportunities for public health practitioners across the East of England.

61. The HDRC Delivery Team will also administer a **fund of £20,000 per year** into which officers from across the host councils can bid to access approved research-related CPD from within the HDRC prospectus. Funding will be awarded based on a set of criteria to be developed and agreed by the HDRC Leadership Board.

62. The prospectus and the availability of sponsorship will be promoted heavily through an internal communications campaigns combining the use of online articles and blogs, social-media posts, and face-to-face briefings (targeting established meetings, including staff roadshows and ECC's annual week-long festival of learning 'learnfest').

For Future Leaders

63. Under a new **GE HDRC Fellowship scheme**, officers working within GE local authorities will have the opportunity to work within the HDRC's four research workstreams. This will help to build their understanding and experience of research methods, processes and effective practice around the engagement and involvement of the public. It will also give them a positive role in steering the research that is carried out to maximise its value and its impact on work to tackle the WDH.

64. We anticipate that HDRC Fellows will not be experienced researchers. Rather, these officers will have been identified by their respective local authorities as 'future leaders' with the potential to develop into senior management positions within the next five years. Each Fellow will be embedded within one of the HDRC's research workstreams for a period of 6 months. Over this period, they will give one day a week (0.2 FTE) to:
    a. steering and learning from academic and researcher colleagues within their workstreams;
    b. participating in an action learning set with other local authority Fellows, undertaking research into themes relevant to health inequalities and the WDH.

65. The HDRC will cover the costs associated with backfilling LA Fellows. We anticipate that this programme will engage four Fellows per year (one per workstream), and up to 20 Fellows over the period of the HDRC. Designed in this way, the HDRC Fellowship will help ensure that future leaders of GE's public services have a deep understanding of the value of research and the role it can play in evidence-based decision-making.

66. We will also develop and nurture a **'community of practice'** for research active/curious employees and for HDRC Fellows across Greater Essex. Wholly separate from HDRC Governance structures, the community of practice will provide an forum to build supportive links between researcher active/curious employees across the system. Quarterly meetings, organised by the HDRC will provide a space for collective learning and for sharing insights and professional challenges, and for the provision of advice and support between peers. These will also help develop networks across partner agencies – enabling collaboration outside the boundaries of the HDRC. As it matures, the Community of Practice will be a helpful foundation for a stronger research culture in GE.

67. We will explore with researchers whether there is added value in involving resident representatives in this community too – balancing the benefits of closer links with the public and the desire to provide a forum for professionals to discuss challenges and share insights openly in a supportive environment.

    For members of the public

68. We will develop information, advice and guidance for members of the public that describes what research is, how to get involved in research and why public involvement is important. This will involve delivering talks, seminars, and workshops on the HDRC, its outputs, the wider determinants of health and the importance role of participating in research.

69. This information will be shared widely. Our PPI lead will spearhead work to reach 'seldom heard' populations who are too often excluded from research. We will ensure that the people from these groups become confident to take part and support the HDRC (see para 40).

70. Building on these activities, our work to foster a **supportive environment for research** will seek to integrate research into key cultural events within the host councils, and target support to senior executive and political decision-makers. The focus on this groups reflects the role these groups play in role-modelling behaviours and shaping incentives for officers across the system.

71. Our work to build research into key cultural events will include, by way of example:
    a. sponsoring an award for the most valuable or influential research projects undertaken by council employees at the council's annual awards ceremonies; or
    b. sponsoring a series of research-focussed learning events as part of ECC's Learnfest – the council's annual week-long festival of learning. This might involve securing keynote

speakers exploring key issues relating to research in the public services, and/or smaller workshops run by members of the HDRC team or the wider community of practice.

72. Our engagement with senior executive and political leaders will involve:
    a. Opportunities to shadow researchers undertaking fieldwork. We will ask senior leaders and elected politicians to commit to accompanying researchers undertaking fieldwork for primary research with GE Essex residents (where doing so is safe, ethical and does not compromise data collection). This may involve having decision-makers observe focus groups, sit-in on qualitative interviews and/or participate in analysis sessions following qualitative fieldwork. This will build on similar work which engaged local authority Chief Executives in the research process in summer 2019 - an experience that participants agreed providing unique insight into the value and depth of research.
    b. The delivery of bespoke workshops for senior leaders. The HDRC delivery team will develop and deliver a series of 'out-reach' workshops, focused on demonstrating the role of the HDRC and the benefits of supporting and facilitating research, and engaging with the public. These will be delivered to executive teams in each of Essex's local authorities. Similar workshops will be rolled out to the authorities' wider senior leadership corps.

Communication and Engagement

73. The HDRC's Communications and Engagement Lead will work as part of an established network of communications and engagement professionals spanning local authorities, university partners and NIHR. They will drive the HDRC's communications and engagement activity, leveraging the communications capabilities of Essex, Southend and Thurrock councils, University of Essex, Anglia Ruskin University and other partners where appropriate, to maximise reach and impact and/or to more precisely target key audiences.

74. To enable the achievement of the HDRC objectives (as set out in para 12-13), the HDRC's Communications and Engagement programme will focus on driving:
    a. **collaboration** – both between GE Essex partners, and between public agencies and the communities they serve;
    b. **engagement** with the work of the HDRC and with its findings and outputs; and
    c. **behaviour change** – with respect to partners' approach to research and to the decisions that are made on local policy.

75. These communications goals should be understood as applying equally to the HDRC's four principal audiences: GE's senior executive and political decision-makers; professionals across public service agencies; Essex residents and our peers across the country. We will seek to influence the views, perceptions and behaviours of these audiences through a series of connected and mutually re-enforcing activities:
    a. **Brand building:** developing content that builds an authentic brand story for the HDRC, positioning it a credible source of insight and evidence on the WDH and driving demand for its work. This will depend upon effective delivery of high-quality outputs; case studies that showcase expertise and impact; compelling storytelling and a clear, recognisable visual identity for the HDRC.
    b. **Impact dissemination:** supporting each research project and evaluation with a bespoke dissemination plan to ensure messages are packaged to achieve maximum impact with each key audience. We anticipate that each project will result in the preparation of:
        i. a briefing paper suitable for non-technical audiences;

ii. a written research report providing the supporting evidence base;

iii. presentation slides to support the communication of key messages in stakeholder forums.

This may include the use of alternative media to communicate insights, including exhibitions, seminars, films, events, and podcasts. Where academic leads seek to publish academic papers in open access journals, the costs will be met by the NIHR in line with its new policy on open access costs.

c. **Securing advocates:** engaging senior leaders professionals and members of the public who are already working with the HDRC as advocates for its work. This may mean equipping senior officials and elected politicians to take messages back to their own organisations and to share messages with key partnership boards.

d. **Stakeholder management:** developing a database of contacts; tracking and investing energy in key relationships. Developing a network of advocates for the HDRC through personal and professional networks.

e. **Working in the open:** publishing all research outputs via a new HDRC website with supportive links to other well-used sources of insight (e.g., Essex Open Data). This will help ensure that research outputs are made public providing an additional driver to the adoption of evidence-based policy policies.

f. **Virtual and face-to-face events:** organising quarterly events and webinars showcasing insights from the work of the HDRC and an annual "WDH Research Conference" bringing together professionals, service users and policy makers in GE to present findings and consider their implications for policy.

76. In addition to these activities, the HDRC will communicate its work and disseminate its findings through established professional networks. For example, the HDRC will work with the network of district-level Health and Wellbeing Boards across GE to ensure findings are made visible and translated into action. Ther GE HDRC will also work with EoEPResH to ensure that research outputs can reach a wider audience of public health practitioners across the East of England region, within local authorities and the OHID. This partnership will also enable the HDRC to bring relevant public health research, conducted across the region to the attention of local decision-makers to the extent that this related to local policy and can inform key decisions.

77. Given the focus of the HDRC's communications and engagement activities on our four principal audiences, most of this programme will be delivered through a combination of:

a. **'owned' media** - an HDRC website (linked to and from the websites of partner institutions), capable of hosting blogs, case studies, video etc; a newsletter issued through ECC's distribution infrastructure;

b. **'shared' media** - social platforms such as LinkedIn, Twitter and YouTube as well as webinars events and our annual conference); and

c. **'earned' media** – in the form of direct attendance at partnership meetings, community events and discussion forums.

'Paid media' (e.g., commissioned materials such as videos) will play a role in project specific dissemination strategies. Various forms of 'earned' media (e.g., guest articles in trade press and other media outlets) may play a supporting role in communicating the work of the HDRC to peers across the country.

78. Across all activities and media categories, we will adopt a digital-by-default approach. Using digital channels, minimising print and prioritising the use of accessible e-documents will allow us to reach professional audiences and to communicate the HDRC's impact effectively.

79. These activities, and the anticipated media mix will help ensure that the HDRC's communications and engagement work has a reach that extends well beyond those working directly with the collaboration, and beyond those who are already disposed to use research outputs to inform their work. In the process of preparing this delivery plan we have engaged with partners and professional groups across the GE system, securing their agreement to receive HDRC research outputs.

80. Although the programme will be led by the HDRC's Communications, Engagement and Public Involvement manager (see Section 3), all members of the HDRC team - and all those who play a role in its governance structures – will have some level of responsibility for communicating the HDRC's work.

81. We will operate on the basis that the Programme Lead will:

    a. have direct responsibility for high-profile activities (generally paid and earned media) as well as those that require professional communications expertise (e.g. the development of an HDRC website; management of social media channels; commissioning alternative media);

    b. provide advice and guidance to HDRC colleagues (e.g., researchers, academic leads, managers) in managing other elements such as dissemination activity, webinars, the preparation of blogs, newsletter articles etc. This advice and guidance will be supported by the development of prescribed document templates; defined editorial and approval processes, requirements around the co-creation of outputs with public representatives and in accordance with pre-agreed standards around branding and accessibility.

82. We also propose to extend ECC existing media protocols to all those working on the HDRC delivery team – providing clarity and professional support to anyone engaging with news media (both print and broadcast).

Section 6: Implementing the HDRC in Greater Essex

83. Having identified named officials/academics in all but one of its senior leadership roles, the GE HDRC delivery team can mobilise at pace from the point that funding is confirmed.

84. The implementation of the GE HDRC will proceed through three phases. These are described below. Milestones/success criteria set for each phase will inform conversations of progress and periodic review discussion between the NIHR and the HDRC. The milestones/success criteria are set out alongside our high-level mobilization plan (Gantt Chart) in an accompanying document.

85. **Phase 1: Mobilisation (months 0 - 12):** the immediate focus during this period will be on recruiting to new posts, the development of shared post/funding agreements with academic partners, and the establishment of HDRC governance structures. Regular updates will be shared with key partnerships throughout, ensuring they remain informed of progress.

86. Early in this period we will undertake a baseline assessment to better understand the use that is made of research across the HDRC councils; attitudes to research amongst professionals and decision-makers; and institutional practices. This will inform our selection of KPIs and support our approach to assessing the impact of the HDRC as set out in paragraphs 15-19 of this plan. We will gather insights through a survey of senior stakeholders (officials and politicians), and through follow-up interviews with a sample of

respondents. This will provide a benchmark for tracking progress and evaluating the impact of the HDRC's future work. These KPIs will sit alongside a broader set of metrics measures that will help the HDRC Leadership team manage the performance of the delivery team. All measures will be published in the HDRC's annual report.

87. This period will also see the creation of, and recruitment to the Citizens Involvement Forum (CIF). Members will be recruited from existing engagement forums and through 'outreach' activity supported by partners such as Healthwatch Essex. It will also be supported by the development of interim webpages and the start of social media communications activity.

88. Between months 6 and 12 – and subject to satisfactory progress in recruiting the HDRC's researcher corps – we will deliver a rapid review encompassing existing data, insight and research on the WDH within GE, and broader evidence on the impacts that different factors can have on health outcomes. This will be supported by academic leads, researchers and the first cohort of HDRC Fellows.

89. The outputs from this work will be shared widely, supported by a bespoke dissemination plan, and used to inform a process of system-wide engagement with partners, professionals and the public on the questions to be explored through the HDRC's Research programme.

90. We aim to secure endorsement of the HDRC's draft four-year research programme via the Leadership Board within 12 months – formally launching consultation on this at our first annual conference.

91. **Phase 2: Embedding the HDRC.** Having mobilised the HDRC, we will focus on embedding its work – establishing it as integral to the work of the HDRC councils on the WDH. This means:

    a. **securing early impact (months 12 – 24):** building the profile and reputation of the HDRC by delivering high-quality insights and an initial round of impactful research outputs. We will promote these through the creative use of digital and social media and our programme of dissemination events.

    b. **providing a foundation for lasting culture change (months 12 – 36):** emphasising the development of research capability across HDRC councils. We will use our communications channels to showcase the work of researchers who have benefited from funded CPD and highlighting the work of the early HDRC Fellow cohorts. We will begin our work to involve political and executive leaders in fieldwork, and step up our workshops with senior leaders and professionals. We will invest energy in securing third-party research funding to support our programme.

92. **Phase 3: Sustaining a research culture (months 37 – 60**): having established the HDRC as an integral part of the HDRC councils work, we will continue to build support and use this to drive changes in attitudes to and behaviour regarding research. We will:

    - build a network of advocates who support the HDRC and its approach to research. We will do this through our continued outreach work with the public; by sustaining a programme of insight focused workshops with senior political and executive leaders; and through our growing HDRC Fellowship alumni group – many of whom are likely to be moving into leadership positions within GE – and through our community of practice'
    - build the intellectual case for sustaining the research activity through the development and dissemination of impact case studies and by shifting the position on fey performance indicators as measured through our annual assessments;
    - build the financial case for sustaining research activity by securing success in research funding bids.