ConnectED: Connecting Evidence with Decision-Making

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1. ConnectED – Connecting Evidence with Decision Making.

2. Summary of Research

This 42-month project aims to establish sustainable partnerships between social care practitioners, researchers and service users and carers, in three local authorities in the South West and two key providers of social care services. It will then evaluate and generalise 'what works'. The structure of the partnerships aims to improve the effectiveness of decision-making in social care by embedding access to research, and the routine use of research, in the decisions of those who plan, commission and deliver social care. There will be three work packages. The first aims to facilitate the integration of research and practice at multiple levels within Adult Social Care (ASC). Agency partnerships will be established comprising *Researchers-in-Residence* (researchers located in each agency), *Evidence Champions* (agency staff seconded specifically to build capacity to access and integrate research into decision-making) and *Services Users and Carers* (identified on a project-by-project basis by a Service User and Carer Advisory Group). Within the context of the partnerships, Workpackage 2 is designed to build capacity amongst social care decision-makers in the knowledge and skills required of research-practitioners and to initiate a research pipeline relevant to those working in social care. Workpackage 3 comprises a realist evaluation of the component parts of Workpackages 1 and 2 and is designed to shed light on what works, for whom, in what circumstances. This involves social care workers in ways that will build their capacity in understanding and conducting evaluative research, and ensures that the project as a whole will provide information about 'what works' in facilitating research use and knowledge mobilisation that will be relevant beyond the partner agencies in this project.

3. Background and Rationale

3.1 The context

ASC matters: it encompasses a wide range of activities designed to help older people, and those aged 18 or over who are living with disability or illness (physical or mental), to live independently, to achieve a better quality of life than would be otherwise possible, and to remain safe from abuse and neglect. In certain circumstances, local authorities (LAs) also have a responsibility to provide support to family carers.

Whilst most social care is provided informally in England, and an increasing number of adults pay for their own social care, net current expenditure by LAs in 2018/19 was £22.2 billion – a real terms reduction of £300 million from the level it was in 2010/11.[1]

The Kings Fund reports that in 2018/19 some 841,859 adults in England received publicly funded long-term social care from an estimated 1.5 million people working in social care. Of these, 840,000 are care workers employed by service providers, delivering care in residential settings or service users' own homes, with another 145,000 care workers directly employed by service users. Other roles encompassed within social care include: senior care workers (87,000), registered nurses (41,000), social workers (18,000) and occupational therapists (3,500).[1]

Much depends on the quality and effectiveness of decisions undertaken by those commissioning and delivering social care services, yet as recently as 2018 the National Audit Office noted the absence of a workforce strategy for those working in ASC. This was despite the fact that the Department for Health and Social Care (DHSC) had committed, as one of nine priorities in its *Shared Delivery Plan: 2015-2020,* 'to make sure the health and care system workforce ***has the right skills*** and the right number of staff in the most appropriate settings ***to provide consistently safe and high quality care'***.[2] The DHSC also aimed to more closely integrate health and social care by 2020. Integrated Care Systems (ICSs) currently cover 18 of the 42 Sustainability and Transformation Partnerships (STPs) across England, with an expectation that they will be implemented everywhere by April 2021.[3,4] ICSs aim to overcome some of the problems of organisational and sectoral divides by pooling budgets and promoting collaboration.[5] However, whilst social care agencies are often involved, the primary focus so far has been the integration of different parts of the NHS.

This proposal focuses on building the capacity of social care leaders and frontline practitioners to identify, access, use and undertake research to improve decision-making in ASC, and to improve the integration of ASC services with health services.

3.2 The research-practice gap

The importance of research use as one factor in effective decision-making (often referred to as evidence-based policy and practice) is embedded in the language of ASC: there is infrastructure support in the form of organisations such as the What Works Centres, Research in Practice for Adults (RIPFA), the Social Care Institute for Excellence (SCIE) and the NIHR School for Social Care Research; NICE now provides Guidelines that cover many areas of social care. Yet, despite broad endorsement and significant investment, the gap between research and practice in social care has remained stubbornly persistent. There are many reasons for this, and candidate factors include:

- Few opportunities or incentives for researchers (usually based in universities or research institutes) to remain truly grounded in practice, resulting in potential mismatches between what research is undertaken and what those delivering or receiving services might see as priorities.
- Until very recently, the absence of a strategic approach at a national level to the development and maintenance of a cadre of high calibre researchers, with a clear ‘social care’ research identity.
- Few incentives for researchers to spend time in knowledge translation and working with organisations on the challenges of implementation (indeed relatively little research has been focused on the implementation challenges in social care).
- For many, a reluctance to embrace an approach (evidence-based practice) that was seen to originate in medicine, and that seemed to be at odds with a social model of disability, that emphasised the importance of users (rather than professionals) being in control of the care and support they receive.[6,7]
- An absence of a strong, embedded research culture in ASC organisations.
- No established history of bringing together all key stakeholders to establish priorities for research that are then reflected in the programmes of work commissioned by funders such as the NIHR. It was not until November 2018 that the James Lind Alliance published the results of a priority setting exercise for Adult Social Work,[8] followed in June 2019 by first scoping review of research priorities in adult social care, conducted by the School for Social Care Research (SSCR).[9]

The separation between the communities of research and practice has contributed to a gap between the availability of high-quality, relevant research and its implementation; a gap between the development of promising approaches and ways of working (models of care) in agencies and their rigorous evaluation; and gaps in the availability of research needed by those commissioning and delivering services. This proposal aims to address these gaps.

3.3 Bridging the gap

To improve the delivery of ASC and achieve closer integration of health and social care services, there is a need to accelerate the development of applied social care research and its integration with practice. In health settings, there is a comparatively well-established system of research-active clinicians who both conduct applied health research and help translate research evidence into practice. In contrast, research active practitioners are rare within ASC, and few academic researchers have applied their skills to the challenges faced by ASC. These factors have contributed to evidence-informed decision-making being largely absent within organisations commissioning and delivering ASC services.

The history of NIHR testifies to the time and investment required to orient complex organisations and those who work in them towards evidence-based practice, and to establish a strong research and evidence-implementation culture.[10,11] Since it was established in 2006, the NIHR has transformed healthcare in the UK by funding excellent research that answers important questions and ensuring that the results are *used* to improve outcomes for patients as quickly as possible. Patients and public, alongside other key stakeholders, have a central role in influencing the NIHR’s research agenda, and there are many ways in which health care staff are supported to develop their understanding and use of evidence, improve their practice, and become researchers themselves.[12]

Whilst one must always be cautious in extrapolating from one sector to another, the achievements of the NIHR provide indicators as to things we might do within ASC to improve the links between research and practice, to improve the quality of social care decision-making, and to generate high quality research that is directly relevant to frontline practitioners, service users and carers, and commissioners of services. Key to bridging the gaps identified appear to be:

- bringing the worlds of research and practice closer together organisationally
- building capacity amongst researchers to make research findings accessible to social care decision-makers
- building capacity in frontline staff and other stakeholders to identify and use research
- involving all key stakeholders in priority setting, including strengthening the role of service users and carers, and
- translating the findings of research for the local context.

3a. Why this research is needed now

The importance of ASC to those who rely on it is amply documented, but the arrival of COVID-19 has underscored its importance, not only to service users and carers, but also to other organisations (such as the NHS) and other sectors of society. The pandemic also drew to the attention of the wider public the impact of years of underfunding, the fragmented provision of care across more than 20,300 organisations, 'with complex chains of commissioning, provision and accountability',[2 p.6] the lack of understanding of the role of the sector and its relationship with healthcare services, and the low status financial remuneration afforded the majority of staff who provide these essential services.

This is, therefore, a sector on which many depend, and where effective decision-making is crucial, both in relation to achieving good outcomes for service users and carers, and in ensuring that public funds are used well.

Recent initiatives (*e.g.* the SSCR, the NIHR Research for Patient Benefit calls) are designed to improve the quality and quantity of ASC research, and important research evidence is being published[13]. However, in order to maximise the benefit from such investment, practitioners and agencies need to be equipped to access and make best use of the research produced.

This entails a substantial knowledge mobilisation (KM) challenge. This could be framed as a knowledge transfer problem, in which the researcher with relevant expertise develops tools which are then 'pushed' or 'pulled' into routine use by decision-makers. Whilst there remains relatively little evidence as to 'what works' in promoting and sustaining evidence-informed practice and policy-making, there is evidence that increasing capacity in research use requires much more than increasing knowledge or developing skills, however important these might be. It requires an understanding of how research is actually used within organisations as a whole, and the factors that promote and constrain its use. Capacity-building activities need to incorporate interventions at different levels (individual, interpersonal, organisational) and to recognise the non-linear relationship between producers and users characterised as 'co-production' of research knowledge.[14-16]

Co-production describes 'a culture of partnership (which can include academic researchers, practitioners, managers, commissioners or service users) with the purpose of creating, sharing and negotiating different types of knowledge'.[14 p67] One model of co-production utilises a 'researcher-in residence' (RiR) role, and this approach has been implemented in a range of healthcare locales, including commissioner settings.[17] The role has the potential to move beyond addressing the needs of practitioners and commissioners for 'support to identify, understand and apply evidence', to creating new knowledge within the existing framework for decision-making, which relies on 'local information' and relationships to influence decisions.[15,18] While the embedded role is being strongly advocated,[19] Davies and colleagues highlighted the need to bridge a gap between KM embedded researcher co-production concepts and appropriate implementation strategies.[20] This gap is being addressed by the current NIHR HS&DR study of embedded researcher roles,[21] and we will apply this study's early findings as we develop this role in the three local authority localities.

The largely separate worlds of research and practice within ASC may exacerbate a mismatch between the 'supply' of research and the 'demand' for research by its intended beneficiaries. The landscape of social care does not lend itself to an improvement strategy that simply mirrors that adopted by the NIHR for the NHS, yet the need to achieve a closer integration between research and the needs of those delivering and receiving services is equally important. This proposal aims to develop an approach to bridging the research-practice divide in ways that can deliver sustainable change, building the capacity of social care leaders and frontline practitioners to identify, access and use research to improve decision-making in ASC, and – more broadly – to improve the integration of ASC services with health.

An important dimension of the project will be to embed a preventive or public health perspective into social care, along with health economics' insights into outcome measurement and resource use analysis, which have potential to strengthen decision-making. This is particularly important for commissioners of services. The focus on improving wellbeing at a community level and applying assets-based approaches resonates with what matters to service users and carers, and with social work's historical focus. It also builds on the growing collaborations between public health and social care within the participating local authorities.

4. Aims and objectives

The overarching aim of this project is to facilitate evidence-based decision-making in a range of ASC contexts, thereby improving outcomes for service users and carers and identifying successful strategies for developing evidence-based practice in ASC nationally.

In order to meet this aim, the project has the following key objectives:

1. To build the capacity of social care workers (including senior practitioners and frontline social care workers, managers, commissioners and analysts) to identify, access and use research to improve decision-making.
2. Using co-production methods, to build capacity within ASC to undertake service evaluation in ASC settings, and develop early stage studies that can form the basis for future research proposals in priority areas for relevant funders.
3. To evaluate both the impact of the capacity-building activities on effective decision-making, and the use of evidence to inform policy and practice in ASC, and to identify key activities, processes and tools that may be widely applicable.
4. To identify factors that facilitate or impede capacity-building in evidence-based decision-making amongst those working in a complex social and organisational context, and successful implementation strategies that support better decision-making.

5. Methods

5.1 Overall approach

In each of five partner agencies (see below) we will establish a Research Practice Partnership (RPP) comprising:

- Researcher in Residence We will locate a social care researcher in each agency who will be employed by and supported from the University of Bristol, using a 'researcher-in-residence' model. This approach is based on evidence suggesting that approaches which embed research in quality improvement[17,22] and which adopt co-production approaches of the kind suggested here[14] are most likely to succeed in achieving sustainable change.
- Evidence champion Each agency will nominate one or more members of staff to work with the researcher in residence to promote and embed the use of research in decision making. They will be known as evidence champions (EC)[23] and further detail is provided below.
- User and Carer Involvement [PPIE] Each partnership will work closely with designated service users or carers, identified and supported by the Service User and Carer Advisory Panel and the PPIE lead (Symonds).

These Research Practice Partnerships will engage in a range of activities grouped within 3 work packages (WPs) designed to achieve the project aims and objectives. WPs 1 and 2 address objective 1, and WP3 addresses objectives 2 – 4. Before describing these, we first outline the theoretical basis of our proposal.

5.2 ConnectED Programme theory

The core theory of change that underpins this proposal is that by bringing the worlds of research and practice closer together *within* the organisational contexts of practice, we can improve decision-making at all levels. This is because the grass-roots partnership arrangements proposed (between researchers, practitioners and service users and carers) will enhance access to research, build capacity in research use at the individual level (decision-makers at all levels), at the interpersonal level (RiR, EC and Service Users and Carers) and at the organisational level (agency) - increasing the organisational value placed *on* the use of research, thereby influencing the development of policies and processes *for* research-use. This, in turn, will improve evidence-based decision making and practice throughout the organisation.

Closer working relationships will facilitate a systematic approach to developing and monitoring service and practice innovation, and the identification of priority topics for research (see WP2 below), supporting a pipeline of research and submission of high-quality proposals to the NIHR.

5.3 Building on existing relationships

The project builds on existing relationships (*e.g.* Bristol Social Care Research Forum, the University of Bristol User and Carer Forum) to establish a larger, formal Partnership between:

- Bristol City, South Gloucestershire, North Somerset Local Authorities (LAs)
- Sirona (independent delivery organisation)
- Dhek Bhal (charitable provider of community-based services and BAME advocate)
- University of Bristol (UoB) and the University of the West of England (UWE)
- Service User and Carer Advisory Panel (comprising service users, carers and nominees from user organisations in the South West)
- NIHR West of England Clinical Research Network (CRN)
- NIHR Research Design Service South West (RDS)
- Bristol Health Partners
- NIHR Applied Research Collaboration West (ARC West)

The Partnership provides a real-world laboratory for natural experiments in identifying ‘what works, for whom, and in what circumstances’ in fostering evidence-based decision making in ASC. The Partnership is well-positioned to foster a multidisciplinary approach to research in a geographical area of considerable health and social care need and complexity. It will lead to the identification of innovative ways of working that will form the basis of a staged approach to co-production activities and associated evaluation and construction of a stronger evidence base in ASC.

The three local authority areas encompass variation in terms of need and practice.[24,25] There are significant inequalities within each area, which include affluent and deprived urban and rural neighbourhoods. All local authorities face personnel challenges, with an aging workforce and reliance on newly qualified staff. Teams in North Somerset and South Gloucestershire are generic, whereas Bristol currently has specialist teams for Mental Health, Visual impairment and Safeguarding. There is a range of private providers, from large organisations such as Sirona to small, family-run businesses and specialist community providers like Dhek Bhal, which supports the Bristol South Asian community and promotes better social care for the wider BAME community. All 3 LAs partners are taking a strengths-based approach (or asset-based working approach) to needs assessment using the ‘3 conversations model’[26]. However, staff and carers have given varied reports about its perceived effectiveness. The North Somerset Carers Forum identified use of the ‘3 conversations model’ as a key area where an evaluation of the impacts on support for clients is needed. Bristol is implementing the innovative Buurtzorg model of home care provision in which small, self-managed teams of integrated health and social care professionals provide care for an area without the restrictive time and task approach.[27] As with all new models of care, variation in implementation and differences in context can impact on effectiveness. In conducting this project across the varied social care contexts of Bristol, North Somerset and South Gloucestershire, there is ample opportunity to evaluate what works in real-world practice and to identify the potential for transferrable lessons for other areas.

5.4 Work package 1 (WP1) – Connecting research evidence with key decision-makers

WP1 provides a foundational step in establishing a culture that will empower social care workers to become research seekers and users. Nationally, the ASC environment has not been oriented to a discerning use of research in decision-making. Typically, practitioners have limited access to research and may lack the skills to assess its rigour or interpret its relevance, whilst researchers have historically paid little attention to the challenges involved in presenting research in accessible ways. Bringing together the worlds of research and practice in the ways set out below will establish an environment that is conducive both to developing an evidence-based decision-making and to fostering research that is relevant to the world of practice. Social care staff will have easier access to research, and opportunities to develop their knowledge and skills in using it, within a supportive organisational culture. The focus is future-oriented, on improvement and how partnerships between researchers, social care workers, service users and carers can improve decision-making in ASC.

WP1 Aims and objectives

The overall aim of WP1 is to facilitate the integration of research and practice at multiple levels within ASC, from those in leadership roles to the frontline workers. Specific objectives are:

1. To facilitate the identification of, and access to, research relevant to staff working at all levels of each agency partner.
2. To build the capacity of decision-makers at all levels, and from all disciplinary backgrounds, to use research.
3. To develop systems that will promote the sustainable use of research in adult social care decision-making.

The Research Practice Partnerships (RPP)

We will locate a social care researcher in each of the three local authorities, and in provider agencies Sirona and Dhek Bhal. These ‘Researchers in Residence’ (RiR) will be employed by the UoB and supervised and supported by the applicants. Each agency has agreed to identify (and release) Evidence Champions (EC) from their social care staff. Service users and carers identified by the Service User and Carer Advisory Panel will complete the Partnerships in each agency. Each RPP will be supported by one of the co-applicants, working in collaboration with a named agency manager who will hold agency responsibility for the work. They will ensure that each member of the RPP receives an appropriate induction, along with any initial training and support required to enable them to become confident in the co-production activities set out below. Our proposal is costed to allow one full-time equivalent member of staff to be working as an EC at any one time. ASC agencies will be able to rotate staff in the EC role to enable a range of team members to benefit, but each EC will be seconded to the project for a significant period (at least 6 months) to work with the RiR. This will enable them to develop their skills in using and producing evidence.

The RPP approach to capacity building

All RPPs will be expected to undertake a number of core capacity-building activities. These core activities stem from our programme theory and will provide important information about the impact of different contexts. Core activities for members of the partnership are listed in Table 1, with a brief description of their aims. Details of how each RPP will work together, and what areas of work they choose to prioritise, will be determined within each agency, in discussion with the research team (see WP3), allowing responsiveness to service needs.

Identifying, appraising and interpreting research

At the outset, ECs and Service Users and Carers will assume the primary responsibility for identifying where research might be useful, and the RiR will assume the primary responsibility for identifying and appraising relevant research. All three will engage in the task of knowledge translation. This approach reflects the fact that many interventions in social care are, by definition, complex social interventions, and this needs to be reflected in how research is interpreted. It will reinforce the importance of co-production whilst building capacity in research use amongst practitioners and service users and carers, and ensure that both evidence and knowledge translation maintain a clear focus on the needs of service users and carers.

The RiR and EC will work with wider groups of staff to disseminate research and discuss its relevance, how it might be used in decision-making, what barriers there might be, and important gaps in the availability or relevance of research evidence. The intention here is to validate the EC's role whilst engaging wider groups of practitioners.

As the knowledge and skills of the ECs develop, they will become more involved in the identification and interpretation of research, under the mentorship of the RiR, whose understanding of the organisational context will also be enhanced.

Developing knowledge and skills

The learning that will happen by collaborative working will be supported and built upon by a range of more formal opportunities, both for ECs and for larger groups of practitioners.

ECs will meet as a learning set designed to develop generalisable skills in understanding evidence and how to use it. The frequency of meetings may vary across the study period, reflecting the development of the work, but will be fortnightly at first. The project will also facilitate EC attendance at training courses in research methods run by ARC West, UoB and UWE.

The Research Practice Partnerships will be supported by Dr MacLeod to gain insight into the economics of health and care, as part of the master-class series we will run. This will take a case-study approach to examine the available evidence and issues relating to specific topics, in addition to training on generic topics including outcome measurement, cost-effectiveness analysis, and the potential of the BNSSG systemwide dataset to inform analysis of resource use and associated costs. We will also focus on the importance of understanding the counterfactual when assessing changes in practice, and accordingly the importance of deploying the most robust study designs possible when seeking to evaluate service innovation.

As ECs become more confident we will organise a series of evidence master-classes designed to develop generalisable skills in understanding evidence and how to use it. In doing so we will draw not only on our own expertise but also make use of existing training courses in research skills, knowledge translation, economics and co-production run by ARC West. The master-classes will be tailored to the needs of social care practitioners. Similar provision, suitably tailored, will be made available to members of the Service User and Carer Advisory Panel.

As ECs and Service User and Carer partners become more confident (see WP2), they will partner with the RiRs to provide training sessions tailored for different groups of ASC staff. These sessions will use 'real-life' scenarios as a starting point for thinking through, and learning about, the potential contribution of research to decision-making and practice in ASC.

Breadth and depth

Not all decision-makers are able to take on the role of EC as described above, for example elected members, senior managers, and commissioners. The RPPs are primarily directed at frontline practitioners, but all RiRs will hold a wider remit to work with other groups of staff, including senior managers, commissioners and (in local authorities) elected members. These individuals have important gatekeeping, assessment and decision-making roles that impact directly on which services are commissioned, who receives services, and the content, quality and acceptability to users and carers of services provided. Activities will also engage a range of services users and carers with experience of the diverse services provided by partner agencies.

Over the course of the project, RiR will take a lead responsibility for one or more specific areas (*e.g.* a service area, commissioning, analytics or working with elected members). This will ensure that we identify commonalities and differences in developing evidence-based decision making within different areas of social care.

Detailed arrangements for the involvement of RiR in each agency will be finalized once the project commences, but discussions with partners have identified a number of strategies that they think will enable the RiR to build their understanding of: the cultural and organisational structures of participating agencies; the organisational cycle of planned decision-making and those decisions that have to be taken more speedily, and the (often competing) priorities and the pressures that constrain the use of research. These include observing meetings of the following groups, reading past (unreserved) minutes, and one-to-one meetings with key individuals with a view to identifying where research-use might improve decision-making:

- The ASC Senior Management Team
- Relevant Cabinet Committees
- Service Commissioners
- Executive Directors and other pan-authority/agency staff (to explore where ASC senior managers could best leverage research)

This will ensure that we identify commonalities and differences in developing evidence-based decision making within different areas of social care. In consultation with these groups, and working with the research team, the RiR will trial a range of strategies designed to be responsive to the needs of these decision-makers.

Table 1: Core activities of ConnectED RPPs

Role	Core activities	Aims
RiR	Identifying and appraising research	Facilitating access to research
	Sharing with EC and subsequently the team or relevant group of practitioners	Modelling critical appraisal
	Collaborating with ECs, Service Users and Carers to identify key messages and interpret research	Capacity building – knowledge translation and better understanding (for RiR) of the practice context
	Identify training needs and facilitate access to external training (*e.g.* provided by ARC WEST); inform the development and delivery of training by applicants; help to deliver evidence master classes and problem-based training sessions to wider staff.	Capacity building – skills and knowledge
	Working with ECs or other social care staff to develop feasibility studies	Building a research pipeline
	Data collection WP1+WP3	Identifying what works in enhancing research use and capacity building
EC	Identifying areas of practice or decision-making that could benefit from research	Identifying and prioritizing need for research to inform decision making
	Knowledge translation and application to inform decision-making and practice in different ASC contexts and needs.	Interpreting for context Making research accessible to colleagues
	Identifying training needs for self and wider ASC staff and (later in project) delivering evidence master classes and problem-based training sessions to wider staff.	Capacity building - improving knowledge and skills
	Identifying areas needing to be better understood or evaluated	Building a research pipeline
	Working with EC and other social care staff to plan and conduct feasibility studies	Building a research pipeline
	Cascading good practice in research use	Capacity building in the organisation
	Data collection WP1+WP3	Identifying what works in enhancing

		research use and capacity building
Service Users + Carers	Identifying areas of practice or decision-making that could benefit from research	Identifying and prioritizing need for research to address SU+C needs
	Collaborate on research synthesis, feasibility studies and knowledge translation	Supporting focus on SU+C needs and implications for impacts on different populations
	Contribute to training social care staff on involving SU+C in research and evaluations	Capacity building – skills and knowledge
All	Take learning to external events	Securing wider dissemination and impact

RiR and their agency partners will meet with members of Service Users and Carer Advisory Panel and the academy on a bi-monthly basis to share experiences, discuss challenges and potential solutions. This forum will also provide an important source of data for the process and implementation evaluation undertaken in WP3 (see below).

Student placements We hope to offer placements to student practitioners on professional courses (*e.g.* social work, occupational therapy) that would combine frontline practice with the opportunity to work alongside an EC. This seems an important step in shifting the culture of social care. Preliminary discussions with Social Work England (social work regulator) indicate that this is something they will consider endorsing as long as we can ensure that students meet their qualifying learning objectives. If funded, we would explore this further with other regulators and partner agencies.

5.5 Work package 2 (WP2) – Fostering research-practitioners and growing an evidence-based culture

It is generally acknowledged that training initiatives *per se* rarely lead to behaviour change. For example, individuals may bring pre-existing beliefs about the relevance of research in decision-making, or the feasibility of incorporating it into decision-making in a timely manner. However, whilst not *sufficient* to bring about change, enhancing knowledge and skills may nonetheless be important components in developing the capacity to use research. There is evidence that training is most likely to be effective when coupled with the opportunity to engage in ‘in-house’ projects that link directly to professional roles,[28] particularly in the context of a supportive organisation such as that provided by the partner agencies in this proposal. The RPPs are designed to link the building of capacity in research use with activities that link to participants’ professional roles. Such ‘hands-on’ experience provides an opportunity to practice and develop skills in ways that promote self-efficacy.[29] Self-efficacy theory, first developed by Bandura[29], suggests that we are more likely to behave in particular ways when we believe that we can ‘perform’ a particular behaviour (*e.g.* find relevant research, interpret it, apply it) and when we are confident that by engaging in that behaviour we can bring about the intended outcome (*e.g.* improved assessment or decision-making). Self-efficacy is therefore associated with motivation and behaviour change. An individual’s self-efficacy can be developed in a variety of ways, and we hypothesize it is important in both building capacity and setting the foundations of sustainable change.[30,31]

This work package builds on the work of the RPPs in WP1 and is designed to develop a cadre of knowledgeable research-active practitioners who will be competent to undertake applied research that could *i*) provide useful information for performance monitoring within their agencies and *ii*) provide the basis for the development of a pipeline of research. This ‘learning-by-doing’ approach (see below) reflects an evidence-based approach to innovation and organisational change, sits well with the capacity building in evidence-based decision-making (and in research understanding), and further develops the research capacity of practitioners and managers. WP2 does not impact significantly on cost, because it capitalizes on some already funded resources.

WP2 Aims and objectives

The aims of WP2 are to build capacity amongst front-line ASC decision-makers in the knowledge and skills required of research practitioners and initiate the beginnings of a research pipeline. The specific objectives of WP2 are to:

1. Develop skills in designing and undertaking small projects that will contribute to their development as research practitioners.
2. Provide opportunities for social care workers to be involved in other activities essential to developing a research pipeline.
3. Involve social care workers in developing proposals for relevant ASC research for submission to external funders.

Approach

'Learning by doing' is the key principle in WP2. Activities will involve social care workers at all levels of the organisations, including social workers, occupational therapists, reablement workers, care workers and analysts. Each RPP will be encouraged to identify *either* an area of practice or service innovation that would benefit from a comprehensive synthesis of the available evidence, *or* a service innovation or current policy or practice for which no relevant or sound evidence-base currently exists. For services where no adequate evidence is currently available, the Partnership may decide to conduct exploratory research which could establish the need for careful evaluation, thereby potentially forming the basis of an application for externally funded research (*e.g.* a feasibility study of an innovative idea, or a pilot study of a service for which little or no evidence is available).

The areas of work will be determined by the ASC agencies and are likely to be different in the different agencies, although some may be common across the Partnership as a whole. There will be flexibility to respond to emerging needs during the project, but our partners have identified several candidate areas for RPP pilots:

i) Summarising evidence for the effectiveness of the '3 conversations' model[26] (also known as strengths-based or asset-based working[32]) and what works in implementation. This might then be followed by identifying what works / does not work in each ASC area and undertaking knowledge mobilisation activities to ensure that frontline workers have the best evidence to inform their practice in their local contexts.

   Why? It responds to the concerns of frontline workers, service users and carers about this new way of working and its impact on service users and carers.

ii) Evidence synthesis of the effectiveness of new technology proposed to enhance or replace usual packages of care, and promotion of feasibility studies and implementation and pilot evaluation of changes in practice.

   Why? New 'problem solving' technology is regularly suggested, and often introduced without due attention to the evidence about its effectiveness, or unintended consequences *e.g.* social isolation.

iii) Evaluating mandatory service improvements such as the Liberty Protection Safeguarding services (due to start in October 2020).

   Why? Social care workers and service users and carers are concerned to understand how it is implemented and whether it is effective and proportionate.

iv) Synthesising evidence around staff retention and other strategies for maintaining a stable and well-functioning workforce.

   Why? Recruitment and retention are key issues for local authorities and providers of services. Skill development and job satisfaction are recognised as important, but little is known about how best to achieve *and sustain this* within the ASC context.

v) Developing routine data collection and associated analysis to produce evidence on social care outcomes and resource use to inform decision-making.

Why? The nascent ICS spanning the three LAs has led development of a data warehouse for linking routine activity data across health and social care providers. It is also developing routine data collection on quality of life measures (the ICECAP capability measures[33-36]) for people with frailty. Extending ICECAP capability data collection to people accessing social care may provide the basis for promoting outcome-orientated social care provision, and provide a test of asset-based policy models. This work, which entails applying research evidence on outcome measurement to ASC settings, in combination with analysis of resource use, could emerge as a major theme for this study. This is because use of quality of life measures in social care services has typically been limited to setting-specific instruments such as the Adult Social Care Outcome Toolkit (ASCOT) measures.[37]

RPP teams will meet with members of the PPIE advisory board and the Programme Board on a bi-monthly basis to share experiences, discuss challenges and potential solutions. This forum will also provide an important source of data for the process and implementation evaluation that is described in WP3, and for the development of key lessons for wider application beyond the partnership.

Focusing on costs and cost savings

We know from research on the use of research evidence by commissioners in healthcare settings, that decision-makers may give little, if any, weight to research evidence. We will seek to use co-production methods to explore how research evidence, including economic evidence, can be better utilised by decision-makers to inform service innovation.

Hugh McLeod will seek to support pilot participants to engage with outcome assessment, in addition to considering cost consequences. This could then be taken forward as part of a larger funded study to assess cost-effectiveness. The content of the pilots in WP2 will be determined using co-production methods. Nevertheless, for example, the '3 conversions' intervention is a candidate pilot for WP2 (pilot (i)), since this intervention is being widely adopted, with expectations raised about its potential to generate cost savings. However, the current evidence base is limited to local councils' internal evaluations. Although the NIHR SSCR has funded a study due to start in January 2021 (https://www.sscr.nihr.ac.uk/projects/p157/), it is not designed to assess cost-effectiveness. Hence, within the scope of this study we will promote use of new data collection to facilitate better understanding of the potential impact of the '3 conversions' intervention, beyond potential short-term direct cost savings. This will include, for example, raising awareness of the ICECAP capability measures (included in WP2 pilot (v)). The use of ICECAP measures to understand clients' experience of quality of life over time may prove helpful in seeking to address the question "How do we distinguish between someone who has been offered effective non-formal support, linked to his or her community, and is now thriving, from someone who has been denied the care they need and is not thriving?".

Candidate pilot (iv) addresses staff retention. If this is progressed, we will assess the extent to which national analysis of staff recruitment costs are applicable to our participating LAs. It may be that national estimates underestimate the direct costs for providers. Furthermore, we will seek to support the pilot's Research Practice Partnerships to explore staff retention within a wider 'system-level' perspective. For example, training care workers to identify and report early signs of clinical deterioration, could contribute to a reduction in emergency admissions to hospital, and various intervention models have been developed. In this scenario, it may be cost-effective to pay a premium to care workers who take on this proactive role, which may consequently improve retention rates. This pilot could undertake some early modelling of such a scenario in terms of costs and outcomes, not only for ASC providers, but the wider health and care system. This activity could inform development of a subsequent feasibility study.

If the pilot (v) is taken forward (likely), this will provide an important focus for promoting economics within this study, both in terms of more comprehensive analysis of costs, but also quality-of-life outcomes for clients (including ASCOT and ICECAP measures). This work will provide a basis for raising the profile of cost-effectiveness analysis, which would most likely be taken forward as part of funding applications made on the basis of a number of RPP pilots developed.

More generally, Dr MacLeod will advise on systematic reviews that include economic data of any kind, and on the design of pilot studies designed to explore the potential cost-saving of innovative or new-to-this-agency services.

We anticipate that opportunities will arise for Dr MacLeod to work with service commissioners and senior managers.

Building a research pipeline

The work described above will form the basis for developing research proposals that can be submitted to external funders, as well as relevant NIHR and Research Council fellowships. Practitioners undertaking research synthesis or feasibility/pilot studies (mainly, but not exclusively ECs) will be mentored by the RiR and a member of the research team, and the project will ensure that other capacity building opportunities within the region are made available. For example, ARC West provides training courses which will be open to ECs, and the research team (applicants) will provide the research expertise to assist them to conduct small scale practice evaluations. This will enable social care workers of any background to work alongside experienced researchers and learn about conducting applied social care research. The RDS can support graduate social care workers (including social workers, care nurses and occupational therapists) to start developing their own research proposals and accessing NIHR funding for those new to research, such as the pre-doctoral fellowship. Staff will also be able to draw on other resources from the partners in this project (the CRN and the CCG), on online resources being developed by the School for Social Care Research (SSCR) and NIHR Learn (specifically research resources for social care). Two of the applicants are SSCR Fellows and the CI is currently working with NIHR to develop appropriate training resources.

5.6 Work Package 3 (WP3) – Assessing impact and identifying lessons learned

Partnering RiRs with ECs with the aim of influencing the use of research in decision-making is a complex social intervention, as is seeking to build a cadre of practitioners able to design and undertake in-house primary research. Understanding how the intervention (WP1+WP2) is implemented, supported, and received will be critical to interpreting the impact of the project as a whole. WP3 is designed to do this, and to help the Partnership to sustain improvements in the use of research in decision-making, to lay the foundations for further developments and to provide a reference point for new partnerships (including interdisciplinary and intersectoral partnerships) seeking to embed research use in their work. It will also help in building capacity across the participating agencies to generate practice-relevant, robust research proposals.

WP3 Aim and objectives

The aim of WP3 is to explore what works in increasing research use, for whom, in what respects and in what circumstances. It has three main objectives:

1. To determine the project's impact on research use and practice.
2. To identify the facilitators, barriers and mechanisms of change and sustainability.
3. To determine the extent to which the Partnership has developed its capacity to support a pipeline of research proposals to external funders, in order to increase the evidence base for social care.

Whilst the RPPs will be taken forward in broadly similar ways in each agency, implementation and the mechanisms of change (both intended and unintended) may differ within each organisation and across organisations and these differences are important to understand. It is in this sense that the proposal forms a natural experiment, in which the experiences of participating organisations can be compared and contrasted, and nuanced lessons learned regarding what organisations might need to consider when engaging in change endeavours of this kind.

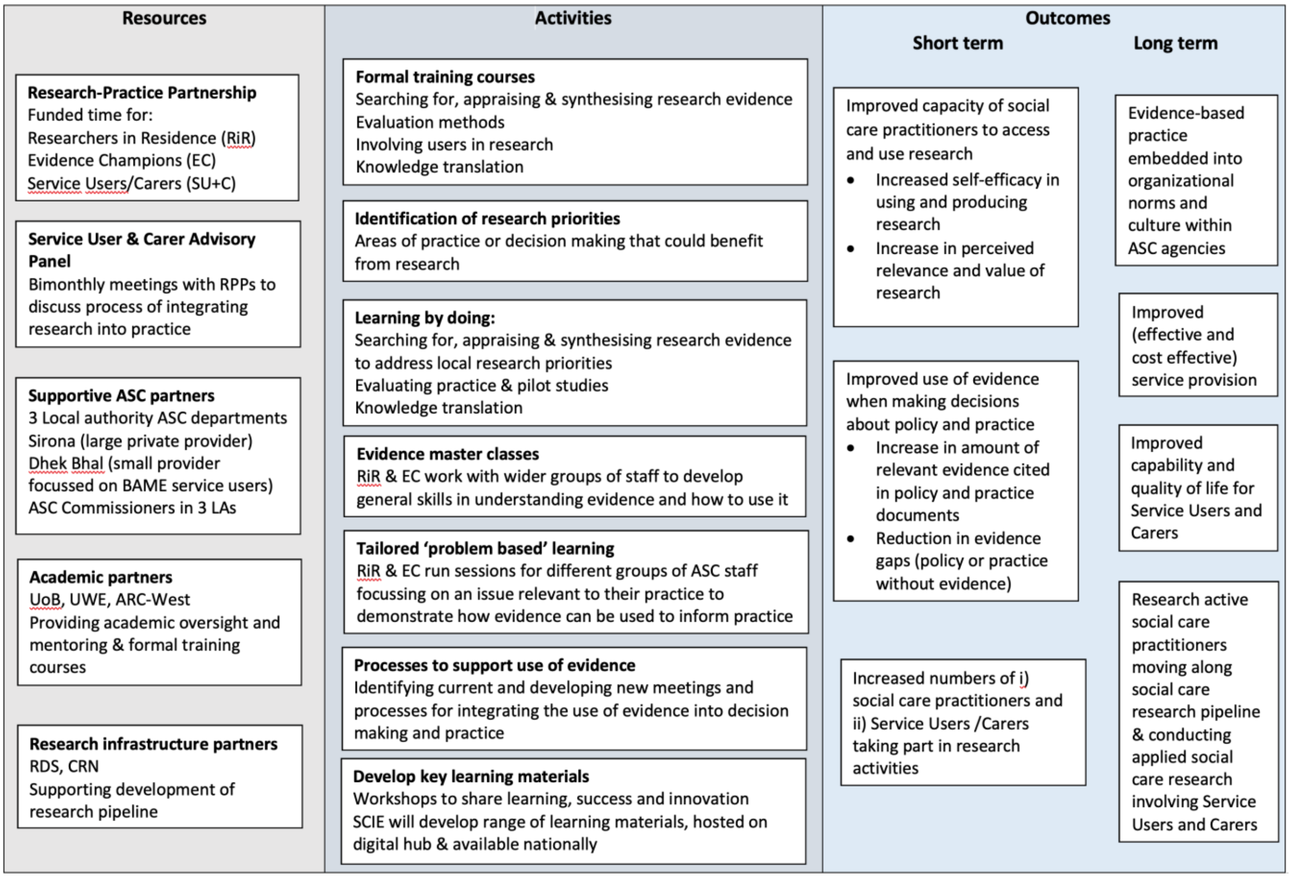
Approach

Because interventions (including change endeavours) are known to be significantly influenced by the contexts in which they are introduced,[38] this work package will follow a realist evaluation methodological framework,[39,40] which will enable us to examine the relationship between:

- the **contexts**[38] in which the programme is delivered (**C**). This includes any factor other than the intervention (the RPP) that nonetheless influences its effectiveness in some way.
- the **mechanisms**[41] (**M**) that are thought to intervene between the introduction of RPPs and their intended outcomes. They are often not possible to observe directly but can be investigated and may be intended or unintended. Examples include organisational processes and structures and the cognitive, emotional and motivational responses of key stakeholders, such as the RPPs.
- and **outcomes**, (**O**) *viz.*, the nature and extent of the RPPs in achieving change in research use within different groups in different situations.

Context-Mechanism-Outcome (CMO) In line with good practice, we have formed some CMO hypotheses regarding what mechanisms are likely to operate, the contexts in which they might operate and what one would find if they operated as expected (outcomes). These will be refined in discussion with participating agencies at the outset of the project and will help to direct the investigation and analyses. They will be revisited in light of the findings. Our programme theory (see Figure 1) posits that *i*) building capacity to use and produce research evidence at an individual, interpersonal and organisational level and *ii*) strengthening the relationship between practitioners, researchers and service users and carers, will result in improved evidence-based decision making and practice. The key mechanisms thought to achieve this are that: RPPs will not only increase belief in the relevance and value of research but also increase self-efficacy and ability to use and produce research, by involving practitioners, service users and carers in the identification of research priorities and co-production of research activities (syntheses, evaluations) and learning activities (evidence master-classes, problem-based learning), supported by key skills training.

Figure 1: ConnectED Initial Programme Theory



Resources

Research-Practice Partnership
Funded time for:
Researchers in Residence (RiR)
Evidence Champions (EC)
Service Users/Carers (SU+C)

Service User & Carer Advisory Panel
Bimonthly meetings with RPPs to discuss process of integrating research into practice

Supportive ASC partners
3 Local authority ASC departments
Sirona (large private provider)
Dhek Bhal (small provider focussed on BAME service users)
ASC Commissioners in 3 LAs

Academic partners
UoB, UWE, ARC-West
Providing academic oversight and mentoring & formal training courses

Research infrastructure partners
RDS, CRN
Supporting development of research pipeline

Activities

Formal training courses
Searching for, appraising & synthesising research evidence
Evaluation methods
Involving users in research
Knowledge translation

Identification of research priorities
Areas of practice or decision making that could benefit from research

Learning by doing:
Searching for, appraising & synthesising research evidence to address local research priorities
Evaluating practice & pilot studies
Knowledge translation

Evidence master classes
RiR & EC work with wider groups of staff to develop general skills in understanding evidence and how to use it

Tailored 'problem based' learning
RiR & EC run sessions for different groups of ASC staff focussing on an issue relevant to their practice to demonstrate how evidence can be used to inform practice

Processes to support use of evidence
Identifying current and developing new meetings and processes for integrating the use of evidence into decision making and practice

Develop key learning materials
Workshops to share learning, success and innovation
SCIE will develop range of learning materials, hosted on digital hub & available nationally

Outcomes

Short term

Improved capacity of social care practitioners to access and use research
- Increased self-efficacy in using and producing research
- Increase in perceived relevance and value of research

Improved use of evidence when making decisions about policy and practice
- Increase in amount of relevant evidence cited in policy and practice documents
- Reduction in evidence gaps (policy or practice without evidence)

Increased numbers of i) social care practitioners and ii) Service Users /Carers taking part in research activities

Long term

Evidence-based practice embedded into organizational norms and culture within ASC agencies

Improved (effective and cost effective) service provision

Improved capability and quality of life for Service Users and Carers

Research active social care practitioners moving along social care research pipeline & conducting applied social care research involving Service Users and Carers

Methods

Not all relevant contexts (or influences) can be identified in advance, but we anticipate that relevant contexts will include organisational context, staff groups, service user groups and stakeholder priorities. For example, organisational and process differences between local authorities, and between local authorities and our large private provider Sirona and our small private provider Dhek

Bhal, may influence the ways in which the RPPs operate, and the extent to which they influence the intended outcomes. Similarly, mechanisms may work differently for different staff groups (*e.g.* occupational therapists *versus* social workers *versus* reablement workers); different service user groups (with different needs or cultural backgrounds) and the type of practice questions (*e.g.* locating and using evidence to inform a technical intervention to help a limited population might be different to finding evidence to inform a change in commissioning). The data we propose to collect will enable us to consider these contexts and others that may emerge and to investigate how each influences the operation of mechanisms for change, *e.g.* do the RPPs enhance research use and build capacity and if so, how and under what conditions.

Data collection

In year 1, data collection and analysis will be conducted by the RiR located within each agency, in collaboration with the applicants (the research team). This will provide each RiR with the opportunity to liaise with key staff and elected members and sensitize them to some of the challenges that 'their' agency faces in integrating research use into their decision-making. The RiR and a member of the research team will present summaries of early findings to the Service User and Carer Advisory Panel to enable the panel to participate in data interpretation. This work will inform the development of agency-specific CMO hypotheses about which features of the context they consider most likely to influence how the RPP is likely to work, for whom, in what ways, and how best this should be assessed. In year 3, data will be collected by an expanded research team comprising one of the applicants plus an RiR and one or more ECs from a partner agency other than their 'own'. This will maximize researcher independence, ensure an efficient use of resources, and provide additional research experience to the ECs, who will be mentored by the co-applicants.

WP3: AIM 1 - Determining the project's impact on research use

Work Package 3 – which runs throughout the project – is the mechanism for evaluating the overall success of the project, including WP2.

When the project begins, and before the RPPs are operating, the applicants will work with participating agencies to identify the aims and objectives that each wants to achieve in relation to research use by the end of the funded work. At the same time the RiR will review key policy and practice documents produced by each partner agency. These documents will be read to identify the range and nature of all types of research cited in support of policies and practice. This exercise will be repeated at the end of Year 3 of the study. In scope will be all the documents within the previous three months which describe current policy and / or practice, and the minutes or other records of meetings in which policy or key service/practice decisions are made at a senior level.

At both timepoints, all those with responsibility for ASC decisions will be asked to complete a short, anonymous, online survey. Areas covered will include the perceived (ir)relevance and value of research evidence, the use of research, the perceived challenges in its use, what factors would make research use easier or more likely. Face validity of the survey will be piloted with a small group of staff. Prize draws within Partner agencies will be used to encourage participation, and steps will be taken to minimise the burden on participants of data collection.

Early in the project we plan to establish *agency-specific indicators* of success in discussion with relevant stakeholders, but what follows is an indication of the objective indicators we anticipate for the project overall, including Work Package 3 - learning by doing.

We are mindful that WP3 is – and in the context of the brief – can only be, an observational study, which necessarily limits the rigour with which we can assess impact.

Learning by doing – indicators of success

- In years 2 and 3, each RPP identifies at least one area of practice or service innovation for which they believe there is currently no robust evidence, and work alongside the RiR to search for relevant reviews/evaluations.

- In years 2 and 3, each RPP conducts a systematic review of the evidence in relation to at least one area of practice, demonstrating an understanding of the core principles of research synthesis (narrative).
- In years 2 and 3, each RPP conducts a pilot evaluation of the quality or effectiveness of one area of service delivery (or commissioning), demonstrating an understanding of the core principles of relevant study design, data collection, analysis and findings.
- Each pilot evaluation undertaken results in a briefing paper summarising the study and its results for managers and other staff.

Numerically, these are *minimum* indicators. It may be that within the local authorities, these activities are repeated over a number of areas or issues.

Overall success

Impact It is quite difficult meaningfully to separate practice from culture in public service organisations.

We will measure impact on **organisational culture and practice** by triangulating several objective indicators measured at the start and end of the project including:

- The frequency and diversity of evidence used to inform decision making, including peer-reviewed research and literature reviews (assessed in relation to: minutes of the Senior Management Teams, Relevant Cabinet Committees, Service Commissioners, Care Plans [if accessible]. An increase over time would be judged an impact on practice and culture). In an effort to determine the impact of natural trajectories, we will, wherever possible, examine documents in the preceding three years, to determine the 'direction of travel' of each of the participating agencies.
- The use of evaluation of service innovation (including design and analysis of impacts). An increase over time would indicate an impact on practice.
- The numbers of research projects or topics for research development generated by the project. An incremental growth over the course of the project would indicate impact on culture.
- Closer involvement of service users and carers in the design and interpretation of service evaluations (would indicate impact on culture and practice)

Part of this work will look at the degree to which economic considerations are incorporated into commissioning and policy decision making at the start and end of the project. This will include not just cost savings, but also improved outcomes for clients and assessment of cost-effectiveness. The economic aspects are discussed more fully in our response in section 4 below.

More specifically in relation to **practice** we will use a combination of interviews and standardised measures to evaluate before and after changes in the following:

- self-efficacy in using research (interviews/survey)
- perceived relevance, value of research (survey, interviews)
- increased use of research in decision making (key stakeholder interviews)

Sustainability

Indicators of the sustainability of impact will include:

- The number of research proposals generated by the project (upward trajectory).
- Continuing upward trend in increased practitioner capacity toward the end of the project (numbers attending training, knowledge of evidence base, numbers of own research projects developed).
- Change in research culture measured through survey of attitudes and beliefs of practitioners and commissioners,
- Sustained upward trend in uptake of research findings to inform decision making

- Integration/continuation of the role or function of evidence champion within the agency at the end of the project.

  Incorporation of the importance of evidence-based practice/research use into the job description /person specification of social care practitioner posts, where appropriate.

WP3: AIM 2 - Identifying the mechanisms of change

We will use semi-structured interviews to explore how key informants think about research and its use in informing key decisions, their views about RPPs and responses to it over time. Interviews will follow a topic guide designed to test our provisional programme theory and our hypothesized CMOs. The topic guide will cover participants' perceptions of the project, aims and objectives, implementation processes (RPPs, secondments, master classes etc), contextual factors (including participants' views and experiences of using research to inform practice, perceived concerns), resources (*e.g.* the reach of RPPs and ECs, time, support from colleagues, management) and mechanisms that enabled or hindered increased use of research in decision-making (*e.g.* resources for service delivery, funding). Interviews will also cover perceptions of the impact of the study on service users' outcomes and resource use, and key areas where evidence is seen to be absent and needed. The guide will be flexible enough to enable participants to raise unanticipated issues.

Interviewees will be purposively sampled to capture a diversity of backgrounds, roles and seniority (from management to frontline workers), experience of both social care (fewer and greater years of service delivery or use) and research (no and some previous experience). The sample will comprise up to 45 informants drawn from social care workers, managers, analysts, elected members and members of the Service User and Carer Advisory Panel. Interviews will be conducted in months 1-3, 18-21 and 36-42. Interviews will be conducted by a RiR working in an agency other than that in which they themselves are embedded in years 2 and 3. With consent, interviews will be recorded.

WP3: AIM 3 - Success in developing a research pipeline

The Project provides a variety of opportunities for identifying research gaps: within the work of the RPPs; during the annual 'whole partnership' workshops; the regular meetings of the Partnership Management Group (PMG) and the Service User and Carer Advisory Panel. The latter, in particular, will provide an opportunity to consider new policy (and other) developments and the implications for local decision-making. These will be documented in the minutes and collated by the Joint-CIs. RiRs will record all research gaps identified in WP2 and each RPP will document the initiatives (pilots) they undertake, using a standardized proforma to support ease of data collection. The results of those projects will be considered by the PMG and Service User and Carer Panel with a view to identifying those that are appropriate to develop into applications for external funding. At the end of the project, these will be reported, together with any results. The interviews conducted in this WP will also explore the processes in place and attitudes towards sustaining this kind of approach.

Analysis plan

Data will initially be analysed as set out in Table 2. We will then categorise the contexts, mechanisms and outcomes for each agency using a bespoke form and coding using NVivo Software. Data will be analysed on both a 'whole project' and agency basis, identifying similar and/or opposing patterns across the five agencies and examining different contexts within each agency, using data triangulation and pattern matching.[40,42]

We will investigate the extent to which the same causal mechanisms play out in different contexts and how these relate to the short-term outcomes of interest, namely perceived value of research, increase in research use, improved decision-making (closer links with evidence) and engagement in research.

Table 2: Overview of initial approach to each kind of data collected

Data type	Analysis
Documentary data	Gaps will be identified, and systematic patterns of use/non-use will be identified. Baseline and follow-up data will be compared to see whether there are changes in the number or type of evidence cited or in the gaps or patterns

	of use/non-use
Survey data	Descriptive data will assist in the identification of differences within and across agencies and how these change over time.
Interview data	Anonymized transcripts will be imported into NVivo qualitative data analysis software. Analysis will begin shortly after data collection starts and will be ongoing and iterative - informing further data collection and identifying changes needed to the topic guide. Thematic analysis[43] will utilise a data-driven inductive approach to identify and analyse patterns and themes of particular salience for participants across the dataset, using constant comparison techniques.[44,45] A subset of transcripts will be independently double coded by co-applicants; any discrepancies will be discussed within the team and resolved to achieve coding consensus and maximal rigour. Initial findings will be discussed with the Service User and Carer Advisory Panel, before being finalised.

6 Dissemination, outputs and anticipated impact

All applicants want to make a difference to social care service users and carers, and to improve the use of research amongst social care staff and their organisation. The aspiration is shared by the agencies collaborating with us on this project. We therefore take knowledge transfer and matters of impact seriously. The development of this proposal has taken an integrated knowledge management approach *i.e.* its impetus came from those leading social care services, and key stakeholders in each agency have influenced its development, as have service users and carers. All three workpackages have been designed with regard to their feasibility and perceived impact. Workpackage 3 will assess impact and distil learning about what works (or does not) in building capacity in research use, in what circumstances. This section provides an overview of our current thoughts about dissemination, outputs and anticipated impacts. A detailed ‘Pathways to Impact’ plan will be developed alongside the programme theory, and revised throughout the project as new insights or evidence emerge.

Dissemination

The study will be carried out in a transparent and inclusive manner with full dissemination of activities and findings.

6.1 Sharing learning within the partnership We will present our findings to those who have collaborated with us as co-producers and participants and incorporate their feedback into the final report and any future research proposals. We will prepare a short, accessible briefing for staff, service users and carers – something this team does well.

6.2 Academic outputs: In addition to the end of study report for NIHR we will submit a report of the study to the open access, interdisciplinary journal *Evidence and Policy* and submit papers based on key aspects of the project to relevant sector journals, such as *Health and Social Care* and *Implementation Science*.

6.3 Wider dissemination and engagement with the sector Our key stakeholders include a wide range of social care practitioners, as well as service users and carers. We will present the results of our work at relevant sector conferences, such as the Summer Conference of the Directors of ASC, the annual National Children and Adult Services Conference (NCASC) and the Local Government Association Conference. Our partner SCIE is well placed to support the widest possible dissemination of our findings. Nationally, SCIE is the ‘go to’ place for information in a wide range of accessible formats. The following indicate its reach (as of July 2020):

• SCIELine regular e-bulletin receivers	120,000+
• Contacts on database	270,000+
• Twitter followers	39,000
• LinkedIn followers	15,000
• Facebook followers	8,000
• YouTube followers	5,000
• YouTube watched minutes per month	210,000+

- e-Learning course delegates 13,000

SCIE's resources are also used by organisations that carry influence and who are pivotal in maximizing the potential impact of the project on policy and practice. These include the Association of Directors of Adult Services, Public Health England, Making Research Count, Research in Practice for Adults (RIPFA), and the Care Quality Commission. SCIE will use a range of channels to raise awareness of, and promote the use of, the resources emanating from this programme, including:

- Annual webinars to engage the sector with new resources (*e.g.* they recently ran a webinar on the evidence of scaling innovation in ASC)
- Promoting project resources through their e-bulletin, Facebook, LinkedIn and Twitter
- Hosting resources and blogs on their website
- Promoting resources at major conferences, including the annual National Children and Adult Services Conference (NCASC) and Local Government Association Conference.

We will also develop short videos for dissemination *via* twitter, and briefings for Social Care Elf.

Knowledge mobilisation and Impact

6.4 Impact within participating local authorities

This project will build on existing processes and structures to maximize the impact of the project on decision-making and practice within and across the Partnership. The following provide details of current plans, but these will be developed or flexed to accommodate each organisation's particular circumstances. In each local authority, there are regular meetings of different types of staff at which short (<20min) presentations of research findings /evidence summaries can be made, including:

- Operational Management Group attended by Senior Practitioners & Management
- Group supervision of Senior Practitioners
- Team huddles to discuss local practice innovation (Senior Practitioners and frontline care workers)
- Bristol 'Making it happen' meetings (monthly)
- North Somerset informal 'lunch & learn' meetings

RPPs will take part in meetings such as the 'Team huddles' and 'Making it happen' to discuss their work with wider groups of social care workers. In addition, they will establish new 'knowledge mobilisation' meetings as needed *e.g.* lunchtime webinars recorded on zoom, or similar. Such presentations are just the first step in achieving impact, and RPPs will elicit social care workers' questions and concerns and engage them in discussion of likely barriers and facilitators to implementation. Further, RiRs and/or ECs will shadow front line workers to observe existing practices (*e.g.* 3 conversations model[26]) and new service innovations developed as a result of evidence summaries produced by the project. These observations will provide insight into how these practices are implemented, the effort and resources used, barriers to implementation and strategies for overcoming them. Findings of these observations will be discussed at further discussion meetings with front line workers and fed back to management. In this way, social care practitioners (from frontline workers to senior management) will be engaged in developing processes for successful implementation of evidence-based practice in the local context.

In order to maximize learning across the three local authorities and delivery partners Dhek Bhal and Sirona, the Partnership will host four workshops during the project, bringing together participants from research, practice, users and carers. Each workshop will highlight a specific area of social care and provide an opportunity to share learning from WP1 and WP2 about how research can inform practice, to identify the implications for practice and future work, and to share innovative practice. Presentations and webinars will be recorded for sharing through public channels such as YouTube.

The project's Host Organisation (see below) will work with the partners to explore the potential for leveraging the lessons learned in terms of commissioning services within the region.

6.5 Impact beyond the Partnership

We will use SCIE's expertise and resources to facilitate knowledge mobilisation beyond the partnership and the life of the project. SCIE will build a micro-site on its website to promote the learning from the project, build a repository of resources, share new resources and any other learning, *e.g.* videos, blogs and case studies. SCIE has exceptional reach and experience this area: for instance, SCIE hosts a site for the DHSC-funded Social Care Innovation Network, which it co-delivers with Think Local Act Personal, Social Care Future and Shared Lives Plus; it has already produced a range of tools and resources to support the adoption of evidence-based policy, for instance the NICE/SCIE Quick Guide on strengths-based practice.

We recognise that dissemination alone has had very little impact in this area, and we plan to explore other mechanisms that are more likely to raise the value placed on research use and generation within ASC. The project is supported by the Care Quality Commission (CQC) and, building on this project, the academic PI will work with David James (Head of Adult Social Care Policy, CQC) to explore the possibility of incorporating a measure of research culture into the inspection of local authority adult services, and how this might best be undertaken.

6.6 Possible barriers for further research, development and implementation

The most likely barrier to the take up of 'lessons learned' about how best to increase research use in ASC is the financial circumstances of local authorities and provider agencies, staff shortages or major reorganizational change. However, insofar as research use is important to high quality decision-making, and to improving outcomes for service users and carers, these are barriers that need to be tackled. We hope to demonstrate that it is possible to build capacity in research use amongst ASC workers in ways that can be sustainable within supportive organisations. We hope to identify minimal or zero cost sustainable changes that can help organisations value research and its use. Essentially the EC role, with high level backing from CEOs and Commissioners, is key to this. Of course, it inevitably reduces some time available for front-line work, and we would hope to be able to evaluate the cost effectiveness of this approach in a future study.

6.6 Beneficiaries

The ultimate beneficiaries of this project will be service users and carers in the agencies involved and, longer term, in other ASC services. Section 6 and the programme theory indicate how we think this can be achieved. We also think that 'growing' a body of social care workers, service users and carers who have the confidence and skills to access, interrogate, challenge and use research will help in the identification of research priorities and the assessment of researchers' proposals.

7. Timeline - Calendar year/quarter (see GANNT chart for further detail)

2021/Q2: Project initiation + Programme Management Group (PMG) meetings; Programme theory refined, risks and mitigations identified; RPPs established; baseline data collection for WP3 begins.

2021/Q3 – 2024/Q2 Baseline data collection for WP3 completed (2021/Q3). WP1 (RPPs) begins; mentors allocated to ECs, fortnightly learning sets for ECs begin; priority topics for RPPs identified and initiated; dissemination and within-agency impact initiatives commence (WP1 continues with rotation of ECs + Service User and Carer partners, as determined within agencies).

2022/Q1-2024/Q2 WP2 (learning-by-doing) commences. Projects identified; bimonthly meetings (RiRs, ECs, HEI staff, Service Users and Carers); training, opportunities for funded research projects identified and developed. Interim Key Information Interviews conducted and analysed.

2024/Q4 – 2004/Q2 Final data analyses, preparation of reports and outputs; resources and tools placed on SCIE website; End of Project Dissemination Plan agreed.

Milestones [Month/42]. Agency Programmes and Programme theory agreed **[3]**; WP1 commences/RPPs begin work **[4];** WP3 Report on Baseline Data Collection completed **[6]** Progress Reports on WP1 **[9, 15, 21, 27, 32, 38]**; WP2 Commences [**10**]; all RPPs working on a project **[13]**; progress reports on WP2 **[17, 23, 29, 35]**; draft report on WP3, interim and post-project data discussed with Key Stakeholders **[39]**; report finalized and submitted **[42]**.

8. Programme management

The study will be led by Macdonald and project managed by Cabral. Both have experience in managing complex projects, including research. Macdonald is a Senior Fellow for the School for Social Care Research and National Social Care Lead for the NIHR Clinical Research Network (CRN). The research team will meet fortnightly in Year 1, and monthly in years 2 and 3, unless more frequent meetings are indicated. Most meetings will be virtual, to reduce travel and time costs and to minimise risk of disruption caused by subsequent recurrences of COVID-19.

A Programme Board, comprising representatives of the agency partners (see above) and representatives of the Service Users and Carer Panel, will be chaired jointly by Hugh Evans, Director of ASC in Bristol and a member of the Service User and Carer Advisory Panel. The Board will meet four times a year to oversee the project, share best practice, and identify priority areas for research and other work. It will receive quarterly reports from the RiRs and the academic leads for the Work Packages. Day to day oversight of the work will sit with the Macdonald and Cabral, who will meet at least monthly with co-applicants.

8.1 Host organisation

The Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) is the system leader for integrated services in the region. Given the importance of commissioning and the move towards closer integration of health and social care, this organisation is well placed to host this project. The CCG has led a Partnership approach to *Knowledge Mobilisation* across the NHS, the three Local Authorities, the two local Universities and linking with the CRN, the Applied Research Centre and Academic Health Science Network. The aims have been to co-develop service-led research and to embed evidence into practice across our local health system. BNSSG CCG is established as the most successful CCG in this endeavour.[46] This proposal aims to do the same for social care research.

The CCG has established a research hosting function which spans organisations and includes staff jointly employed by the CCG, the University of Bristol and UWE, as well as posts based within the three Local Authorities of Bristol, North Somerset and South Gloucestershire. The CCG, in partnership with the CRN, acts as the research governance office for the Local Authorities. As such, the CCG is very well placed to ensure both engagement and dissemination within the integrated services which are the focus of this application. The Lead Applicant (Macdonald) has an existing honorary contract with the CCG.

8.2 Monitoring and mitigation of risks

8.2.1 Overall approach to risk

The monitoring arrangements identified above include senior representatives of each partner organisation, plus a member of the BNSSG CCG. At the outset of the project, and as a matter of good practice, we will develop a risk register within the partnership, covering the project as a whole, and dealing with the individual circumstances of each participating agency. Identifying, managing and mitigating risks is a routine practice of all participating agencies and has been a key feature of Macdonald's work in various roles, including as a Business Director of the Commission for Social Care Inspection, as Director of a research institute, as Chief Investigator of a number of large projects, and Trustee of the University of Bristol and various charities.

8.2.2 Project dependency on staff and managers' buy-in. This issue was specifically raised by the Prioritisation Committee in its letter dated 22nd January 2020.

The decision to submit this proposal emerged from discussions within the Bristol Social Care Research Forum (see 5.3). The Director of ASC in Bristol then invited the Directors of North Somerset and South Gloucestershire to join the partnership, along with invitations to Sirona and Dhek Bhal. Bristol has since appointed a new Director of Adult Social Care who is equally supportive of the proposal. In recent months, all of our partners have given this proposal time and attention despite the challenges for them presented by COVID-19, and this is evident in their letters of support, which make clear the buy-in from management, the commitment to release staff to act as ECs and their willingness to host the RiRs. We therefore rate the issue of buy-in from senior management and commissioners (see below) as low risk and high impact. However, we propose the following actions to realise this assessment.

If funded, we will draw up a Memorandum of Understanding between the research team and the participating agencies which will set the framework for the work detailed in the proposal. This will include:

i) what can be expected of the RiR and what they can expect from their agency

ii) the generic role of each EC in respect of protected time (duration and mechanisms to ensure), responsibilities, support and other capacity building activities

iii) the generic role of Service Users and Carers (SUC) in relation to the SUC Advisory Panel and SUC Reps and a clear protocol when difficulties arise, including an agreed escalation route.

These core expectations will be personalised for each EC and SUC involved in the project and, in the case of ECs, countersigned by their Line Manager.

8.2.3 Project dependency on staff buy-in. We have experience of encountering problems when senior managers ‘volunteer’ staff for projects on which they themselves have not been consulted. We would currently rate this as a moderate risk with high impact. In order to mitigate this risk, which may particularly affect front line staff, the applicants plan a range of engagement activities at the beginning of the project to engage and involve all staff, and at various points throughout (to ‘refresh’, to troubleshoot and to address the issue of staff turnover). Experience suggests that these actions will help reduce this to low risk, and the location of RiRs within agencies will also help to reduce this.

8.2.4. Impact of COVID-19 We recognise that COVID 19 may place constraints on some of the planned activities *e.g.* some of the pilot studies in WP2 may need to be adjusted in order to accommodate the need for distanced working, but systems for managing this aspect are already in place within the agencies. The economic impacts of COVID-19 might impact on the scope for adopting newly identified evidence-based approaches to policies and working practices, but equally they may make it all the more important to identify efficient and effective ways of working. Contingency plans for on-line alternatives to face to face activities are in place. We would currently rate future impact of COVID-19 as high risk, but given the steps already taken, moderate to low impact, depending on the particular activity. A detailed Risk Register will unpack these and be monitored carefully using established RAG reporting by the appropriate ‘risk owners’.

9. Ethical Approval

Ethical approval will be sought from the relevant REC for WP3 and any exploratory studies conducted as part of WP2, all of which will be conducted in accordance with the principles set out in the UK Policy Framework for Health and Social Care Research. The requirements of individual local authorities and the detail of their research governance arrangements will vary, and we will initiate early conversations with each local authority to ensure their requirements are met. The following considerations apply to all aspects of the project, but particularly WP3.

9.1 Consent, confidentiality and anonymity Care will be taken to ensure that all interviews are conducted with freely given, informed and written consent. We will use clear, accessible, and well-drafted documentation to introduce the study to potential study participants. All participants will be given an assurance that all information they provide will be treated confidentially, except in relation to any safeguarding issues They will also be assured that no information will be used in any report that could identify them. Details about individual cases will be forgone or disguised to comply with this. Where data might identify an individual (for example a head of service describing something unique to their authority), specific consent from that individual will be obtained. The names of those participating will not be known outside the research team. We will discuss with the participating local authorities at the outset whether they wish to be named in any report or subsequent dissemination.

9.2 Disclosure and safeguarding Whilst unlikely, it is possible that in the course of an interview a respondent may disclose information that indicates a threat to their welfare or that of others. The Participant Information Sheet will make clear that in such circumstances the interviewer will be obliged to inform the appropriate authorities.

9.3 Data management Data will be managed in accordance with the University of Bristol's Research data management and information security policies. Standard operating procedures will be developed to ensure that data capture is complete, accurate, reliable, and consistent. All data will be stored on the University's Research Data Storage Facility (RDSF), with anonymised data stored separately from any information that could identify participants. Only authorised users can access data stored within the RDSF.

The RDSF provides nightly backup of all data, with further resilience provided by three geographically distinct storage locations. A tape library is used for backup purposes and also for long-term, offline data storage. All data held on portable equipment, such as laptops, memory sticks or digital audio-recorders will be risk-assessed, encrypted and password-protected. Such data will be moved onto the secure server within an agreed number of hours, and the data deleted form the portable equipment.

10. Patient and Public Involvement and Engagement (PPIE)

The study will be informed throughout by the involvement of the public through two mechanisms: a PPIE Advisory Panel and PPI representatives. These mechanisms will enable the views of service users, carers and community organisations to inform the progress of the project at operational and strategic levels.

The PPIE Advisory Panel (in this proposal known as the Service User and Carer Advisory Panel) will provide expert opinion and advice from the community on each stage of the project. Members of the Advisory Panel will be selected on the basis of their own expertise in different fields of ASC. They will be comprised of representatives from a range of different client groups and therefore bring in a broader range of perspectives. Panel members will be recruited from all the project partners, including the LA agencies, Sirona and Dhek Bhal, a community based social care organisation that focusses on the needs of the South Asian community. They will include people who have personal expertise in different areas of adult social care, and representatives from community support organisations in each field (*e.g.,* adult mental health, older adults, dementia, carers, physical disability, learning disability). At all points, we will be alert to the ways in which different user characteristics and demographic profiles may impact on appropriate choice of research topic, and on their implementation, evaluation, interpretation and generalisability.

The Advisory Panel will meet bi-monthly to consider the fields of practice to focus on, receive progress reports and address challenges from the research sites, decide on pilot projects, advise on recruitment and consent materials, contribute to the analysis of findings and assess the accessibility and acceptability of written and training outputs.

Third sector organisations will be invited to join the advisory panel, and advertisements will be sent out through Voscur, an umbrella organisation of third sector organisations.

The team has already had successful working relationships with third sector agencies across a range of different fields including Milestones (learning disability), St Monica's Trust (older people), Age UK (older people), Brandon Trust (learning disability), Second Step (mental health), Princess Royal Trust (carers), Bristol Black Carers (carers), and Bristol Reclaiming Independent Living (physical disability). Dhek Bhal plays a role in advocating for the wider BAME community and thought them we will be able to invite representatives from the South Asian and Afro-Caribbean communities.

One member of the Advisory Panel will attend, and have voting rights on, the Programme Board. Advisory Panel members will be recruited through placing advertisements on the People in Health West of England (PHWE) website, supplemented through existing channels known to the research team.

PPIE Reps (in this proposal known as Service User and Carer (SUC) Reps) will be recruited to contribute to the work in each partner agency, alongside the RiR and the EC. They will be recruited on the basis of relevant personal expertise in the targeted area or topic, and will receive training through PHWE and the study learning sets. At all points, we will be alert to the ways in which different user characteristics and demographic profiles may impact on appropriate choice of research topic, and on their implementation, evaluation, interpretation and generalisability.

SUC Reps will be funded for half a day per month, to be used flexibly between learning sets and meetings with the RiR and EC. For example, it might consist of a single half-day meeting, or a two-hour meeting plus two half-hour telephone calls. The Reps will ensure that the client perspective is reflected in decisions about the areas of research to prioritise, designing and delivering workshops, and identifying pilot projects. SUC Reps will co-deliver progress reports to the SUC Advisory Panel in their bi-monthly meetings.

The SUC Advisory Panel and SUC Reps will ensure the SUC (PPI) perspective will contribute to the delivery of the study in each of the Work Packages below:

WP1: The SUC Advisory Panel will be recruited and offer views on the particular fields in adult social care that will be the focus of the research sites. PPI Reps will be recruited on this basis and work with the RiR and EC to identify the priority area of research, to appraise and present the research to decision makers, and report on progress to the PPIE Advisory Panel.

WP2: SUC Reps will work with the RiR and EC to co-produce the workshops, including deciding on which specific area to focus, the design of the workshop, co-delivering the workshop and assessing the accessibility of outputs.

WP3: SUC Advisory Panel members and SUC Reps will be asked to consider how best to obtain consent for observations of meetings for evaluation. Research materials for the evaluation will be reviewed by the PPIE Advisory Panel for acceptability. The SUC Reps will contribute to decisions in each research site about the ‘theory of change’ model and contribute to the processes of data collection and analysis, mentored by the co-applicants. SUC Advisory Panel members will consider early findings and accessibility / applicability of outputs.

The SUC strand will be coordinated by Symonds and has been developed through conversations with members of the University of Bristol Service User and Carer Forum. The Forum was set up in 2004 and is co-chaired by a Forum member and a member of staff (currently Symonds). The model proposed here was based on an initial proposal from a Forum member, supplemented by additional suggestions from PPI leads in the NIHR. The application has been reviewed by members of the Forum and feedback used to make further amendments.

11. Project/Research expertise

The research team brings multidisciplinary expertise and skills relevant to all aspects of the work proposed. **Macdonald**, **Symonds** and **Willis** hold recognised social care qualifications, and **Jones** has a practice background in community development. All have experience of co-production with service users and carers. **Cabral** brings expertise in service evaluation, research synthesis, qualitative methods and capacity building. She has extensive experience of project management writing for lay audiences, including several blogs translating research findings. **Cameron** is a Senior Fellow of the NIHR School for Social Care Research (SSCR) and brings expertise in inter-professional and interagency working in a range of social care settings, and an important aspect of commissioning and service delivery. She is an experienced evaluator and is also the social care expert on the NIHR Research for Patient Benefit panel for the South West. **Jones** brings expertise in public health and social care workforce development, the role of service intelligence, data integration and digital systems relevant to ConnectED. His methodological expertise spans realist evaluation of complex programmes and services, including social care; local policy analysis and implementation research and co-production with service users and social care professionals. **Macdonald** is a Senior Fellow of the NIHR SSCR and National Speciality Lead for Social Care in the NIHR Clinical Research Network. She specialises in the evaluation of social care and other interventions and brings expertise in research synthesis and implementation science, and knowledge translation. She previously worked for England’s Social Care Regulator, the Commission for Social Care Inspection, where she was Business Director for Information and Knowledge Management. **McLeod** is an economist whose focus is on how economics can be used to inform local decision-making. He is currently researching the use of ICECAP capability measures to promote outcome-oriented provision by commissioners of health and care services, and will lead on the work with commissioners. **Symonds** is conducting research on older men at the margins and outcomes in ASC assessments. He has a long-standing interest in marginalised groups, such as fathers with learning disabilities, and in co-production. He will support Service User and Carer (PPI) involvement throughout this study. **Willis** specialises in ASC research, with a particular focus on older men's experiences of loneliness and social isolation; sexuality, care and ageing; trans ageing and gender identity.

Collaborators: In addition to the participating agencies, we are collaborating with the Social Care Institute for Excellence to realise our plans for dissemination and impact, within and outwith the partnership. Commissioners from all 3 local authorities have also agreed to collaborate, namely: Bristol (Carol **Watson**, Head of Adult Care Commissioning and Lucia **Dorrington**, Principal Commissioning Manager), South Gloucestershire (Jon **Shaw**, Head of Commissioning, Partnerships & Performance) and North Somerset (Gerald **Hunt**, Head of Commissioning, North Somerset).