This protocol has regard for the HRA guidance and order of content

FULL/LONG TITLE OF THE STUDY

Peninsula Adult Social Care Research Collaborative (PARC): Embedding research into practice to improve social care outcomes

SHORT STUDY TITLE

Peninsula Adult Social Care Research Collaborative

ACRONYM

PARC: Peninsula Adult Social Care Research Collaborative

PROTOCOL VERSION NUMBER AND DATE

- Version 2, August 22 2022

RESEARCH REFERENCE NUMBERS

IRAS Number: IRAS 311195

FUNDERS Number: NIHR 133629

SIGNATURE PAGE

The undersigned confirm that the following protocol has been agreed and accepted and that the Chief Investigator agrees to conduct the study in compliance with the approved protocol and will adhere to the principles outlined in the Declaration of Helsinki, the Sponsor's SOPs, and other regulatory requirement.

I agree to ensure that the confidential information contained in this document will not be used for any other purpose other than the evaluation or conduct of the investigation without the prior written consent of the Sponsor

I also confirm that I will make the findings of the study publically available through publication or other dissemination tools without any unnecessary delay and that an honest accurate and transparent account of the study will be given; and that any discrepancies from the study as planned in this protocol will be explained.

For and on behalf of the Study Sponsor:

Signature: S Jones

Date:
...23./...08./.2022.

Name (please print):

Sarah C. Jones

Position: University of Plymouth Sponsor Representative, Research Governance Specialist.

Chief Investigator:

Date: 22/08/2022

Penelope Welbourne

……………………………………………………………………………………………

LIST of CONTENTS

KEY STUDY CONTACTS

Insert full details of the key study contacts including the following

Chief Investigator	Penelope Welbourne, Associate Professor of Social work University of Plymouth 07963512590 p.welbourne@plymouth.ac.uk 01752 586636
Study Co-ordinator	Laura Gill laura.gill@plymouth.ac.uk 01752 764879
Sponsor	Sarah C. Jones plymouth.sponsor@plymouth.ac.uk 01752 585339
Funder(s)	National Institute for Health Research
Key Protocol Contributors	Penelope Welbourne, Associate Professor, University of Plymouth p.welbourne@plymouth.ac.uk Rod Sheaff, Professor, University of Plymouth Rod.sheaff@plymouth.ac.uk Sheena Asthana, Professor, University of Plymouth s.asthana@plymouth.ac.uk Richard Byng, Professor, University of Plymouth Richard.byng@plymouth.ac.uk Jill Mansthorpe, Professor, Kings College London Jill.mansthorpe@kcl.ac.uk Julian Elston, Research Fellow, University of Plymouth j.elston@plymouth.ac.uk Felix Gradinger, Research Fellow, University of Plymouth Felix.gradinger@plymouth.ac.uk Rachel Purtell, PPI / Expert by Experience expert advisor R.A.Purtell@ex.ac.uk

Committees	Independent Advisory Group / Study Steering Committee Chair – Professor Hugh McLaughlin, Manchester Metropolitan University.

STUDY SUMMARY

Study Title	**Peninsula Adult Social Care Research Collaborative (PARC): Embedding research into practice to improve social care outcomes**
Internal ref. no. (or short title)	**Peninsula Adult Social Care Research Collaborative (PARC)**
Study Design	**Summary** Mixed methods exploratory 'proof of concept' study. This is a mixed methods study with embedded researchers-in-residence working with practitioner researchers in adult social care, and with experts by experience providing input, including as co-researchers. Research includes a phased design, with three work packages that are partly overlapping. The research uses a mixed methods approach to data collection using semi-structured interviews, focus groups and workshops, ethnographic observations of naturally occurring events, studying service data and publicly accessible material including findings from service evaluations and other existing evidence. **Research questions**: 1. Is the embedded Researcher in Residence (RR) model an effective method for sustainably increasing social care research capacity? 2. Is the embedded RR model an effective method for generating agile, timely and generalisable social care research? 3. Is the embedded RR model an effective method for improving social care practice in terms of service user and carer wellbeing, and cost-effectiveness **Background** This project addresses the long-standing problem of the scarcity of evidence on which to base social care practice and work cultures in which this is under-valued. Demographic changes, rising

	expectations for personalised care, growing inequalities and the impact of challenges such as Covid-19, are placing more pressure on commissioners and providers of social care to develop effective and efficient services **Aims** 1. To carry out a proof of concept study to test the feasibility of setting up embedded research teams in adult social care, and, 2. To test feasibility of co-producing generalisable research knowledge of local and national relevance through embedding research teams in social care organisations **Objectives** • Investing in ‘Practitioner Researchers’ and Researchers in Residence to create social care agency -based research expertise in embedded research teams; • Developing a cross-area research collaborative structure including senior social care staff, commissioners, providers, service users and carers / members of the public, and researchers to support the embedded teams; • Carrying out nationally relevant robust studies of local innovations and/or implementation of evidence informed practice changes. The project will have three overlapping Work Streams (WS) leading to completion at 48 months, with the aim of testing the potential of embedded research to establish sustainable positive change in participating agencies and enhance knowledge mobilisation. Two nested packages of research will test the potential for this approach to stimulate and support rigorous locally relevant research. They will be coproduced with stakeholders, including service users and carers. Rigorous formative and summative evaluation will assess the ability of the networks to respond in an agile and timely way to adult social care challenges, and the capacity of the embedded teams to produce generalisable social care research. Two evaluation streams: one formative, Action Research based, and the other summative, with an arms’ length element for a clean room analysis, will gather data on the effectiveness of this approach to stimulate and support research activity in adult social care and its potential for wider implementation.
Study Participants	Staff working in adult social care, primarily in two local authorities (LA) (Devon and Torbay) with the possibility of consulting with staff

	in other (non-NHS) social care settings and consulting with service users and carers.
Planned Size of Sample (if applicable)	Context This project is based primarily within two local authority settings. It involves experienced researchers and practitioners and managers of social care services. It also involves consultation with a range of stakeholder groups, including employees of other services that deliver social care; people who receive social care services, or care for someone who receives such services, and people who volunteer for organisations that support people in receipt of social care. We will engage with social care professionals as widely as possible in different ways (interviews, invitations to focus groups, invitations to research meetings, consulting about service provision issues and priorities, etc.) according to interest, position in their organisation and availability of their time. The involvement of all service users / experts by experience will be as participants or advisers to the study: the study is about the culture and practice of use of research in social care. None of them will be 'research participants' or 'research subjects' in the sense in which those terms are commonly used. All will be adults who will have been able to give informed consent to taking part, having been fully briefed about the project. Participation will be voluntary, transparent and following establishing that they understand the project and wish to take part in it. All participants (expert by experience participant advisers and social care professionals), whether they are involved in one to one or group interviews, focus groups or observation of their everyday activities e.g. team meetings, will be given a copy of the Participant Information Sheet for service users and carers / experts by experience or practitioners, as relevant, and invited to consent, in writing, using the relevant consent form for practitioners or experts by experience. The researchers in residence or practitioner researchers will be responsible for ensuring this is done in an open, non-pressuring way and is recorded with a signature from the participant. We will also obtain organisational consent for the involvement of all staff who engage with the project. Sample size We intend to involve as many relevant staff in the LAs as possible from different positions in the social care agencies, and with different levels of involvement according to interest and time availability.

	We also intend to recruit 6 service user /carer representatives to be actively involved as researchers or consulting to the research. The study will have within it two ‘nested’ research projects, one led by each study area, in which service users and carers will be involved (potentially as co-researchers). Identifying the adult social care issues to be researched is part of this wider PARC project. To this end, a wider group of service users and carers / experts by experience will be invited to engage with us, but they will not be research subjects in the sense in which the term is usually used (see above). They will not be the subject of the study, nor will any data be collected about them other than identifying their status as a stakeholder (e.g. ‘carer’) and those views and experiences they wish to share with us.
Follow up duration (if applicable)	Not applicable.
Planned Study Period	16 months
Research Question/Aim(s)	Research Questions 1. Is the embedded Researcher in Residence (RR) model an effective method for sustainably increasing social care research capacity? 2. Is the embedded RR model an effective method for generating agile, timely and generalisable social care research? 3. Is the embedded RR model an effective method for improving social care practice in terms of service user and carer wellbeing, and cost-effectiveness? Aims 1. To carry out a proof of concept study to test the feasibility of setting up embedded research teams in adult social care, and, 2. To test feasibility of co-producing generalisable research knowledge* of local and national relevance through embedding research teams in social care organisations. (*Note – the reference to co-produced research relates to both this overarching study, and two ‘nested’ research studies (subject to be determined as part of the wider study) which will be the subject of separate ethics applications. Determining the topics for these nested research studies is part of the embedded researcher in residence role in the overarching study which is the subject of this application.)

FUNDING AND SUPPORT IN KIND

FUNDER(S) (Names and contact details of ALL organisations providing funding and/or support in kind for this study)	**FINANCIAL AND NON FINANCIAL SUPPORT GIVEN**
National Institute for Health Research **Research for Social Care (RfSC)** **rfsc@nihr.ac.uk**	**£572,000**

ROLE OF STUDY SPONSOR AND FUNDER

The Sponsor for this study is University of Plymouth represented by the designated Sponsor, who is Ms. Sarah C. Jones. Email: Sarah.C.Jones@plymouth.ac.uk. Postal Address University of Plymouth, Drake Circus, Plymouth Devon PL4 8AA.

Neither the sponsor nor the funder will be involved in study design, conduct, data analysis and interpretation, or manuscript writing. NIHR will be consulted about any alterations e.g. to timescale because of the impact of Covid 19, but not the design of the study as approved for funding. If the Sponsor or Funder raised any concerns about any aspect of the study design or its implementation, this would be taken seriously and the study would not go ahead against advice from either, but responsibility for the design of the study and its appropriate and ethical implementation remains with the research team.

We shall use communication through NIHR networks to discuss progress of our project and share emerging results with projects with a similar area of interest, e.g. those funded from the same NIHR funding stream. University of Plymouth may wish to facilitate dissemination of results through its own website.

ROLES AND RESPONSIBILITIES OF STUDY MANAGEMENT COMMITTEES /GROUPS & INDIVIDUALS

Aim: To outline any committees or groups involved in study coordination and conduct.

Study Steering Groups

- Independent Advisory Group / Study Steering Committee: Chair – Professor Hugh McLaughlin, Manchester Metropolitan University. Biannually. Membership approved by NIHR, with a majority of independent members

Throughout the project and in all workstreams we will hold (in addition to Expert Advisory Group meetings):

1. Research governance meetings in each area every two months to support establishing the team and developing networks, review progress, consider proposed areas for research, problem solve. Attended by PR, RR, supervisors of researchers, core research team representative/s and organisation manager or their representative. Independent of sponsor and funder, not independent of investigators.

2. Quarterly meetings of the Stakeholder Advisory Group for the embedded teams from both areas to meet together, together with experts by experience (EE) and relevant stakeholders to engage, explore ideas and concerns and plan future / ongoing EE involvement in research activity and implementation (note that EE who become actively involved in research may have much more contact: these meetings are for all interested EE) – these may be held virtually or face to face. Independent of sponsor and funder, not independent of investigators.

3. An annual event to involve all stakeholders, partners, EE, organisation senior managers, research champions and the research team including PIs and all co-PIs and partners in both areas; to review progress, plan future research end explore common interests/ concerns/ ways of working together in research and implementation of findings. Independent of sponsor and funder, not independent of investigators.

4. Independent Expert group, made up of advisors holding senior positions in different social care professional backgrounds and academic posts and Experts by Experience. None have any connection with the research or the bid which led to the funding of the research, although the Experts by Experience may be people who have involvement with the project and therefore have an interest in the scrutiny process. Members of the research team will be invited to speak to the Group, particularly the PI and co-Pi, but it is chaired and conducted independently of sponsor and funder and investigators. Reports directly to NIHR, the funder. The brief for this Group is to provide robust review and feedback to the research team.

RRs and PRs in each area would have supervision meetings on a fortnightly basis (which are envisaged as a mix of face to face and online), and training and mentoring from the core research team and access to Plymouth University teaching resources.

A process of embedded teams discussing and reviewing each other's work across the areas will, in our experience, promote ownership, and helps in building relationships face-to-face (for example in eHealth and Social Care Productivity and Innovation Cornwall (EPIC)) and is based on work previously conducted across Sustainability and Transformation Partnerships (STPs) in the region.

Research training will be delivered through supervision, seminars, and attending courses at the University of Plymouth (Level 7 research modules). If PRs or their employers wish to fund assessment as well as attendance, together these modules carry 40 M level credits in research.

Learning activities across both sites will facilitate mutual support for research and identification of areas of research interest. Each site would have access to research support and mentoring for the RRs and PRs and others to be involved in research streams, including EE, from the core delivery team, support from senior applied researchers on the wider project team and the NIHR Academy. Funds have been included for attending additional training or conferences, and fund participation in existing (e.g. 'Making Sense of Evidence' training and sessions on qualitative interviewing events delivered by NIHR ARC South West) as well as tailored training for RRs, PRs and EEs.

We will also hold Weekly Team Review meetings, open to all researchers: Chair – PI / co-PI. Not independent.

Patient & Public Involvement: ***Linking embedded teams to experts-by-experience****:*

EE input in the drafting stage is described elsewhere. During the process of the study EEs will continue to be central to research, having a dual role. EE will have roles in each of the three work streams: to work as part of the embedded teams to maintain a research focus on new ways of working that can benefit service users and carers; to make a significant input into research planning, bid writing, and development, and to contribute to the evaluation of the embedded research model. EE have told us that a focus on independence not dependence, on the support needs of carers, on transitions within and between care systems, and person-centred accessible systems that avoid repetitive assessment, are important to them. This has given us a valuable orientation that we shall use from the outset in thinking about the kinds of research areas to consider in the collaborative and coproduced research process. Insights from our EE collaborators will inform the research approach to understanding the questions researched.

We are aware that we need to go beyond relying on established groups of service user and carer representatives. We will seek to contact and make productive engagements with representatives of less heard service user groups, such as members of minority ethnic groups (arguably little heard in the South West), service users with learning disabilities, and carers of self-funding older people.

EEs will support us in a range of knowledge exchange and research planning activities, including evaluation, implementation and dissemination. They will be actively involved in research as far as any individual wishes to do so, including as consultants and co-investigators on research projects. We have included funding for training to support EE in engaging with this project, and are committed to supporting their progression to active involvement and leading research with support according to interest and scope for such involvement.

Specific members of the research team (FG and RP) have a brief to ensure recruitment and support for EE is effective and ethical in its approach. RP is a consultant and collaborator on the project, and is a nationally respected expert on involving EE in research. She will support, train, challenge and advise on training for EE throughout the project. Lead for PPI/EE is Dr Felix Gradinger, the PPI co-applicant is Rachel Purtell (University of Exeter).

EE collaborators will have consultation roles: a smaller number of EE will (if they choose) be members of embedded research teams and project governance. PPI activities will focus on two stages in particular: 1. Co-Design: consultation on design of the research projects, and 2. Co-production: analysis, outcomes and dissemination. PPI activity (input and outputs) will be considered in the evaluation of the overall 'Proof of Concept', to which process EE will also be contributors.

In the first stage, relationships will be built through a wide range of people being consulted, including those who need support to have their voice heard and understood, in accordance with the NIHR guidance. Initially people will be invited from the two Local Authority areas, Torbay and Devon, using statutory and third sector public involvement networks and meetings (e.g. Local Authority Involvement and Equality Teams, carer evaluators, Living Options Devon, The Turning Tides Project, Healthwatch Devon volunteers etc), and (depending on the topic areas) topic specific national organisations. This will create two opportunities: firstly, to recruit a diverse group of 10 EEs, five from each LA area, to give feedback at quarterly meetings. Secondly, to seek six EEs, three from each LA, to become part of the Embedded Research Teams to co-produce the later stages of the research, including through qualitative data analysis, dissemination and reporting (including attendance at conferences and local events).

Embedded research teams and EE members will receive training to support EE, co-ordinated by FG and RP (i.e. using the PIIAF, NIHR and SCIE resources as a framework for engagement and an evaluation tool). EE co-producers/researchers will receive research methods and ethics training. As well established in co-production of research, everyone on the research team will be bound by the same ethical protocols, confidentiality, and best practice standards.

The project has a dedicated budget to deliver this, applying PenARC rates of £50 for preparation and attendance per half day, plus any expenses to EE to attend governance meetings, training events, meetings, conferences and take part in research. An accessibility fund takes account of the fact some EE may need additional support for attendance, e.g. enabling digital access through pay -as-you go phones, child-/respite-care, using taxis rather than public transport.

Anyone who takes part in the overarching study that is the subject of this application will be given an information sheet about the project, and we will ask participants to sign an agreement to take part in the study and have the information they share with is used anonymously. They will all have contact details for people to whom they can speak if they have any questions, concerns, or wish for further information e.g. at follow up. For our PPI collaborators this will also ensure they have information about their eligibility to make expenses claims.

EE will be participants in (2) and (3) above, invited as collaborators and / or co-researchers, according to their role in the project. They will additionally have regular meetings with RP and FG for training in research, support and as experts by experience to be consulted about areas for research in the two nested research projects.

PROTOCOL CONTRIBUTORS

Aim: To describe all the contributors to the protocol.

This Protocol has been written based on the funded application to NIHR (application ref: 133629). It was written by the Principal Investigator (P. Welbourne) following consultation with the Plymouth Sponsor and co-applicants on the study bid.

The funded project was agreed to be funded following amendments made following feedback from NIHR about areas of the design of the study the wished us to reconsider. We also had input at the design stage from the NIHR Research Design Service and research design experts at University of Plymouth. We had specific input from our PPI expert co-applicant Rachel Purtell. The application also benefited from external and internal peer review, see below. We also consulted with a range of service users and carers from different groups (e.g. University of Plymouth's Service User and Carer Advisory Group) when designing the study.

The input from our consultations concerned study design and implementation, the most significant areas of input being around inclusiveness of the study with service users and carers; reimbursement of service users and carers, and training and support for service users and carers who choose to become involved in research. We also consulted with senior staff from our local authority sites concerning feasibility of running the study concerning issues such as accommodation, access to data, releasing staff to take up researcher practitioner roles on a University honorary contract, honorary contracts with the local authority for researchers in residence, and training for practitioner researchers.

Service users and carers will play a key role in the development of the research agenda for the two research projects 'nested' within this overarching one, which will be the subject of independent applications for ethical approval.

KEY WORDS:

- **Adult social care**
- **Researcher in Residence**
- **Embedded research**
- **Practitioner research**
- **Co-production**
- **Research informed practice**

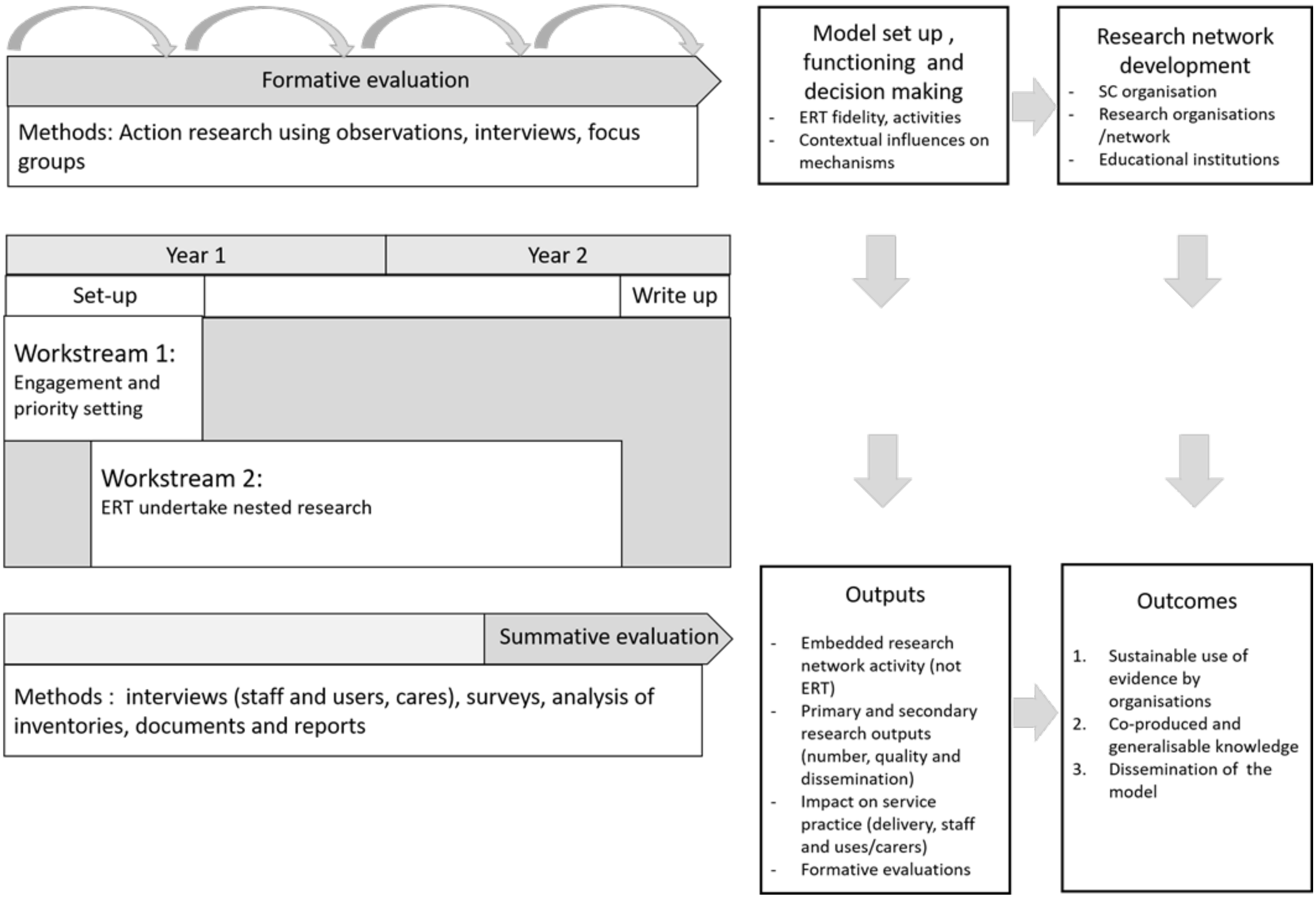
STUDY FLOW CHART

Work streams	Objective	Activity, Milestone, Output					
			3	6	9	12	15
WS1 – (0-6 months) Engagement and	Embedded Research Teams (ERTs)	Recruiting Experts by Experience, Practitioner Researchers, Embedding Researchers-in-Residence, Stakeholder	▨				

		mapping/engagement; Cross-area event (Terms of reference)	▨				
	Training	Training embedded research teams and wider workforce	▨	▨			
	Experts-by-experience	Networking, training, research question prioritisation		▨			
	Prioritisation	Co-design of two research projects in WS2, data sharing agreements		▨			
	Scoping/Knowledge Mobilisation	Rapid reviews/advice, knowledge exchange, baseline analysis performance data (for WS2) / research readiness (WS3)	▨	▨	▨		
WS2 – (3-21 months) Delivering 2 nested research projects	Ethics	Research ethics submission for two cross-site projects (one hosted in each site)	🟩				
	ERTs	Ongoing training, wider workforce development			🟩	🟩	🟩
	Dissemination	Local and national dissemination and networking			🟩	🟩	🟩
	Research	Primary and secondary data collection for two research projects			🟩	🟩	🟩
	Collaborative/ Research bids	Local and national partnership-building, further research bids				🟩	🟩
WS3 – (0-24 months) Formative/ Summative Evaluation	Governance	Stakeholder advisory group, and core project group meetings; independent evaluation (incl. EEs)	■	■	■	■	■
	Formative	Activities and methods of ERTs (Mechanisms), ongoing/iterative	■	■	■	■	■
	Summative	Impact of proof-of-concept (Context, Outcomes of logic model; independent evaluators, EEs)			■	■	■

Flowchart of PARC Workstreams

PARC: Workstream 3 in relation to Workstream 1 and 2



Formative evaluation

Methods: Action research using observations, interviews, focus groups

Year 1 | Year 2

Set-up | Write up

Workstream 1:
Engagement and priority setting

Workstream 2:
ERT undertake nested research

Summative evaluation

Methods : interviews (staff and users, cares), surveys, analysis of inventories, documents and reports

Model set up , functioning and decision making
- ERT fidelity, activities
- Contextual influences on mechanisms

Research network development
- SC organisation
- Research organisations /network
- Educational institutions

Outputs
- Embedded research network activity (not ERT)
- Primary and secondary research outputs (number, quality and dissemination)
- Impact on service practice (delivery, staff and uses/carers)
- Formative evaluations

Outcomes
1. Sustainable use of evidence by organisations
2. Co-produced and generalisable knowledge
3. Dissemination of the model

1 BACKGROUND

This project addresses the long-standing problem of the scarcity of evidence on which to base social care practice and work cultures in which this is under-valued. Demographic changes, rising expectations for personalised care, growing inequalities and the impact of challenges such as Covid-19, are placing more pressure on commissioners and providers of social care to develop effective and efficient services

Users of adult social care have a right to expect services to be based on the best evidence. Research should advise services about what helps people best, and what people say they want and need. Social care providers should also get value for money. Research on how to make this happen is limited and of mixed quality. Our key idea is that when researchers move out of universities and into practice settings, they and the service providers and service users and carers can learn from each other.

Placing researchers in social care organisations and bringing staff, service users and researchers together will help identify important areas for research and make change happen more quickly, to make a difference to the lives of service users and carers. It is important for everyone using services that there is good research about how well they work, but at present this is limited and more is needed. We want to test a new way of making this happen.

The knowledge base for the project / literature review (see also refs. at end of the Protocol)

Knowledge about social care problems and the effectiveness of solutions is limited by several factors. First, the absence of a unified body, such as the NHS, to fund, support, stimulate and demand research to inform practice, and less extensive cohort data are collected relating to social care than in the NHS 6.

Second, adult social care takes place in multiple settings, much of it in private homes or residential settings, staffed by a diverse and low paid workforce, many of whom have limited formal links to further or higher education institutions. Third, many service users' needs are unmet 7, making researching effective solutions challenging, but leaving open the possibility to test innovative approaches across a wide area of social care provision.

Approaches to knowledge transfer remain largely 'top down'. The Alliance for Useful Evidence emphasises the importance of understanding the 'demand side' of evidence users 8. Experts in the field have been emphasising this tension, and suggest considering contextual factors and situational learning for capacity building 9. When it does happen, social care research has a long tradition of community engagement, public involvement and action-based participatory research 10, 11. Although the strengths of public involvement are known in principle, success can be challenged by differences in values 12, paradigms 13 and power dynamics 14 between stakeholder groups. Co-production of research, a specific form of community engagement, is promoted by the Social Care Institute of Excellence and Think Local, Act Personal partnership, among others.

An embedded research approach 15 with researchers based in social care organisations can build on these principles, while mobilising use of theory and knowledge in practice 16, 17. Embedded research is directly invested in the changes it is supporting because it is prompted by problems in the immediate service environment, and researchers can observe change directly 18. Its outcomes depend to an extent on the degree of immersion 19. Furthermore, the service impacts can be estimated, for example in terms of possible cost savings for host organisations 20. It can also be agile: facilitating better and more rapid feedback loops 21.

Relationship-building is not enough to create co-production of useful research 22. Embedded research goes beyond ‘partnership’, aiming to create ‘an evidence ecosystem’, i.e. a research-receptive environment and infrastructure 23. Evidence from the NHS suggests that commissioners’ capacity to absorb and apply evidence involves a process of acquiring new knowledge, assimilating it to existing knowledge, transforming it for application to service development, and using it to evaluate those developments 24. This requires systems for knowledge exchange, socialisation capabilities to promote shared interpretations of that knowledge, and co-ordination capabilities such as ‘cross-functional interfaces’, as well as liaison roles and job rotation.

Practitioner behaviour is shaped by informal networks, collective sense-making in communities of practice and trust 25. Explicit recommendations from experiences in the field include the need to focus on making partnerships work across and within organisations, rather than just focusing on completing ‘projects’ 26. Informed by the evidence on research capacity building 27, 28, we propose that a research receptive environment in social care requires:

- Understanding the ‘demand side’ of evidence use, keeping service user and carer perspectives central.
- A ‘phasing in’ approach, focusing on making partnerships work across and within organisations, rather than focusing solely on completing ‘projects’.
- Networks and collaborations of researchers, including enhanced higher education (HE) – service agency partnerships 29, 30 (https://ise.org.uk), and supporting the role of key intermediaries in embedding and implementing research 31. Networks in general are usually more durable and functional when they emerge from existing practical collaborations 31-38.
- Mentoring and training prospective new research users and researchers; “multifaceted approaches” to teaching 39 and fostering ‘research-minded’ practitioners 40.
- Managerial prioritisation, including funding, of research capacity building 41, 42.

The literature cited above suggests that an embedded research approach might increase both the relevance of research and practitioners’ and managers’ likelihood of mobilising the use of theory and knowledge in practice. In realist terms, the approach that informs our reflective evaluation of the project, this suggests the theory (and corresponding logic model) of embedded research involves the following two mechanisms (with corresponding contexts) for producing those outcomes: embedding researchers-in-residence (RRs) i.e. locating academic researchers within social care organisations; and developing Practitioner-researchers (PRs), i.e. involving practitioners already located in social care organisations to participate and eventually lead applied research projects there. These partnerships and networks would undertake cross-site research. In doing so, both kinds of researchers also model, for their fellow workers, the ways and advantages of putting evidence into practice 43.

Embedding researchers ensures that problem identification and research and evaluation are directed at locally relevant challenges and innovative practice 44. Both kinds of researchers (RR and PR) can then initiate and conduct applied/evidence-applying research; and act as knowledge- and relationship-brokers from within social care, spanning horizontal and vertical organisational and inter-organisational boundaries 45,46, thereby establishing and sustaining research networks (collaborations) both within and between social care organisations and service users and carers.

What we want to do:

We will try a new idea: setting up research teams inside social care organisations. We will develop a network of 'embedded' research teams. Each team will have a social worker trained to carry out research and an experienced researcher, based in the social care organisation. Senior managers, university staff and other research specialists will form part of a wider team to support them, with service users and carers who wish to become involved. Researchers will learn about service delivery, and practitioners will learn how to do research to help improve services. Embedded teams will also build relationships between practitioners and people receiving services. The networks will produce research that will enable services to improve what they do.

How we will do this:

Embedded teams will use a mix of approaches, including training practitioners so they understand better how to improve what they do through research. They will carry out two research projects to help improve services, and find out how well this approach works. Service users and carers will be an important part of this process. Meaningful involvement with a wide diverse group of experts is an integral feature of the project. We will offer training in research and involvement methods to experts by experience and learn from each other. Our co-applicants worked with experts by experience for many years and our team includes an experienced service user researcher who will be an 'independent critical friend'. We will actively involve people who use support and services or are carers both when doing the research and sharing our learning. Evaluating our project – finding out how it is working and finding things that are not working as well as we hoped – is an important part of this study to test out our ideas.

Reaching different people with our work

The research networks will work together to:

- Co-produce accessible research reports, service evaluations, publications and other outputs, which will be shared regionally and nationally;
- Rapidly implement improvements based on research to improve services;
- Provide insight into service problems, leading to research tailored to local need.

Developing future services

This is a 'proof of concept' study', meaning we are going to test these ideas and report back to help other organisations decide whether this approach could help them understand issues in their area and support service users and carers in their area better.

2 RATIONALE

Research plan

This project addresses the long-standing problem of the scarcity of evidence on which to base social care practice and work cultures in which this is under-valued. Demographic changes, rising expectations for personalised care, growing inequalities and the impact of challenges such as Covid-19, are placing more pressure on commissioners and providers of social care to develop effective and efficient services. This issue is common to other settings and professional groups, such as child and adolescent social care, but we have elected to start the study with adult social care as one defined area of work in social care provision, and one which is perhaps the one least well served with evidence at present. It is envisaged this model, if successful, could be utiltised to enhance use and creation of research in other areas of social care, with the possibility of testing transferability and flexible application.

Design: This research comprises building and evaluating research capacity through a range of activities centred on developing networks centred on social work/care practitioner researchers (PR) working together with embedded researchers in residence (RR) in adult social care settings. A realist informed perspective, based on the above logic model, will underpin the identification of the baseline data needed to assess the effectiveness of the embedded research teams, as well as each of the two nested research projects. Data will be collected with a view to understanding what contextual factors affect implementation, and how and why change occurs as well as the enablers and barriers to the development of research in social care organisations. This perspective will also be used to consider what information is needed to understand the impact of the research, including the perspectives that need to be considered, such as those of service users and carers and community groups, to obtain a multifaceted understanding of the impact of the research. A concurrent evaluation will draw upon the above data on the effectiveness of the project to explore mechanisms and contexts (including challenges to implementation) promoting the intended and projected outcomes. We will do this as set out below:

The embedded researchers:

- Access and use line-management relationships, team structures, routine administrative information, inter-organisational links, informal communications networks within their host/employing social care organisation(s) and proximity to services to identify research priorities based on current practice issues and identify internal ‘champions’ for them. Embedding researchers thus ensures that problem identification and research and evaluation are directed at current challenges and innovative solutions.
- Formulate research proposals that are feasible and timely to carry out in their host/employing social care organisation(s), with managerial and practitioner support
- Involve staff, service users, carers, non-statutory and community voluntary organisations and other providers in carrying out the research in ways that are action oriented, participatory, democratic and trust-building. The embedded researchers motivate and help their fellow-workers to access evidence, and it to change their practice in response.
- Readily access internal or closely-networked data sources (e.g. staff, documentation, routine data, service users, carers) for the research
- Complete the research and feed the findings back within their host/employing social care organisation(s)
- Inform and advise practitioners and managers to make any corresponding service changes, on the basis of evidence from research, and consider wider applicability of findings
- Involve greater numbers of permanent staff in research, putting the development of research capability, capacity and activity on a longer-term basis than conducting ad hoc isolated projects does, building organisational research readiness

The expected outcomes of these mechanisms are to:

- Identify new practically-motivated research questions for research projects concerning innovations or service challenges in the participating social care organisation(s)
- Create a sufficiently receptive context to conduct the corresponding research

- Feed the findings back into work-practices and/or managerial decisions in the participating social care organisation(s) (‘research mobilisation‘)
- Motivate other social care workers (besides the embedded researchers) more strongly to become able to access evidence and apply it to change their practice.
- Increase and sustain the absorptive capacity for research in the participating organisations by increasing the number and range of people within them who can, and do, acquire new knowledge, assimilate it into existing knowledge, apply it to service development, and evaluate those developments. We hypothesise that the potential for relatively rapid generation of research results of manifest utility will support the development of interest in further research on the part of practitioners and their managers.
- Use the research findings to identify further potential improvements in service delivery and / or service user and carer outcomes, based on the evidence from the research
- Disseminate the findings into other social care organisations facing similar challenges. The new and existing research together enable an extension of evidence-based social care which itself results in better service outcomes for service users and carers (and for other stakeholders such as the NHS)

Outcomes depend to an extent on the degree of research immersion, which suggests that embedded research will achieve the intended outcomes more extensively, faster, needs-relevantly, cheaply, and sustainably than reliance on external researchers alone 47. However, realist theory suggests that the link between mechanisms and outcomes is shaped by context. In this instance, relevant contexts are likely to include:

- The availability of social care staff able and willing to become practitioner researchers throughout the study period
- Managerial willingness to support the embedded research model and apply its findings during the study period
- Sufficient support in kind (staff time, routine administrative data) and financially to sustain the embedded research throughout the study period
- Independent providers, users and carers able and willing to participate in the research throughout the study period
- The impact of the coronavirus pandemic and its legacy on the feasibility of suitable research projects.

The research question thus arises as to whether, given the right inputs and relationships, the development of embedded research teams can lead to meaningful change in adult social care service organisations with respect to research receptivity, readiness and capacity; and a demonstrable ability to co-produce agile, generalisable high quality research and inform evidence-based improvements in practice.

While we will be testing how far research-informed decision-making, engagement in specific projects and knowledge mobilisation can be achieved by the embedded research model in the lifetime of the study, we recognise the need to examine whether there are indicators this model is sustainable beyond the lifetime of this project. Can this process lead to an enduring shared managerial approach to research and its mentorship, and a commitment to resourcing a supportive research infrastructure? Can local social care organisations balance potential conflicts between e.g. their regulatory imperatives and budget pressures against conducting research that might support innovation (and risk)? By developing, implementing and conducting an evaluation of this novel approach to engaging front line adult social care practitioners and managers in embedded research, we hope to provide some answers.

The context: why this research is needed now

Adult social care has long been described as being in crisis 48 due to strict eligibility thresholds, levels of unmet need are known to be high. Evidence of stress among social workers suggests a workforce under pressure that exits early 49. The Covid 19 pandemic has amplified the fragility of the system, as acknowledged by senior politicians (Health Select Committee 2020). Our start date is during the time when Covid 19 is still a challenge to adult care services, but we believe we shall be able to commence the research shortly as the intensity of demand on service permits organisations to begin to engage with research.

We made a preliminary overview of the state of evidence use in English social care by means of a literature review of the major databases and repositories of research and grey literature (including Pubmed, NICE, SCIE), of academic centres of excellence in the UK (e.g. What Works Centres, Social Policy and Practice), dedicated journal searches (e.g. British Journal of Social Work). Search terms included methodological terms (e.g. ‘participatory research’) in conjunction with terms for ‘adult social care’. The methods included forwards and backwards reference- and citation-chaining, and expert advice. The research to date concerning the development of research mindedness in organisations 50, 51 and literature reviews of knowledge utilisation in social care describes a knowledge-to-practice gap 52, 53. The gap appears to stem, at least partly, from:

1. Social care provider organisations’ engagement in research is often short-term, which impedes emergence of the sustainable partnerships, learning and assessable impact 54.

2. Practitioner behaviour is shaped by informal networks, collective sense-making in communities of practice, and trust 55; which implies that the knowledge-practice gap may stem partly from characteristics of these networks and communities of practice.

3. Patchy alignment between researchers’ research ambitions (on one hand) and (on the other) practitioner and manager motives and needs for evidence-based practice, hence ‘silos’ in social care research between managers and academics 56, exacerbated by academically-produced evidence not necessarily being either relevant to the practitioners’ and managers’ practical needs or available soon enough to address current practical problems.

4. Differences in values 57, paradigms 58 and power dynamics 59 between stakeholder groups, especially the public, practitioners, managers and researchers.

5. Absence of a unified body such as the NHS or NIHR to support, stimulate and demand research to inform practice.

6. Provision in a range of settings, much of it in private homes or residential settings, staffed by a diverse and unstable workforce, many of whom have limited formal links to higher education institutions (HEIs).

7. Many service user needs are unmet 60, making researching effective solutions challenging, but leaving open the possibility to test innovative approaches across a wide area of social care provision.

8. Fragmented, impermanent research activity and capacity 61, 62.

9. Less extensive cohort data is collected than in the NHS 63. UK adult social care data 64 and Nuffield Trust 65 studies emphasise the need for improving the quality of [routine administrative]

data and its analysis to underpin policy and practice in adult social care. Yet when it does happen, social care research has a long tradition of community engagement, public involvement and action-based participatory research 66, 67. The service impacts of applied research findings can be estimated, for example in terms of significant cost savings for host organisations 68, 69.

As this research project is based on a philosophy of co-production, we cannot say which of the many challenges facing adult social care will be the focus of the nested embedded research studies in this project. What we can say is that there is a significant evidence gap with respect to social work practice and a need to improve receptivity, capacity and readiness among local authorities so that they can engage – in the same way as NHS organisations – in the development of evidence-based research and practice 70. For example, only four examples of adult social care guidance are showing on the NICE website for 2019-2020, compared with 36 for clinical care (https://www.nice.org.uk/guidance/health-andsocial-care-delivery/adults-social-care)

See also our discussion of the literature in Section 1 above.

3 THEORETICAL FRAMEWORK

Aim: To describe the theoretical framework for the study.

See also the Logic Model / flow chart above.

We will be drawing on concepts from Action Research, a realist approach to research, and Grounded Theory (this is expected to be of particular relevance in the two to-be-defined nested research projects). We will also be drawing on ideas from knowledge mobilisation theory, since learning about successfully embedding a research culture is one of the key goals of this project.

Organisational learning theory 71, 72 suggests that the uptake of evidence into practice involves action learning at three levels:

1. Service development, resulting in learning about how to adapt or re-organise services for greater benefit to users and their cares ('single-loop learning').

2. Wider learning about what organisation- or network-wide changes are required (e.g. changes in management practices 73, norms, rules and skills training) to help implement the above service developments ('double-loop learning').

3. Learning about how to promote the first two kinds of learning: 'learning about learning' or 'triple-loop learning' about how to acquire and exploit research evidence, in this case through embedded researchers.

Recent studies suggest that the presence of two or more of these conditions helps to increase practitioner and managerial use of evidence, build their capacity to do so, and make research activity more sustainable: in short, to set up the three loops. This is what we aim to achieve through the embedded research project, and its practical application in two nested research projects.

In realist terms, the approach that informs our reflective evaluation of the project, this suggests the theory (and corresponding logic model) of embedded research involves the following two mechanisms (with corresponding contexts) for producing those outcomes:

- embedding researchers-in- residence (RRs) i.e. locating academic researchers within social care organisations; and

- developing Practitioner-researchers (PRs), i.e. involving practitioners already located in social care organisations to participate and eventually lead applied research projects there. These partnerships and networks would undertake cross-site research. In doing so, both kinds of researchers also model, for their fellow workers, the ways and advantages of putting evidence into practice 43.

Our realist approach means that we are looking at what happens as a result of this intervention, and also asking questions as to why and how it affects research-related behaviour in organisations. Context is expected to be an important factor, and we will be documenting:

- The availability of social care staff able and willing to become practitioner researchers throughout the study period
- Managerial willingness to support the embedded research model and apply its findings during the study period
- Sufficient support in kind (staff time, routine administrative data) and financially to sustain the embedded research throughout the study period
- Independent providers, users and carers able and willing to participate in the research throughout the study period
- The impact of the coronavirus pandemic and its legacy on the feasibility of suitable research projects.

The research question thus arises as to whether, given the right inputs and relationships, the development of embedded research teams can lead to meaningful change in adult social care service organisations with respect to research receptivity, readiness and capacity; and a demonstrable ability to co-produce agile, generalisable high quality research and inform evidence-based improvements in practice.

Formative evaluation will be a process evaluation taking place from the outset of the project, focussing on the conditions that influence the feasibility and success of the project at each stage, to establish whether the study gives ‘proof of concept’ of the embedded research model in social care, or not. The realist basis for the evaluation underpins asking questions about the influence context has on implementation, and what makes some elements or areas work better or meet more challenges. An Action Research approach feeds learning back for rapid response to early result.

While we will be testing how far research-informed decision-making, engagement in specific projects and knowledge mobilisation can be achieved by the embedded research model in the lifetime of the study, we recognise the need to examine whether there are indicators this model is sustainable beyond the lifetime of this project. Can this process lead to an enduring shared managerial approach to research and its mentorship, and a commitment to resourcing a supportive research infrastructure? Can local social care organisations balance potential conflicts between e.g. their regulatory imperatives and budget pressures against conducting research that might support innovation (and risk)? By developing, implementing and conducting an evaluation of this novel approach to engaging front line adult social care practitioners and managers in embedded research, we hope to provide some answers.

4 RESEARCH QUESTION/AIM(S)

4.1 Objectives

Our objectives are to:

- Develop a research collaborative in two local authority areas with different profiles and organisational features, which is inclusive of a wide range of stakeholders (senior social work managers, commissioners, frontline practitioners, service users and carers, academics) to support the embedded teams locally and link to national research and opportunities.
- Co-produce detailed research plans and proposals with Experts in Experience (EEs) (users and carers), researcher and service collaborations for the previously identified study outlines addressing adult social care priorities.
- Foster the development of practising social care professionals as 'Practitioner Researchers' (PR), and experienced social care researchers as Researchers in Residence (RR), and through this creating embedded research teams together with service users, senior managers and engaging front line practitioners.
- Initiate ongoing training for embedded research teams to identify common priorities, share best practice and learning, and engage in primary research.
- Test the embedded research model by carrying out two research projects relating to workforce, new ways of working, and/or implementation of evidence informed service changes to establish whether practitioner researchers, supported by RRs and EEs can be sufficiently empowered to carry out robust research.
- Promote and explore the development of a research aware and informed organisational environment for adult social care services through stimulating direct involvement in research.
- Evaluate what effects the above activities had, why the interventions had the effect they did, and what helped or hindered the embedded research model in producing its intended outcomes.

4.2 Outcome

We envisage several immediate and longer-term benefits arising directly and indirectly:

• Impact on research culture, quality of service planning and evaluation, enhanced liaison between academics, practitioners, managers and users and carers concerning social care, sustainable network to promote and produce research

• User and carer outcomes: less than a third of care users are satisfied with the services they receive (British Attitudinal Survey, NatCen 2019). The research has the potential to impact on effectiveness and user/carer satisfaction locally, and with the potential for further benefits nationally if the proof of concept study yields positive results

• Frontline and managerial staff: gaining research skills and knowledge on how best to support people with complex conditions, and contributing to professional development, job satisfaction and workforce retention.

• Organisations/agencies participating: we expect commissioners and providers to have a better understanding of their finances, resource use and user/carer outcomes, reducing the risk of wasting time and money on services that provide low benefit or poor quality

• Health and social care system: further benefits as an evaluative culture embeds in local systems, resulting in additional research projects being identified and funding sought, extending the intervention's benefit and impact beyond its current funding frame

5 STUDY DESIGN and METHODS of DATA COLLECTION AND DATA ANALYSIS

Aim: To describe the study design. To clearly describe the data collection methods and outline the roles involved in data collection. To clearly describe the data analysis methods.

Study design

Research capacity development: Engagement in research by social care organisations is often short term, which impedes the emergence of the sustainable research partnerships, generalisable learning and assessment of the impact of research, which we have as central aims 11. While aspects of organisational culture may sometimes be resistant to change, others may welcome it. We will collect data documenting the extent of change and identify why, where and how it happens. Literature reviews of knowledge utilisation in social care acknowledge the existence of a knowledge-to-practice gap 75, 76. Embedding research and engaging practitioners in research is a direct way of addressing this.

By investing in embedded research capacity building, the project brings the design and leadership of research closer to the places where practitioners and service users and carers are, creating the possibility of more agile responding to identified needs for research.

Workstreams

We will research the potential of embedded research to develop sustainable high-quality research with others through three iterative, overlapping, and co-dependent work streams (see also Gantt chart below and logic model).

Workstream 1 (WS1) – (0-6 months) –engagement and priority setting (Leads PW & FG)

This workstream is about developing embedded research teams. The focus will be identifying areas of evaluation, priority setting, and identifying and mobilising evidence to help support service changes, and implement change. It is designed to: help motivate practitioners to increase their capability in the use of existing evidence; increase research capacity, as more people become engaged in research, and promote coproduction through engagement of EEs and practitioners in research. The resulting embedded research teams will co-produce an initial small programme of substantive research questions and projects in WS1 to develop further through WS2. Activities in WS1 include research and engagement training, rapid reviews, identifying baseline data concerning research activity in the organisations, prioritisation/networking and engagement exercises.

The embedded research teams will be set up in WS1 with a view to stakeholder mapping; brokering relationships among stakeholders; eliciting existing expertise; identifying secondary data sources; capacity building/training; carrying out rapid evidence reviews/evaluations, promoting EE involvement in research.

Key objectives for this work stream are:

- recruiting and embedding PRs x2 and RRx2, setting up the Embedded Research Teams (ERTs): linking with senior managers and other stakeholders in host organisations and their networks and
- EE. We aim to have two EE as members of each of the two ERTs.
- stakeholder mapping and engagement, including adult social care providers
- initiate the project evaluation (WS3, below),

- identifying research questions for the two nested research projects (WS2) through exploring stakeholder, service user and service provider priorities for evaluation and research views about research priorities, identifying examples of new approaches to practice and knowledge gaps
- baseline analysis of performance data and current practice to inform research in WS2, to include qualitative and quantitative baseline data on research awareness, capacity and capability
- identifying future research questions for research beyond the project

Setting up the embedded research teams: Two RRs will commence work on the study (one per study area, 4 days per week) (FG and JE). They have extensive experience of embedded research in areas related to social care. PRs (50% FTE or above, depending on salary) will be recruited from social care practitioners already in post, one per area. Selection will be based on experience in social care, interest in research and enthusiasm for being a champion and advocate for research in practice. Recruitment of PRs will be a joint process between the research team, employers, and EE.

Research training will be given to PRs through joint supervision and mentorship by members of the core project team and representatives of the host organisation, e.g. the PR's line manager, and access to Plymouth University research training activities (postgraduate research training modules) for PRs. They will also receive research methods support from co-applicants who are research methods experts, and mentoring and guidance on working with service users and carers on research projects.

Members of the public involved in the consultation about drafting this bid thought that engaging local voluntary organisations and Community Interest Companies was important, and effort will be made to involve hard-to-hear groups as well as formal / established groups. Stakeholder mapping will be carried out in WS1 to identify relevant stakeholders using existing networks and identifying smaller / emergent organisations and groups. Co-production with EEs and diverse stakeholders is a core principle of this project, EEs being centrally involved in the evolution of the networks and projects, and in the project evaluation.

Scoping work: the work in this first stream will be largely exploratory: evaluating existing research activity and enablers and barriers to enhancing research activity. This will be done through:

- qualitative interviews with adult social care professionals and their managers and data analysts, policy officers and other stakeholders;
- exploring data sets held in the organisation's systems to profile existing provision;
- identifying current engagement with research in the host organisations;
- talking to staff and users of services in semi-structured interviews about research priorities and future directions for services, and
- exploring the fit between data collection systems and the data needs of a research-aware organisation.

This will build on work done prior to this application to set up a network of collaborators, experts, EEs, and organisations and to explore potential social care questions for two nested research projects. Given the diversity of organisational approaches to service delivery, this scoping work alone promises some valuable insights and learning about attitudes to and use of research in social care organisations and their potential research capacity.

From the outset, WS1 will support partnership building, researcher development (adult social care professionals becoming practitioner researchers), engagement with the wider adult social care provider community and prioritise locally and nationally relevant social care questions for research.

Embedded researchers in residence (RRs) and practitioner researchers (PRs) will work together with organisational managers and 'research champions' from within adult social care providers, third sector / voluntary organisations, service users and carers and researchers to establish networks in each organisation as well as inter-agency collaboration in research. A key aspect of this WS is the creation of partnerships between researchers based within adult social care organisations, with other care providers, service users and carers, and researchers, to locate some of the drivers for taking research more directly into the communities and organisations that provide and receive services.

These partnerships will identify key areas and priorities for research, focusing on under researched areas of social care. They will support the embedded researchers and identify opportunities to cascade learning through social care organisations, and facilitate links with non-statutory providers of services and service users and carers who might otherwise not have the opportunity to participate or be heard in relation to social care research. Through this process, we aim to discover what motivates organisations to engage in social care research and what barriers exist within social care itself, and learn about the potential for creating impetus for research within social care organisations.

A cross -area event for all stakeholders at approximately the 3-month point will explore the following questions and draw up a shared agreement to guide the work of the embedded teams in the second year:

- What are the priority issues for research locally and nationally?
- How should embedded research teams prioritise the projects they evaluate?
- What steering / governance arrangements need to be in place, including across areas and
- organisations?
- Where will research outputs be shared from the project?

This will help to develop a Memorandum of Understanding for the ERTs in the early stages of the project. It would be a valuable early output of the project, and constitute a resource for other local areas wishing to develop a similar approach.

In WS1 we will also focus on developing research–related communication channels through, for example: developing research focused working groups; identifying research champions; forums for knowledge exchange in organisations; establishing journal clubs or regular mini-seminars where social care workers, service users and/or academics and subject experts can present on a particular topic; and seeking sources of internal and external funding to sustain the research collaborative beyond the end of WS1. WS1 will also exploration the potential for sharing learning about the researcher in residence model as a means of strengthening research capacity with national organisations and social care organisations in other areas seeking to develop their research capacity. In particular we will link with networks and organisations for sharing learning e.g. SSCR; Future Health Foundation/ESRC "UK Centre for Evidence Implementation in Adult Social Care": https://www.health.org.uk/fundingandpartnerships/programmes/uk-centre-for-evidence-implementation-in-adult-social-care.], ADASS (Association of Directors of Adult Social Care)

Workstream 2 (WS2) – (3 – 14 months) - The embedded research teams carry out the nested research projects (Leads RB and SA)

WS2 develops from the base created in WS1. It entails the formulation through participatory discussions of research questions, research planning, consideration of potential funding streams, key collaborators and research skills needed, provision of research skills training and addressing ethical approval issues relevant to the specific research studies to be carried out. Members of the research team are already engaged in evaluating integrated care models of COVID-responsive work in Cornwall (SA), Plymouth/Somerset (RB), Torbay/STP Devon (FG and JE). Two questions scoped for research in WS1 will be developed into research projects. It is envisaged these will cross both study areas and are likely to also involve third sector organisations. One project will be based in each participating organisation (local authority). Engagement with non-statutory partners and community organisations, increasing engagement with national research initiatives and organisations, and report writing and dissemination activities underpin this stage.

WS2 will focus on delivering new primary research, which will apply qualitative, quantitative or mixed methods as each question requires, tailored to the specific issues being investigated. It flows directly from the exploratory work in WS1. In WS2, the subject for two research projects nested within the wider ERT project will be finalised, one based in each of the two participating areas. The foci of these research projects will be selected for their potential to be conducted as cross-area studies, with data gathered across both participating areas, but each will be based in one of the two participating areas. Throughout WS2, feedback from the ongoing formative evaluation (described in detail in WS3) will enable the research teams to fine tune the work of the project.

PRs will be supported by the RRs and academic and specialists in research design, literature scoping, methodology, analysis and report writing. Exact details of the methods to be used in the substantive research projects will depend on the specific issues / research questions identified by the partners during WS1. For each of the subsidiary research projects, we will start from the research questions agreed with partners and co-design the best methods for answering those questions.

Key objectives for this workstream are:

- To carry out two robust research projects
- Developing further the ERTs
- Gathering ongoing evaluation data about the impact of the research project on participating organisations and other stakeholders

Methods used will comprise a range of quantitative and qualitative techniques. While being epistemologically pluralistic, this fits with our commitment to understand not only what changes as result of embedding research teams in social care organisations, but also why it happens, and how the context for provision affects uptake, effectiveness, sustainability, etc. It is also consistent with our commitment to including a range of methods as well as ‘voices’ in our evaluation of the effectiveness of our programme.

The focus and methodology of the two research projects will be explored by RRs and PRs in collaboration with partners and stakeholders, including third sector and private organisations involved in the delivery of social care and experts by experience (EE). Potential collaborators in these sectors, as well as small not-for-profit and community organisations, will have been identified through profiling the providers of social care as it is most widely conceptualised (i.e. including less formal community support groups, etc.) in WS1.

PIs and co-applicants already have established local and national links on which to build, which include:

The Association of Directors of Adult Social Services South West; Principal Social Workers for Adults; Peninsula Social Work Education Group; BASW, Social Work England; Skills for Care; NIHR Clinical Research Network and Research Design Service; NHS England and NHS Improvement South West; Public Health England South West, NIHR School for Social Care Research, and the NIHR Applied

Research Collaborations South West Peninsula, and ARC West. We will also link with other NIHR funded adult social projects, in the region and nationally, to share learning.

Potential areas identified by senior adult social care organisation managers and EE engagement during the planning of this application include: exploring the impact of social care on wellbeing in deprived areas; the unique contribution of social care workforce in the care of people with dementia, provision of services to minority ethnic users in a low diversity population, addressing workforce challenges, and the impact of Covid19 on care homes. Feedback about this stage, including feedback from EEs, will be used to shape the ongoing focus of the wider research into embedded research teams (WS3), as well as feeding into the summative evaluation in WS3.

We want service users and carers to have a voice in the selection of projects, and we also know there are research questions that relate to pressing concerns among service providers, policy makers, etc. Our selection will seek to build consensus and take account of the following indicators that a research area is an important to ‘adopt’: such as the James Lind Alliance priorities for adult social work research; areas where agencies tell us there is a pressing need for more evidence and where better data is thought to have the potential to improve care quality and/or experience; areas identified by service users and carers as matters of high concern, which also have the potential to improve services; indicators from research and policy that particular areas of social care merit urgent investigation. With reference to selection, we will involve all our partners in a discussion about priority questions. Criteria would include:

- Is this an area with scant research, and little other research on a similar topic ongoing?
- What service user and carer benefit can be expected to follow from this research?
- The potential for positive impact on social care systems

Selection of priorities will be through conversations with all stakeholders: online or face-to-face. We plan a process similar to a Schwartz round to ensure all participants in the discussion have an opportunity to explain why certain topics are important to them, and hear the views of other stakeholders. We have had various conversations with stakeholders about possible research topics. Perhaps unsurprisingly, practitioner representatives, service users and operational managers presented different perspectives on important issues to research. One that had particular traction across stakeholders is the effect of a move to more online and distant working on adult social care assessments. Indicators we might use in the research could include:

- the impact on quality of assessments (looking at the validity and reliability of assessments);
- on any impact on the range and extent of services offered;
- on service user and carer satisfaction;
- on cost and timeliness of assessment;
- and the impact on practitioners, including their views as well those of service users and carers on the effect on relationship building and its importance in social care delivery.

Please note this is an illustrative example.

The box below gives another example of the kind of work that might take place, developed in collaboration with our collaborating local authorities.

Title: *Comparing Adult Social Care Development and Support Programmes for staff across host organisations – what approaches work, and how do they impact on workforce resilience?*

Question to be addressed: Both host organisations’ workforce strategies highlight pressing workforce challenges (vacancies and turnover) and the important of workforce development. They use varying approaches to do this, with one host organisation (Torbay) due to start a specific intervention in 2021 focussed on leadership, while Devon County Council has a strong focus on investment in specific recruitment, e.g. Nursing Associates in social care. Both host organisations' workforce strategies highlight pressing workforce issues, and the important of workforce development. They use varying approaches to do this, with one host organisation (Torbay) due to start a specific intervention in 2021, while the other has a strong focus on recruitment (https://www.proudtocaredevon.org.uk/) but is not using this specific intervention

Design: Mainly qualitative, mixed methods, comparative case study across 2 host organisations; use of workforce data on sickness, retention and absences.

P –Population: social workers, care workers.

I – Intervention: Each leadership cohort in Torbay receives six half day learning modules bi-monthly across the year (blend of teaching, group coaching/reflection, and skills practice in small groups)

C – Comparison/Control: Naturalistic comparison of need / demand for workforce recruitment and support across both sites, exploration of staff support and development approaches across sites.

O – Outcome(s): Qualitative: staff focus groups/interviews (wellbeing/resilience, reflective space, communication, peer networks, etc.) Quantitative: existing data from staff surveys during observation period, exit interviews with consent, etc.

Initial reviews are likely to be scoping and/or rapid. Quantitative methods are likely to include secondary analysis of service delivery and process data where this exists, as well as analysis of primary data using, for example, surveys or user experience or outcome measures. The researchers are likely to use a range of qualitative approaches, including thematic analysis and grounded theory 59 to explore new areas of study (e.g. responding to adult abuse concerns during a pandemic) and use a realist approach 60 to designing research studies and analysing data.

Our plan involves service users and carers at every level, from considering what sort of research to undertake through to dissemination. Our framework for collaboration will be informed by, for example, Ward, Pinkney and Fry's SUFFICE framework (https://link.springer.com/article/10.1186/s13104-016-2230-0), and the work of Marshall, adapted to take account of our primary research. The positioning of Researchers in Residence in agencies is key to maintaining communication and collaboration between service users/carers, practitioners and senior managers. Our framework for collaboration is based on the underpinning principles set out by the NIHR for involving people. These are embodied by the dedicated funding to cover involvement costs and needs, such as paying expenses, paying for time, and having accessibility capability funding. The project has experienced PPI leads who are skilled in holding and delivering a process that is emergent, but controlled to deliver the research based a well-facilitated, open and emergent process. Through the contacts made through networks and organisations, we will bring together a group of people (as described in the PPI sections of the bid) to discuss topics and to agree together who will be co-researchers joining the embedded research team. Other aspects of coproduction, such as support and training for co-researchers, are also outlined in this bid.

Specific activities in WS2 will include:

- Dissemination locally and nationally of findings from research and rapid evidence reviews, sharing learning with national organisations such as the Association of Directors of Adult Social Care and SCIE.

- Building / sustaining links with other research centres and organisations locally and nationally
- Exploring with stakeholders (organisations, service users, etc.) potential strategies for the continuation of any enhanced adult social care research capacity established during the project
- Workforce capacity building: ongoing work to increase the wider workforce engagement in research
- Planning future collaboration between service providers, service users and carers and HEIs around applied ‘real world’ research; promoting research informed practice in future generations of social workers
- Continuing network development: WS2 will work to consolidate and keep under review the work to build a network to deliver research in social care. This includes setting up cooperative systems for information sharing, and network-building within the participating organisations (local authorities) and with external organisations involved in the delivery of adult social care.

At the same time as carrying out the nested research into areas of service need and service development, we will be collecting data for our process evaluation (WS3) about the impact of setting up embedded research teams in the two study areas. This is to explore as ‘proof of concept’ the potential for the embedded researcher model to increase research readiness, research informed policy and practice and carry out primary research in adult social care. Our Action Research informed approach, combined with our realist process evaluation, will feed formative evaluation data back into the project in real time to build on successes and address areas of slow progress or difficulty.

Workstream 3 (WS3) – (0-14 months) – Formative and Summative Evaluations (Leads PW and RS)

WS3 is a realist informed summative evaluation of WS1 and WS2, the work-streams that implement the embedded research model. This evaluation continues throughout the project and has a hybrid research design 77 comprising a formative element concurrent with WS1 and WS2, and towards the project end a second, summative element: WS3 will be carried out in partnership with an independent organisation, Research in Practice, with a long record of independent evaluation and research in social care. We will include two or three experts by experience in both elements throughout the evaluation.

Design of the concurrent formative evaluation

In parallel with WS1 and WS2 we will make a formative evaluation the activities and methods of working of the embedded teams, while the summative evaluation will review the impact of the proof of concept project. The formative evaluation includes setting up the organisational arrangements for, and networks of, embedded researchers. We will use Action Research methods with a whole-system orientation 78-80 because their cyclical nature facilitates real-time feedback in WS1 and WS2, learning from experience as those workstreams progress, and because action research facilitates involving user and carer (EE) coinvestigators.

Formative evaluation will be a process evaluation taking place from the outset of the project, focussing on the conditions that influence the feasibility and success of the project at each stage, to establish whether the study gives ‘proof of concept’ of the embedded research model in social care, or not. The realist basis for the evaluation underpins asking questions about the influence context has on implementation, and what makes some elements or areas work better or meet more challenges. An Action Research approach feeds learning back for rapid response to early result. This evaluation will address questions, which include:

- What type of organisational contexts support the deployment of embedded researchers and the practitioner-researchers' take-up of opportunities to become involved in research?
- What factors affect success or failure of research network development? What does 'success' mean to different stakeholders?
- What level of academic support and training is required to enable practitioners to become practitioner researchers?
- How does organisational context affect responses (i.e. what research and research questions get priority) when the research priorities of EE and organisations diverge?
- How do the organisations, EEs and embedded researchers deal with unwelcome or inconclusive research findings?

This approach is consistent with realist evaluation provided that the action research includes, as WS3 will, the implementation of a logic model as one of the actions to be studied. Across WS1 and WS2 members of the core research group will carry out content analysis on the research outputs produced and collect data about how the embedded research model was managed and implemented, extracting data from meeting notes, reports, briefing papers, policy documents, practice guidance, other data gathered by the embedded teams, any relevant substantive research data from WS2, and interviews of front-line staff, managers, service users and carers. By these methods WS3 will document how the embedded research mechanisms worked, the impacts of the research intervention, what contexts impacted on that, and how. Specifically:

1. how groups of collaborators were established, the activities they undertook to build partnerships, develop and embed a research culture, engage with stakeholders and create networks.

2. what decisions the researchers and local authority collaborators took, and why, in deciding the initial set of substantive research questions for WS2.

3. what contexts (organisational, political, financial, geographical) influenced these decisions, and in what respects.

4. what actions were then taken, by whom and why; including any adaptations to the research activities and how the researchers and collaborators monitored and evaluated the consequences of those changes; and any adaptations of the project's organisational and network arrangements.

From these data, we will induct explanations of what activities and contexts assisted, and which impeded, the implementation of the WS1 and WS2 and the realisation of its intended outcomes (see above).

Within the project, the WS3 formative evaluation will have four reporting stages, at six-month intervals from the start of WS2. At each stage the activities, contexts and outcomes for WS1 and WS2 with be compared with assumptions and logic model outlined above. Depending on what findings emerge, these comparisons will identify any ways in which these work-streams, and the embedded research model generally, could be adjusted or implemented differently to increase the likelihood of producing the intended outcomes for WS1 and WS2 (and therefore the project as a whole). Conversely, the comparisons will also identify any ways in which the above assumptions and logic model have to be revised in the light of experience.

Each set of cumulative interim findings will be fed back to the embedded researchers, their host or employing organisations and the research network, to inform and nuance their ongoing activities. In this way, the evaluation will be formative in the sense of providing evidence-based proposals, in real time, by which to refine the embedded research model, WS1 and WS2.

Two members of the core research team (PW and RS) will concentrate on the formative evaluation without participating in WS1 and WS2 so that they can provide a 'clean room' analysis of activities in which they will not be directly involved, thereby minimising the risk of self-justificatory bias in the analyses.

Independent Summative Evaluation

The summative evaluation will address how far the embedded research did in practice:

1. create sustainable change in the use of evidence to inform social care management and practice,

2. co-produce generalisable research knowledge about how to develop and manage social care.

3. disseminate best practice in embedded research at the national level.

To minimise the obvious risk of justification bias when a project team evaluates its own work we will recruit independent researchers (Research in Practice: see above) not involved in WS1 and WS2 to gather and analyse data on the progress and outcomes of the project. In order to remove self-justificatory bias as far as possible, we will engage Research in Practice as consultants to the evaluation, and to provide an arm's length analysis of our data.

Data for the summative evaluation will focus on:

- Embedding research (from WS1): such data as the number and distribution of stakeholders, beyond the embedded researchers, engaged in research informed practice including their time given in lieu (matched-funded return), their engagement in training, inter-organisational networking and learning. We will compare the level of research activity at the initiation of the project, the first and second summative evaluation points, and investigate the extent to which research was co-produced.
- Research outputs (reports, evaluations, publications, rapid reviews, evaluations etc.) including an assessment of the research quality of the two nested WS2 research projects and these outputs
- The impact of WS2 on services themselves i.e. evidence that research has informed practice in ways that may be assumed (insofar as they are evidence-based) to promote better outcomes for users of services and their carers.
- Findings from the formative evaluation (see above), which it will incorporate.

Data collection methods will include surveys, content-analysis of project documents, inventories of research activity including research reports, and qualitative interviews of a sample of the stakeholders, including service users and carers, involved in WS1 and WS2 as research partners or by being affected by the services involved. We shall draw on the findings of the Local Authority *Champions of Research* study for delivery and formative evaluation of this project.

Provisionally (subject to what the independent researchers find and recommend) the analysis would include two comparisons:

1. Across participating sites, to help identify local organisational contexts that promote or hinder the embedded research activities (WS2)

2. Across the practical nested research projects, to help identify approaches to research project management (WS1) that tend to strengthen the embedded researchers' research capability and

their ability to enable fellow-workers to make greater practical use of evidence With the same proviso, the summative evaluation data and findings will also be compared with the above original logic model for embedded research in social care. We will assess the logic model empirically, to examine the feasibility of and favourable conditions for implementing the embedded research model, and therefore to adjust and formulate the embedded research logic model to make it most likely to be generalisable to other areas.

Besides contributing to the final project report, the summative evaluation will be evidential raw material for developing a succession strategy, i.e. plans for how to continue the project activities, and who will do so, after the project ends.

Specific questions re: data collection methods:

- **Observation** –Observation of naturally occurring meetings such as team meetings and discussion of policy development will be part of the project. Such meeting may be recorded with the informed consent of the participants with a view to transcription / note taking. Recordings will be audio and kept securely on a password protected computer, or on a secure site accessible only by password to researchers, hosted on the University of Plymouth website. Observers may include the Researchers in Residence, Practitioner Researchers and research-trained co-researchers (PPI partners) and possibly members of the research management team.

- **In-Depth Interviews**- Any interviews will be conducted by the research team as set out in the previous bullet point. Any interview schedule will be developed by the research team, and carried out by the Researchers in Residence, Practitioner Researchers and research-trained co-researchers (PPI partners). They may be via Zoom, by telephone or in person. They would, with informed consent, be audio recorded for transcription / note taking purposes. As described in the last bullet point, all research material will be stored securely and retained for ten years when it will be destroyed securely.

- **Focus Groups** - Any focus groups will be led by the research team as set out in the previous bullet point. As above, any focus group schedule will be developed by the research team. They may be via Zoom or in person. They would, with informed consent, be audio recorded for transcription / note taking purposes. As described in the last bullet point, all research material will be stored securely and retained for ten years when it will be destroyed securely.

Data analysis will be using content analysis, informed by the underpinning principles of grounded research. It will be transcribed, coded and de-identified by the research team, primarily the Researchers in Residence and Practitioner Researchers.

Research data may be accessed by all members of the research team prior to anonymization, and once completely de-identified it may be shared with senior officers in the local authorities and our independent evaluators (Research in Practice, Dartington).

We may use a qualitative analysis programme such as Nvivo in assisting data analysis

6 STUDY SETTING

Setting: Southwest England presents a diversity of contexts for social care: this project will cover two local authority areas: Torbay - a coastal town experiencing many challenges 74 associated with deprivation, geographic isolation and seasonal fluctuations in employment and population. Devon encompasses large rural areas, with pockets of low employment and an aging population, many retirees with weak local family links and multiple long-term conditions, reflecting the strain on social and economic networks. A wide range of ethnic minority groups live in the South West, but in smaller numbers and groupings compared with minority ethnic communities in many larger cities, which presents a challenge in providing tailored support.

The region comprises varied models of service delivery, such as Torbay's Integrated Care Organisation, set up in 2015 and one of the first areas in England to bring acute, community and social care together in a single organisation, while Devon delivers services through 21 Community Health and Social Care Teams.

7 SAMPLE AND RECRUITMENT

The two local authority research sites were identified and agreed with those sites prior to the project funding being agreed. We currently have one of those sites working closely in partnership with us, and are negotiating with two potential second replacement sites, having lost one of our original partners. We hope to work with one of those alternative sites, or, if both prove keen to work with us, potentially to split the funding for the second site between both local authority areas (Somerset and Cornwall).

7.1 Eligibility Criteria

The study we are conducting does not define study subjects in the same way as, for example, a clinical trial, because we want to hear as wide a range of relevant views and opinions as possible, but there are inclusion and exclusion criteria.

7.1.1 Inclusion criteria

- Working as a professional in adult social care
- Having experience of being a user of adult social care services, or a care for such a person
- Working in an organisation that provides services and support to people in receipt of adult social care, e.g. in the non-statutory sector, or private sector (such as workers in adult residential provision).
- We only intend to talk to adults (over 18) who have the capacity to understand the aims of the project and communicate their views, including those who use assistive technology or an interpreter. There is no upper age limit.
- We only intend to talk to people who are within the areas covered by our study area (Devon and Torbay) either for work or as user of services in those areas, or are a carer for someone who lives in those areas.

7.1.2 Exclusion criteria

- Outside stated age range.
- Outside stated location.
- Not a professional, voluntary worker, service user or carer for a service user in adult social care in Devon and Torbay.
- Not able to understand the aims of the project or express views about adult social care, even with support.

7.2 Sampling

7.2.1 Size of sample

Aim: to explain the rationale behind the size of the sample.

We cannot give precise numbers of people to be involved in this project. We wish to be inclusive which means we may have more – or less – adult social care social workers, social care service managers, social care experienced members of the public and other stakeholders involved. We would seek to hear the views of anyone who wishes to be involved, and will adapt our strategy for gathering data according to interest in taking part.

7.2.2 Sampling technique

Aim: To describe the selection of participants.

Our sampling strategy is really a strategy for inclusion, since we do not anticipate excluding anyone who is eligible (see above) from taking part in this study. The rationale for this is that we wish to draw on a wide range of views in determining the subjects for our two nested research projects (which will be the subject of separate applications for approval) and engage as many staff as possible in our participating local authorities in the research project, although we anticipate their participation may vary from attendance at briefings to becoming a co-researcher.

7.3 Recruitment / sample identification

Aim: To describe how participants are identified and recruited.

Practitioner, professional and social care manager participants: Recruitment will be through communication via the practice leads and existing organisational communication channels, online as well as in-person attendance at e.g. team meetings. Screening is not expected to be necessary, but in the exceptional situation where a researcher has concerns about the capacity of a potential participant to give informed consent, action would be taken as set out above, with the dignity, welfare and rights as principles underpinning any decision to exclude them from the study.

PPI participants: Recruitment will be through direct contact with co-ordinators or key individuals in organisations that support PPI, many of whom are already known to our PPI leads (RP and FG) and through snowball contacts where organisations may suggest other groups that may be interested in our project.

There will be no screening process, the exception being when a researcher has capacity concerns about a potential participant, as set out above.

There will be no payments for participating, but expenses and costs to support participation will be paid and have been budgeted for in the bid.

7.3.2 Consent

Informed consent will be managed in this project through ensuring that every participant has the opportunity to read a briefing about the project (sample document attached to this application).

Local authority employees will be participating as part of their workplace activities, and there will be an agreement between the local authorities taking part that staff who are interested to take part in the project will have the support of their employer to do so. No staff will be required or pressured to take part.

PPI co-researcher participants will be asked to sign a participation form once informed consent has been established (sample form attached with this application).

Meetings with PPI participants will involve giving full information about the project and ensuring they have full knowledge that participation is voluntary, and choosing not to take part will have no direct impact on any benefits, services or other aspect of their lives; nor will choosing to take part, although we hope it may have a longer term positive impact on some aspect/s of services generally.

The issue of capacity has been addressed elsewhere in this Protocol.

8 ETHICAL AND REGULATORY CONSIDERATIONS

The groups that it is anticipated may benefit from this research are users of adult social care services, and providers of adult social care services.

Our participants are drawn from both groups, along with other stakeholders such as members of organisations that support users of adult social care services. The potential benefits to both providers and users of adult social care are that future services may be more effective, and more efficient. Having an opportunity to be involved in defining a research agenda and participating in co-production of research may benefit individual service users and others with whom they are connected through empowerment and acquisition of new knowledge and skills in research. Participating adult social care workers may benefit through acquisition of research knowledge and skills, and organisations may benefit through enhancement of the ability to use and conduct research in planning and delivering services.

Potential risks include:

- are that service user and carer participants may find the burden of participation places them under additional stress
- that adult social care professional participants may find the burden of participation is an additional strain on their time management, or they feel it takes away time that could be spent on other activities
- that organisations (e.g. the local authorities) find the release of professional time places additional strain on their organisation.

We have strategies to address these risks:

- Service users and carers will be fully informed about the project at the outset, and about the demands involved in taking part at a range of levels from consultation to co-researcher roles. They will also be informed about their right to step away from participation at any time and without the need to give an explanation. Please note also the funding for support, e.g. for someone to be employed to provide alternative care for someone a co-researcher cares for, to enable them to take part.

- Professionals may be involved at a range of levels, from taking part in a single discussion group to becoming a research champion or practitioner researcher. Our funding for the practitioner researchers is to enable the employers to buy in 'backfill' to reduce pressure on the organisation, and we have senior management support for the project. We will build on this by working with front line managers as well as practitioners to facilitate a research-facing culture that supports staff at all levels to take part in research related activities without this being seen as an integral and important aspect of the 'day job'.
- Regular meetings with senior staff in participating organisations will be used to manage any issues arising for the organisation as well as the research project to minimise conflicts of priorities, be responsive to organisational challenges, etc.

Data collection methods will all be open, honest, and respectful of all participants. We are mindful of and will respect legal requirements in terms of confidentiality and data storage, as described elsewhere in this Protocol in more detail.

8.1 Assessment and management of risk

Risk analysis plus risk management plan if a researcher were to come into information which had safeguarding implications

There is a possibility that researchers, Researchers in Residence and Practitioner Researchers (RR, PR) will become aware of issues of concern about people they talk to or others known to them. If this should happen, there will be clear guidance as to what action they should take, and this will be reinforced through training and supervision.

The guidance (which it will be clear is an expectation, not a choice) will say:

- RR and PR will advise all participants that have a responsibility to seek further advice and possibly breach confidentiality if they become aware of any possible safeguarding risks to any person. It will be made clear that this will only happen if there is a risk of harm to somebody that is a potential safeguarding matter.
- RR and PR will be instructed to bring any such concerns to the attention of their manager in the research project (for RR) and the PI and senior management team for the project will make a decision whether or not this meets the threshold for referral to adult social care, and / or the police. This does not take away their right to report concerns on their own behalf if they believe referral is necessary to safeguard a person at risk of harm. The project PI has experience of and is qualified as a social worker and social work manager with extensive experience of making 'safeguarding' decisions. PR will have their own supervisor in an adult social care agency and have been trained to identify and respond to safeguarding concerns, including appropriate referral of concerns to the relevant safeguarding team.
- Discussion of safeguarding and risk will be a regular item in supervision for RR, and will already be an expectation in PR supervision in their employing social care agency. PRs will be trained in working with members of the public in receipt of services, and will have had

training in responding to safeguarding concerns. This will be supplemented by discussion of safeguarding in research as part of their support and training sessions in their role as PRs.

- Concerns about safeguarding will be referred to the local safeguarding hub covering the subject of concern's residential area. If the matter involved a crime against another person, consideration would be given as to whether referral to the police was also necessary (although this may be more appropriately achieved through referral to the multiagency safeguarding hub). In an emergency, e.g. someone expressing immediate suicidal ideation, the RR would be expected to take urgent action, including if necessary calling 999.
- PPI co-researchers will through their training be given the same information, as part of their training about data security and safeguarding. They will be expected to contact their PPI lead (RP) or the RR with whom they are working, or any one of the project management team with whom they are comfortable talking, to pass on any safeguarding concerns.

It would be made clear through training and supervision that all RR, PR and PPI co-researchers would be expected to take action immediately if they had concerns. They will be expected to explain to the person sharing safeguarding concerns that this is the action they intend to take, and talk with them about any implications for them of this information being shared, unless this would put another person at heighted risk. The conversation should be recorded in writing as soon as possible after the conversation leading to safeguarding concerns. Any events leading to a safeguarding referral would be followed up with an offer of a 'debrief' by one of the research team, the expectation being that the PI would be involved in this debrief either directly or supporting the 'debriefer'. The research team would offer the investigating agency all information permissible under data protection law, but no more than was required for the purpose of safeguarding.

8.2 Research Ethics Committee (REC) and other Regulatory review & reports

- Before the start of the study, a favourable opinion will be sought from a REC for the study protocol, informed consent forms and other relevant documents e.g. advertisements.
- All correspondence with the Plymouth University Social Care REC will be retained.
- It is the Chief Investigator's responsibility to produce the annual reports as required.
- The Chief Investigator will notify the Plymouth University Social Care REC of the end of the study.
- An annual progress report (APR) will be submitted to the Plymouth University Social Care REC within 30 days of the anniversary date on which the favourable opinion was given, and annually until the study is declared ended.
- If the study is ended prematurely, the Chief Investigator will notify the Plymouth University Social Care REC, including the reasons for the premature termination.
- Within one year after the end of the study, the Chief Investigator will submit a final report with the results, including any publications/abstracts, to the Plymouth University Social Care REC.

This study has received internal governance review and ethics approval from Plymouth University FREIC.

- Before any site will enrol participants into the study, the Chief Investigator/Principal Investigator or designee will ensure that appropriate approvals from participating organisations are in place. Specific arrangements on how to gain approval from participating organisations are in place and comply with the relevant guidance. Different arrangements for NHS and non NHS sites are described as relevant.

- For any amendment to the study, the Chief Investigator or designee, in agreement with the sponsor will submit information to the appropriate body in order for them to issue approval for the amendment. The Chief Investigator or designee will work with sites so they can put the necessary arrangements in place to implement the amendment to confirm their support for the study as amended.

Amendments

All approval amendments will be handled in line with the sponsors and site management organisations polices, and notified to the England NHS R&D office and communicated to the participating organisations local R&D office and local research team including participating sites to assess whether the amendment affects the NHS permission for that site.

The Expert Advisory Group, independent evaluator and PPI partners involved in the conduct of the research will also be notified about substantial amendments in case the amendment affects their opinion of the study.

Some amendments that may be considered to be non-substantial for the purposes of REC, but will still be notified to NHS R&D (e.g. a change to the funding arrangements).

Amendments to the research plan will, apart from minor and trivial changes, be agreed with the Funder (NIHR) and the Plymouth University Sponsor. They will be responsible to referring the study back to the ethical review process with the Plymouth University Social Care REC. Any amendments will also be discussed with the External Advisory Group (which includes PPI representatives) and the Independent Evaluator. Other members of the research team, such as Local Authority managers, will also be informed, in the event they have not been directly involved in the decision.

Responsibility for amendments lies with the research team, ultimately with PI and co-PI. They will be responsible for communicating amendments to the bodies and individuals named above. They will also be responsible for determining whether an amendment is substantial or not.

Any amendments will be communicated in writing to the relevant bodies / agencies / groups via the identified lead contact or Chair by the PI / Co-PI.

Amendments will be tracked through version controlled (numbered) versions of the relevant documents on the research team’s shared webpage, and , where relevant, also updated with version control numbers on the public access website for the research project.

8.3 Peer review

High quality peer review

The study was reviewed by a number of research experts including:

- three internal peer reviewers with considerable experience of research, but who was not involved in the design of the study and who are not co-applicants or involved in the study.

They all have expertise in research design, and one of them has particular expertise in social research. All are either senior experienced researchers at Plymouth University, or employed to provide advice to researchers in research design.

- two external reviewers employed by a Health Authority, both of whom have considerable experience and expertise as researchers and advisers and reviewers of research applications.

None of the above were involved in the design of the study.

8.4 Patient & Public Involvement

Linking embedded teams to experts-by-experience: EE input in the drafting stage is described in detail above. During the process of the study EEs will continue to be central to research, having a dual role. EE will have roles in each of the three work streams: to work as part of the embedded teams to maintain a research focus on new ways of working that can benefit service users and carers; to make a significant input into research planning, bid writing, and development, and to contribute to the evaluation of the embedded research model.

EE have told us that a focus on independence not dependence, on the support needs of carers, on transitions within and between care systems, and person-centred accessible systems that avoid repetitive assessment, are important to them. This has given us a valuable orientation that we shall use from the outset in thinking about the kinds of research areas to consider in the collaborative and coproduced research process. Insights from our EE collaborators will inform the research approach to understanding the questions researched.

We are aware that we need to go beyond relying on established groups of service user and carer representatives. We will seek to contact and make productive engagements with representatives of less heard service user groups, such as members of minority ethnic groups (arguably little heard in the South West), service users with profound learning disabilities, and carers of self-funding older people.

EEs will support us in a range of knowledge exchange and research planning activities, including evaluation, implementation and dissemination. They will be actively involved in research as far as any individual wishes to do so, including as consultants and co-investigators on research projects. We have included funding for training to support EE in engaging with this project, and are committed to supporting their progression to active involvement and leading research with support according to interest and scope for such involvement. Specific members of the research team (FG and RP) have a brief to ensure recruitment and support for EE is effective and ethical in its approach. RP is a consultant and collaborator on the project, and is a nationally respected expert on involving EE in research. She will support, train, challenge and advise on training for EE throughout the project. The four researchers (researchers in residence and practitioner researchers) will form the kernel of the embedded teams. Keeping service user and carer perspectives central to priority setting can be a challenge for national research programme 6,7 8. In our programme, we will build on existing links between service providers and EEs and have budgeted for sustained co-production with members of the public. Service users and carers will be recruited as part of research teams through contacts with practitioners, approaches to local third sector organisations and community organisations. They could be identified because they are already known to organisations, or through contacts made and invitation extended through routes such as voluntary organisations, care providers, support groups, GP surgeries, etc. We will provide support for service users and carers to become involved in the research process through inviting them to be partners in highlighting aspects of social care that require research, and for those who are interested, in becoming active members of research teams. This could include engagement in research design, data collection, analysis and discussion of research findings, report writing and considering practice and funding implications of findings.

To achieve this, we will actively engage with service users and carers and organisations that work with them, and each of the research projects as well as the overall management of the research project will involve service user and carer input. Service user and carer representatives will be members of the research team at the level of management of the whole project as well as involved in each of the two nested research projects. They will also be involved in all reviews of the progress of the wider embedded researcher project. We will however encourage engagement at any level in which a service user or carer would like to become involved, including data collection, analysis, and considering policy implications and dissemination. Our members of the wider research team with nationally recognised expertise in PPI involvement (RP and PB) will have as part of their remit ensuring the team does this, while supporting best practice.

We will make concerted efforts to sustain our prior involvement with and to identify groups in our study area that have a stake in the research studies. We have contacts already in place for a number of groups representing diverse and minority groups, for example, Turning Tides (Learning Difficulties/Autism); Inclusive Exeter (minority ethnic communities); Living Options Devon (Disabled adults). We will attend naturally occurring events by these and other relevant organisations, and we will contact them in a way that will promote engagement, supported by the dedicated budget. Using the protected characteristics of the Equality Act 2010 we will note under-served groups and work on building relevant relationships. We will also work with local community groups and smaller local organisations rather than rely only on higher profile and larger national organisations, and will be guided by where the outcomes of working with these networks will lead us. We will use data on the profile of our communities (e.g. census, local authority data) to inform our consultations, involvement and studies. We are aware that in areas of lower ethnic diversity, e.g. rural areas, it can be harder to identify members of such groups because they are more distributed, and are mindful rural areas also include minorities such as travellers. With support and input from our PPI leads we will ensure our communications provide positive encouragement to take part. We will use our PPI budget to ensure financial and practical support for attendance, with accessibility arrangements in place. Our offer to include service users and carers in every aspect of research will be clear and, we hope, encourage participation. We will keep records of the profile of people who engage with the project, subject to their consent, and use this to identify groups who are not/less represented. We will make efforts to engage them during the research, and the effectiveness of this will be a finding from the study, including barriers we encounter to wider involvement.

8.5 Protocol compliance

In relation to this research:

- Any protocol deviations will be adequately documented through an email setting out the deviation, the date and time of its occurrence, who was involved and a description and explanation as to what the deviation was. This must be reported to the Chief Investigator (PI or Co-PI) and Sponsor immediately.
- Deviations from the protocol which are found to frequently recur are not acceptable, will require immediate action and could potentially be classified as a serious breach.

8.6 Data protection and patient confidentiality

Aim: To describe how patient confidentiality will be maintained and how the study is compliant with the requirements of the Data Protection Act 1998

All investigators and study site staff are required to comply with the requirements of the Data Protection Act 1998 with regards to the collection, storage, processing and disclosure of personal information and will uphold the Act's core principles.

Research Data Management Plan

Data storage and use

Data will be stored on password protected computers. This will protect data during the collection, transcription and analysis stages. Once data is processed through these initial stages, it will be uploaded to the shared team site. The site for sharing of data within the research team is a shared site on the University of Plymouth web, which is only accessible by research team members with an invitation to join it. Any research data that is not electronic, such as handwritten notes, will be stored securely in a locked filing cabinet until such time as it can be transcribed into a digital format for secure electronic storage. It will be destroyed at the end of the project. At the end of the project, all researchers will be asked to securely delete through electronic shredding any data they hold separately.

Research data will include but not be limited to transcripts and notes of meetings and discussions, anonymised questionnaires, data from consultations and knowledge sharing events. All participants will be adults who are capable of giving or refusing informed consent, including to data storage and use. They will be given information about the project and about their right to cease to participate as collaborators / participants at any time if they choose to be involved in the project and change their minds. Secure maintenance of the data will be maintained through the linking code for primary data and processed data being kept in separate locations using encrypted digital files within password protected folders and storage media.

Data will be rendered anonymous through being coded and depersonalised data where the participant's identifying information is replaced by an unrelated sequence of characters.

We do not intend to store data as part of the study data which identifies individuals other than by role (e.g. Social Work participant study are 1 No. 5) or pseudonym "Ruth (not her real name)", with the exception of named co-applicants and researchers (but not 'PPI' co-researchers unless they consent to this – some may wish their input to be recognised in this way). The key that links number /pseudonym to individuals will be held on password protected laptops only (for confidentiality purposes) and deleted securely at the end of the project. Secure maintenance of the data and the linking code in separate locations using encrypted digital files within password protected folders and storage media.

Data security will be protected through ensuring through the use of passwords and encrypting of files that the only people with access to the files will be those necessary for quality control, audit, and analysis (researchers, co-researchers and research team members, and if required the Chair of the Independent Advisory Group, who is an experienced senior researchers (emeritus professor of social work) with expertise in co-creation and PPI involvement in research.

Data will be stored for 10 years on Plymouth University's One Drive. Access will be password protected and limited to the research team, unless there are compelling reasons to share it (e.g. a safeguarding matter). After that, it will be destroyed through secure shredding. If the PI leaves before the end of the ten years, responsibility for the data will be passed to a named and suitable individual, such as another senior researcher at Plymouth University.

Research activity will comply with all requirements of the Data Protection Act, the General Data Protection Regulations and the Freedom of Information Act. Due consideration will be given to any implications of Intellectual Property legislation. When data is transmitted to sponsors and funders it will be done after depersonalisation and care will be taken to ensure that data security is preserved.

Data will be stored in Word or Excel format, and audio files, which will be stored with participants identified by an unrelated sequence of characters, the link to participants being kept separately, as described above.

Plymouth University computing backup arrangements will keep the data safe from accidental loss.

Cost of storage and analysis.

Data gathering and analysis is budgeted for within the PARC grant, and will be carried out by the researchers in residence supported by other members of the research team, such as the practitioner researchers and expert by experience co-researchers.

Decisions about what data to store are ultimately the responsibility of the PI, Co-PI and senior researcher members of the research team. Access once the project ends will be the discretion of the PI / person holding responsibility for the data storage, and will be conducted in line with the principles of openness, while retaining any relevant intellectual property rights in the data.

The data will be owned by the participating local authorities and Universities. Local authority partners will own data about services and service users, while the Universities will own data that has been aggregated and anonymised for e.g. research reporting, including analysed data for publication. Access to anonymised data will be via the shared research project site on the Plymouth University site.

Data will be stored securely for ten years from the end of the research project. The data custodian will be the PI, and if the PI leaves the University on whose database the data is stored before ten years, arrangements will be made for an alternative custodian.

8.7 Indemnity

The University of Plymouth has appropriate insurance to cover all of the activities in this study and the indemnity certificates can be accessed here:

https://liveplymouthac.sharepoint.com/sites/u343/SitePages/Site%20Home.aspx

This indemnity insurance covers all of the below:

- insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research,
- insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research,
- insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research

- insurance and/ or indemnity to meet the potential legal liability arising in relation to the equipment (e.g. loss, damage, maintenance responsibilities for the equipment itself, harm to participants or site staff arising from the use of the equipment).

8.8 Access to the final study dataset

Individuals involved in the study who will have access to the full dataset are:

- The PI, Co-PI, all co-applicants, researchers in residence, researcher practitioners, and lead individuals for the research (named senior social care staff) in the two partner local authorities. Access will be to anonymised / group data only, not to data that could identify individuals, and members of the core research team that have a role as supervisors of the Researchers in Residence. Other members of the research team, such as Practitioner Researchers and PPI co-researchers, will have access to data sets after anonymisation that relate to specific pieces of research in which they have had a role as a researcher.
- Researchers (R in R and PR) will have access to full non-anonymised data sets for any sets of data for which they are data collectors, on the terms specified in this application relating to maintenance of confidentiality, secure storage of data, anonymisation and deletion of data in compliance with GDPR / Data Protection Act 1998 / principles of ethical and lawful data management.

Restrictions to access

- Only members of the core research team steering group PW, RS, RB, SA, FG and JE will have access to the full data sets including, if required for the purposes of addressing any safeguarding concerns should any arise, the codes that link individual participants to specific data.
- Investigators who wish to access the full data set (anonymised / group data only) may be permitted to do so with the consent of the steering group.
- Secondary analysis of the data from this study may be undertaken with the consent of the relevant local authority/ies from which it came and the PI, Co-PI.

9 DISSEMINATION POLICY

9.1 Dissemination policy

- On completion of the study, the data will be analysed and tabulated and a Final Study Report will be prepared.
- The full study report will be made available to be accessed on the Project webpages, and via the NIHR web pages, and the Plymouth University web pages in addition to any other arrangements made to disseminate it. It will be made available to anyone who contributed to the study in any way, including EE and LA and voluntary sector participants. Information as to where to find it will be given during the project itself as well as offering to make it available by another means (e.g. by email) to any EE participant who wishes it.
- The investigators with access rights to the data will have rights to publish articles based on the study data.

- There are no time limits on publications
- There is a peer review requirement for any publication not expressly agreed with the PI and co-PI (e.g. an article to be submitted to ‘Community Care’).
- The funding body will to be acknowledged within the publications but do not have review or publication rights over the data from the study.
- The participants of the outcome of the study will have access to the final report, either by provision of the publication, or via the project website, and through invitation to attend presentation of the findings at a final event (which may be virtual attendance, depending on level of interest and Covid restrictions in force at the time).
- Whether the study protocol and full study report, but not anonymised participant level dataset, will be made publicly available within six months of completion of the project.

Embedded research teams in the two areas will focus on two research projects, one leading on each.

We will support practitioners and stakeholders to participate in the writing of articles for peer reviewed publication and conference papers, and work with Community Care Inform and ADASS to ensure research findings reach a wide practitioner, manager and policy maker audience. We have funding for project participants to attend national and regional conferences, including for participating EE.

The embedded teams may be able to commit swiftly to research needs and knowledge gaps. The summative evaluation will ask questions about impact on service effectiveness and efficiency, with potential associated cost savings and improved quality care provision. The Action Research informed approach of using data and feedback throughout the project to identify key learning and fine tune interventions will help to demonstrate in real time the value of research to the organisations and the users of their services

Exploration of potential for national implementation: as this is a ‘proof of concept’ study, we shall be focusing on collecting data about the challenges and benefits of the embedded researcher approach to research. As noted, this includes its potential to produce high quality research, and to contribute to a move by host organisations towards a more research-ready and research engaged status. We shall share our learning with national and other local organisations and offering to support and mentor other areas looking to develop their research capacity through a researcher in residence model. We shall do this throughout the project, and monitoring the development of our channels for sharing learning externally as well as internally will be an element of performance of the research that is included in the formative and summative evaluations, using social media and rapid means of knowledge transmission such as through ‘Community Care Inform’ as well as academic journals and conference presentations.

Governance and project management: advisory group and project management

We will set up a Stakeholder Advisory Group made up of representatives of the University of Plymouth and participating service provider organisations, and EEs. Members will include: Professor Sube Banerjee, Dean of the Faculty of Health, Plymouth University, Pauline McGlone, NIHR SW Clinical Research Network, regional care provider representative, Regional ADASS, regional Skills for Care, public health representatives, and others to be confirmed. Core members of the research team: PI, co-PI, PPI lead & other lead members of the research team will attend this group. The Stakeholder Advisory Group will support research teams' links into both adult social care and academia, ensure that research activity is oriented to address current national and regional concerns and maximise benefits for adult social care organisations and service users and carers, and support development of the succession plan. The Advisory Group will meet quarterly: some meetings will be online, but we have budgeted for attendance at in person meetings up to twice a year, which may be timed to coincide with other meetings.

Weekly meetings of the core research team including PI, co-PI and the senior Researchers in Residence (FG and JE) and other research team members as appropriate will provide day to day oversight of the project.

The senior Researchers in Residence will provide supervision and support to the Researchers in Residence (a FT or 2 x 50% FTE post currently being appointed.) This will be through weekly and later perhaps fortnightly meetings depending on the training and support needs of the R in R/s.

FG and RP will provide support and training as appropriate to EE involved in the project, flexibly and as required.

The Independent Expert Group, as described in this document, made up of advisors holding senior positions in different social care professional backgrounds and academic posts and Experts by Experience, is also an important aspect of our governance arrangements. This group feeds back to NIHR, but will also provide us with feedback which may challenge us as well as identifying areas of good practice in research.

The core management team (PI, co-PI, specified co-applicants to include EE representatives and designated organisation liaison staff from across both areas of the study) will meet monthly to provide regular oversight, advice and support during the project and review progress towards milestones. The PI will liaise with a named project link from within the research team for each site, and they will together endorse the summative reports to NIHR as complete and accurate and incorporating the views of all stakeholders. The link person in each organisation will ensure ethical principles and GDPR are followed in all project activities. Accounts will be prepared quarterly by University of Plymouth project management administration and checked by the PI.

Ethics

All research, other than evaluations using existing data, will be submitted for prior scrutiny by the UoP Faculty of Health Ethics Committee and the Research Ethics Committees of the participating local authorities. No research will commence until agreed by the sponsor, and all relevant research ethics bodies, including the Social Care Research Ethics Committee (REC) and Plymouth University's Ethics Committee. All agreements about conduct of the research will be adhered to throughout the research. For all research, the PI will satisfy herself that any relevant systematic reviews and prior and current research have been taken into account; the involvement of EE has been sought and enabled at development and implementation; the proposed study is feasible, ethical and safe; peer review and ethical approval has been obtained prior to starting and is kept under review. The key ethical challenges will be confidentiality and the proper boundary between research and service delivery/professional duty of care. Policies will be developed on whistleblowing, professional boundaries, safeguarding and data sharing.

Each of the nested research projects will be managed through partnership between an RR and an RP, with supervision and oversight by senior organisation personnel, the supervisors for the RR and the

RP, and the PI. Information for participants will be reviewed by a panel of EE for readability and comprehensibility, and all persons involved in the research, including and EE, will be adequately prepared for their role, including through relevant training, and supported by the RR / PR / research supervisor/co-applicants with designated responsibilities concerning EE involvement. Involvement by EE and research participants will be voluntary and the aims and methods of the research transparent.

Academics from the University of Plymouth will give support and ensure research rigour and quality as well as ethical probity. All research will conform to the Principles and Responsibilities set out in ss8 and 9 of the UK policy framework for health and social care research and General Data Protection Regulations 2018. Specifically, any personal information obtained through research will adhere to GDPR principles in relation to processing and safe storage of data. Any research involving participants or settings that engage a duty to obtain ethical approval through the Social Care Research Ethics Committee will be the subject of an application to that Committee by the Sponsor and begin only when such approval has been obtained. It is likely of course that some studies will be audits and reviews. The challenges for researching colleagues' activity are acknowledged and also the need to establish the boundaries of confidentiality and risk management between 'researchers' and 'practitioners' and their duties of care, professional obligations and ethical codes of practice.

Success criteria and barriers to proposed work

Our success criteria are captured in our evaluation criteria, and relate to both the success of the project in embedding the research (engagement of stakeholders, increase in research activity and outputs, and impact on services), and the other proof of concept which is the success of the embedded research as context and enabler for the successful completion of two nested research projects. We anticipate barriers to this, and indeed the exploration of barriers to embedded research is one of the questions we intend to explore in this project. They include the pressure on all adult social care services to complete their core functions in the context of Covid19, against a backdrop of services being under long standing operational stresses. We also anticipate that engagement in research will not be of immediate interest to all social care staff, and changing attitudes to research will entail showing benefits and advantages within a relatively short time frame. To mitigate this, we have part-funded posts for adult social workers in each study area to become engaged in research, and to become research 'champions'. The commitment of senior managers in both of our study areas is another way we have sought to mitigate barriers within organisations. The integral involvement of service users and carers will help us to keep our focus on issues of acute concern to them, keeping research relevant to service providers. Our ongoing formative evaluation will help to pick up any issues rapidly so we can consider and address them. Lastly, our diverse, knowledgeable and experienced advisory group will provide us with guidance throughout the process.

We will use this proof of concept research project to explore the potential for embedded research to stimulate the development of research informed and engaged practitioners. The main elements of sustainability will come through activities that flow from this: ongoing research, grant applications to support continuing a research stream, or start innovative projects. We will also be training and leading by example to support service users, carers and senior managers to be more discerning and demanding in requiring interventions to be based on good quality evidence and value for money. Before the project ends, we will develop strategies and policies to support any positive changes in practice. One advantage of our model is that although the Researchers in Residence will cease to be funded by this project, the practitioners, managers and service users and carers who have been involved will not. The project will provide an environment in which relationships between practitioners, managers, service users, researchers and academics can develop, which will be an asset in exploring further collaborative (or in house) funding.

9.2 Authorship eligibility guidelines and any intended use of professional writers

The authors of the final study report will be the PI (PW), Co-PI (RS), and co-applicants FG, JE, RP, SA, RB (see list of applicants and co-applicants). All these individuals are anticipated to make input into the final report. Contributing authors from local authority partners or EE co-researchers will also be included where they have contributed to the report writing. The criterion for individually named authors is membership of the core research team and /or contributing to the final Report. We do not intend to use professional writers from outside this research group.

10 REFERENCES

List the literature and data that are relevant to the study, and that provide background for the study. Please ensure the text contains appropriate cross references to this list.

1. Bottery, S., Varrow, M., Thorlby, R. and Wellings, D. A fork in the road: Next steps for social care funding reform: The costs of social care funding options, public attitudes to them - and the implications for policy reform King's Fund & The Health Foundation London 2018

2. Campbell D, Cote G, Grant J, Knapp M, Mehta A, Morgan Jones, M. Comparative Performance of Adult Social Care Research, 1996-2011: A Bibliometric Assessment. Br J Soc Work 2016, 46, 1282-1300.

3. Morris ZS, Wooding S, Grant J. The answer is 17 years, what is the question: understanding time lags in translational research. J R Soc Med 2011 104, 510-20.

4. Asthana S, Gradinger F, Elston J, Martin S, Byng R. 2020. Capturing the Role of Context in Complex System Change: An Application of the Canadian Context and Capabilities for Integrating Care Framework to an Integrated Care Organisation in the UK. International Journal of Integrated Care, 20(1).

5. Elston J, Gradinger F, Asthana S. et al. Does a social prescribing 'holistic' link-worker for older people with complex, multimorbidity improve well-being and frailty and reduce health and social care use and costs? A 12-month before-and-after evaluation. Prim Health Care Res Dev, 2019 20, e135.

6. Dixon J, Fernandez JL, Noyes J, Marczak J, Lorenz K. Commissioning of Social Care Research Recommendations: Scoping Review Prepared for the National Institute for Health and Care Excellence(NICE) Research Support Unit (RSU) - PSSRU Discussion Paper 2902 LSE

7. Watt T, Varrow M, Roberts A, Charlesworth A. Social care funding options. How much and where from? London: The Health Foundation and the King's Fund, 2018.

8. Puttick R. Mapping the Standards of Evidence used in UK social policy. London: Alliance for Useful Evidence, 2018

9. Powell J, Orme J. Increasing the Confidence and Competence of Social Work Researchers: What Works? British Journal of Social Work, 2011 41, 1566-1585.

10. McLaughlin H. Understanding Social Work Research - 2nd Edition, London, SAGE Ltd, 2012.

11. Blackburn H, Hanley B, Staley K. Turning the pyramid upside down: examples of public involvement in social care research. Eastleigh: INVOLVE, 2010.

12. Gradinger F, Britten N, Wyatt K. et al. Values associated with public involvement in health and social care research: a narrative review. Health Expectations, 2015 18, 661-675.

13. Allen K, Needham C, Hall K, Tanner, D. Participatory research meets validated outcome measures: Tensions in co-production of social care evaluation. Social Policy & Administration, 2019 53, 311-325

14. Beresford, P. Public Participation in Health and Social Care: Exploring the Co-production of Knowledge. Frontiers in Sociology, 2019 04/01/2019

15. Allen T, Grace C, Martin S. Making the Most of Research: Final Report of the ESRC Local Government Knowledge Navigator, Local Government Knowledge Navigator, Birmingham, 2015

16. Argyris C, Schön D. Theory in practice: Increasing professional effectiveness, San Francisco, Jossey-Bass, 1974.

17. Van De Ven A. Engaged Scholarship: A Guide for Organizational and Social Research, Oxford University Press, 2007.

18. Vindrola Padros C, Pape T, Utley M, Fulop NJ. The role of embedded research in quality improvement: a narrative review. BMJ Quality & Safety, 2017 26, 70-80.

19. Churruca, K, Ludlow, K, Taylor, N, Long, JC, Best, S, Braithwaite, J. The time has come: Embedded implementation research for health care improvement. J Eval Clin Pract. 2019; 25: 373– 380. https://doi.org/10.1111/jep.13100

20. Gould MK, Sharp AL, Nguyen HQ, et al. Embedded Research in the Learning Healthcare System: Ongoing Challenges and Recommendations for Researchers, Clinicians, and Health System Leaders J Gen Intern Med. 2020;10.1007/s11606-020-05865-4. doi:10.1007/s11606-020-05865-4

21. Vindrola-Padros C, Vindrola-Padros B. Quick and dirty? A systematic review of the use of rapid ethnographies in healthcare organisation and delivery. BMJ Quality & Safety, 2018 27, 321-330.

22. Pollitt C. (ed.) Context in Public Policy & Management The Missing Link? Cheltenham, Elgar 2013.

23. Cooke J, Gardois P, Booth A. Uncovering the mechanisms of research capacity development in health and social care: a realist synthesis. Health Research Policy and Systems, 2018 16, 93.

24. Currie C, Burgess N, White L, Lockett A, Gladman J, Waring J. A qualitative study of the knowledge-brokering role of middle-level managers in service innovation: managing the translation gap in patient safety for older persons' care. Health Services and Delivery Research. Southampton (UK): NIHR Journals Library 2014.

25. Le May, A. & Wenger, E. Communities of Practice in Health and Social Care, Chichester, John Wiley & Sons, 2008.

26. Campbell H. & Vanderhoven D. Knowledge That Matters: Realising the Potential of Co-Production [Online]. Manchester: N8 Research Partnership 2016. http://eprints.whiterose.ac.uk/99657/

27. McBeath B, Mosley J, Hopkins K, Guerrero E, Austin M, Tropman, J. Building Knowledge to Support Human Service Organizational and Management Practice: An Agenda to Address the Research-to-Practice Gap. Social Work Research, 2019 43, 115-127.

28. McDermott F, Bawden G. New ways of seeing: Health social work leadership and research capacity building. Social Work in Health Care, 2017 56, 897-913.

29. Emmenegger P, Seitzl L. Social partner involvement in collective skill formation governance. A comparison of Austria, Denmark, Germany, the Netherlands and Switzerland. Transfer: European Review of Labour and Research, 2020 26, 27-42.

30. Webber M, Hardy M, Cauvain S. et al. W(h)ither the academy? An exploration of the role of university social work in shaping the future of social work in Europe. European J. of Social Work, 2014 17, 627-640.

31. Martin S. Practical Approaches to Increasing the Utilization of Research. Public Administration Review, 2016 76, 18-19

32. Wilson S, Lilly A. Local Government Knowledge Navigator - Case Study [Online]. London: Institute of Government, 2016.

33. Campbell HJ, Vanderhoven D. Knowledge That Matters: Realising the Potential of Co-Production [Online].Manchester: N8 Research Partnership 2016. http://eprints.whiterose.ac.uk/99657/

34. Ward V. Why, whose, what and how? A framework for knowledge mobilisers. Evidence & Policy 2017, 13(3): 477-497

35. Asthana S, Sheaff R, Jones R, Chatterjee A. eHealth technologies and the know-do gap: exploring the role of knowledge mobilisation. Evidence & Policy 2020 DOI: 10.1332/174426420X15808912803267

36. Southon G, Perkins R, Galler D. Networks: a key to the future of health services. Austrialian Health Review 2005 DOI: 10.1071/ah050317

37. Gericke CA, Boiko, O., Child, S., Nokes, T., Copplestone, A , Sheaff R. PCV143 Implementation of Evidence-Based National Guidance on Venous Thrombo-Embolism Prophylaxis for Hospital Inpatients in England. Value in Health 2011 DOI: https://doi.org/10.1016/j.jval.2011.08.862

38. Ferlie E, Addicott R. Determinants of Performance in Cancer Networks. A Process Evaluation. Cardiff University 39. Spensberger F, Kollar I, Gambrill E, Ghanem C, Pankofer S. How to Teach Evidence-Based Practice in Social Work: A Systematic Review. Research on Social Work Practice, 2019 30, 19-39.

40. Chakradhar K. Forging and sustaining research-minded professionals: teaching undergraduate research through student-community partnerships. Social Work Education, 2018 37, 428-441.

41. McBeath B, Mosley J, Hopkins K, Guerrero E, Austin M, Tropman, J. Building Knowledge to Support Human Service Organizational and Management Practice: An Agenda to Address the Research-to-Practice Gap. Social Work Research, 2019 43, 115-127.

42. McDermott F, Bawden G. New ways of seeing: Health social work leadership and research capacity building. Social Work in Health Care, 2017 56, 897-913.

43. Marshall M, Pagel C, French C, Utley M, Allwood D, Fulop N, Pope C, Banks V, Goldmann A. Moving improvement research closer to practice: The Researcher-in-Residence Model. BMJ quality and safety 2014 DOI: http://creativecommons.org/10.1136/bmjqs-2013-002779

44. Gradinger F, Elston J, Asthana S, Martin S, Byng, R. Reflections on the Researcher-in-Residence model coproducing knowledge for action in an Integrated Care Organisation: a mixed methods case study using an impact survey and field notes. Evidence & Policy 2019 15, 197-215.

45. Ward V. Why, whose, what and how? A framework for knowledge mobilisers. Evidence & Policy 2017,13 (3): 477-497

46. Asthana S, Sheaff R, Jones R, Chatterjee A. eHealth technologies and the know-do gap: exploring the role of knowledge mobilisation. Evidence & Policy 2020 DOI: 10.1332/174426420X15808912803267

47. Lockett A, El Enany N, Currie G. et al. A formative evaluation of Collaboration for Leadership in Applied Health Research and Care (CLAHRC): institutional entrepreneurship for service innovation. Health Services and Delivery Research. 2014 Southampton (UK): NIHR Journals Library.

48. Bottery, S., Varrow, M., Thorlby, R. and Wellings, D. A fork in the road: Next steps for social care funding reform: The costs of social care funding options, public attitudes to them - and the implications for policy reform King’s Fund & The Health Foundation London 2018

49. Moriarty, J., Gillen, P., Mallett, J., Manthorpe, J., Schröder, H., McFadden, P. (2020) Seeing the Finish Line? Retirement Perceptions and Wellbeing among Social Workers. Int. J. Environ. Res. Public Health 17 (13), 4722. 10.3390/ijerph17134722

50. Pope ND, Rollins L, Chaumba J, Risler E. Evidence-Based Practice Knowledge and Utilization among Social Workers. Journal of Evidence-Based Social Work, 2011 8, 349-368.

51. Gray M, Sharland E, Heinsch M, Schubert L. Connecting Research to Action: Perspectives on Research Utilisation. The British Journal of Social Work, 2014 45, 1952-1967.

52. Heinsch M, Gray M, Sharland E. Re-conceptualising the link between research and practice in social work: A literature review on knowledge utilisation. Int. Journal of Social Welfare, 2016 25, 98-104.

53. Scurlock-Evans L. Upton D. The Role and Nature of Evidence: A Systematic Review of Social Workers' Evidence-Based Practice Orientation, Attitudes, and Implementation. Journal of Evidence-Informed Social Work, 2015 12, 369-399.

54. Andrews N, Gabbay J, Le May A, Miller E, O’Neill, M. & Petch, A. Developing Evidence-Enriched Practice in Health and Social Care with Older People [Online]. Joseph Rowntree Foundation, 2015. Available: https://www.jrf.org.uk/report/developing-evidence-enriched-practice-health-and-social-care-olderpeople [Accessed 14.05.20].

55. Cheetham M, Wiseman A. Khazaeli B. et al. Embedded research: a promising way to create evidence informed impact in public health? J Public Health (Oxf), 2018 40, i64-i70.

56. Wilson S, Lilly A. Local Government Knowledge Navigator - Case Study [Online]. London: Institute of Government, 2016. https://www.instituteforgovernment.org.uk/sites/default/files/local-governmentknowledgenavigator.pdf

57. Gradinger F, Britten N, Wyatt K. et al. Values associated with public involvement in health and social care research: a narrative review. Health Expectations, 2015 18, 661-675.

58. Allen K, Needham C, Hall K, Tanner, D. Participatory research meets validated outcome measures: Tensions in the co-production of social care evaluation. Social Policy & Administration, 2019 53, 311-325.

59. Beresford, P. Public Participation in Health and Social Care: Exploring the Co-production of Knowledge. Frontiers in Sociology, 2019 3.

60. Watt T, Varrow M, Roberts A, Charlesworth A. Social care funding options. How much and where from? London: The Health Foundation and the King's Fund, 2018.

61. Smith R. Doing Social Work Research. Maidenhead, Open University Press 2010.

62. Mitchell F, Lunt N, Shaw I. Practitioner research in social work: a knowledge review. Evidence & Policy, 6, 7-31 2010.

63. Dixon J, Fernandez JL, Noyes J, Marczak J, Lorenz K. Commissioning of Social Care Research Recommendations: Scoping Review Prepared for the NICE Research Support Unit (RSU) - PSSRU Discussion Paper

2902 [Online]. London School of Economics, 2015. Available: ttps://www.pssru.ac.uk/pub/5113.pdf

64. OSR. Adult Social Care Statistics: a way forward for Great Britain. London: OSR 2020. https://www.statisticsauthority.gov.uk/WScontent/uploads/2020/04/ASCR_GB_summary.pdf

65. Schlepper, L. Adult social care statistics: the potential for change [Online]. London: Nuffield Trust, 2020. https://www.nuffieldtrust.org.uk/news-item/adult-social-care-statistics-the-potential-for-change

66. McLaughlin H. Understanding Social Work Research - 2nd Edition, London, SAGE Ltd, 2012.

67. Blackburn H, Hanley B, Staley K. Turning the pyramid upside down: examples of public involvement in social care research. Eastleigh: INVOLVE, 2010.

68. Campbell D, Cote G, Grant J, Knapp M, Mehta A, Morgan Jones, M. Comparative Performance of Adult Social Care Research, 1996-2011: A Bibliometric Assessment. Br J Soc Work 2016, 46, 1282-1300.

69. Cheetham M, Wiseman A. Khazaeli B. et al. Embedded research: a promising way to create evidence informed impact in public health? J Public Health (Oxf), 2018 40, i64-i70.

70. James Lind Alliance Adult Social Work Priority Setting Partnership Adult Social Work PSP Top 10, 2018. https://www.jla.nihr.ac.uk/priority-setting-partnerships/adult-social-work/.

71. Argyris C, SchÖn D. Theory in practice: Increasing professional effectiveness, San Francisco, Jossey-Bass 1974.

72. Lalani M, Hall K, Skrypak M, Laing C, Welch J, Toohey P, Seaholme S, Weijburg T, Eyre L, Marshall, M. Building motivation to participate in a quality improvement collaborative in NHS hospital trusts in Southeast England: a qualitative participatory evaluation. 2018 Health Services Research DOI:

73. Iles, V. and Sutherland, K. Organisational Change: A Review for health care managers, professionals and researchers, London UK, National Coordinating Centre for Service Delivery and Organisation, 2001

74. Corfe, S. (2017). Living on the Edge: Britain's Coastal Communities. London: Social Market Foundation

75. Heinsch M, Gray M, Sharland E. Re-conceptualising the link between research and practice in social work: A literature review on knowledge utilisation. Int. Journal of Social Welfare, 2016 25, 98-104.

76. Scurlock-Evans L. Upton D. The Role and Nature of Evidence: A Systematic Review of Social Workers' Evidence-Based Practice Orientation, Attitudes, and Implementation. Journal of Evidence-Informed Social Work, 2015 12, 369-399.

77. Bernet, A., Willens, D. and Bauer, M. Effectiveness-implementation hybrid designs: implications for quality improvement science. Implementation Science : IS 8(Suppl 1): S2. 2013

11. APPENDICES

11.1 Appendix 1- Required documentation

List here all the local documentation you require prior to initiating a participating site (e.g. CVs of the research team, Patient Information Sheet (PIS) on headed paper etc.).

11.2 Appendix 2 – Schedule of Procedures (Example)

Procedures	**Visits (insert visit numbers as appropriate)**				
	Screening	**Baseline**	**Week 4**	**Week 8**	**6 Months**
Informed consent	x				
Demographics		x			
Medical history		x			
Observation of treatment		x	x	x	x
Focus Group					x
Interview				x	

13.3 Appendix 3 – Amendment History

Amendment No.	Protocol version no.	Date issued	Author(s) of changes	Details of changes made

List details of all protocol amendments here whenever a new version of the protocol is produced.

Protocol amendments must be submitted to the Sponsor for approval prior to submission to the REC.