Coventry Health Determinants Research Collaboration

Business Plan

1 Background

1.1 The City of Coventry

Coventry, the 2021 City of Culture, is a diverse and cohesive city with a young population. The city's 2020 mid-year population estimate was 379,387 residents, and the city has seen its population grow over the past decade, especially its population of young adults aged 18-29[1]. People of working age (18-64) represent 65% of the adult population.

Coventry is the 18th largest local authority in England and is ranked 64th out of 317 UK local authorities in the Index of Multiple Deprivation 2019, with 14.4% of the population living in one of the 10% most deprived neighbourhoods in England[1].

Overall, one-third of the population has an ethnic minority background compared to 20.2% in England (2010 Census), and just under half of school-aged children have an ethnicity other than white (2021 School Census).

Coventry City Council (CCC) works closely with its strategic partners through the Anchor Alliance (an informal network of local chief executive officers from anchor organisations, universities, and the Local Enterprise Partnership), One Coventry Partnership, and specific partnership boards[2].

The mission of the **Anchor Alliance** is primarily focused on reducing inequalities[2] - "An anchor institution alliance for Coventry and Warwickshire with an individual and collective commitment to the delivery of transformative actions to; address the inequalities in our communities in health and wellbeing, access to education, employment opportunities; and to supporting the development of enterprise and the economy."

Similarly, our three priorities which are set out in our **One Coventry Plan** are all aligned to reducing inequalities[3], as follows:

1. Increasing the economic prosperity of the city and region.
2. Improving outcomes and tackling inequalities within our communities.
3. Tackling the causes and consequences of climate change.

Our **One Coventry Partnership** is a multi-agency partnership that seeks to provide joined-up strategic leadership across different organisations and to develop a culture that truly **enables collaboration with the voluntary and community sectors** and a cohesive approach to delivering the health inequalities agenda. It is connected to all mainboards such as the Health and Wellbeing Board, Coventry and Warwickshire Integrated Care System, and the Anchor Alliance.

1.2 Our Marmot Partnership

Coventry has been a 'Marmot' City since 2013, with a multi-agency partnership overseeing and driving forward action to reduce health inequalities[4]. Coventry has taken a lead in the UK in highlighting the importance of the wider determinants of health across key sectors: local government, education, fire service, police, public health, health and social care, and business. There is an enduring and strong commitment from councillors and senior leaders to tackle health inequalities through all aspects of council policy. Over the years we have taken an 'Equity in all Policies' approach, rather than a 'Health in all Policies' approach. This has been a helpful nuance to influence and shift mindsets from the automated thinking which associates 'Health in all Policies' with health behaviours and is essentially the sole domain of public health within the council.

An evaluation of our Marmot City approach, published by University College London (UCL), indicated that this partnership has contributed to an improvement in Coventry's deprivation

ranking (index of multiple deprivation)[4]. Between 2015 and 2019, the number of Coventry neighbourhoods among the 10% most deprived in England reduced from 18.5% to 14.4%, a period during which all but one local authority in the West Midlands have seen a worsening in their relative ranking[4]. Additionally, within the period from 2015 to 2020, the proportion of Coventry's residents with no qualifications has reduced from 15% to 7.1%[5]. Whilst this is good progress, we want to do more, especially through focussing our efforts on the early years and building the aspirations of our young people. At every level, we aim to improve life chances across the life course, working across our social gradient to support all our residents to achieve their potential.

We continue to actively work with Professor Sir Michael Marmot and his team, the latest initiative being the national launch of 'The Business of Health Equity: The Marmot Review for Industry' report, with a roundtable event held at CCC on 31st March 2022[6-7].

This national work to engage businesses reflects our 'Call to Action' to businesses, which is led by our Marmot Partnership and was launched by Professor Sir Michael Marmot and Sir Chris Ham in June 2021. This is a campaign to encourage and support businesses to do more to reduce inequalities. We now plan to align our CCC work across skills, employment, and economic development to this framework. We are also now working to harmonise our Marmot work to the levelling up agenda by aligning it with the Purpose Coalition's levelling up goals[8].

We have had some successes in recent years, but there is so much to do, especially in the light of the amplification of inequalities through the COVID pandemic and the current cost of living crisis.

1.3 Why the HDRC framework is needed

We do not currently have an overarching research framework. Our collaborations with universities have been relatively ad-hoc and limited; dependent on connections made around specific projects. A recent assessment of our research capacity and infrastructure, led by a team from the West Midlands Applied Research Collaboration (WM-ARC), identified significant needs, with priorities being:

- Growing collaborations with local academic institutions.
- Encouraging and facilitating greater engagement of frontline employees in dedicated research roles.
- Addressing barriers such as time and resource availability.
- Providing research training and increase the ability to use research evidence.

We need to create an environment within which research and the use of evidence in decision-making will flourish, but we do currently lack the infrastructure needed to embed this culture within our organisation. Senior staff report that they do not have sufficient resources to properly evidence and evaluate interventions, including those aimed at improving transport infrastructure, air quality, living environments, digital inclusion, and economic prosperity.

The City of Culture partnership[9] has been an exception, as for a period of time this achieved a more cohesive connection between CCC and local universities, but it is now in danger of losing momentum and focus. Nonetheless, the City of Culture provided a 'glimpse' of the potential of a more systematic and sustained way of working together on research, focusing on addressing inequalities. The HDRC opportunity has come at the perfect time for us; we have the right thinking, the right leadership, and the right opportunities, right now. We see the huge opportunities that an HDRC framework offers us to develop, maintain and expand our research activity, specifically in areas such as community engagement, City of Culture legacy, transport, regeneration, migrant health, skills, and employment. This would not only benefit Coventry, but through the dissemination of research findings and through broader networks, this has the potential to impact regionally, nationally, and internationally.

2 Vision & objectives

2.1 Coventry HDRC vision

Our vision is to create a collaborative research ecosystem that is open, creative, dynamic, and evidence-driven. We will respond to tackling health inequalities through understanding the power of the wider determinants of health. Our networks count, so at local, regional, national, and international levels, we will add value by harnessing these different perspectives.

Our internal CCC mechanisms are also important. We will embed a research consciousness within our organisation through the commitment of the Chief Executive Officer and specifically aligned Directors, through our senior leadership team, and on through to all our employees. Employees will be able to engage and develop research skills and their voices along with those of our communities will reverberate throughout everything our HRDC seeks to achieve.

2.2 Coventry HDRC objectives

Our key aim is to evaluate Coventry's experience, to produce generalisable evidence on strategies to reduce health inequalities. Specific objectives are:

1. **Culture change, partnerships, and leadership**
    - 1.1. Develop and embed a research culture across our organisation.
    - 1.2. Effectively utilise existing research evidence in our decision-making.
    - 1.3. Align incentives across CCC and Higher Education Institutions (HEI) to maximise the benefit to both, sharing skills and expertise across sectors.
2. **Infrastructure and capacity**
    - 2.1. Establish research governance processes.
    - 2.2. Provide staff training to mobilise and evaluate evidence.
    - 2.3. Create pathways to disseminate research to impact local and national policy.
    - 2.4. Evaluate the progress of the HDRC, identifying barriers and solutions as we develop.
3. **Public engagement**
    - 3.1. Prioritise and co-develop research with the public, including under-represented communities.
    - 3.2. Develop a 'real-world' research approach to engaging with communities through our current and developing networks; testing approaches, seeking feedback, revising, retesting, and allowing a 'best-fit for Coventry' approach to emerge
    - 3.3. Drive the research agenda in a way that links to our priorities and key decisions with the voice of communities and the prioritisation process
4. **Sustainability**
    - 4.1. Use our experience of establishing the HDRC to support other local authorities to develop their research capacity.
    - 4.2. Aim for long-term financial sustainability for the HDRC by attracting external research income.

2.3 How these objectives will be achieved

Strong collaborations with higher education institutions will be central to developing a multi-disciplinary team that drives positive culture change across CCC and develops research infrastructure. Building trust with the public and the voluntary sector based on effective communications will ensure we develop mechanisms for setting the right priorities. The commitment of our political and senior leadership, will facilitate organisational culture change and ensure that we get the right people in place to motivate, nurture, and inspire a sustainable 'research excellence' environment. We will measure the quality of our collaborations so that we can identify and address weak areas.

3 Coventry HDRC structure

HDRC activities will be structured around five pillars; objectives from section 2.2 are mapped against pillars in Table 1. These pillars will be delivered in collaboration with relevant CCC departments, ensuring that the HDRC builds on and adds capacity to existing infrastructure (see Leadership & Governance Structure Chart & Organogram). Each pillar will be led by a senior CCC officer (department heads), paired with a partner who will provide external expertise. Voluntary sector co-leads will provide community insight and ensure the HDRC responds to voluntary sector priorities and supports the sector's capacity.

Pillar		Objectives	CCC lead (collaborating departments)	Partner co-lead	VSCE co-lead
1	Data & Governance	2.1	Ward (Information Technology)	Robbins (UHCW)	Boagey (PYF)
2	Training & skills	2.2	Haynes (Human Resources & Training)	Whelan (CU)	Bukhari (FWT)
3	PPIE	3.1, 3.2, 3.3	De Souza (Public Health)	Staniszewska (UW)	Wightman (Grapevine), Stern (CELC)
4	Evaluation	2.4, 4.2	Chapman (Public Health)	Oyebode (UW)	Ogle (VAC) & Algate (CCA)
5	Impact & Implementation	1.1, 1.2, 1.3, 2.3, 4.1	McGinty (Strategic Transformation)	Allen (UCL) & Currie (UW)	Amoakoh (HC) & Markey (CIAS)

Please see the annex at end of the document for abbreviations

Table 1: HDRC pillars and management. Please see abbreviations in Annex.

4 Coventry HDRC management

The following standing committees will oversee the management of the HDRC:

- An executive Committee (quarterly meeting) will provide strategic oversight. It will include senior staff representing key collaborating organisations (CCC, Coventry University [CU], University of Warwick [UW], University Hospitals Coventry & Warwickshire [UHCW]).
- A management Committee (monthly meeting) comprised of pillar co-leads (see Table 1) plus two public representatives to oversee detailed implementation.
- A Stakeholder Group (quarterly meeting) will enable direction and feedback on the programme's activities from partners representing the wider system. It will comprise key CCC departments, government agencies, and voluntary organisations (see Table 2).
- Subject matter subgroups will be ad-hoc groups focused on specific wider determinants that have been prioritised. The roles of these sub-groups will be to co-identify evidence gaps and research opportunities.

Local authority	Public & private sectors	Voluntary sector
Education	Office for Health Improvement & Disparities	Central England Law Centre
Employment	Department for Work & Pensions	Coventry Citizen's Advice
Sustainability	West Midlands Police	Coventry Independent Advice Service
Housing	Chamber of Commerce	Foleshill Women's Trust
Economic development	Coventry City of Culture	Grapevine
	University Hospital Coventry & Warwickshire	Highlife Centre
	Change Grow Live	Positive Youth Foundation
	Coventry & Rugby Clinical Commissioning Group	Sky Blues in the Community
		Voluntary Action Coventry

Table 2: Stakeholder group membership

5 Coventry HDRC governance

The governance framework is illustrated in the Leadership & Governance Structure Chart.

The HDRC Programme Director will be line managed by the Director of Public Health (DPH), embedding the HDRC within internal CCC governance, feeding through to One Coventry Leadership Team (OCLT: corporate leadership) and cabinet. The HDRC Programme Director will attend monthly OCLT meetings to present updates on HDRC progress. If significant barriers are encountered, additional ad-hoc meetings will be held with a subgroup of interested "link" Directors who have committed to supporting the HDRC's objectives: Knight (Director of Transport and Highways), Newing (Director of Human Resources), Williams (Director of Business, Investment and Culture), Fahy (Director Adult Social Services, including housing), Gregg (Director of Children's Services).

External oversight will be by an independent steering committee (annual meeting) chaired by Prof Sir Michael Marmot. It will include representation from public health (Association of Directors of Public Health), policy (King's Fund, Health Foundation), and research communities (Academic Health Science Network, Clinical Research Network). Additional members will provide specific expertise in Patient and Public Involvement and Engagement (PPIE) and sustainability.

6 Coventry HDRC partners

6.1 HDRC partners

Each of the core external partners involved in the development of this proposal will co-lead pillars, supporting CCC to become increasingly independent:

- The Research & Development (R&D) department at University Hospitals Coventry & Warwickshire will provide expertise to support the establishment of R&D infrastructure and mentor newly appointed R&D staff (Randeva & Robbins, Pillar 1).
- Centre for Intelligent Healthcare, Coventry University will support training needs analysis, provide oversight of HEI training provision, and mentor HDRC staff (Lycett & Whelan, Pillar 2).
- Warwick Medical School, University of Warwick will support the set-up of PPIE pathways (Staniszewska, Pillar 3), support HDRC evaluation (Oyebode, Pillar 4), and mentor HDRC staff.
- Warwick Business School, University of Warwick will provide expertise in culture change (Currie, Pillar 5).
- Institute for Health Equity, University College London (Allen, Pillar 5) will provide expertise in the wider determinants of health and support national and international dissemination of findings.
- Voluntary sector organisations (see list in Table 2) will provide experience and networks to support the engagement of people representing diverse communities in Coventry.

Activities will be aligned to the related NIHR infrastructure. UW are members of the NIHR School for Public Health Research and the NIHR West Midlands Applied Research Collaboration, whose Public Health Theme is led by Oyebode. The NIHR Clinical Research Network Public Health lead will sit on the Independent Steering Committee.

Wider system partners, including government departments, NHS, and voluntary organisations will be represented in the Stakeholder Group (see section 4).

6.2 Delivery team expertise

Our delivery team combines deep expertise across a range of disciplines:

- **Director:** Frossell is an experienced consultant in public health who has previously led the health inequalities agenda in Milton Keynes and has led Coventry's Marmot Partnership since 2019. She already has established deep links across Coventry's public, private, and voluntary sectors focusing on tackling the wider determinants of health.
- **Public Health:** Chapman and De Souza are experienced consultants in public health who will each co-lead a pillar. Duggal is CCC's Director of Public Health and Wellbeing, and will provide senior support.
- **Organisational culture:** Reeves is CCC Chief Executive Officer and Haynes is CCC Head of People & Culture. Currie is Professor of Public Management at Warwick Business School and has expertise in public services organisation and management and culture change. Currie has extensive experience in NIHR research, including WM-ARC.
- **Research governance:** Randeva is Director of R&D at UHCW and Robbins is an NIHR Clinical Lecturer and UHCW's Clinical Research Information Officer. UHCW has extensive experience in the delivery of NIHR, charitably-funded, and industry-funded research, and the team also has expertise in digital health. Randeva will provide senior oversight, with Robbins acting as Pillar 1 lead. UHCW R&D staff will provide expertise in data management and sharing.
- **Community engagement:** Boagey, Ogle, Stern and Wightman are senior leaders of voluntary organisations, with deep knowledge of Coventry and excellent links across the city's diverse communities. They will contribute as pillar co-leads as well as helping to develop the PPIE strategy.
- **Health policy focused on the wider determinants:** Allen is Deputy Director of the Institute of Health Equity at UCL, which is led by Professor Sir Michael Marmot. Allen is a leading health policy expert who has been deeply involved in the development of the Marmot agenda. She will co-lead the Impact & Implementation pillar and will support the national and international dissemination of research findings.
- **PPIE:** Staniszewska has extensive NIHR experience in public engagement[10-11]. Grant and Whitehurst are experienced PPIE representatives who have previously contributed to NIHR research, including to WM-ARC.
- **Research methodology:** Oyebode is Associate Professor of Public Health and Gill is Professor of General Practice. Both have led and contributed to major NIHR programmes. They will be supported by Chen who has extensive experience in systematic and health technology assessment; he will mentor the new post in evidence synthesis. Oyebode will supervise Public Health speciality trainee HDRC placements.
- **Pedagogy:** Lycett is Executive Director of the Director of Centre for Intelligent Healthcare with a track record in mentorship and training. She will provide senior oversight for training across the HDRC. Whelan is Assistant Professor and has worked extensively with colleagues at local authorities (including CCC) and will be the training pillar lead. They will be supported by Patel who will mentor the HDRC mixed methods researcher, Kurmi who will mentor the HDRC epidemiologist, and CU research support staff will provide research governance, ethics, impact, and dissemination training for HDRC staff.

7 Capacity building

Capacity building will encompass the establishment of research infrastructure as well as the training and development of CCC and wider system staff. Detailed information about capacity building in relation to PPIE is in section 9.

7.1 New posts

New posts (see Table 3) will be created to facilitate the establishment of an ethics committee, research governance and data sharing frameworks, and PPIE pathways. Joint CCC-HEI appointments will support evidence mobilisation, development of research funding applications, and pilot studies. Physical space is available at CCC premises to host these new employees for face-to-face working arrangements.

Post	Mentorship	Roles
Programme Manager	Programme Director	Overall programme management, budget management, and reporting
Programme Officer	Programme Manager	Primary responsibility for establishment and running of training offer
Governance Officer	Robbins / R&D team (UHCW)	Primary responsibility for establishment and running of research ethics pathway
Research Information Officer	Robbins / R&D team (UHCW) & Ward (CCC Information Technology)	Primary responsibility for establishment and running of data sharing pathway
PPIE Officer*	Staniszewska (UW) & Buckley (CCC)	Primary responsibility for the development and delivery of PPIE activities.
Epidemiologist*	Kurmi (CU)	Expert support for pilot studies and funding applications, with focus on quantitative study design and analysis
Mixed methods researcher*	Patel (CU)	Expert support for pilot studies and funding applications, with focus on qualitative study design and analysis
Evidence synthesis researcher*	Chen (UW)	Support for CCC evidence-based decision making, pilot study design, and funding applications through the delivery of rapid systematic reviews

Table 3: New HDRC posts

*Staff members will also contribute to the development of online training materials.

7.2 Training & skills

CCC staff career development targets will be identified through the appraisal process, led by Haynes (CCC Head of People & Pillar 2 lead). A spiral approach to learning will be taken, with a series of formal training needs assessments undertaken by CU to identify what resources, training, and support are needed. The initial training needs assessment will be completed within the first six months and will assess the needs of CCC staff, PPIE contributors, and the voluntary sector. Further assessments will be completed in years 2 and 4 to identify changes in need.

The HDRC training offer will include:

Embedding an evidence-based practice culture focused on the wider determinants

- Induction procedures for new CCC employees with line management responsibilities will be adapted to incorporate information about the HDRC. This will help cultivate a collaborative, evidence-based, inclusive research culture within the system as new employees join CCC.
- Annual half-day symposia (250+ attendees per year) on the wider determinants of health led by Prof Sir Michael Marmot for CCC staff, colleagues from the wider system, and the voluntary sector.

Developing research skills

- Training brochure to signpost existing local and national training resources accessible to CCC staff and wider system colleagues, including the voluntary sector.
- Joint HDRC-HEI staff will co-develop a range of training resources with HEI and voluntary sector partners to address identified unmet learning needs. Topics could

include ‘Introduction to the HDRC’, ‘Research governance’, ‘Core research skills’, ‘Data management skills’, ‘PPIE and co-production’, ‘Research leadership and impact’ depending on identified needs. This will include workshops, sessions built into mandatory training requirements, and e-learning (200+ people trained per year). Materials will be Coventry context-specific, aligned to prioritised topics around the wider determinants with support of PPIE. Materials will be offered to voluntary sector colleagues to garner system-wide benefits.

- Access for CCC staff to masters modules at CU and UW. Modules will include: Understanding Research and Critical Appraisal (MH923); Methodologies in Applied Research (7087PY); Synthesising Evidence (7092PY); Qualitative Research Methods in Health (MH930); Epidemiology and Statistics (MH900); Introduction to Research Design and Writing (7009CPD); and Introduction to Health Economics for non-economists (MD990). A total of 140 modules will be funded. In addition, Warwick Business School offers a distance-learning 4-week executive programme that, if desired, could be tailored to middle managers e.g. ‘Distributed leadership for health (and social care) innovation’ or a face-to-face Diploma in ‘Strategic leadership in healthcare’.

Developing the next generation of research leaders

- A HDRC placement will be offered to Public Health specialty trainees, as part of an initiative to disseminate learning across the West Midlands.
- Research placements for frontline CCC staff that allow them to ringfence time to develop research ideas, with mentorship from HEI partners. Proof of principle for this is an NIHR-funded Research Assistant who is co-supervised across CCC and CU.
- Bilateral exchanges between CCC, the wider system (including CU and UW), and the voluntary sector to facilitate targeted skill development and project co-development. The duration and focus of these exchanges will be flexible to project needs (e.g. intense 4-week period or one day a week for 3 months). Proof of principle was provided by an NIHR-funded PhD student who worked across both CCC and UW.
- Individuals seeking to pursue formal academic careers will be signposted and supported to apply to NIHR Academy schemes, including fellowships. CU will offer fee waivers for PhD students using internal QR funding to facilitate staff development through a formal research qualification. We anticipate two PhD students being supported in this way during the lifetime of the HDRC.

Supporting the development of research ideas

- CCC staff will be supported to access collaborative pump-priming funds from partner HEIs. This will support pilot studies aimed at gathering preliminary data to support larger funding applications.
- Supervision of discrete CU/UW undergraduate and postgraduate projects by collaborative teams comprising CCC and CU/UW staff. This will bolster employment prospects of aspiring adults in the West Midlands (through acquiring research experience) and enable CCC staff to acquire supervision opportunities and oversee capacity development within the local authority.

Management Committee meetings will include a permanent agenda item relating to training, aimed at identifying and signposting additional external training opportunities.

7.3 Research and data governance

The design of new research governance structures will be supported by UHCW R&D and CU who have expertise in NHS / Health Research Authority and university ethics procedures. We anticipate many local-authority studies will be low-risk, therefore whilst our governance structures will be robust, we will ensure there is a rapid, proportionate, enabling approach when appropriate, in order to reduce barriers to research. Initial outlines for both research ethics and data governance pathways are outlined in Figure 1. The Programme Manager will have overall responsibility for the running of these pathways, with the Governance Officer and Research Information Officer leading day-to-day management. HDRC staff will be trained and receive

ongoing mentorship from UHCW and CU. The internal research ethics committee (REC) will include PPIE representatives.

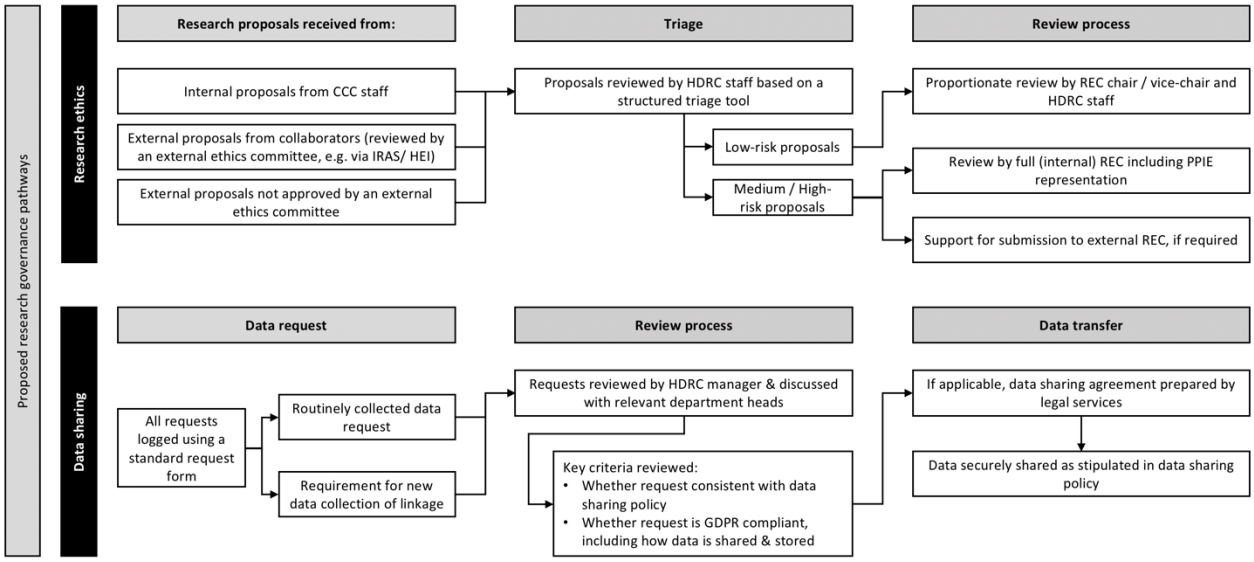

Figure 1: Proposed research governance pathways

8 Collaboration, Culture & leadership

8.1 Overview

Partners across Coventry already have strong underpinning cultural values which are in line with the needs of an HDRC; we have a diverse, inclusive, collaborative, learning and improvement culture within which all partners for the HDRC already closely collaborate.

Examples of our relevant collaboration, culture, and leadership approach and how this links into our HDRC and wider potential dissemination of learning and influence:

- Ongoing collaboration across the two main academic partners (Coventry University and the University of Warwick) aligned with their civic responsibility. The Universities have ‘low walls’ with health and social care partners to support collaboration. The HEI leadership across Coventry is well placed to be scaled up to support the HDRC.
- Work through NIHR WM-ARC, neighbouring public health and related delivery agencies, and universities in Birmingham and the Black Country. Consequently, our proposed HDRC has reached beyond Coventry.
- Support of an emerging cadre of ‘practice savvy researchers’ and ‘evidence savvy practitioners’ generated through sustained research and impact co-production over many years. This experience can be used within the HDRC to impact our co-production approach and to shift our culture to become more research and evidence-driven.
- Clear leadership to support the people of Coventry to be an integral part of the co-production of research and impact across health and social care in Coventry and Warwickshire, as evident in our NIHR WM-ARC, within which many of the co-applicants for the HDRC collaborate.
- Close relationships and ongoing research programmes across health sciences, social sciences, and digital engineering to address health challenges.
- We drive novel domains of research and impact, linked to the development of the integrated care systems, such as how economic prosperity and population well-being go hand in hand, with funding flowing from the Economic and Social Research Council through to the Enterprise Research Centre and the Productivity Institute.
- Investment in our HDRC is also an opportunity to scale up our impact on children and young people’s services through ongoing work in the NIHR-funded Applied Research Centre West Midlands (NIHR WM-ARC) in the area of mental health services for the Black and Minority Ethnic population.

- Data science expertise is embedded at CCC, CU, and UW, the fruits of which have been evident in the development and delivery of the Coventry City of Culture. Researchers have worked with the City of Culture Trust and CCC to ensure not just economic, but also health and social impact for the more socially deprived populations so that a legacy effect from cultural investment remains. With investment in our proposed HDRC, we would build further our capability in both data science and measuring the impact of investments in the wider determinants of health.

8.2 Our approach to culture change

Having described some success factors which will underpin the new HDRC infrastructure, we recognise the complexity and the leadership challenge of this collaboration, and the cultural shift required to maximise our productivity. We intend to cultivate and sustain a collaborative, evidence-based, inclusive, and learning culture through the HDRC that focuses on health inequalities and is in line with our Marmot City status.

We will:

- Cultivate and sustain a senior leadership culture that embeds evidence in their decision-making around inequality in health determinants.
- Utilise the clear commitment of the Chief Executive Officer and the Directors within CCC to drive culture change throughout the organisation, embedding our 'research and evidence' culture within the wider 'One Coventry' organisational culture change process being led by Human Resources.
- Incorporate political leadership through the development of a cross-party statement of commitment and through a small cross-party group of councillors committed to leadership in the research and evidence arena.
- Develop new 'knowledge brokering' roles for middle-level managers with a professional background, positioned between executive managers and frontline practitioners who will co-produce research and impact programmes around the wider determinants of health with our academic partners (key areas have been identified within transport innovation, economic development, business impact, climate change, care leaver support through apprentice and mentoring support).
- Develop communities of practice encompassing key stakeholders for change (including PPIE), and broker research evidence into frontline practice with maximum impact.
- Distribute leadership across all our partners through our governance structures, to ensure joint purpose (partners' efforts aligned in the same direction) and synergy across partners, so that outcomes exceed the sum of the parts of our proposed HDRC.
- Embed our training and capacity-building development plan within organisational structures
- Engage with elected members in our governance structures to assure political support for our plans, and provide a 'critical friend' scrutiny approach.
- Include CCC Directors within the HDRC governance structure to ensure senior leaders' commitment assure delivery of our plans, key amongst whom is Coventry City Council's Director of Human Resources.

8.3 HDRC impact

Coventry's HDRC funding will support us to embed a culture of research and evidence through:

- Removing any bureaucratic tendency that stymies evidence-based innovation and research.
- Strengthening collaboration and capacity to develop our learning and improvement culture with a greater focus on the wider determinants of health, in line with our Marmot City status.
- Helping us to shift mindsets in the creation of an environment where professional curiosity can flourish.

- Systematically accelerating, broadening, and deepening our capabilities to implement, sustain, and scale-up evidence-based interventions to address inequalities around health determinants (many initiatives are perfectly aligned to the HDRC, but are currently not systematically evidence-driven or robustly evaluated).
- Strengthening our approach to diversity and inclusion, with the voice of the communities and specific groups a significant force in informing our research priorities and chosen outcome measures.
- Ongoing evaluation of the quality of our collaboration and depth of cultural shift.

9 Patient and Public Involvement and Engagement

9.1 Overview

Our overarching vision for PPIE is to make a clear contribution to the reduction of inequalities by addressing the issues of importance to our diverse communities. We seek to ensure their voice is heard on what priority research topics are, how research should be undertaken, what important outcomes should be measured, and how results should be implemented. From our conversations with community organisations and existing Marmot Partnership work we already have some understanding of key issues for our communities, including poverty, poor quality jobs, isolation, and disconnection; all of which are in the context of diminishing public services and facilities.

9.2 Our approach to PPIE

We will build on the strong networks already established by CCC, the local voluntary sector, and by statutory healthcare organisations. These include:

- The Marmot Partnership[4], providing a strong foundation for our collaboration.
- We have identified city councillors who will help us to convene a small cross-party group of councillors who will provide input into PPIE activities and provide a broad perspective on the needs of the different communities and specific groups within Coventry, especially across diverse socio-economic and ethnic groups.
- Local branches of Healthwatch and Citizens Advice, which will enable us to highlight key issues within our communities.
- Networks of voluntary and community sector organisations are currently supported by the council's Community Resilience Team.
- Community messengers: a team of community groups developed as a response to the COVID pandemic but continuing to work to engage the most vulnerable groups around health and care issues.
- City of Culture 2021 City Hosts: over 100 City Hosts (community volunteers), many of whom are committed to continuing to serve our city – we will harness this energy.
- Drawing on VCSE Alliance in Coventry, a body of hundreds of grassroots to large organisations which is a member of the VAC. The Coventry and Warwickshire VCSE Mental Health Alliance has 50 members with a MH remit/focus. We can also access other sector mechanisms with mailing lists/members such as Positive Images Festival, Sacred Spaces, Women's Partnership, Coventry VCSE Leaders Network.
- The Integrated Care System (ICS) Communities Strategy is currently being written as part of the local ICS development.
- The Council's customer service platform is currently being developed to include a two-way mechanism for citizens to engage with the council and proactively identify citizens' priorities.

9.3 Listening and understanding

Drawing from others[12], we will listen to how communities want to work with us, what they want to work with us on, and how we create impact together. We will also prepare our researchers, academics, and Council employees to develop their understanding of our communities, the context within which people live, through activities that illuminate a sense of 'life in my shoes'.

9.4 Co-production

Our core vision for how we undertake research is co-production. Recognising the unequal ways in which research can operate, we will actively create ways of working that share power in key decision-making processes, using the NIHR definition and approach to co-production[13]. We recognise that the public contributors and communities are experts by experience and want to shape the knowledge we produce all the way through the research cycle, including as co-authors on publications, reflecting our philosophy of co-production with the public in academic publishing[14].

9.5 Reciprocity

A key aspect of co-production is reciprocity, where everybody benefits from working together[13]. We will actively search for such opportunities to strengthen our communities, recognising that research sits in a much wider community and civic context.

9.6 Building relationships and trust

A key focus of our work will be building relationships with individuals and communities which research has shown to be vital to good involvement and engagement[14]. There needs to be enough time, the right arenas for relationship building, and a sense of reciprocity.

9.7 Creativity and innovation

We want to create new ways of thinking and spaces where our communities create innovative forms of engagement, that take us beyond usual practice and create new areas of thinking.

9.8 HDRC impact

In the first six months of the HDRC, we will work with our communities to develop a Public and Community Engagement Strategy, enabling our communities to help us identify the best approach and to prioritise key areas for research, and the outcomes of interest.

We will establish a Public and Community Advisory Group which will include representatives from communities in and around Coventry, to help us develop our strategy. The community representatives will be linked to and represent our Community of Interest.

We will develop a wider Community of Interest, made up of individuals and organisations who see research as a way of strengthening their community and can help us identify the wider community benefits that we can create together. This will develop as a hub of activity that will help identify innovative opportunities for research, action, and community benefit.

Our suggested strategic aims in the table below represent 'a starter for 10', which we will further develop with our Advisory Group and our Community of Interest. Once established, these strategic aims will provide a framework for our conversations with individuals and communities, continuing to allow for emergent change as we progress. We want people to be creative, innovative and offer surprising ways in which we can build engagement and involvement. We are keen to be bold, creative, and innovative but will ask for help to identify what that might look like from a community perspective.

Strategic aim	Rationale	Workstream Activities
Capacity building for engagement	We will build capacity in our communities for the co-production of research	• Development of an engagement toolkit. • Set of learning pathways with a range of optional modules. • Mentoring to build the capacity of researchers, academics, clinicians, individuals, communities, and Council employees. • University of Warwick Award for CE training for community representatives.
Governance, systems, processes	We will set up governance arrangements, systems, and processes that support public and community engagement and implement the NIHR PPIE Standards	• Incorporate lessons from the Oxford Listening project. • Ensure community representation on key committees. • Ensure effective payment systems, drawing on key NIHR and community guidance. • Co-produce ground rules for how we work together with communities. • Establish a priority-setting mechanism. Adapt the James Lind Alliance priority setting mechanism.
Diversity and inclusion	We will use the NIHR Race & Equality Framework to build diversity in the people and communities we work with	• Recruit a diverse Public and Community Engagement Group and the Community of Interest from the communities in Coventry and surrounding areas. • Our philosophy- ‘leave no one behind’.
Developing reciprocal ways of working	We will actively identify ways in which our communities can benefit from working with us	• Extend traditional ways of working in research to more fully consider how we can directly support communities to create social good. • Enhance life chances of care leavers through opportunities for learning at university • Support community organisations to apply for funding that benefits core goals, even if not directly linked to research.
Building relationships based on trust for community benefit	We will develop activities that build strong relationships with our communities, develop mutual understanding and trust, and create good collaborations	• Allow time to build relationships. • Consider reciprocity in our ways of working, including benefits not connected with research. • Nurturing the leadership skills of young people through mentorship. • Build on the extensive community networks that the Council already has with voluntary organisations.
Creativity for innovation	Our involvement and engagement activity will look for creative and innovative ways to work with communities, to support their contributions	• Draw on creative methods and approaches, using arts-based techniques that support community engagement in ways that build relationships and trust. • ‘Sandpits’ to bring people together virtually or physically to play and be creative. • Draw on wider evidence and knowledge of different creative approaches in health and social care research.
Evidence for practice	We will draw on peer-reviewed evidence and grey literature to inform our practice and contribute to the evidence base through publication	• Regular horizon scans of literature. • Support researchers and communities to create involvement and engagement opportunities in ways that can be captured and reported, contributing to the wider evidence base. • Blogs and films to bring evidence to life. • Value different forms of evidence and knowledge including practitioner and community knowledge.

Table 4: PPIE strategic aims and activities

10 Wider Determinants of Health

Local authorities are uniquely placed to impact the wider determinants of health, with responsibility for housing, education, planning, and licensing alongside many other drivers of health behaviours and outcomes. However, a barrier to evidence-based or evidence-informed policymaking in the local authority is the paucity of useful evidence about how to best influence these determinants to drive equitable progress towards improved population health. Our HDRC will build on the prior work of the Marmot Partnership. We will enhance the relationships between stakeholders, and build the infrastructure needed to support the generation of robust evaluations of pragmatic, feasible interventions. Specifically, interventions that local authorities are positioned to implement, aimed at addressing the wider determinants of health.

Coventry has had some well-known challenges with respect to the wider determinants of health; for example, high levels of unemployment as the car industry retreated. While employment is increasing along with education standards there are significant pockets of deprivation that limit people's opportunity to succeed in life. Nearly 15% of Coventry's neighbourhoods are among the 10% most deprived in England and 7% of the population has no qualifications at all, limiting their ability to access good jobs. The HDRC will provide a stimulus to better understand the impacts of the wider determinants of health and how to use limited resources to the best effect.

The work of the Stakeholder Group (see Table 2) will be mapped against Public Health England's wider determinants of health domains tool: (i) the natural and built environment, (ii) work and the labour market, (iii) vulnerability, (iv) income, (v) crime, and (vi) education alongside the set of Marmot indicators[15]. Additional members will be identified, as required. This will inform the HDRC's strategic direction.

The HDRC will engage with all CCC departments to establish a wide perspective of the full range of services that impact the wider determinants of health, in line with the above health domains tool. This engagement will drive both the identification of relevant research questions for every domain and the current need for evidence reviews around existing decision-making challenges. Key Directors are committed to working closely with the HDRC to strengthen its place within CCC: Newing (Director of HR), Knight (Director of Transport and Highways), Williams (Director of Business, Investment and Culture), Fahy (Director of Adult Social Care, including housing); Gregg (Director of Children's Services).

In addition to our local impact on the wider determinants of health, we plan to work closely with other Marmot Cities (e.g. Gateshead, Manchester, Newcastle) to amplify our national impact.

11 Health inequalities & Equality, Diversity, Inclusion

11.1 Health inequalities

Overall health in Coventry is below average for England. Residents in more deprived parts of the city have shorter lives and spend a greater proportion of their lives in poor health, than residents in the most affluent areas. As a Marmot City, we have embedded reducing health inequalities (HI) in policies across the council, ranging from those that address the environment, green spaces, and city centre redevelopment, to youth violence prevention, physical activity, smoking cessation, and licensing.

Examples of our leadership approach around health inequalities include:

- Health inequalities underpin the One Coventry Plan, the Health and Wellbeing Strategy[16] (designed around the King's Fund model), and the Coventry & Warwickshire Anchor Alliance. The CCC Joint Strategic Needs Assessment (JSNA) also defines key priorities[17].
- Our health inequalities approach has influenced a range of other programmes across the city, including Thrive at Work and the City of Culture.
- Public Health England's 'HEAT' tool principles have been embedded into the statutory equalities impact assessment[17].

- A requirement for scrutiny boards' reports to include health inequalities impact assessment in addition to equality impact assessment.
- As part of our Health Inequalities Call to Action [7], we have formed a Voluntary Community and Social Enterprise (VCSE) sector Health Inequalities Network which could be used to further engage the VCSEs in research.
- Recently launched a West Midlands regional roundtable event, working with UCL (Prof Sir Michael Marmot) and Legal and General's Chief Executive to stimulate discussion around the newly launched report 'The Business of Health Equity: The Marmot review for Industry'[18].
- Recently undertaken a 'Talent Inclusion and Diversity Evaluation' and we actively promote an inclusive and learning culture.

We know that there is still much to do. Coventry is becoming increasingly diverse. Nearly half of Coventry pupils are from minority ethnic groups. The city's diversity and cohesion are assets to Coventry, people from different backgrounds report that they mix and get on well with one another. However, understanding health inequalities, not just based on socio-economic status, but on age, sex and gender, ethnicity, sexual orientation, disability, and family circumstances (marriage, pregnancy, and parenting) and the intersections between these will allow us to go further. Our HDRC will champion research that can support a greater understanding of how the wider determinants of health are experienced differently, and impact differently upon different groups of people.

11.2 Equality, Diversity and Inclusion

We are committed to ensuring that all Coventry residents benefit from the work of the HDRC, regardless of their background or personal characteristics. The DPH (Duggal) has been designated as the HDRC Equality, Diversity and Inclusion (EDI) lead; she is also the external-facing EDI lead for CCC. She will be supported by Haynes (Head of People), who holds an internal-facing EDI lead for CCC. EDI will be aligned within the HDRC's formal Health Inequalities strategy, which will be finalised in the first six months. Elements relating to EDI will include the following:

- Commitment to diversity in the membership of the HDRC leadership, team, and collaborators. Although women have traditionally been under-represented in health research, currently five of eight named Executive Committee members are women and 14 of 21 named Management Committee members are women.
- Meaningful public engagement to identify research priorities that are important to diverse communities in the city.
- A mandate for HDRC-related research studies to have the widest possible inclusion criteria, to ensure that individuals can participate regardless of their characteristics. This will ensure that our research findings are broadly generalisable and benefit all Coventry residents.
- A mandate for HDRC-related research studies to be co-designed and co-delivered with meaningful PPIE representation. We will support researchers to access PPIE representatives from across a wide range of communities to ensure that they receive diverse input. The voluntary sector will be critical in supporting us to identify and recruit PPIE representatives, particularly from under-represented and vulnerable groups. PPIE input will help to anticipate and address potential barriers to participation in research, ensuring that all Coventry residents have an equitable opportunity to participate in research.
- Producing study materials in a wide range of formats that enable participation in research by under-represented groups. This includes ensuring that our materials use plain English, that translations to relevant languages are available, and that the needs of groups such as visually impaired people are addressed.
- Disseminating HDRC outputs with input from PPIE representatives across a wide range of media that appeal to diverse audiences.

12 Barriers to success

A previous assessment of CCC's research capacity and infrastructure has highlighted challenges (see 1.3). Potential challenges and mitigations are described in Table 5.

Challenge	Mitigations
Lack of research governance experience	UHCW will provide expertise and mentorship for staff appointed to establish research governance infrastructure and development of standard operating procedures (Pillar 1)
Complexity of the wider determinants of health	The HDRC Stakeholder Group and 'PPIE' will help identify and prioritise feasible interventions across the wider system (Pillar 3)
Time and Resource for frontline employees in dedicated research roles	Additional payment for busy frontline staff rather than attempting to backfill (Pillar 2, see section 7.2) Support and commitment to using evidence and take-up of research opportunities, driven through the commitment of identified CCC Directors
Ensuring meaningful input from PPIE representatives who reflect Coventry's diversity	Prof Staniszewska will provide PPIE expertise and partner VSCEs have a broad reach across diverse communities (Pillar 3, see section 9)
Too many parts of the system seeking to effectively engage with our communities leading to poor use of system resources and preventing effective engagement	Embrace the complexity, be prepared to tune into what others are doing, seek to learn and evolve, look out for system-wide efficiencies; respect the vision of others operating in this arena, and seek to harness opportunity rather than try to stick with organisational objectives (see section 9)
Evolving organisational culture to embed research	Collaboration with Warwick Business School will provide expertise in organisational change (Pillar 5, see section 9)
A Culture required to create and maintain a collaborative, high functioning, quality-driven HDRC.	The culture of the collaboration will be set by the members. It will promote a willingness to be open and committed to dealing with any conflict as it arises and a robust ongoing evaluative process around the quality of the collaboration (see section 13)
Aligning priorities between CCC and partners	Close communication with all partners represented on Executive and Management Committees (see section 9)
Data sharing	There is a perfect opportunity for a solution to be found through big developments around the digital agenda. Data is a foundational element of the Digital Coventry strategy vision. Over the next 12-18 months, in line with the One Coventry Plan, CCC will consolidate all of these approaches into a single Digital strategy for Coventry which covers the internal ICT of CCC, our city-wide approach to digital, and a new strategic vision for data and analytics, both internally and for the wider city. Governance expertise will be provided by UHCW.

Table 5: Barriers and solutions to achieving HDRC objectives

13 Evaluation & markers of success

13.1 Stop-go criteria

The stop-go criteria will be assessed months 6 and 12. Success will be considered achievement of the following key milestones:

- Contracts executed with key partners (CU, UCL, UHCW, UW).
- Programme manager and programme officer appointed and in post.
- Executive committee constituted and has met.
- Management committee constituted and has met.
- Training needs assessment completed.
- PPIE strategy completed.

If a key milestone has not been met by month 6, the HDRC Executive will produce a plan for ensuring it is met by month 12. If milestones have not been met by month 12, external support from NIHR will be sought.

13.2 Evaluation plan

The intended benefits for each HDRC partner have been identified to align priorities and anticipated outputs. The longer-term impact of the HDRC locally will be its contribution to the new CCC One Coventry Plan, the Marmot Partnership, the Anchor Alliance, and the new Integrated Care System.

The development and evaluation of the HDRC will be aligned with the wider performance management framework for the One Coventry Plan. This will enable us to set out the HDRC's progress in the context of our work towards becoming a globally competitive city-region in terms of human, physical, financial, and social capital aligned to Levelling-Up Goals.

The development and impact of the HDRC will be evaluated using a mixed-methods approach, mapped against our Logic Model, which sets out our theory of change, and the NIHR's framework for describing a successful HDRC[19]. A detailed evaluation plan will be co-designed in the first 6 months, with input from all stakeholders including the public. Data collection will continue throughout the life of the HDRC, and this will allow us to be responsive and fix any issues that arise. For example, the brief self-assessment forms and attendance audits will enable us to identify any partner concerns, so that these can be explored and resolved.

We also expect to complete in-depth data collection at 3 points across the lifetime (likely to correspond to formal reporting to NIHR at months 18-24, year 3, and year 4). An indicative evaluation plan is presented in Table 6.

Measure	**Domain(s)**	**Year**				
		1	**2**	**3**	**4**	**5**
HDRC set-up						
Contracts/MOU in place with partner organisations	RC	✓				
HDRC staff appointed and in post	RC	✓				
HDRC-HEI staff appointed and in post	RC	✓				
Pillar 1						
Research governance processes established	RC	✓				
Research governance process effectiveness (user feedback)	RC	✓	✓	✓	✓	✓
Pillar 2						
Training needs analysis completed	RC	✓				
Annual symposium (attendance, feedback from attendees)	Col, Dis	✓	✓	✓	✓	✓
Development of local research training modules	RC	✓	✓			
Training completed by local authority staff. Training evaluations/ surveys on skills/confidence gained	RC	✓	✓	✓	✓	✓
Career development for local authority staff (including academic qualifications, personal awards)	RC	✓	✓	✓	✓	✓
Pillar 3						
PPIE strategy completed within 6 months	Col	✓				
PPIE evaluation using the EDGE tool	Col	✓	✓	✓	✓	✓
Pillar 5						
Brief self-assessment forms and scorecards for HDRC members to regularly feedback on their satisfaction with the collaboration	Col	✓	✓	✓	✓	✓
Survey of appropriate local partners (ICS, Anchor Alliance, Marmot Partnership, H&WB) and national public health bodies to gather opportunities for collaboration and to understand the perceptions and reputation of the HDRC	Col		✓	✓	✓	

In-depth qualitative research with HDRC members & wider local authority (including elected members) to record and understand their perspectives and experiences of culture shift.	Col, Cul		✓	✓	✓	
Counts of shared documents, workshops, mentoring relationships with other local authorities in the West Midlands, nationally or internationally	Cul, Col, Lead, Dis	✓	✓	✓	✓	✓
Creation of an active HDRC network to share best practice and learning and active participation in this network	Cul, Col, Lead, Dis	✓	✓	✓	✓	✓
Outputs and sustainability						
Documentary analysis (identifying and obtaining major local authority documents from all departments and auditing what is cited in the documents and whether citation of academic research increased across the 5 years)	Cul		✓	✓	✓	
Counts of peer-reviewed publications co-authored by HDRC members (and assessment of the breadth of disciplines, journals, and members involved), conference presentations, media and social media engagement, other dissemination activities	Dis	✓	✓	✓	✓	✓
Number of evidence reviews completed to support local authority decision-making (at least one per council department by the end of 5 years)	Cul	✓	✓	✓	✓	✓
Number of grants applied for by members of the HDRC, to support opportunities for research and evaluation of local authority initiatives (to consider the breadth of engagement across council departments and relevant HEI disciplines)	Cul, Col, Lead	✓	✓	✓	✓	✓

Col: Collaborations; Cul: Culture; Dis: Dissemination; Lead: Leadership; RC: Resource and capacity

Table 6: Evaluation framework

14 Dissemination

We will disseminate our work to the public, the wider system in Coventry, and regional and national policymakers through a range of mechanisms, which are detailed below.

14.1 Dissemination to the public

We will feedback to local communities on the results of research that they participate in, as well as other research findings that are important to Coventry residents. This is a core aim of our PPIE pillar (see section 9).

We will highlight how people from diverse communities have helped to prioritise, design, and deliver research in order to encourage more people to get involved in research. We will:

- Hold regular workshops for the public in community spaces.
- Co-produce research summary videos with PPIE participants.
- Summarise HDRC activities in a regular public email newsletter.
- Present research findings at public forums, such as the ESRC Festival of Social Science.
- Develop a website to provide information about the HDRC partners and activities.
- Communicate HDRC activities through social media platforms.
- Publicise key research findings through press releases to regional and national broadcast and print media.

14.2 Wider system in Coventry

We will disseminate research findings both within CCC and the wider public, private, and voluntary sectors in Coventry. We will ensure that, when applicable, decisions taken at all levels within CCC are informed by relevant evidence generated by the HDRC. We will share information about the HDRC's progress and activities to further embed culture change. Dissemination channels will include:

- Provide regular updates to the multidisciplinary Stakeholder Group (see Table 2) and the Marmot Steering Group.
- Provide regular HDRC updates through internal CCC communications.
- Publish learning summaries disseminated across the wider system.
- Hold seminars to share skills, experiences, and identify opportunities for future collaboration.
- Set up a city-wide podcast (e.g. through the Anchor Alliance).

14.3 Regional and national policymakers

We will share nationally important research findings through regional and national networks, so that policymakers put our research into practice so that our research benefits as many people as possible. We will share our experience of establishing the HDRC to support other local authorities to develop their own research capacity and to encourage cross-authority collaboration. By establishing itself as a centre for research excellence, CCC will influence other local authorities to embrace and conduct collaborative research. We will:

- Provide regular updates to the Independent Steering Committee (see section 5) which includes representation from diverse national policymaking organisations.
- Communicate our activities across a regional university network.
- Feed our findings to the Regional Oversight Group for Health Inequalities and Prevention, which is chaired by NHS and Office for Health Improvement and Disparities.
- Develop a Midlands regional local authority network, facilitated by the regional Association of Directors of Public Health (ADPH) office
- Develop a national local authority network in collaboration with other HDRCs and ADPH.
- Participate in a national network led by Legal & General PLC [14] and Prof Sir Michael Marmot that focuses on the role business can play in addressing health inequalities.
- Develop an international research network (municipalities, HEI, WHO) to share expertise in local government research and wider determinants of health.
- Present at national and international conferences (e.g. Local Government Association, WHO Healthy Cities).
- Publish academic papers and policy reports in peer-reviewed publications.
- Contribute to trade publications (Local Government Chronicle, Municipal Journal).

15 Timescales

The programme is split into two phases. In years 1-3, we will seek to establish a research platform that provides infrastructure essential to the development and delivery of robust research: ethics framework, data sharing pathways, methodological expertise, PPIE, and cultural change within CCC. In years 4-5, we will focus on establishing an impact platform that effectively influences decision-making locally, regionally, and nationally, and supports the growth of a local government research culture across the Midlands. By the end of the programme, the HDRC will have the capacity to manage a full research cycle from project co-development with PPIE through to delivery of research, implementation, and dissemination of research findings.

A detailed breakdown of activities is provided in the GANTT chart.

16 Sustainability

The initial 5-year HDRC programme will be delivered within the NIHR's funding envelope, with matched funding (£260,988) representing costed time dedicated to HDRC management by existing CCC staff (Chapman, De Souza, Duggal, Haynes, Nelson, Nepogodiev, Reeves).

The HDRC will signpost funding opportunities to partners and facilitate the development of bids through the following mechanisms:

- The HDRC will help researchers to identify relevant public, private, and voluntary sector partners through the Stakeholder Group (see Table 2).

- The HDRC will help researchers to identify relevant public and patient groups to support PPIE (see section 9).
- The HDRC will provide methodological expertise to help design research (see Table 3). It will also provide targeted training to individuals based on specific project requirements, for example, by providing access to CU and UW modules.
- The HDRC will offer research placements to CCC staff (see section 7.2).
- The HDRC will run a bilateral exchange programme (see section 7.2)

We aim to achieve long-term sustainability by the end of the 5-year programme by establishing a pipeline of competitive research funding from NIHR and other public, charitable, and industry funders.

17 Regulatory issues

Ethics: As part of Pillar 1, with support from our partners, we will develop a research ethics framework that will provide independent review and oversight of our research. When applicable, we will seek additional ethical approval from NHS and/ or HEI bodies.

Regulations: We do not anticipate that the HDRC will be involved in drug or device studies, however, if the HDRC undertakes any studies that might require, for example, Medicines and Healthcare products Regulatory Agency approvals, we will seek expert input from HEI partners.

Data transfer agreements: As part of Pillar 1 we will develop a comprehensive data-sharing framework, including template data transfer agreements to be used when required.

Intellectual property: If any of our workstreams generate intellectual property we will seek expert input from partner HEI commercialisation teams.

Safeguarding: We will develop a dedicated safeguarding policy for the HDRC, particularly focussed on our public engagement activities. If safeguarding concerns are identified these will be channelled through CCC's existing safeguarding processes.

18 Annex: abbreviations

CCA	Coventry Citizen's Advice
CCC	Coventry City Council
CELC	Central England Law Centre
CIAS	Coventry Independent Advisory Service
CU	Coventry University
DPH	Director of Public Health
FWT	Foleshill Women's Trust
HC	Highlife Centre
HEI	Higher Education Institution
OCLT	One Coventry Leadership Team
PYF	Positive Youth Foundation
UCL	University College London
UHCW	University Hospitals Coventry & Warwickshire
UW	University of Warwick
VAC	Voluntary Action Coventry