HDRC Manchester: Putting communities at the heart of policy.

Version Control Table

Version	Title	Date	Amends
V1.0	Stage 1 Expression of Interest (EoI) application	18/04/2023	
V2.0	Stage 2 Research Plan	26/07/2023	In-depth Research Plan, building on the initial EoI
V2.1	Stage 2 Research Plan with Development Year	22/11/2023	Incorporated addition of Development Year Plan
V2.2	Final Protocol	26/01/2024	Finalised Protocol – including amendment to milestone dates.
V2.3	Final Protocol	01/02/2024	Finalised Protocol with funding attribution statement

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Detailed Research Plan – headings and sections

Full title of HDRC (Limit: 300 characters)

Putting communities at the heart of policy: the development of a neighbourhood and community-led research culture and system across Manchester.

Background and rationale

Manchester is one of the most diverse cities and local authority (LA) areas in England. As a city, we have achieved strong growth in terms of both population and economy over the last two decades.

Improving health outcomes, inclusion and tackling inequalities remain key challenges for Manchester. The COVID-19 pandemic amplified and exacerbated existing health inequalities. The factors that contribute to health inequalities across the city are multi-faceted and impact differently across neighbourhoods and communities.

The “Making Manchester Fairer” (MMF) Action Plan was launched in October 2022 and provides a comprehensive, cross-sector programme for tackling health inequalities and poverty based around 8 priority themes. It aligns with the City Council’s “Our Manchester” approach which places residents at the heart of what Manchester City Council (MCC) does - starting from strengths, genuinely listening to communities and working with other partners.

Manchester has developed strong multi-agency teams in 13 neighbourhoods where key agencies and voluntary, community, social enterprise and faith (VCSEF) sector organisations work together on 4-5 key priorities for the place and the people who live there. Communities consistently tell us that we are ‘consultation heavy’ but ‘action light’, raising levels of cynicism and disengagement. Partners need to be enabled to better support residents to navigate a huge number of issues affecting the population’s health and wellbeing.

To demonstrate commitment to our HDRC offer, we are undertaking a preliminary piece of engagement with communities and residents. There is a strong and long held commitment to public health and partnership working in Manchester. However, a culture of evidence-based commissioning and practice, centred on places and communities is not fully embedded. Becoming a HDRC would enable Manchester to significantly accelerate and scale up the research, analysis and insight into what works to tackle health inequalities in a complex and diverse city.

Embedding a research culture, through a complex, coherent multi-agency action plan for the whole city, will allow us to capture community voice and insight and channel this for proactive, improved services for residents. The Government Green Paper “Advancing our health: prevention in the 2020s” advocated that preventative health services need to draw on high quality research that includes an ambitious evidence base incorporating a range of disciplines and co-production that helps answer important questions facing local authorities and service providers. This means focusing research on areas where challenges are greatest, establishing and improving information, sharing networks.

Manchester has some strong foundations within this model (see below) but we need to increase our pace and progress to scale up areas of good practice across the whole system by making use of:

- Existing infrastructure
- MMF workstreams, programmes and forums
- Strong leadership with ambitious plans, committed to evidence-based decision-making
- Well organised and proven central resources within MCC (supporting localities)

- Established place-based locality model known as “Bringing Services Together” (BST)
- Strong local partnerships to facilitate cross organisational efforts to tackle wider determinants of health
- Relationships with colleagues across local and central government
- Existing collaborations with researchers in the University of Manchester (UoM) and other Higher Education Institutions (HEIs) in the city to facilitate the process of embedding researchers into MCC and funding the cost of MCC elected and non-elected officials’ time for academic placements within HEIs.
- Learning from successful work already happening e.g. the Manchester Urban Ageing Research Group (UoM) working with and on behalf of the Age Friendly Manchester (AFM) Team on social research, co-production and novel longitudinal

The Manchester HDRC will realise its vision through investment in communities, residents, and staff. Our strong foundations, emphasis on locality and community-based working, and commitment to sustainable cultural change will be consolidated and intensified, leading to a mainstreaming of evidence-based policy making across MCC. Our organogram, management and governance diagram, and ‘justification of costs’ section demonstrate how our HDRC structure aligns and integrates with internal (Neighbourhoods Directorate) and external (UoM) structures. This alignment is essential to ensure optimum function and facilitate sustainable organisation-wide culture change.

Delivery plan - describe your approach to implementing and delivering an HDRC.

Overarching vision, aims and objectives:

The overarching vision of the Manchester HDRC is to place communities at the heart of policy by creating a city-wide co-produced research system, linking the City Council, the UoM and other Higher Education Institutions (HEIs), community groups, housing providers and VCSEF partners to identify and undertake shared research priorities on the wider determinants of health.

This collaborative research system will be enabled by the development of procedures and processes to ensure research findings are translated into action across MCC with a measurable impact on health inequalities and to craft a sustainable research culture for all levels of decision-making across MCC and its partners. As part of this, we will:

- Develop systems so that people working in neighbourhoods and communities have access to evidence to influence policy and decision-making through an asset-based approach focusing on place and people
- Develop processes which allow strategic leaders to incorporate locally generated research and evidence into policy
- Embed researchers in places and communities that experience the effects of inequality to develop, undertake and adopt quality research and evaluation in partnership with residents
- Support people living and working in local areas to generate research priorities, co-produce and disseminate research through fostering links with academics
- Develop systems that enable agile responses to adopt evidence in Local Government (LG) policy
- Measure changes on health inequalities to develop an evidence base on how to improve wider determinants of health
- Disseminate findings widely including with and by communities, residents and workers
- Develop a culture where multi-agency and community-led research on health inequalities is mainstreamed
- Develop true research partnerships and capacity building through training local people to undertake research, continual professional development (CPD), academic placements and honorary contracts for elected and non-elected officials

As referenced in ‘Changes from first stage’, we have developed three key themes to clarify our aims and objectives and set out the key mechanisms of action required to achieve these. Specific examples reflect existing good practice, strong foundations and connections with communities. These examples are, however, fragmented across the Manchester system: the HDRC offers the opportunity to develop a cohesive, strong learning system, and to translate such findings into organisation-wide policy.

Theme 1: Engaging and empowering communities

Aim: To ensure that residents in geographical and shared interest communities have opportunities to influences policy and services

Our objectives are to:

- Embed researchers in places and communities that experience the effects of inequality.
- Develop, undertake and adopt quality research and evaluation in partnership with residents through capacity building and participatory research methods.
- Build trust with people living in geographical neighbourhoods and communities of identity
- Develop systems so that people working with neighbourhoods and communities have access to high-quality evidence to influence policy and decision-making
- Support people living and working in local areas to generate research priorities, co-produce and disseminate research
- Disseminate findings widely across communities, using local residents to create a virtuous cycle of learning using our position within communities, anchor organisations and national/international partnerships (e.g. academic, service, industry, governmental)
- Demonstrate meaningful impact, knowledge exchange at all levels and pathways to ensure mainstreaming of a research culture within the partner organisations.

Proposed Mechanisms:

- The Embedded Community Researchers (ECR) will be responsible for engaging with local communities and working with residents, empowering them to participate in research & use evidence to influence decision making
- During year 2, we will develop user-friendly systems to disseminate findings among places and communities with shared characteristics to ensure involvement at all stages including the implementation of findings and measuring impact
- We will integrate best practice developed by the HDRC into wider MCC structures and departments to ensure demonstrable longevity and sustainability of our work

Example A: The annual MCC neighbourhood directorate away day includes stalls providing information and engagement activities from multi-agency neighbourhood teams and attracts staff from diverse teams such as public health, highways, libraries, and recycling. The ECRs can use this, and similar events, to build new networks, develop pathways to resident engagement and raise awareness of the HDRC.

Example B: Through the vehicle of “Our Year”, the ECRs will engage with young people to understand their priorities and needs. The MCC Performance, Research & Intelligence (PRI) team will draw on existing gap analyses to identify wider training needs for this cohort from intelligence to support co-development of interventions ensuring that the HDRC engages with MCC specialist resources to target services to those most in need.

Example C: The Manchester Integrated Care Partnership (MICP) Patient and Public Advisory Group (PPAG) has identified hidden strengths in the community that are not formally appreciated or

recognised, including the benefits and potential for peer-to-peer engagement and research through shared knowledge and assumptions about a community; residents ability to identify and converse in community languages (of which there are 100+ in Manchester); identification of community leaders and positive influencers. We will aim to harness the existing skills and talents that lie within communities ensuring that action taken is led by residents. By embedding the lay researchers within the partner organisations (LA, NHS and HEIs), we will create an iterative learning health system.

Theme 2: Building networks and skills

Aim: To embed the findings of bottom-up research into practice by disrupting existing hierarchical structures and creating equitable new systems across organisations and departments

Our objectives are to:

- Support people living and working in local areas to generate research priorities, co-produce and disseminate research through fostering links with academics and partner organisations while breaking down power structures as confidence grows
- Identify potential solutions through working with academics to access and develop an evidence base on how to improve wider determinants of health
- Foster an asset-based approach to developing and supporting interventions to tackle wider determinants of health where residents themselves are seen as key assets

Proposed Mechanisms:

- Develop true research partnerships and capacity building through CPD, academic placements, mentorship and coaching
- Systems to award honorary contracts for Community Insight Representatives (CIRs) so that they can access UoM library and IT services
- Work with local providers to map research priorities onto existing services and develop referral mechanisms; Identify strengths and gaps by reviewing existing research skills and assets across existing neighbourhood groups and staff working in local areas and develop appropriate training
- Support CIRs to undertake a rapid review of skills and assets, facilitated by neighbourhood teams which, combined with strength-based intelligence from PPAG, will inform the development of bespoke ‘resident researcher’ training by UoM colleagues
- Identify priorities for research interest with residents and local partners, (e.g., Manchester's Voluntary Community and Social Enterprise sector support organisation (Macc), other VCSEF partners, UoM, Housing Providers, NHS) and co-produce research and funding proposals (e.g. NIHR PHR, RfPB, LAAF programmes)
- Pool resources to offer funded PhDs to conduct research on community priorities

Example A: Community researchers, with the assistance of the operational delivery team and PPAG, develop resident engagement strategies to identify the top 3 priority issues associated with the wider determinants of health and examples of how residents are affected. In partnership with UoM a co-produced strategy to produce research with the aim of finding solutions to these issues is produced. ECRs can disseminate training and development to the wider VCSEF sector through Macc networks, colleagues across the public health ecosystem, and wider partners such as the Core Cities (CC) Group and the Greater Manchester Combined Authority (GMCA) in collaboration with Policy@Manchester and the UoM’s wider ‘Social Responsibility’ Team.

Example B: Access to library systems and training provided by the UoM will provide residents and staff in partner organisations with the skills and resources to conduct rapid literature reviews. We

will utilise technology to assist with this, for example exploring the use of AI to synthesise evidence findings in an accessible format.

Example C: HDRC Knowledge Mobilisation and Policy Coordinators (KMPCs) will work with the UoM embedded researcher, experts, and residents to co-design a training programme, tailored to staff and communities. The content will be informed by the Training Needs Assessment, which is anticipated to include:

- How to understand and use research evidence
- Rapid evidence synthesis
- Research methods including evaluation
- Co-production and engagement
- Intervention mapping
- Presentation skills
- Innovative dissemination methods

Example D: Several HDRC-aligned organisations pooling resources to develop a James Lind Alliance Priority Setting Partnership based on a topic derived from community generated intelligence

Theme 3: Mainstreaming community-based research and evidence-based policy

Aim: To develop a culture where multi-agency and community-led research is mainstreamed across MCC

Our objectives are to:

- Develop processes which allow strategic leaders to incorporate locally generated research and evidence into policy
- Ensure that the HDRC's governance and structure will communicate value and impact of findings to senior leaders, enabling them to routinely use research to inform decision making at all levels
- Ensure that leadership and commitment from the DCE and DDPH, aligned with key policy to tackle health inequalities (MMF) is embedded into council decision making and policies
- Develop systems that enable agile responses to adopt evidence in LG policy

Mechanisms:

- Our research will ask residents and key HDRC members "what does equity focused research culture mean in practice?"
- Effective leadership and training will implement changes based on the above findings (the HDRC will be led by the Assistant Chief Executive and Deputy Director of Public Health (DDPH) to ensure all Council Directorates, Services and corporate functions contribute to the work, and there is full engagement of elected members and the Council's Senior Management Team (SMT). SMT has given its unanimous support to the HDRC, collaborating in its proposed design
- We will disseminate findings to ensure that our HDRC will function as an exemplar model for research driven practice for LAs with similar contexts, resident demographics, and issues (through networks such as CC, GM Research Leads)
- The Joint Lead Applicants both sit on MCC's Senior Management Team (SMT) with the Chief Executive, Director of Public Health and the Chief Officers of each MCC Directorates - placing the HDRC Programme Director under the management of the Assistant Chief

Executive, the HDRC will enable it to influence and effect change from the most senior strategic level
- The KMPCs will be integrated into specific Directorate Management Teams (DMT), each will have a 'Directorate Portfolio' – they would be part of the DMT, their role as 'connector' between service strategy and the community; Working across thematic and geographical communities, the ECRs, operational team & strategic management will develop networks to facilitate and embed knowledge exchange that enables behaviour and policy changes
- Using CC infrastructure (an alliance of 11 large UK cities), Greater Manchester (GM) and UK Health City networks to share learning

Example A: The MCC Neighbourhoods Directorate has provided funds to support resident engagement as part of the Making Manchester Fairer evaluation in their most recent budget scoping document. Adopting similar models of resourcing across the council will support sustainability and mainstreaming of community-led research.

Example B: Applying learning from previous good practice e.g. during COVID-19 pandemic hyper-local interventions were tailored to the needs of local communities to affect change. Our evaluation of the COVID vaccine programme found significant loss of trust in statutory bodies and a harnessing of community assets. By residents working with UoM, UKHSA and local GP practices, we are continuingly learning how we can improve childhood vaccination programmes.

Example C: The HDRC will be integrated into existing MCC decision making and policy channels in the following ways:

- The Assistant's Chief Executive's portfolio in MCC is Policy, Performance & Reform (PPR) which provides access to senior strategic decision-making and influences current data collection across all parts of the Council, connecting to Policy and Service Reform teams to effect change
- MCC HDRC will report to the Health and Wellbeing Board (HWB), and the MMF Programme Board
- Updates will be provided to MCC's SMT
- We anticipate that the HDRC will be required to report to MCC Scrutiny Committees (e.g. Health, Economy, Communities and Equalities) dependent on the areas of focus identified
- Leadership and commitment from the ACE and DDPH, aligned with key policy to tackle health inequalities (MMF) will be embedded into council decision making and policies

Linking the HDRC to these boards ensures maximum exposure and visibility to key statutory partners (HWB), wider VCSEF, public and private sector partners and elected members.

Culture

The research culture that the HDRC will generate is aligned with key policy to tackle health inequalities (MMF) and will be embedded into council decision making and policies. The Council's SMT has given its support to the HDRC, collaborating in its proposed design. With leadership from the ACE and DDPH, the HDRC will act as a catalyst to ensure that all Council Directorates, Services and corporate functions contribute to, engage with and implement findings and outputs. This has been demonstrated through SMT involvement in the development of the bid.

Culture and Leadership

- The success of the HDRC is contingent on creating and mainstreaming a research culture across the HDRC and partner agencies. Evidence indicates effective leadership with a clear local and national mission is key to nurture the disruption needed to sustain success. As part

of our statutory responsibilities, we must consult on annual budget proposals; evidence and insight generated through the HDRC will contribute to service and organisation wider budget setting plans.

- A key aspect of culture change is understanding value and impact. The HDRC's governance and structure will communicate value and impact of findings to senior leaders, enabling them to routinely use research to inform decision making at all levels in the council and across other local organisations. Key senior decision-making groups will have Community Generated Insight as a standing agenda item, SMT representatives will update on particular thematic areas, and the involvement of the HDRC as standard.
- Use of evidence and research in commissioning is currently sporadic. Accelerating findings from locally generated evidence and research to the right people will influence service commissioning. Prompts around incorporating evidence and insight from the HDRC will be included on commissioning templates / specifications.
- Using CC Group infrastructure (an alliance of 11 large UK cities), Greater Manchester (GM) and UK Healthy Cities networks to share learning. Emerging findings from the HDRC will be standing agenda item; collaboration throughout CC meetings will provide perspective on how best to interpret and communicate findings for maximum impact and transferability.
- Learning through a continuous embedded process of rapid cycle evaluation to create a learning health system. This methodology allows for mixed methodology real-time evaluation to disseminate positive findings as well as the "fail fast" ideology.
- Embedding the asset-based approach across the whole system to facilitate the learning health system within all partnerships from the communities and individuals through to the elected and non-elected officials within the local authority.

Collaborations and partnership

The Manchester HDRC will cement existing collaborations and partnerships with UoM, wider Manchester HEIs (through the Independent Advisory Group), Macc, and broader public sector partners through Teams Around Neighbourhoods (TANs).

Over the past year a partnership between MCC and UoM has been formalised through the vehicle of Policy@Manchester.

The HDRC will act as an exemplar model for research driven practice for LAs with similar contexts, resident demographics, and issues (through networks such as CC, GM Research Leads).

Collaboration activities

- A mapping exercise and training needs assessment for all aspects of the current collaborations and collaborations that are needed will be the first piece of work. This will be co-produced with the PPI teams
- ECRs will be integral to the place-based research infrastructure and will link with existing MCC networks (BST, "Our Year" (MCC's commitment to children and young people) to enable a greater understanding of how services can coalesce to improve health equity (HE)
- A key responsibility of the ECR will be to engage with local communities and work with residents, empowering them to participate in research
- ECRs will foster an asset-based approach to developing and supporting interventions to tackle wider determinants of health.
- HDRC networks will develop priorities for research interest with local partners, (e.g., Macc, other VCSEF partners, UoM, Housing Providers, NHS services) and co-produce research and funding proposals

The HDRC will:

- Adopt an asset-based approach e.g. identifying and embedding organically developed best practice, such as responses to the Covid-19 pandemic that brought communities, statutory and voluntary partners and the NHS together to support people in innovative ways, drawing on local strengths.
- Mainstream the generation and use of research and evidence around the best ways to tackle health inequalities and promote equity across Manchester.
- Coordinate with existing resident-focussed partnerships ("Age Friendly Manchester", "Our Year").

Partners include:

- BST networks and groups
- Key services in MCC including insight networks and Neighbourhoods directorate
- NHS Trusts in Manchester
- VCSEF (commissioned and community providers)
- MICP PPAG
- Resident networks
- Manchester TANs
- "Our Year" partnership (including schools / education partners)
- Manchester NIHR infrastructure including Health Innovation Manchester which hosts the Applied Research Collaborative, Biomedical Research Centre and Clinical Research Facility, Manchester Housing Provider Partnership (MHPP)
- UoM: dedicated thematic institutes, platforms, centres, research beacons: Global Inequalities; Health Inequalities; Levelling Up
- Other HDRC's including Blackpool and the HDRC network

Leadership and staffing structures

MCC is committed to effecting sustainable and organisation-wide culture change about the involvement of communities, and the use and integration of community derived research and evidence to influence policy and decision making. The joint leadership of the HDRC by the ACE and DDPH will ensure that the HDRC creates and supports a sustainable research culture where use of research and evidence are mainstreamed.

A defining feature of the Manchester HDRC is building on the foundations of existing, Locality and Community-based programmes of work and engagement.

A key element will therefore be the alignment of HDRC staffing structures with existing Neighbourhood-based models. CIRs and KMPCs will complement, but be distinct from, the 'intervention / delivery focussed' roles of Neighbourhood Managers (NM), Neighbourhood Community Development Workers (NCDW) and Neighbourhood Project Leads (NPL). Though 'delivery-focussed' neighbourhood working is well embedded across Manchester, teams' priorities are not systematically 'evidence-informed'. The involvement of residents is piecemeal (and usually represents 'informing' or 'consulting' on the ladder of co-production) and challenges in time, capability and capacity means that interventions are not routinely evaluated to understand what works for whom, how, and in what circumstances. This means that valuable knowledge and evidence aren't surfaced, and opportunities to feed this evidence to policy, and thus affect decision making at a senior and strategic level, are missed.

Our core staffing structure comprises 21 staff, reflecting the 'research in practice', 'strategy and delivery' and 'evaluation' arms of our HDRC. HDRC staff will work with and alongside 'Community Insight Reps' – residents and representatives of communities (of interest or geography) who will help identify and prioritise the research areas, conduct research in tandem with the ECRs and

interpret findings. KMPCs will synthesise and disseminate research findings, tailoring outputs to ensure maximum reproducibility and impact.

To maximise the responsiveness and agility of the HDRC and to use this opportunity to 'do something different', we have allocated a pool of hours for our CIRs, instead of fixed 'FTE' posts. This alternative model increases the breadth of lived experience / community co-production, increases the resilience and sustainability of the HDRC and supports those wanting to work flexibly. CIRs will be paid a Real Living Wage (RLW), though other forms of remuneration will also be available (training courses, qualifications, and vouchers).

The attached organogram outlines HDRC staffing, and the complementary logic model shows the various inputs, activities leading to outputs, outcomes and impact.

Leadership within existing structures

The Joint Lead Applicants both sit on MCC's Senior Management Team (SMT) with the Chief Executive, Director of Public Health and the Chief Officers of each MCC Directorates.

The ACE will be the Senior Responsible Officer (SRO) and Director of the HDRC. The ACE's portfolio in MCC is Policy, Performance & Reform (PPR): the HDRC will be a new Team within PPR. PPR is the 'driving force' of analysis, insight, policy development and implementation and transformation across MCC encompassing MCC's Performance, Research and Intelligence (PRI), City Policy (Policy) and Reform and Innovation (R&I) services and teams. PPR also works as part of wider network of intelligence and research teams across the wider health and care system, including the Public Health Knowledge and Intelligence (K&I) Team and the GM Integrated Care Partnership (ICP) Locality Data Insight and Intelligence (DII) Team.

Locating the HDRC within PPR provides access to senior strategic decision-making and will enable the HDRC to influence current data collection across all parts of the Council and other partners. It will improve how we gather the voices of residents less heard and connect with Policy and Service Reform teams to effect change.

A HRDC Strategic Lead (HSL) will be recruited to lead the HDRC programme of work within PPR and line manage HDRC staff.

Additional support will be provided by PRI's Head of Service (HoS), who will take on a dual role as 'HDRC Research and Insight Lead', as well as being a co-applicant. The HoS will also provide leadership support to the HSL and matrix line management with the HDRC Director. This approach will ensure the HDRC will benefit from knowledge sharing with the PPR Team, integrate with PRI, and maximise opportunities to influence and effect change at all levels – from senior strategic, to operational and analytical.

The Joint Lead Applicant (DDPH) will provide specialist public health expertise and a conduit to other resources within the Public Health Department as well as ensuring alignment of the HDRC with MMF. This will ensure that public health approaches are at the heart of everything the HDRC does and that the work of the HDRC is informed continually by public health best practice. They will also provide a link to local, regional and national priorities.

HDRC staffing structure

Manchester's HDRC staffing structure has three interdependent arms: 'research in practice', 'strategy and delivery' and 'evaluation and skills'. This structure is multi-disciplinary and focussed on research generation, co-production, collaboration, and knowledge mobilisation and translation.

The focus of each ‘arm’ is:

- Research in Practice - direct research, community-generated insight, knowledge mobilisation and co-production
- Strategy and Delivery - leadership, strategic oversight and operational delivery
- Evaluation and Skills - ongoing rapid cycle evaluation, academic challenge and skills’ development

Strategic support will also be provided by direct MCC corporate functions and wider stakeholders to amplify HDRC findings across local, regional, and national partners. Core partner organisations (such as Macc, co-applicant) will co-produce HDRC outputs and work with HDRC staff in understanding community priorities and facilitating engagement.

Research in Practice

The ‘Research in Practice’ arm represents the core function of the HDRC – researchers who embed themselves within communities, who work in tandem with residents and community groups to co-produce insight and evidence.

- **Embedded Community Researchers** (6 FTE) to undertake research with Manchester communities. The role profile for the ECRs will be crafted to align with existing MCC structures to ensure maximum integration and on par with academic salary scales to maximise expertise and skills. The ECRs will work with NMs, via existing structures such as TANs, to identify research priorities of interest, and will be responsible for engaging with CIRs.
- **Knowledge Mobilisation and Policy Coordinators (**3 FTE) to synthesise, mobilise and translate research findings for maximum impact.
- **Community and Co-Production Coordinator (**1 FTE) to work with existing networks and coordinate community co-production.
- **Community Insight Representatives (CIR)** are an essential component of the Manchester HDRC. CIRs are individuals or representatives of community groups who will be the ‘voice’ of the community, incorporating feedback from PPAG representatives, Neighbourhood Managers and wider stakeholder teams. There will not be a defined number of CIRs. Instead, the structure allows for a pool of hours per annum, at the RLW for CIR activity.

Strategy and Delivery (MCC)

The strategy and delivery arm will be responsible for integration with MCC staffing structures, strategic oversight and the embedding of community generated research across core decision-making functions. It includes the following roles:

- HDRC Research and Insight Lead (0.2 FTE)
- HDRC Strategic Lead (1 FTE)
- HDRC Programme Manager (1 FTE)
- HDRC Business Support (1 FTE)

Evaluation and Skills (UoM)

- Higher Education Strategic Lead
- HDRC Academic Advisors
- Embedded Researchers – to understand what works well, for whom, and in what circumstances, to enable ‘real time’ course correction / amendments of the HDRC to maximise impact.

- Qualitative and quantitative methodological experts
- Training and capacity building expertise
- Inclusive research lead
- Policy@Manchester lead with a communications and engagement officer
- link to other NIHR infrastructure through the NIHR CRN Practitioner role
- Grant writing support

Resource, Capacity and public involvement

Resource and capacity building

MCC has some established research expertise across services, but skills and expertise are unevenly distributed, and staff have insufficient capacity and time to share existing skills. 'Business as usual' pressures mean that opportunities to develop are limited and all too often are neglected. Service and organisational pressures mean that research is sometimes viewed as a luxury, with time and resource intensive activities such as co-production, and community focussed qualitative research substituted for more immediate involvement, such as survey-based consultation and desktop analysis of activity and process measures, all of which are seen as ends in themselves.

The skills, knowledge and expertise inherent within communities are not fully nor routinely used to the detriment of MCC policy and community potential. All too often, residents and communities are 'done to' - we consult on pre-defined solutions which may have little relevance, importance or meaning for communities themselves.

As detailed above, three overarching themes characterise our approach to delivering and achieving the aims of the HDRC:

- **Theme 1: Engaging & Empowering Communities**
- **Theme 2: Building networks & skills**
- **Theme 3: Mainstreaming community-based research and evidence-based policy**

Through 'Building Networks and Skills', the HDRC will deploy an asset-based approach to identify existing skills and capacity in MCC and adopt formal processes for cascading and enhancing this knowledge. Through the existing vehicles for community engagement and involvement (such as TANs), a similar asset-based approach will be undertaken with CIRs. HDRC KMPCs will work with the UoM embedded researchers, experts, and residents to co-design a training programme, tailored to staff and communities. This approach will amplify and make visible the skills, knowledge and expertise of communities, and promotes connectedness, engagement and longevity. Training provided will encompass new, innovative methods to enhance participants' future skills and to deploy resources in areas of greatest impact (i.e., generating 'insight').

Capacity building activities

- Identifying strengths and gaps by reviewing existing research skills and assets across existing neighbourhood groups and staff working in local areas
- Undertaking a teaching and capacity building needs assessment
- Investing in a network of Embedded Community Researchers (ECRs) to undertake research to understand and work with residents and communities
- Co-producing a training programme for residents and communities, enabling them to undertake and participate in research at all levels from the public and public contributors to elected and non-elected officials

- The HDRC Strategic Lead will be responsible for developing an MCC-wide 'Research Strategy'
- Developing systems to disseminate findings among places and communities with shared characteristics enabling timely action to address wider determinants of health.
- Evaluate in real time to create a learning system

A **Training Needs Assessment** will explore existing research capability across the HDRC, including community insight representatives, and inform our training package. We anticipate that his will include: (Work will begin in our Development year)

- Understanding and using research evidence
- Rapid evidence synthesis (including the use of artificial intelligence (AI))
- Research methods (qualitative and quantitative) including evaluation
- Co-production and engagement
- Intervention mapping
- Presentation skills
- Innovative dissemination methods
- Collaborating and ensuring skills mix within teams

Public Involvement

Public involvement (PI) is integral to the HDRC: our approach places communities and residents its heart. PI is embedded throughout the HDRC's development and through all phases of its implementation.

We have consulted with partner organisations extensively for Stage 2 and have had input from MCC Neighbourhood Teams including staff working on the ground in our most deprived neighbourhoods who have insight into the best way to make the MCC HDRC a success. This has supported the way we addressed the panel's Stage 1 feedback, including providing examples of how we might deliver on our objectives and general feedback (e.g. changing the name of future HDRC PPI representatives to "Community Insight Representatives" from "Resident Researchers"). Further findings from our "scoping existing opportunities to engage with residents from MCC neighbourhoods" carried out for stage 2 are presented in an upload.

Our PPI co-applicants have attended all application development meetings for stage 2 and have contributed extensively (e.g. plain English summary, PPI remuneration, engagement planning).

We have worked with multiple organisations (e.g. Manchester PPAG; Multi-agency TANS; Manchester's Voluntary Community and Social Enterprise sector support organisation (Macc); UoM PPIE partners across Manchester; Community Health Equity Manchester (CHEM) 'sounding boards' representing specific communities known to experience health inequalities to develop Stage 1 & 2 of the application and have their commitment to deliver on our MCC HDRC aims and objectives (see letters of support).

Our plan is to embed PPI throughout the HDRC via the CIR role (see organogram). We aim to have CIRs from each community of interest in addition to neighbourhoods and these roles will be essential to drive the MCC culture shift towards meaningful long-term resident involvement and away from a light-touch consultation approach. This will be done in the following ways:

- Building trust with residents in areas of highest needs through an asset-based approach and community development as identified by the Place Based Approaches methodology
- Training residents to plan and conduct research
- Employing residents through MCC data science apprenticeships

- Employing local researchers where possible based on UoM/MCC as anchor institutions
- Mainstreaming of equitable approaches across all organisations in Manchester, normalising conversations around wider determinants of health, moving away from blaming individual behaviour to understanding of complex systems
- Having PPI as a standing agenda on our steering group meetings
- Building in time to reflect on what has gone well/ not so well and how we can improve and capturing lessons learned
- Secondments with UoM for public contributors, a dedicated training fund to support their development and consultancy opportunities to develop their researcher skills

Resources required to support the HDRC include (please see our detailed breakdown of costs):

- Costs & renumeration (including payment above the national living wage)
- Training and development opportunities
- Engagement events
- Dissemination including conferences and stakeholder meetings

Governance and management structures

Through the Manchester Partnership Board (MPB), the HDRC will be able to ensure that best practice for evidence-informed decision making is shared with, and adopted by, a wider range of system partners including the Manchester Local Care Organisation (MLCO) and the Manchester Foundation NHS Hospital Trust (MFT).

Governance: the HDRC will report to the Health and Wellbeing Board (HWB), the Manchester Partnership Board (MPB) and the MMF Programme Board. Updates will also be provided to MCC's SMT and the MICP Locality Management Team (LMT). Linking the HDRC to these boards will ensure maximum exposure and visibility to key statutory partners (HWB and MPB), wider VCSEF, public and private sector partners (MMF) and elected members. We anticipate that the HDRC will be required to report to various MCC Scrutiny Committees (i.e. Health, Economy, Communities and Equalities) dependent on the areas of focus. The Knowledge Mobilisation and Policy Coordinators (KMPC) will be integrated with specific Directorate Management Teams (DMT), with each of them having a 'Directorate Portfolio'. They would be part of the DMT, acting as a 'connector' between service strategy and the community.

Justification of costs

Please see dedicated section for a fuller justification of costs**.** Significant cost items include:

- HDRC Staffing - changing organisational culture requires us to dedicate time and resource to integrate at all levels of MCC; our staffing model reflects this.
- Investment in the Community - a defining feature of the HDRC is the CIRs and various remuneration options.
- Evaluation - longevity is dependent on understanding what works, how, for whom and in what circumstances.
- Building in capacity building and sustainability throughout the HDRC. All contributors (lay, elected and non-elected) will have the opportunity to build their knowledge and skills through a learner-centred programme of open access and face to face training opportunities from the UoM. This will be an iterative strategy and build sustainability e.g. research training to successfully apply for more grants, research skills for the next generation of researchers from lay and other backgrounds via participatory research approaches and inclusive research to reduce inequalities and embed core projects into "business as usual" for the LA and partners.

Implementation, Milestones, KPIs & stop/go criteria

Timepoint	**Measure** (see justification of costs for timelines of recruitment and details of budgetary implications)	**Stop go indicator (yes/no)**	**Mitigation**
End of Development Year	Please see our separate development year plan		
End of year 1	Recruitment of all HDRC funded staff	Yes	Disseminate vacancies among networks, use secondments and back filling where needed
	Establishment of External Reference Group (Now moved to Development year)	No	Disseminate vacancies among networks and academic professional networks
	Training Needs Assessment Completed (Now moved to Development year)	No	Prioritise with HDRC staff
	Asset mapping complete	No	Engage community teams and utilise PPI expertise to find solutions
	Embedded community researchers have developed networks for meaningful community engagement	Yes	As above
	Leadership and Governance Structures in place	Yes	HDRC leadership to engage and promote within MCC leadership
End of year 2	Priority setting activity in place and research protocols developed	Yes	Work closely with UoM and PPI representatives
	Training programme developed	Yes	As above
	MCC senior leadership and elected representatives engaged	Yes	HDRC staff attending meetings of other MCC directorates and services
End of year 3	Research based on community priorities underway	No	Extensive community and PPI engagement to find solutions to barriers to engagement
	Local residents trained appropriately to undertake peer to peer research	Yes	As above
	Feedback of early findings through management structures	Yes	HDRC leadership engages in extensive engagement
End of year 4	Dissemination of initial findings through outputs and events	No	Extensive community and PPI engagement
	Manchester context and approach to HDRC defined	No	Synthesise findings from previous years
	Findings adopted in policy	Yes	Evidence of policy with direct link to HDRC
	Research funding applications submitted to support HDRC-generated projects	No	NIHR infrastructure to support grant writing (RDS/ CRN)

End of year 5	Mainstreaming of embedded community researcher role (e.g. in budgets, service plans)	Yes	Evidence of similar roles planned and budgeted for
	Local evidence-based approach to policy making disseminated and adopted by MCC directorates	Yes	Extensive engagement across MCC services and directorates
	HDRC final report submitted	Yes	Supported by dissemination strategy and findings from years 1-5

Evaluation Framework

We will evaluate if the HDRC has achieved all the objectives outlined in the plan and logic model, developing outcome measures based on these and our success criteria. We will work with all the other partners for the full-scale evaluation of the process, interventions and policy implications.

Our data collection and evaluation methodology use validated tools and robust data collection methods to ensure that all outcomes are captured and reflect what stakeholders see as important. Realist evaluation methods will capture what worked, why it worked and whether it would work in a different setting, whilst systems wide datasets will be analysed over time investigate the potential impact at a wider geographical level.

Methodology

We propose a mixed methods approach to the evaluation, combining qualitative research methods with quantitative analysis where data sources can be identified through the co-design of a theory of change.

Reporting directly to the HDRC steering group, we will co-ordinate monitoring and evaluation activities with MCC's Making Manchester Fairer monitoring and evaluation teams to ensure work is not duplicated and resources and knowledge are shared.

Monitoring

We routinely monitor the overall health and wellbeing of the city: many outcomes link to the wider determinants of health. We will review this monitoring to understand the impact of the HDRC on health inequalities, drawing on the "inequalities first" approach, adopted by Making Manchester Fairer. This approach reports health inequalities data as primary long-term programme outcomes, utilising gap metrics' and national and matched LA comparisons.

We will map appropriate and relevant routinely collected data and identify gaps (what data are collected, when, where, and what is important to each stakeholder).

Secondary and shorter-term term outcomes, for example those focused on interventions, policy and workstreams developed following the priority setting process with communities will be co-developed based on what is important to residents and those delivering services "on the ground".

After consultation with all partners and co-producing strategies for improving monitoring, we will produce baseline and annual data. Monitoring will report to the HDRC Management Board. We will start with monitoring against the development year objectives in the workplan and inclusivity and diversity. This will form the basis of the anonymous and unlinked collection of inclusive data on the workforce and participants of all HDRC activities. We will utilise the NIHR Workforce survey for the questions used for monitoring and prepare confidential reports for the Management Board to ensure

deductive disclosure is not possible. The Management Board will be presented with reports to demonstrate changes from baseline to demonstrate successes of our interventions to improve diversity and inclusivity within all aspects of the HDRC. The methodology will be tested and then reiterated/refined for the full HDRC after consultation with the Management Board.

Evaluation

Realist evaluation provides policy makers and the practice community with a rich, detailed and practical understanding of complex interventions. This is particularly helpful when exploring a whole systems approach.

We will apply for ethical approval to UoM research and ethics committee and approval from research and innovation departments of all partners.

The basis of the evaluation is the Plan-Do-Study-Act cycle where we will co-produce with all our partners including the public contributors, a series of priorities. We will use small area analyses of census, MCC, NHS and other routine data sets to assess need “hot spots” – high burden/demand and “cold spots” – where need should be greater but demand data are not capturing true need,

Qualitative methods will be used to identify what works, where it works and why it works.

We will use validated self-report tools such as the Warwick-Edinburgh-Mental Wellbeing Scale, Quality of Life and resilience and maturity matrices to explore potential impact of the HDRC.

Economic evaluation will be undertaken through the social return on investment methodology.

Drawing on previous successful approaches, we will use ABCD and other community development approaches to ensure we capture the views of all stakeholders, especially residents. These methodologies are adaptive and ensure we do not make residents conform to a limited number of views and opinions. For professionals, we will use an adapted Delphi technique for reaching consensus whereby we need a transdisciplinary whole-systems approach.

The routine and individually collected data will be collated to reflect the proposed logic model (revised from PPI outputs) within a causal inference framework reflecting the complex interactions between components and outcomes

Semi-structured interviews and focus groups with stakeholders to understand what happened within the HDRC, with emphasis on understanding equity and social impacts, unintended consequences, and how much of the outcomes achieved can be attributed to the interventions and effectiveness of stakeholder recruitment.

Proxy values and costs for the intended and unintended outcomes will be identified through searches of academic and grey literature to assign monetary values to the outcomes. Impact of the interventions is measured from ‘deadweight’ i.e. the amount of outcomes that would have occurred anyway without the interventions, and consider attribution, informed by two elements: stakeholder views on the contribution that the interventions made to the outcomes and other influences on the outcomes; and analysis of the routine and individual collected data identified in the data synthesis and gap analysis compared to matched control areas based on the outcomes and factors identified in the modelling will identify any differences that may be attributable to the programme.

The Manchester HDRC will take a phased approach (see Gantt chart):

- Year 0: Development Year

- Manchester HDRC's Development Year incorporates a feasibility approach. Our development year is constructed around objectives and activities which both test the material enablers for our HDRC (vision, engagement and specific activities which address feedback items from our interview and Stage 2 application.

- Year 1: Understand, create and collaborate
  A phase dedicated to creating the HDRC, co-produced with partners, residents, and communities, understanding the research picture across Manchester and identifying and prioritising needs.

- Years 2-4: Pilot, demonstrate and disseminate
  An implementation phase, focussed on testing, learning, and refining the HDRC, developing an agile and responsive model, and mainstreaming an 'evidence to action' culture.

- Year 5: Transition, evaluate and maintain
  The final year will be dedicated to transition and ensuring sustainability of the most successful elements of the HDRC to embed culture change and build research skills and capacity into local, regional, and national policy.

The Logic Model sets out our proposed indicators of success (outputs / outcomes).

Socioeconomic position and health inequalities:

The long-term, engrained nature of health inequalities in Manchester means that a new and more radical approach to the generation, mobilisation and use of research evidence in respect of heath determinants is needed. We know from our intelligence to inform MMF that Manchester residents are among the poorest in England, are affected disproportionately by wider determinants of health and where these communities live. We also have large diverse communities of identity e.g. LGBTQIA; asylum seekers. The HDRC embodies this new approach, which will start by asking residents what matters most to them and using this knowledge to focus resources on local priorities. A scoping review of local assets will assist planning around how to tackle priority topics.

Evidence from COVID-19, and recent work on the cost-of-living crisis demonstrates health inequalities are affected by systemic and practical challenges across the life-course. LAs commissioning co-produced services are best placed to mainstream equity planning in multi-agency preventive services. The HDRC will lead this culture change, building on our dedicated MMF campaign promoting conversations on health inequalities with local media.

Dissemination, Outputs and anticipated impact

Key measures include:

- Funding bids for co-produced research priorities
- Community evaluation of skills
- Formal MCC reports, strategies, and policy
- Mixed methods evaluation of impact and value
- Case studies of best practice and where challenges exist

ECRs will disseminate training and development opportunities to the wider VCSEF sector, colleagues across the public health ecosystem, and wider partners such as the CC network (led by a Co-Applicant), across Greater Manchester via the GMCA in collaboration with Policy@Manchester and the UoM's wider 'Social Responsibility' Team. The UoM has social responsibility at its core: it is the only U.K. University to have formally documented social

responsibility as a core goal in its strategic plan, “Our Future”. This commitment, and the UoM’s expertise in translating knowledge into action (Pathways to Impact) will be a key element of partnership working and collaboration

What do you intend to produce?

- Outputs that influence policy at local, regional, and national levels
- Findings than can be rapidly embedded in policies, programmes, and services during and beyond the HDRC via evidence- based systems generated by our work
- A feedback loop to residents and communities
- Innovative co-production methods e.g. installations with local community artists, performances, community workshops
- Using local media
- Maximising social media outputs
- Reports, academic papers, conference presentations

How will you inform and engage elected members, local authority staff and the wider population about the work of the HDRC?

The existing CHEM Sounding Boards will provide the HDRC with a direct point of contact with communities experiencing health inequalities. We have already begun the process of informing and engaging the Sounding Boards in the development of both the Stage 1 and Stage 2 HDRC application and have received several positive letters of support which indicate that the aims and proposed work programme of the HDRC are backed by members of these particular communities. We will continue to use this route to inform and engage these communities throughout the lifecycle of the HDRC.

How will your outputs enter society as a whole

We will engage in further collaboration activities:

- The HDRC will work across thematic and geographical communities, to develop networks to facilitate and embed knowledge exchange that enables behaviour and policy changes
- We will collaborate and work in partnership with neighbouring local authorities, NHS Greater Manchester Integrated Care (the GM ICS) and GMCA to support work with communities that cut across administrative boundaries e.g. the Orthodox Jewish community and Gypsy, Roma and Traveller (GRT) communities, drawing on evidence collected on a wider geographical and organisational footprint.

Policy@Manchester is the University's policy engagement unit. It connects researchers with policymakers and influencers, nurtures long-term policy engagement relationships and seeks to enhance stakeholder understanding of pressing policy challenges. The GM Policy Hub sits within Policy@Manchester and is a dedicated resource for GM policymakers to access academic expertise to help inform evidence-based policymaking. This strategic partnership will ensure dissemination, knowledge exchange and communications can be maximised within and beyond the HDRC and wider network.

What other funding or support will be sought if this HDRC is successful (e.g. From NIHR, other Government departments, charity or industry)?

Sustainability of the programme of work will be through early demonstrations and exemplars that will support the external co-funding opportunities listed above through the lifetime of the project. Though end points will be realised within the 5 years, long-term effects will need to be measured and tools

will be developed to provide long-term monitoring and evaluation, thus embedding research and evaluation within statutory bodies.

What are the possible barriers for long-term impact?

Potential Barrier	Mitigation
Recruitment of staff and volunteers / community insight representatives	Disseminate vacancies among networks, use secondments & back filling where needed
Overcoming mistrust within communities	Use trusted voices to engage and participate in co-production. Consult neighbourhood teams (scoping exercise) Be transparent and open
Sharing information between communities with a history of statutory service distrust and other partner organisations	Using knowledge gained from Covid-19 vaccination work, be clear about limitations of data and always incorporate lived experience
Over-promising on outcomes and managing expectations/cynicism especially given twelve years of significant savings driven by cuts in central Government funding of the Council	Co-production throughout the lifetime of the HDRC to build trust throughout. Engaging with senior leaders to ensure that research findings are heard and acted on. Ensure that our dissemination and feedback loop is robust
Challenges with prioritisation due to community and / or place diversity and need	Ask “what matters to you” when developing at monitoring outcomes. We recognise that local MCC challenges necessitate a comprehensive staffing system to support diverse needs and have included this in our planning
Sustainability, longevity, and exit-strategy beyond HDRC	Incorporate HDRC into wider MCC priorities; funding applications in partnership with UoM; Focus on system wide culture change to ensure the adaptation of this new way of working is embedded in decision making at a senior level

What do you think the impact of your HDRC will be?

An inclusive and innovative co-production approach will connect key stakeholders in public health and local communities, which will underpin policy and strategy in community-based approaches to health and wellbeing in Local Government. We will generate new systems and infrastructures to tackle health inequalities. As a result, we will generate a system-wide culture change of community-driven, evidence-based policy that tackles the wider and social determinants of health.

This will in turn impact on our residents and communities, who will be empowered to engage with local organisations, including MCC services, as an equal partner, rather than just a recipient of services and consultations. Their lived experience will be a vital part of policy making. This, combined with our action on the wider determinants of health, will mean that the physical and mental health of residents in our most deprived neighbourhoods is improved.

Capacity building:
We have detailed knowledge transfer and exchange plans. This will be underpinned by the deliverables and the cycle of PPI from co-production to dissemination activities. The logic model demonstrates the specific outputs which will translate into knowledge exchange activities in the three CSs (Bronze level), the commissioning teams (Silver level) and strategic groups (Gold level) which will include policymakers and influencers at local and national level.

Collaboration:

The logic model identifies outcomes for a range of beneficiaries from individuals, communities, organisations to wider systems and the academic community. Through our multifaceted approach, the pathway to impact is wide with the potential for maximum effect. Our systems approach to the data analysis will allow for impact to be identified within a complex system as well as at a programme level. The inclusion of stakeholders as co-producers will ensure that impact is relevant to users.

Culture and leadership:
The HDRC leadership coupled with local knowledge will enable findings to be developed appropriately for maximum impact. Our targeted, system-wide culture change allows for a multiplier effect of additional benefits that will reduce inequalities by inclusion that can impact a person's health, wellbeing and life chances.

Project timetable

This is detailed in the attached Gantt chart and throughout relevant sections above. There are four phases to the HDRC:

- Year 0: Development year (appendix 1)
- Year 1: Understand, create, and collaborate
- Years 2-4: Pilot, demonstrate and disseminate
- Year 5: Transition, evaluate and maintain

Approach to Collaborative Working

As detailed, a collaborative way of working already exists between partner organisations. Using the existing schedule of monthly partnership with Policy@Manchester meetings, every two months there will be a dedicated 'HDRC-focussed' meeting. Representatives from wider partners will be invited. Areas covered will be project progress, new initiatives, funding opportunities. Emerging research ideas will be raised and discussed through this forum and key personnel required identified. As described earlier, a key responsibility of the SL will be to develop a Research Strategy which articulates the Manchester approach for collaborative research.

Safeguarding and ethics

Each organisation has governance arrangements including mandatory training e.g., adult and children safeguarding, GDPR, Data Protection, cyber security training etc. ECRs will be subject to MCC's usual role-specific requirements (e.g., DBS checking) for staff working with sensitive data. Usually, public health research does not fall into the remit of Health Research Authority (HRA) Approval. To ensure ethical considerations are peer-reviewed e.g., UoM Research Ethics Committees and MCC Research and Innovation approval committees will oversee all activities.

Bid Writing Team

University of Manchester

Arpana Verma (Clinical Professor of PH and Epidemiology), Tracy Farragher (Senior Lecturer in Healthcare Sciences (Epidemiology)) and Anna Coleman (Senior Research Fellow) contributed research and co-production expertise, wrote the evaluation plan and scientific abstract, and advised on multi-agency research approaches and contributed to all application drafts. AV worked on and obtained detailed costs from the University of Manchester.

Manchester City Council

Kasia Noone (Performance and Insight Lead) co-ordinated the application development and writing, liaised with co-applicants and partners in the development of the bid, co-wrote the application and acted as application administrator.

Joanna Goldthorpe (Evaluation Lead for Making Manchester Fairer) co-ordinated the application development and writing, liaised with partner organisations to address feedback from stage 1 and co-wrote the application.

Paul Holme Paul Holme (Head of the Performance, Research & Intelligence (PRI) service has supported the development of our pathways to impact with MCC senior management team, developed the detailed costings for MCC and contributed to all application drafts.

Neil Bendel (Public Health Specialist) initiated, convened and acted as chair for the application-writing meetings, liaised with co-applicants and partners in the development of the bid, publicised the HDRC and obtained letters of support and contributed to all application drafts.

Mark Rainey (Strategic Lead for Neighbourhoods) along with Katie McCall (Making Manchester Fairer programme Lead) supported development of the HDRC and our neighbourhood and resident engagement strategy and advised on pathways to impact

VCSE Sector

Lauren Rosegreen (Policy and Influence Manager at Macc has provided expertise on involving VCSE sectors, helped to develop the HRDC approach and contributed to all application drafts

PPI

Gwen Crossley (Chair of the Manchester Patient and Public Advisory Group (PPAG) and Lisa Jones (Manchester PPAG) has provided crucial insight into this application and HDRC planning and contributed to all application drafts.

NIHR159419 - Putting communities at the heart of policy: The development of a neighbourhood and community-led research culture and system across Manchester *(Appendix 1)*

Development Year proposal: Manchester HDRC's Development Year incorporates a feasibility approach. Our development year is constructed around objectives and activities which both test the material enablers for our HDRC (vision, engagement and specific activities which address feedback items from our interview and Stage 2 application. Our feasibility approach brings forward engagement and key enablers to our HDRC and stress-tests these enablers, allowing us to understand, monitor and refine how they perform within a complex system. To do this and deliver the above we will be using the Development year funding to invest in key enabling roles withing Manchester City Council (MCC), so they can lead the work, and investing in UoM to release capacity and expertise to develop the key collaboration and evaluation infrastructure we need. These investments will involve bringing some roles on-line early to focus on development year priorities, but they will also transition into the full HDRC as key long-term roles.
The activities and stop / go criteria in our Development Year plan have been refined through detailed consultation with Round 1 HDRC Development Year Local Authorities: this consultation has informed some of our activities (i.e. acting on learning and advice re: recruitment and accelerating the HR process internally). This peer to peer knowledge exchange resulted in us focusing our stop / go criteria on the preparatory and logistical elements necessary for successful delivery of our HDRC.

Comment	Development year plan – work objectives	Planned activities / actions	Stop go criteria	Milestones and date
<u>Vision</u> The Panel agreed that the team articulated the wider vision for the HDRC and how they would achieve this in practice	To develop the vision, aims and objectives for the full HDRC through engaging widely. To better understand the strengths and development regarding use of community research and community engagement across the Council, University and other partners. To identify the priority actions needed during the full HDRC to create a place-based research infrastructure that enables residents and communities to direct research and evaluation activities.	We will engage with services and teams across the Council, University, other partners, and communities to further develop the vision, aims and objectives as set out in our bid: To place communities at the heart of policy by creating a city-wide co-produced research system that identifies and undertakes shared research priorities on the wider determinants of health. This will be done through key MCC groups such as Senior Management Team, Senior Leaders Group, Executive Members, Directorate Management Teams and similar groups in partner organisations. We will map the existing strengths and development areas within the Council, University and other partners regarding community research and community engagement. This will enable the team to identify services, cross cutting policy themes, and geographical areas of the city	1. Refinement of vision, aims and objectives based on engagement 2. Identify HDRC 'champions' across MCC directorates with responsibility for bringing HDRC-generated research into policy and operational forums 3. Summary of existing strengths and development areas across community research and engagement to inform the full HDRC 4. Identify priority actions for the first year of the full HDRC.	May 2024 November 2024 Progress review point: May – June 2024 October 2024 November 2024

		to prioritise for further work during the full HDRC.		Progress review point: July – Oct 2024
<u>Engagement</u> The Panel welcomed the strength of community engagement and involvement, equality, diversity and inclusion.	With our PPI co-applicants we will: Identify networks based on thematic areas of interest, communities of interest and place. Develop an inclusive recruitment plan for community representation. At least 2 members of the community will sit on each of the various governance boards Support our community representatives and PPI co-applicants through connections with other HDRCs and community networks. Co-produce an inclusive communication plan and approach, which incorporates findings and positive feedback from current programmes of work (I.e., Making Manchester Fairer, using the Community Health Equity Manchester Sounding Boards).	Review of existing research and networks across communities of interest and geography Promote and socialise the HDRC across networks and Manchester communities. Consult with communities and residents to inform key monitoring indicators ("what matters to me?") Engage with Round 1 HDRCs and Round 2 development year HDRCs to exchange knowledge and peer support between community representatives and PPI co-applicants. Convene a communications working group with community and resident networks and partners to develop the HDRC communication strategy and engagement materials.	5. Consultation with community groups undertaken 6. Communications plan produced by working group 7. Community representatives recruited to governance boards	November 2024 Progress review point: May – June 2024 August 2024 July 2024
<u>Collaboration</u> The Panel would like to see academic collaborations with the council strengthened and this should be developed during the development year of the HDRC	UoM and MCC will collaboratively with our PPI co-applicants, representatives from Macc (VCSE infrastructure organisation) and Neighbourhood Teams: • Develop a Memorandum of Understanding between MCC & UoM regarding the delivery of the HDRC • Conduct a training needs assessment across the HDRC workforce. Initially this will focus on the existing members of MCC staff committed to the HDRC, • Develop a community engagement plan for the full HDRC	MCC and UoM will develop and sign the Memorandum of Understanding to formalise the use and transfer of funds and setting out the roles and responsibilities of both parties. This will include data sharing agreements, confidentiality and non-disclosure agreements as well as the contracted work programme for the development year. We will convene our HDRC Management Committee / Steering Group (see Governance and Management structure diagram). This group (which includes PPI co-applicants), will collaborate with Elected Members, VCSE organisations, Macc and their community panels, Community Health Equity Manchester (CHEM) and the CHEM	8. Manchester City Council (MCC) and University of Manchester (UoM) to sign a Memorandum of Understanding in line with NIHR contract negotiations 9. Joint training needs and strengths-based assessment completed, and training plan developed	June 2024 June 2024

	with key stakeholders that aligns with wider citywide approaches. • MCC staff to secure honorary contracts with UoM, with opportunities explored for embedding HDRC PPI representatives within academia. • Develop a cross-organisational placement programme that focuses on knowledge exchange and translating scientific and political literacy across organisations. • Appoint scientific management and steering board members. • Develop an inclusive recruitment programme and job description for key HDRC roles. • Draft a dissemination plan for outputs from development year (year one) • Understand opportunities for working with other Higher Education Institutions in Manchester so that the HDRC can draw on the full range of academic expertise available within the city.	Sounding Boards, CAHN and across MCC and partner departments (i.e. MLCO) and directorates to co-develop strategic and operational plans resulting in outputs to achieve the stop-go criteria. Identify potential barriers to research culture change within MCC and wider locality partners. The development funding will facilitate the appointment and embedding of the academic team within MCC and vice versa. MCC will also appoint an (already) identified embedded researcher and posts within the Insight and Evaluation Team. Additional resources to support the £250k have been secured by UoM to double the time allocated to the HDRC of the staff already employed at UoM (AV, TF, AC) and transfer an identified, named researcher to HDRC activities. UoM have secured office space and networking facilities to allow group work. An additional £35,000 has been secured to fund additional activities to support the development year. Honorary contracts for MCC staff applied for We are currently exploring opportunities to facilitate undergraduate and postgraduate students to support the work programme for the development year and full HDRC. The development of the Steering Group and Management Committee will be essential for the development year to ensure all milestones are met and produce documentation required for the full HDRC.	10. Community engagement and co-production plan for year one developed 11. Data sharing plan developed and completed 12. Inclusive recruitment plan and job description developed and ready to advertise for Embedded Community Researchers and Knowledge Mobilisation and Policy Coordinators	November 2024 Progress Review point: June 2024 September 2024 June 2024

		The Academic Liaison Team of the Steering Group will advise on priorities and day to day running of the development year.		
<u>Monitoring and Evaluation</u> Evaluation and monitoring lacked specificity and this should be developed during the establishment of the HDRC	UoM will work with MCC, PPI co-applicants, Macc and Neighbourhood Teams to co-produce protocols for monitoring and evaluation Co-ordinate monitoring and evaluation activities with MCC's Making Manchester Fairer monitoring and evaluation teams to ensure work is not duplicated and resources and knowledge are shared. Apply for University Research Ethics Committee approval for the work outlined in the research protocol. Work with NIHR to understand how local monitoring and evaluation plans align with national activities.	**Monitoring**: • Conduct stakeholder workshops to identify potential outcomes that are meaningful to residents, service users, frontline staff and policy makers • Map appropriate and relevant routinely collected data and identify gaps (what data are collected, when, where, and what is important to each stakeholder), aligning to the Making Manchester Fairer Monitoring Framework and PSR 'Knowing our Residents' programmes. • Incorporate Making Manchester Fairer's inequalities first approach, e.g. gap metrics, national and matched LA comparisons approach to reporting monitoring data **Evaluation**: • Identified the evaluation metrics to use in the full HDRC, covering inputs, outputs and outcomes as per our logic model (e.g. resources committed, community research undertaken, and measuring changes that will take place as a result of community research). This will be informed by engagement and literature review. This will inform cost effectiveness and other analysis	13. Completion of stakeholder workshops 14. Production of monitoring framework including development of outcomes 15. Agreed set of research questions for the evaluation in alignment with overarching Logic Model 16. Agreed evaluation protocols in place (process, acceptability and impact / outcomes)	June 2024 November 2024 Progress Review point: July 2024 November 2024 Progress Review point: July 2024 November 2024 Progress Review point: June - July 2024

		• Conduct a literature review to identify potential creative methods to engage participants and collect data in ways that are acceptable and respect confidentiality.		