London Borough of Islington HDRC Detailed business plan. Reference: NIHR15399

1.0 Summary information

1.1 Full title of HDRC (Limit: 300 characters)

London Borough of Islington Health Determinants Research Collaboration: accelerating evidence-based approaches to challenging inequalities.

1.2 Background and rationale

Population. London Borough of Islington is the sixth most deprived borough in London. It has the highest level of child poverty in London and the tenth highest in England, with 28% of children living in income-deprived families. High levels of poverty are also experienced by elderly residents, with Islington having the fourth highest level of poverty amongst older people. Importantly, the pattern of deprivation in Islington differs to other boroughs, as deprivation is found throughout the entire borough with affluent areas found immediately next to deprived areas [1]. Our residents, over a third of whom are from Black, Asian, and Minority Ethnic groups and a further 16% of whom identify as "other white" [2], experience wide disparities in income, opportunities, and outcomes. Men living in the most deprived areas of Islington are expected to live 9.8 years less than those living in the least deprived areas, and this inequality is higher compared to London as a whole (7.2 years). Islington had the highest proportion of the working age population claiming sickness and disability benefits in London in February 2020, principally due to mental ill health, of which the borough has among the highest rates in the country. Groups and communities disproportionately affected by inequalities include people from ethnic minority groups, those with mental ill health, learning disabilities, and are concentrated in Islington's many social housing estates, with our Local Authority (LA) being the seventh largest registered social landlord in the country [3].

Context. Challenging inequalities is central to our LA's vision. Our 2023 strategic plan "Islington Together 2030 plan: for an equal future", articulates a relentless determination to create a more equal borough [4]. Informed by the expansive 'Let's Talk Islington' community engagement programme (in which public health played a key role) and Inequality Task Force recommendations, this strategy takes a community and place-based approach [5] to reduce inequalities by taking action on the wider determinants of health (WDH) through five overarching priorities: ensuring children and young people have the best start in life; local jobs and business in a thriving local economy; a borough where everyone has a place to call home; a cleaner, greener, healthier borough; and communities that feel safe, connected, and inclusive. Moreover, the strategy identifies new ways of working, including putting communities at the heart of everything we do, embracing innovation, enabling dynamic leadership and governance, investing in a high performing workforce and ensuring impact for local people – all of which will be further enabled through targeted HDRC capacity building and PPIE investments.

To achieve these priorities for improving outcomes and tackling inequalities, we recognise the importance of research and development to provide evidence-based, integrated services [6,7]; working in partnership across the organisation and with residents and Voluntary and Community Sector (VCS) organisations; a focus on prevention and early intervention; enthusiastically embracing change and innovation; and above all a drive to achieve tangible improvements in health and wellbeing outcomes for all residents. Establishing a HDRC in our LA aligns with our long-term priorities and would add significant value to work that is already being done across Islington.

Current research and development functions. Our LA has already established several research and development initiatives that aim to improve the use of data and insights to inform evidence-based decision-making, reduce inequalities, and improve resident health and wellbeing. These include:

- A strong public health team with expertise in research, deployed across the borough, and with exceptional analytic capabilities which also include housing and adult social care.
- Joint posts between our LA's public health department and LSHTM (London School of Hygiene and Tropical Medicine and UCL (University College London)

- Clinical Research Network (CRN)-funded secondments, including a successful collaborative bid (£100,000) for evaluation [12].
- Established a joint LA/UCL general practice/public health trainee placement scheme. Outputs include training resources and publications [13-15].
- Strong links with several academic groups across Islington, including beyond our LA's public health department.
- Cross-service research and analyst networks to strengthen internal capacity, provide quality assurance, and guidance on ethics around primary data collection.

Examples of existing collaborative research include:

- Creating an innovative dataset linking NHS and LA data to facilitate analysis of patterns in WDH, health status, and service utilisation, informing strategic planning (Health Foundation).
- Investigating with London School of Economics (LSE) the potential use of adult social care free text analytics in predicting and understanding health and social care demand and outcomes for residents using adult social care services (NHS Digital) [16].
- Attaching Unique Property Reference Numbers to healthcare records to facilitate analysis of data at household level (local NHS funding).
- Developing with the Social Progress Imperative a local social progress index on children's personal safety, and working with the Ministry of Housing, Communities and Local Government for a pan-London social progress index.
- Research with the University of Bedfordshire to explore care leavers' transitions to adulthood in the context of Covid-19.
- An NIHR-funded PhD with LA/UCL/LSHTM supervision leading to publications [17,18], and influencing Integrated Care System (ICS)-level decision-making.
- An NIHR-funded project aiming to understand how systematic reviews and meta-analyses can be made more useful by understanding whether their findings are generalisable [19].
- Working alongside NIHR School for Public Health Research (SPHR) researchers undertaking evaluations of alcohol policy initiatives [20-22].

Barriers to research and development. Despite these initiatives, we recognise that there are gaps and missed opportunities in integrating and using research at scale across our LA to address the WDH and reduce inequalities [23-27]. Establishing an HDRC would enable us to address the following barriers to research and development at our LA:

Whole-borough approach. Although our LA is proud to pursue a culture of effective partnership working underpinned by a commitment to prevention and reduction of inequalities, related research activities often occur in isolation or at a small scale. Driven by strong leadership and commitment, the HDRC will support us to develop a sustainable model, aiming to transition from an organisation responsive to individual research projects, towards an organisation that initiates evidence use and generation across all departments.

Competing priorities. Against a backdrop of considerable financial pressure and uncertainty, developing and using evidence can be seen as 'nice to have' and not a priority. The HDRC will help to dispel this myth, provide the funding to enable staff to protect time for research, and cultivate an organisational mind-set where being research-active is seen as beneficial, and fundamental to managing complex issues and delivering better outcomes for residents.

Data systems. We recognise data as an asset and our Population Health Management system is considered as one of the most developed in the UK. This is evident in our investment in a data platform (2.3) and a clear articulation in our strategic plan to "enhance our data and systems" [4]. Furthermore, in the last year non-public health departments such as housing and adult social care have made a step change in investing in resource to improve data quality. While there is progress being made, a cross-organisational approach to data and insight does not yet exist to bring together service-level data for cross-cutting insights to better support targeted service development and strategic decisions to address WDH. In recognition of this, the LA's leadership group has sponsored the establishment of a Data and Insights Board to oversee and provide strong, visible

leadership on all data, insight, and digital activities, with a key deliverable being a data strategy. The HDRC will enable us to accelerate the development and maturity of this function and realise our ambitions of being a data-driven organisation. We aim to increase our capabilities to better link and process data to inform decision-making by improving data from across Islington and by raising awareness and supporting staff confidence and competence in how to use it (2.3).

Qualitative research. We have invested in qualitative research capacity, including analysis using Nvivo, and there is a thriving qualitative team within the public health department. For large initiatives, we currently synthesise qualitative and quantitative insights, which are presented to support decision-making. However, these activities are largely limited to the public health department. The HDRC will enable us to increase scope by providing other departments with enhanced opportunities to use joined-up data to support the LA in tackling WDH.

Resident engagement. There is tremendous enthusiasm for resident engagement, but variation in understanding and practice of how data collected can be used to inform decision-making. Much of our work could be classified as informing and consulting, often with the same groups. Our LA has strong partnerships with borough-wide VCS organisations and specialised community groups; has multiple resident groups (e.g. parent, community and Covid-19 "champions") and a Youth Council; and routinely conducts resident consultations. However, we recognise the need to coordinate these activities across the organisation and improve their sustainability. Through the Patient and Public Involvement and Engagement (PPIE) work proposed, the HDRC will facilitate this process, encouraging, empowering, formalising, and maximising the involvement of residents across the research to policy and practice cycle, ultimately aiming to improve their health and wellbeing.

Staff mobility and existing capacity building opportunities. Current research and development activities are often driven by individuals with a specific interest or research background. Moreover, while research training is available through organisations like Applied Research Collaboration North Thames (ARC NT), it has traditionally been targeted towards NHS staff, and lacked LA engagement. In addition, turnover of LA staff is high and developing and sustaining a research-active workforce is not a one-off intervention. It is essential that the importance and value of research and development is embedded into our culture and processes in a sustainable and resilient way and is not reliant on specific staff. Establishing an HDRC will enable us to do this and partnering with ARC NT will support development of LA-focused research training.

Links with external research generators. The LA has links with multiple HEI, involving different teams and departments. The HDRC will enable us to co-ordinate and strengthen these relationships, in a planned, strategic way aiming to enhance the identification of gaps and evidence needs and communicate these to HEI seeking partners in their research in a way that optimises the decision-making functions the LA. This will ensure the development of more collaborative and co-produced approaches to generating evidence that break traditional siloes between evidence generators, evidence users, and beneficiaries of evidence-informed decision-making.

2.0 Delivery plan

2.1 Overarching vision, aims and objectives (see Logic model)

Vision. To reduce inequalities and improve health and wellbeing among our residents by creating an organisational culture where research, data, and resident insights are intrinsic to the way our LA works. This will drive equitable and effective policy and decision-making across all functions and departments, enabling our LA to make a difference to residents' lives, particularly those experiencing greatest deprivation.

Aims. Within our LA and Islington as a place, to:

1. Create a sustainable research culture that places research at the heart of how we work with communities to improve outcomes and reduce inequalities.
2. Strengthen preventive and population health and wellbeing by generating and mobilising data and insights overall and at a hyper-local level to identify inequalities and support and evaluate action to improve outcomes.

3. Build capacity and participation in research as a way of driving change and making a positive difference to residents, ensuring they are central to research design and delivery.

Objectives. Our HDRC will be focussed on three, interrelated workstreams. Whilst elements of each workstream are independent, we envisage that they will work synergistically to achieve our success criteria. Each workstream is described in detail and summarised here:

Strengthening collaborations and culture (2.2), linked aim 1.

a. Develop and implement an HDRC strategic plan/research strategy with widespread ownership.
b. Develop stronger local, sector, and regional research networks for the development and evaluation of initiatives to improve health and wellbeing by:

- capitalising on models of good practice to work in partnership with residents and the VCS;
- engaging LA leadership, departments across our LA working on WDH, and regional partners including the ICS and Office for Health Improvement and Disparities (OHID) to promote collaborative working; and
- enhancing existing partnerships and developing new collaborations with HEI to ensure that evidence and capacity needs within the LA are communicated to HEI and vice versa; and establishing a robust approach for peer review, challenge, and development through external partners (e.g. ARC NT) and other HDRC sites.

Data and infrastructure (2.3), linked aim 2.

a. Establish a Centre of Excellence for Data and Insights to accelerate our data and insights programme through increased data linkage; improved quality; and greater accessibility.
b. Establish a LA data/ethics function and HDRC surgery to support and underpin this and provide a clear pathway to research initiation within Islington.

Capacity building (2.4), linked aim 3.

a. Develop and implement a research capacity building strategy informed by the needs of the LA, staff, and residents. This will support LA staff, VCS and HEI partners, and residents at all levels to develop their research capabilities and apply the principles of research and development across their entire scope of work, and to have access to data sets and to see how data is being used to shape local policy, or to challenge when it is not. Among LA staff this includes building capacity in identifying and interpreting existing evidence as well as generating locally-based evidence.

b. Widen participation in research by empowering residents and VCS partners to become involved in existing research, and provide opportunities from them to lead community research.

Success criteria are summarised below and detailed in 2.8, including evaluation. The overarching vision of our HDRC is to reduce inequalities and improve health and wellbeing, and our preliminary success criteria have thus been developed to include outcomes that we believe can be measured and attributed to the HDRC that will enable us to do this.

Culture and leadership. An organisational culture where research is seen as everyone's business, there is a clear pathway for undertaking, and/or using research, and where residents are central to all HDRC activities.

Decision-making. Data and insights are routinely mobilised and collected as standard practice in the delivery and evaluation of initiatives, thus ensuring that policy and decision-making demonstrably meets the needs of residents and addresses inequalities in access and outcomes.

Wider influence. Audience-appropriate dissemination to share learning across Islington and beyond, leading to sustainable partnerships and knowledge exchange both during and after the initial five-year programme.

2.2 Strengthening collaborations and culture

Strengthening collaborations across Islington is critical to embedding a sustainable culture of research and development centred on reducing inequalities and creating a more equal borough. To inform our strategy for collaborations, we have brought together potential partners within the LA, across Islington and the region, and with HEI, all of whom have contributed to the strategic vision.

*LA leadership and non-public health departments***.** The HRDC will be embedded and build upon structures already in place within the LA, ensuring longevity, sustainability, and senior leadership. Importantly, our HDRC proposal is strongly supported by the LA's Corporate Management Board (CMB) and the Health and Wellbeing Board (HWBB) (see letter of support), which will provide executive oversight (2.7). The HDRC will encompass the breadth of LA functions that contribute to WDH through the delivery board and HDRC research officers, embedded into teams that address WDH across the LA. This will enable cross-LA collaboration and engagement.

Residents. As described in 1.2, we are acutely aware of the importance and benefits of involving residents as creative collaborators to solve complex problems. Although we have already established processes for resident engagement, the HDRC will provide us with the capacity to develop dedicated mechanisms for resident engagement in research and development, particularly by those under-represented. This will help us to develop our understanding of our residents, their lived experience and ideas for change, and thus ensure that the HDRC addresses their priorities. Residents will be offered training to undertake and co-produce research, review plans, survey and research tools, and liaise with other community organisations. This is described in detail in 2.5.

VCS. Because we recognise the importance of working with our communities and local VCS as equal partners, we will use the HDRC infrastructure as an opportunity to further strengthen our existing collaborations with the VCS, building on their knowledge and connections as co-deliverers of sustainable change. This includes partnership with Healthwatch Islington (see letter of support), whose director is a co-applicant on this proposal with funding and time commensurate with LA staff. Following our development year activities, we plan to expand direct involvement of additional VCS organisations (and residents) to ensure a wider representation of our population and enable us to reach underrepresented subgroups, including private renters. This is reflected in the amended budget and justification of costs.

*Sector/regional partners***.** Some of our HDRC's activities will benefit from working at the regional level and align with ICS priorities (see letter of support). We are well-placed to develop effective collaborations with sector and regional partners and act as a champion for research. Our LA previously had a shared public health function with Camden, so we are experienced in the challenges and benefits of working with different organisational priorities. Regionally, our LA sits on an evolving partnership network with colleagues in OHID/UK Health Security Agency (UKHSA) comprising LA, regional public health teams, and HEI interested in WDH research. Examples of sector collaborative working in Islington are exemplified by our leadership within the ICS and the Fairer Together partnership. The HDRC will enable us to build upon the joint working and staffing that we have already established, particularly for those working on Population Health Management. Staff are already seconded from the LA to the ICS to provide leadership for data and analytics, providing a solid basis for building research collaborations further as the ICS develops. Furthermore, leads in our HDRC delivery board are already represented on key boards within the ICS (e.g. Population Health and Inequalities committee). This provides the opportunity for sharing resources and methods developed in the Islington HDRC with the wider North Central London (NCL) footprint.

*HEI***.** Our LA has already developed a strong history of partnership working with HEI (1.2). The HDRC will enable us to strengthen these established links and forge new ones. Dalya Marks (DM) and Jessica Sheringham (JS) (co-applicants) work on NIHR-funded programmes (e.g. ARC NT, SPHR). DM holds a joint post with the LA, sits on the ARC NT Board, and is co-Chair of the Population Health and Social Care stream and the LSHTM SPHR3 Management Board. Both DM and JS will link our HDRC with specific research expertise through their wide research networks.

Furthermore, an ARC Academy/LA post (training) and co-developed research capacity building strategy will bolster these links (2.4). DM and JS's funding will allow them dedicated time to provide more academic rigour to different levels of LA working, both directly (to bring an evidence perspective into strategy) and indirectly (by linking with key academics, e.g. through the proposed contextualising systematic review evidence-base work described in 2.3). Similarly for Jonathan O'Sullivan (JS), Charlotte Ashton (CA), Mahnaz Shaukat (MS) and the Head of Research role, dedicated research time will enable them to proactively develop funding bids with HEI for LA-led research and contribute to HEI capacity building (e.g. CA lectures on UCL health services courses and MS lectures on the MSc in Public Health). DM, as an MSc Programme Director on the LSHTM MSc in Public Health, can expand opportunities for LA staff to lecture and facilitate small group teaching.

HDRC strategic plan and research strategy. Our planned engagement activities with these collaborators will inform the development and implementation of an HDRC strategic plan and research strategy to improve WDH and reduce inequalities in Islington that:

- Articulates senior level commitment to the HDRC, e.g. through agreement to embed research and development into core policies and procedures; resourcing capacity building, e.g. protected time and funding for training; a commitment to all research following an approvals process; and resourcing audit to monitor adherence to research approvals and governance.
- Is informed by staff perceptions and resident experiences, e.g. extending activity undertaken by CRN-embedded practitioners, which identified barriers to being research-active in public health, to all LA staff [12]. This will involve regular surveys and interviews to monitor perceptions of research activity and barriers to being research-active (2.8). VCS and resident representatives will input into the strategic plan so priorities address their key concerns.
- Has widespread ownership by the partners described above.

Housing has emerged as an early priority for the HDRC in part due to clear evidence from the Let's Talk Islington consultation with over 6000 residents and resident and VCS discussions during the development year and due to strong buy-in from housing to adopt an evidence-informed strategy. This gives an opportunity to test out ways of working in one directorate that could be adapted to others.

Embedding a sustainable culture-shift. Strengthening these collaborations will enable us to develop stronger local, sector, and regional research networks, contributing to a culture shift within Islington where research is routinely on the agenda and seen as essential to everyday practice both at the LA and with our partners. Importantly, the data and infrastructure (2.3) and capacity building (2.4) workstreams will help to further embed this culture shift by providing people with the skills, resources, and environment that they need to undertake research.

2.3 Data and infrastructure

Good use of information and intelligence is central to evidence-based decision-making to improve residents' lives by ensuring that we are making a difference, providing efficient services effectively targeting those in most need, shifting the balance towards prevention and early intervention, and demonstrating progress and impact on inequalities. The LA holds an abundance of data about residents' lives, from early years to housing status through to social care needs. These data are held on a variety of systems and are largely used to generate performance reports for single service areas. Limited analytical capacity is spent on strategic analytics that provide deeper insight into a specific issue e.g. routes to homelessness, or longitudinal analysis to understand how residents' lives in an area or estate change over time. Unlike NHS data, data in LAs are not coded and there is no unique identifier to enable easy linkage. This is a significant barrier in enabling sophisticated strategic analysis on WDH and inequalities. There are opportunities to improve the quality and use of three main sources of data: i) quantitative data; ii) mixed-method data from resident surveys, interviews, and group discussions; and iii) qualitative data from practitioner case notes. We will progressively integrate these data sources across service areas and source type (e.g. quantitative and qualitative performance, resident, and practitioner data). Furthermore, we plan to strengthen the role of existing published evidence in decision-making.

Accessible research datasets. To address the challenges outlined above, the LA has invested in a data platform to support the use of big data in both structured and unstructured formats. This will ingest data from disparate LA systems, such as Housing, Adult Social Care, Children's Social Care, and Safeguarding; and these data will be formatted, cleaned, and normalised. Data will be made available to analysts and other staff through various mediums including dashboards for operational use and purpose-specific pseudonymised linked datasets to investigate more complex social issues. Key benefits include: improved business insight and processes, by pulling together multiple data sets; enabling the automation of existing data processes; and removing duplicate copies of data being held in various locations. Subject to legal and ethical considerations, the HDRC will help us to develop linked pseudonymised datasets to enable us to assess the patterns in WDH at individual, family, household, and hyper-local geographical levels. Figure 1 provides an example of how Early Years' data captured from various LA systems would be ingested into the data platform. Domains would be created with the minimum number of variables needed to conduct analysis for operational purposes, and then segregated for secondary use purposes. The same would apply to other areas (e.g. Housing). The HDRC will fund a data manager and a data quality manager that will support the development of these datasets (6.0). These will be supported by data engineer consultants, who will create processes to extract data from LA systems; create tables of data to load and link to the data platform (by extracting, transforming, and loading data pipelines); test data upon completion of loading, including linkages; and develop automation processes so that these data can be updated periodically or as needed. Over the five years we aim to:

1) Develop linked datasets that will provide us with deeper insight into complex issues such as residents/households facing multiple disadvantage/debt.
2) Create a longitudinal linked dataset to facilitate understanding of the impact of interventions/outcomes of residents in a specific geographical area and/or cohort over time.
3) Create a linked health and WDH dataset to to quantify the impact of the WDH on health status, outcomes, and service use. We have already received approval from the Independent Group Advising on the Release of Data to link these data at household level.

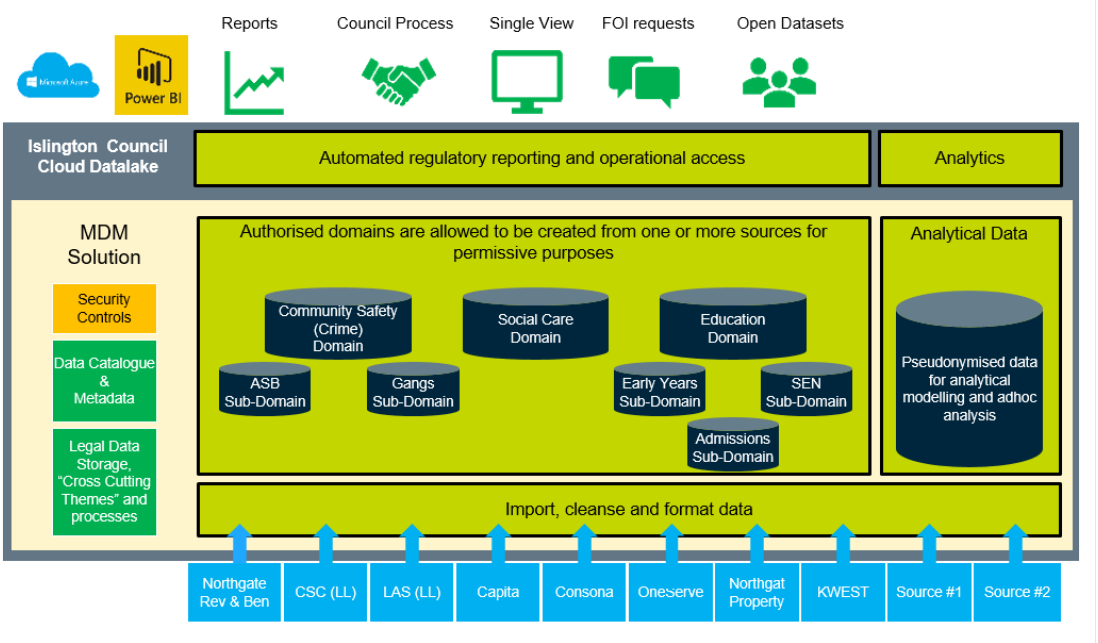

Figure 1. Proposed corporate data platform (example showing Early Years' data connectivity).

In parallel, the LA is in the process of rolling out a corporate consultation tool, which will create a centralised repository of resident input and feedback. Similar to the quantitative platform, this tool would enable all service areas to see this information, including the demographic characteristics of respondents. Centralising this information will help to minimise duplicate requests and enable us to make use of the rich resident insights that cross multiple service areas. For example, in two recent

large-scale surveys about Covid-19 and inequality (n=2000+), residents raised a range of issues beyond what a single department can address, reflecting the inter-connectedness of the WDH (e.g. housing, finances, cost of living, safety, education, employment, exclusion, physical environment, transport, access to services, social isolation, community cohesion, LA remit, and decision-making and participation processes, among others).

The HDRC would help to accelerate both processes and importantly to integrate data from both platforms. This would create an institutional culture where all staff use common systems, rather than continue to rely on their own systems shared in an ad hoc manner, if at all. We will support researchers in HEI to apply for access to use these datasets in line with information governance requirements and seek to further develop co-investigator funding opportunities with HEI.

Robust analysis and quality assurance processes. Improving the accessibility of data will enable quantitative and qualitative analysts to spend more time analysing data, rather than cleaning and consolidating datasets. This time, as well as investments in upskilling staff (2.4) will improve systematic analyses and standardisation of quality assurance processes, particularly for qualitative data (e.g. creation of codebooks, use of Nvivo, and analysis of inter-rater reliability). Findings from pilot work undertaken with LSE on free text analysis for adult social care (1.2) will inform the value of investing in similar large-scale analysis of free text data in other areas of our LA, e.g. Children's Social Care case notes and resident engagement insights.

Data governance and ethics. The above use of data and insights are subject to careful ethical and legal considerations. Our LA has an existing Information Governance Panel that reviews Data Privacy Impact Assessments for analytical projects that require data to be linked. An internal community of practice previously provided guidance and review of plans for resident consultation and qualitative research; however, due to staff changes, this group and informal ethics review has lapsed. Beyond legal constraints, there are also ethical questions about how data should be used, and what processes and systems are needed to ensure organisations have good data ethics practice.

During our HDRC development year, data ethics has been more explicitly integrated into the Information Governance team and the role of head of information governance now includes ethics as a responsibility. A cross-council research ethics review process has been updated and reinstated. HDRC will help to further institutionalise these internal processes and standards and to discuss ethics concerns and LBI responses with residents. We will monitor the use of this function across Islington, aiming to show an increase in awareness and the quality, number and breadth of research ethics review applicants.

HDRC surgery. As part of our ambition to create an easy pathway to research within Islington, we will establish an HDRC surgery. This would provide a central hub within our LA to provide advice and support on all aspects of research, including literature review, study design, data collection and analysis, and audience appropriate dissemination.

Optimising dissemination and use of evidence. We will develop a data and insights hub to bring together research, evaluation, and analyses from across our LA to improve evidence synthesis and learning. Internally, this will enable staff to probe deeper beyond the initial analysis linked to the primary purpose of the original data collection (e.g. service user feedback to inform a new strategy or commissioning can also provide insight on the intersectionality of residents' lived experiences/WDH). The hub, led by MS, will manage an updated, accessible, user-friendly public-facing website to allow residents and external stakeholders to readily see key borough statistics and search and download the multiple resident engagement reports (2.5 and 3), improving dissemination and closing the feedback loop. We aim to increase the number of reports that are publicly available, aiming to make this the default rather than the exception. Experience from our development year has highlighted the importance of effective dissemination to staff and residents. This is an area we want to further develop over the full HDRC, noting, to be effective and meaningful the communications need to be nuanced and bespoke. We acknowledge that this is a

gap in the original structure. As such we intend to recruit a communications officer to support this area of delivery and Healthwatch have also now costed in additional time for this work dedicated to VCS organisations and residents.

Levering existing external evidence. Not all evidence needs should be achieved by relying on research generated within Islington. Our capacity building plans (2.4) include building familiarity with evidence generated elsewhere to inform decision-making. This will involve enhancing capacity and developing skills in identifying evidence, appraising quality, interpretation, and integration within policy. This will ensure that we have the capacity and competence to use the published evidence base in one setting and adapt it to inform decision-making in our setting. Evidence from systematic reviews can be instrumental in shaping service development. To ensure that this evidence base is salient for Islington, we will work with Dylan Kneale (DK) to consider the extent of the match between the context of published studies and Islington's needs. We will use structured tools [28], implement innovative approaches for conceptualising local systems, and implement new methods of using locally generated data to understand the salience of systematic review evidence [29]. These approaches were further developed during a recent NIHR-funded methods project (1.2). DM has been part of SPHR systems-thinking research in which Islington was a case study site for one such project [30] to further contribute to this ambition.

2.4 Capacity building

Infrastructure. Our strategy to build research capacity across our LA and in Islington as a place has been developed in partnership with Silvie Cooper (SC), ARC NT Academy lecturer who will provide strategic oversight during the HDRC (see letter of support). The strategy will cover a range of areas including the training offer, corporate commitment for staff to have protected time to participate, and resource development to support implementation. We will recruit a training coordinator in partnership with ARC NT Academy. Initially they will lead an Islington wide training needs assessment with all LA staff including members, residents, and VCS partners) by exploring skills needed to co-produce and use research, as part of an overarching baseline for the HDRC in year 1 (*see: evaluation*). This will in part build on the recent survey of the public health department's research training needs undertaken by CRN-funded research practitioners [12]. It will also draw on knowledge from development year engagement activities. As an example, learning from overcrowding community researcher involvement highlighted the need to ensure access to information governance training. During the development year we facilitated this through linking up with training provided through UCL and as we develop will look to how we can offer such training in a more routine and embedded way.

Findings will be used to set priorities, develop a training schedule, and map and adaptARC Academy resources to apply research skills training to WDH projects, thus adding value by building on already established ARC Academy work. Through working with LBI colleagues in Learning & Development we have already identified the need for substantially different training formats to meet the needs of colleagues that are not office-based for whom half day or full day training packages are not feasible, We will investigate how to deliver research capacity training in small bite-sized e.g. 10 mins chunks, before/after a shift change. Training needs have also come through the resident co-design group, including how to synthesise existing evidence to determine if additional research is needed, monitor programmes, map and influence a range of decision-making processes, educate residents about their rights and feel confident with public speaking.

Mapping will include a review of relevant training provided within Islington, and consideration of how this could be further developed to build on research skills at different levels (e.g. adapting ARC's evaluation course to focus on WDH interventions rather than clinical ones). This approach will have many benefits including: i) developing transferrable skills among individuals to help with their wider career development; ii) establishing a cohort of staff and residents with skills that meaningfully and effectively inform research; and iii) widening participation by providing non-healthcare LA partners, VCS, and residents with training opportunities to establish a Researcher in the Community programme (2.5). Because the needs and asks will not be uniform across

Islington, our strategy will develop a diverse offer to facilitate a research active workforce through a three levelled offer (Figure 2):

- Level 1: Engaging with research. This will focus on supporting staff and residents to develop the skills and confidence to be effectively and proactively involved in research and decision-making (these are transferrable skills that will be beneficial across other areas too, e.g. understanding the research cycle).
- Level 2: Doing and using research. This will focus on developing transferable research skills across the workforce, including residents, to create the capacity for using research skills, e.g. local evaluations and applying evidence into practice. We will utilise existing ARC courses, and develop responsive co-designed bespoke courses.
- Level 3: Leading research. This will focus on developing more specialist academic and research skills, and placements to enable our LA to initiate and lead externally funded research in partnership with academic collaborators (e.g. supporting staff applications to NIHR SPARC). We will draw learning from ARC NT's MH ALL programme to adapt approaches they have used to attract staff not typically exposed to research opportunities, and to develop their research skills, e.g. through guiding self-assessment of broad transferable research competencies, to design personalised development programmes.

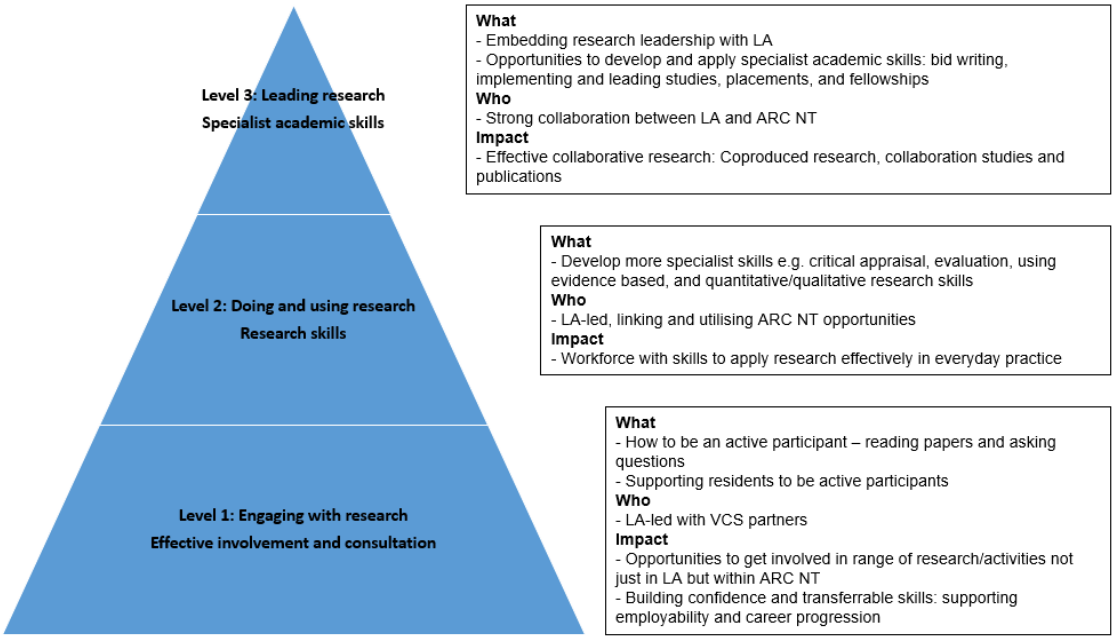

Figure 2. Levelled approach to building research capacity across Islington.

Joint offer, building on existing opportunities. The approach will bring together the existing LA and wider ARC offer that is already on offer and identify gaps and explore options to address them. We will develop bespoke courses and adapt existing ones (introductory to advanced) on topics including critical appraisal/literature review; study design; analysis; research synthesis; evaluation into practice; participatory/visual methods; process, impact, and economic evaluation; and using data and insights to inform decision-making. This will also involve working with the data and governance function (2.3) to design induction-level training on ethical issues and research governance. The capacity building strategy will help inform how these courses are designed and implemented and we envisage that in some instances the offer will be organisation specific and in others, a more theme-based offer could be rolled out across a wider footprint. One priority area is how to better address WDH within research, developing a model of training which we would share across a wider footprint. Training will be accompanied by a mentoring/peer support system to encourage using new skills, contribute to the evidence base, and share learning to develop a community of practice for development. Once the programme is established, and collaborators have participated, we will extend this to partners across the ICS, adding value across the wider system.

HDRC Research Officers. We will create three HDRC-funded posts and anticipate securing further funding, including from within our LA, to create others. Research Officers will work across the LA to provide support for skills development, map existing research, navigate the funding landscape, research dissemination, and link LA staff with academic partners. Key to their role will be identifying how skills gained can be applied across the LA in order to meet the needs of the LA. This will support embedding the approach within business as usual to increase sustainability. Following reflection on the development year and work delivered through the CRN, we realise that for these roles to be truly impactful, they need to be graded at a higher level than initially planned. It is important that the research officers have the experience, competence, and confidence to work more independently, particularly when embedded in another department. Additionally, we realise that a core part of the work of these roles is likely to encompass evaluation. We have therefore removed the evaluation lead role proposed in the original model and replaced this with a third embedded researcher role. This will mean that evaluation will be encompassed across a number of staff as opposed to sitting with one individual, increasing capacity in this important area as well as encouraging better cross organisational learning. We have reviewed our staffing model to take account of this. The researcher roles will rotate around the council and be embedded in different parts of the council, focusing on a discrete number of specific projects/pieces of work at one time. This will enable cross-fertilisation across the council and increase learning opportunities for staff (both the embedded researchers and teams they are working with). Additionally, Islington is a training site for GP and Public Health Registrars, we plan to provide opportunities for these staff to get involved in the embedded research projects, thereby increasing the capacity to deliver this work. The approach should support our vision of embedding research/evidence-based approaches across the council in a collaborative and sustainable way.

Secondment opportunities. We will establish a work experience programme for VCS and residents and provide enhanced two-way secondment opportunities between LA staff and academics to create a more sustainable and motivated research community. We will create a matchmaking 'hub' to widen opportunities for LA staff and academics to collaborate, identify under-served populations, and coordinate work in a mutually beneficial way. We will explore how we work with the wider community including colleges and school leavers to offer more opportunities for supervision, mentorship, and placements. This builds on expertise within the wider team on understanding the influence of embedded researchers on LA decision-making.

Sustainability. In galvanising a research active workforce, the needs of individuals and organisations will not remain static. Essential to ongoing success and sustainability will be an adaptive approach that builds on skills. We plan that the offer builds up from being around engagement in research initially towards wider application. The support needed at different periods will change and this will be factored into our strategy, informed by evaluation findings (2.8).

2.5 Public involvement

Our LA is committed to placing residents' needs and experiences at the heart of decision-making and there is a senior-level recognition that this needs to be better embedded and coordinated. This proposal has been shaped by consultations with members of existing PPIE and VCS groups (Parent Champions, Covid Champions, Healthwatch Islington); coordinators of these groups, strategic decision-makers, staff and operational decision-makers across service areas, and health system partners, all of whom interact with residents in different ways; and engagement activities during the development year. The HDRC PPIE function will aim to respond to current fragmentation, representation, and co-production challenges whereby simultaneous consultations issued by different services make one-time requests for resident feedback, often channelled through the same organisations. In an attempt to deliver at pace, 'engagement' is predominantly oriented more towards the informing and consulting end of the ladder of engagement [31], with less time and investment in meaningful co-production. Moreover, we currently do not have an accurate, borough-wide understanding of who engages on what, and how those residents' profiles relate to the overall population – leading to what we suspect is an overreliance on some groups and underrepresentation of others.

Our HDRC will help us to accelerate momentum across our LA to coordinate engagement requests, reduce duplication, minimise engagement fatigue and capture impact. It will also enable us to set up a robust mechanism to systematically document PPIE processes to actively reach out to missing voices, including people who do not access services and those with few institutional affiliations. Building on existing relationships, our focus will be to better understand and expand who is involved and to create structured, ongoing mechanisms that enable different levels of involvement. We will pay particular attention to the two ends of the research and policy cycle where residents are often less active: agenda/priority setting (e.g. identifying research questions) and dissemination (e.g. closing feedback loops). The latter will help us share findings in a more accessible way and better communicate what changes are made because of engagement.

During the development year, we have co-designed our HDRC resident engagement strategy with a diverse group of residents, who met monthly from April to September to develop the strategy, test approaches, including through a pilot resident-decision-maker discussion session with the Director of Housing Operations. The strategy was also informed by two workshops with DCHV members. In addition, LBI has identified internal resources to develop a representative resident panel, on which HDRC and departments across the council can draw.

Our core PPIE approach is underpinned by a set of principles and values and includes two new mechanisms for sustained resident involvement:

i) Resident Response Network. This will comprise approximately 20 residents recruited over time, to flexibly contribute according to relevance, need and stage of decision-making, to input into and advise on LA plans and programmes (e.g. reviewing strategies, dissemination documents and proposals, including research proposals). To inform new strategies and commissioning, in the last several months alone, individual LA programmes have undertaken consultations about community safety, substance misuse, people friendly streets, and inequality. Establishing a standing group would provide a forum to discuss the relationship between a range of health determinants and outcomes, inequalities, and intersectionality rather than a siloed single-area focus. A sustained mechanism would also benefit our LA by reducing the time involved in separate outreach/payment processes and streamline requests. Importantly, this group could proactively identify resident concerns and areas of enquiry not on our agenda (which strongly came through our development year activities). Residents will be invited to take part in specific activities that will stem from three main referral routes i) priorities identified by EI's Strategic Delivery Board, ii) in response to Council-determined initiatives and iii) where the Resident Working Group (which will include residents) have highlighted a priority area that requires deeper resident exploration.

We will aim for a group composition that is representative of Islington, complementing existing targeted groups like the Diverse Communities Health Voice.

Learning from the development year activities has highlighted that residents feel strongly about not only being reactive and consulted once the priorities have been set by LBI. We will create opportunities within the Resident Network and the Community-based research teams for residents to review and scrutinise data already collected by LBI (mapping and secondary analysis) as well as involvement in new primary research data generation.

ii) Community-based Research Team. The aim of this group is to broaden the profile of who is undertaking research and evaluation from staff, academics, and external consultants to a range of Islington residents; and in turn, bring new perspectives to the design, interpretation, and dissemination of research findings. Residents will be involved in synthesising and gathering evidence to address questions that the EI Strategic Delivery Board deem are a priority. Community researchers will be involved at all stages of the research process. This has the potential to improve data collection and recruitment, particularly among residents who feel more comfortable speaking with their peers. In addition to conducting surveys and focus group discussions, this group also provides the opportunity to increase the use of participatory and visual methods (e.g. PhotoVoice, participatory mapping, and ethnographic film [33]), which have been used sporadically in the past.

25 residents will be recruited in total (8 in year one), aiming for educational, language, ethnic and gender diversity, not necessarily representativeness, as with the **resident response network** members. Community researchers will work on a project basis, entailing a more substantive time commitment and reciprocally, greater professional development experience.
Recruitment. For both groups, we plan to recruit members through existing links with VCS resident engagement groups, Islington's Youth Council, tenant resident associations, and the new Community Wellbeing Networks. We will also recruit broadly through print and social media and community events in order to reach residents who are not currently affiliated with our LA or VCS organisations. The total numbers we plan to recruit have been reduced slightly following the development year – in part to enable more VCS involvement (which in turn should lead to even greater resident involvement) and to fill gaps not covered by the new LBI citizens panel. Rather than breadth, our focus will be on depth and longevity of engagement. .

Training and mentoring. Both groups will receive training (2.4), with a focus on transferrable skills (e.g. organisational skills). Community researchers will also receive tailored training in basic social research methods. We will match members to existing champions and Camden community researchers, so they are part of broader peer networks who can provide valuable training and mentorship. They will also be supported by established researchers, VCS and LA training leads. The initial request will be for a one-year commitment, with the hope that a subset will continue for a longer period. We do expect there to be attrition, requiring ongoing recruitment, training, and mentoring as members move on and have therefore accounted for this in our budget. As part of the 'pathway' approach to showcasing the possible benefits of participation, we will build into the model entry routes in and out, and work with LA partners, e.g. in employment and training, as some PPIE panellists might be attracted to further education or job opportunities enabled by the signposting, skills, and confidence they gained through membership of our proposed models.

Remuneration. To align remuneration with both our LA and NIHR, we will offer members several choices for remuneration, e.g. to overcome the inflexibility of the benefits system, our LA has piloted the 'Tempo Credit' approach, which allows residents to bank their credits accrued to use at a variety of 'spend partners' that our LA has recruited (e.g. local leisure/entertainment outlets). Some remuneration will be via access to free training and support (e.g. work experience and shadowing opportunities), which will feature on the pathway outlined above. Feedback during the development phase of this proposal is that many 'champions' participating in current schemes are wanting to 'give something back' and/or be provided with access to training and experience. We are acutely aware of the spending squeeze, so we will offer cash-based rewards where residents are not bound by benefits restrictions, and we will follow the NIHR PPIE framework and ARC NT model [34,35].

In addition to these two new mechanisms, we are discussing options to support the existing, underutilised NCL residents health panel, which currently has ~250 members from Islington who take part on a voluntary basis in online surveys. There are plans to revitalise the panel as part of the ICS transition and there may be opportunities to support this process in four key ways: improving representativeness of Islington panel members; expanding options for providing feedback beyond online surveys to include telephone and in-person surveys, focus groups, and interviews; expanding consultation topics from clinical topics to also include a WDH focus; and trialling a borough-specific approach, liaising with the NCL coordinator to identify which topics and requests are most appropriate to consult on at a borough versus regional level. This regional relationship also provides a natural mechanism to expand the HDRC and ICS investment to the other NCL boroughs where resident panels do not already exist, adding value.

PPIE coordinator. The PPIE coordinator will lead the PPIE activities, working closely across LA departments, with VCS organisations, and with residents. They will develop and manage the new engagement mechanisms and act as the conduit to triage and coordinate consultation requests. Establishing a single point of contact for VCS requests represents a significant shift from current practice and will help to prompt and embed new ways of working. The coordinator will report to the HDRC Head of Research and will be co-located across our LA and a VCS organisation to enable

both the strong internal and external relationships necessary for this work to take place. Finally, we have incorporated PPIE into the HDRC governance structure: two residents and the Director of Healthwatch Islington will be members of the HDRC Delivery Board, reflecting our commitment to widening engagement and involvement at both strategic and operational levels.

2.6 Wider determinants, socioeconomic position, and health inequalities:

Our HDRC vision is aligned to our LA's core commitment to challenge inequalities and creating a more equal future by 2030 (1.2), which places emphasis on the central role of WDH in affecting resident health and wellbeing and was recently announced as the winner in the Local Government Award category at the GG2's Leadership and Diversity Awards [36]. The HDRC will enable us to build on our existing, highly valued work with HEI to improve our understanding of how WDH impact health and wellbeing outcomes across Islington. This is critical to inform strategic planning and develop a model focused on prevention and early intervention, taking a place-based approach. As part of our approach to Population Health Management, we have already worked with NHS partners to create linked datasets to inform our work on WDH (1.2). HDRC funding will enable coordination with other LA departments that address WDH but whom are not ordinarily under the direction of the public health department. Our proposal for creating an active research workforce includes development of training and support materials that focus on how WDH can be better assessed within research. This focus on the WDH will add value to our core aim of challenging inequalities by:

- Working with academics to introduce innovative approaches to identify, measure, and monitor inequalities, including within protected characteristic groups.
- Improving process for learning from published evidence of what works to reduce inequalities.
- Ensuring the voice of residents at highest risk of marginalisation is central to the strategic direction of the HDRC through the resident engagement described in 2.5.
- Improving service delivery decisions, through increasing the use of evidence syntheses and insights from new programmes through more robust and relevant evaluations.
- Accelerating innovation in reducing inequalities, through increasing our LA's contribution as (lead) partner in externally funded research of novel strategies to address inequalities.

Equality Diversity & Inclusion (EDI). Our LA is committed to incorporating EDI at all levels of the organisation [37] and believes everyone should have access to the same opportunities, whatever their background. As part of our work to create a fairer borough, we have committed to eliminating discrimination, valuing diversity, and looking for opportunities to build community cohesion across our entire scope of work. The HDRC will aim to strengthen this commitment and ensure that every person eligible to take part in research will be able to, and that employment, volunteering, and secondment opportunities generated as part of the HDRC are available for everyone, regardless of background. As well as having a statutory duty to eliminate discrimination and advance equality, especially for the nine protected characteristics under the Equality Act 2010, we have also committed to assessing the socioeconomic impact of strategic decisions, set equalities objectives, and complete resident impact assessments for all our initiatives to consider how decisions impact on protected groups. All HDRC initiatives will be subject to similar processes, and data on protected characteristics will be routinely collected as part of our evaluation to track inclusivity. Any information generated as part of the HDRC will be made available to residents in an accessible and usable format, compatible with all modern accessibility technology. Furthermore, we will provide information in a range of formats (e.g. translations) in line with our current policies [38].

2.7 Leadership, governance and management structures

HDRC leadership will ensure synergy with key organisational priorities, demonstrating the value of research. Director of Public Health JOS is a member of the CMB and HWBB, which are ideally positioned to bring the HDRC's role directly into formulation and evaluation of policy; and to support the appetite to engage with residents affected by inequalities. To help embed a research culture, our HDRC will align with 'flagship' initiatives, shaping how the LA uses data and insights, including the Data and Insights Board and HWBB's leadership of Population Health Management. We will implement a three-tiered governance approach (see ORGANOGRAM and LEADERSHIP AND GOVERNANCE STRUCTURES attachments). Roles and responsibilities of individuals are

detailed in 6.0. Interdependencies with other work streams across Islington have been identified and priorities will be agreed collectively to ensure delivery adds value rather than duplicating or silo working.

i) Executive Governance. Oversight and critical challenge at executive level from the LA's CMB and HWBB, and partners (ARC NT Population Health and Social Care theme and ICS Population Health and Inequalities Committee). The HDRC leadership team will present progress to the CMB on a regular (at least quarterly) basis.
ii) Strategic Delivery Board. This will be hosted by public health with representation across our LA and others (e.g. Healthwatch Islington and residents) to facilitate two-way dialogue, feedback, and accountability. Director of Public Health JOS will lead the HDRC vision and oversee governance and management, supported by the HDRC Director (CA) and Assistant Director for Intelligence (MS). Theme leads will work across the LA to establish and implement a clear work plan and embed new ways of working. Academic theme leads (DM/JS) will be partly funded by HDRC to maintain and widen academic networks (2.2), and provide academic oversight to evaluation and PPIE functions.
iii) Implementation Team. They will work closely with theme leads and embed across the LA to spread research systems and practices. This will enable our wider staff to generate research in routine practice, and apply this approach in a robust and systematic way.

Integration and sustainability. Central to our approach is developing an embedded and sustained approach to research so that we can clearly evidence how research is part of all that we do (2.8). Theme leads within the delivery board will be responsible for working with colleagues across the LA and elected members to facilitate this, so that core decision-making policies and governance structures address their role in research. For example:

- In developing or procuring new services, we will be able to demonstrate that the evidence base has been considered and the approach has been informed by this.
- We will have effective evaluation built into service delivery with systems in place to develop robust evaluation from the outset and staff with skills to implement these.

Critically, our management and governance structures have been designed to add value and embed within current processes rather than adding layers of bureaucracy or duplicating systems. For example, when considering how the data/ethics function (2.3) during the development year work has occurred within the council which has strengthened internal governance and ethical consideration in decision making. As such the approach we proposed to take in this area has been reviewed to ensure it is embedded into other governance discussions that are already occurring, to ensure a sustainable approach. See above for further explanation. Theme leads will attend divisional management team meetings, initially to increase awareness of the HDRC and its benefits, and then developing this is into opportunities for joint work across services and academia. This will build on previous work, e.g. in the developing of our licensing policy and evaluation of the cumulative impact approach [39].

Although the HDRC implementation team will be managed as a team they will not work in silo. Essential to their success will be how they embed and collaborate across the LA. For instance, when supporting the development of a piece of work, it is envisaged that they will spend part of their time in the department they are working with, fully immersed in developing the initiative and supporting others in those areas to be part of the process. This will enable those staff to develop skills, knowledge, and understanding of others so that they can do similar work in the future. All HDRC staff, regardless of employing organisation will be given access to LA systems to facilitate effective collaborative working (e.g. access to IT and desk space). The HDRC implementation team will be employed by the LA, and where appropriate will be encouraged to apply for honorary contracts with our academic partners (see ARC NT letter of support), reflecting the joint and integrated approach to delivery, and recognition that contributions also flow from our LA to HEI.

2.8 Evaluation and success measures

Aims of evaluation.

The goals of the evaluation are two-fold:
1. Formative – to shape how the HDRC works and develops;
2. Summative – to assess how well the HDRC helps us to address our vision.

Objectives
- Collate and maintain a list of projects supported by or initiated as a result of HDRC and evaluations undertaken.
- Gather and analyse evidence of the outputs and impacts of these individual projects supported by/initiated as a result of HDRC.
- Gather and analyse evidence of the outputs and impacts of HDRC overall, based on the success measures outlined below.

Rationale for success measures. The overarching vision of our HDRC is to reduce inequalities and improve health and wellbeing outcomes among Islington's residents. Although we will be unable to attribute borough-wide reductions in inequalities directly to the HDRC, we will build on the data we already collect and track measures of inequalities in access and outcomes during the lifetime of the HDRC and beyond. Furthermore, we will measure the impact of specific HDRC-led initiatives on measures of health and wellbeing, and how these measures differ between key priority groups. Our preliminary success criteria (summarised in Table 1 and which are likely to evolve over time) reflect the outputs listed in our logic model and have been developed to include outcomes that we believe can be measured and attributed to the HDRC. Although elements of each of the three workstreams are expected to impact some outcomes more than others, we broadly envisage that their integrated effect will impact on three areas outlined below.

1. Culture and leadership within Islington
a) An organisational culture driven by senior leadership, where research is seen as everyone's business, barriers to being research active are identified and addressed, and key HDRC functions are shared across Islington.
b) A clear pathway is established in Islington for initiating and undertaking research and a data/ethics function is developed.
c) Resident research champions, including those from under-served and under-represented communities, are central to all HDRC activities and will have:
   - Better access to reliable sources of information
   - Developed improved communication and social science research skills
   - Defined pathways for new opportunities as part of the HDRC (e.g. access to training, work experience, and employment).
   - Better signposting and access to existing opportunities (e.g. Islington Small Grants for communities – community researchers can enhance the opportunities for local communities to identify areas of concern, define the research question, and successfully apply for, and evaluate the success of, the grant).
   - Increased confidence and perceived belonging to the community
d) Healthwatch Islington and other VCS organisations will be better connected to, and embedded within our LA, where requests and workflows will be co-ordinated and sustainable.

These will be measured by:
- A baseline assessment, to build a common understanding of our position at the start of the HDRC in relation to evidence use, awareness, and readiness to be more research active. We will align our data collection where possible to other HDRCs to enable some cross-site comparison
- A repeated staff survey (quantitative) and staff interviews (qualitative) at approximately three key points in the programme, aligned to LBI staff surveys, including for members of VCS organisations, to monitor changes in research culture and leadership, knowledge, attitudes and opportunities to participate in/contribute to research. In recognition that a significant proportion of staff in Islington are not officed-based (e.g. street cleaners, repairs teams), a different approach to surveying staff will be undertaken to that used in public health, which may include discussions at team meetings, quick polls, outreach to service locations. We will also make use of LBI's polling technology, which can be targeted to particular groups of staff and residents for

a quick 'pulse check on specific issues. To identify: areas requiring further work, inequalities between staff groups.

- Tracking the outputs of the capacity building programme (e.g. numbers of courses developed and delivered; whether delivery was LA-led or in partnership with academic, VCS, or resident partners; numbers attending courses; immediate feedback; six-monthly feedback including measuring the use of training to inform practice, and uptake; and feedback on mentoring/secondment opportunities provided).
- Documenting resident research ambassador recruitment and activities and conducting resident surveys and interviews to characterise experiences of working with the HDRC, identify areas for improvement, and ambassadors' capacity to contribute to the design, conduct, analysis, and communication of research.
- Monitoring the progress of developing a data/ethics function, HDRC surgery, and the establishment of collaborative research endeavours with HEI and other partners.
- Monitoring the "next destination" of HDRC staff (including residents) who move to a different role (e.g. numbers taking up a research role or studying a degree/post-graduate education).

2. Decision-making

a) Local, national, and international data and insights are routinely mobilised when initiating and reviewing LA-led initiatives, e.g. literature reviews feature in design/development.
b) Action-based evaluation is standard practice for LA-led initiatives including process, outcome, and economic evaluation as appropriate, and is continually fed back to enable adaptations to strategic and operational direction.
c) Evaluation and analytic outputs of LA-led initiatives inform future decision-making.
d) Development of a streamlined and functioning engagement mechanism, co-produced by residents, to include residents' voices into LA strategy.
e) Demonstrable evidence of how data and insights and residents' voices are being used to identify and measure existing inequalities and change services to reduce inequalities.

These will be measured by:

- Documentary analysis to track evidence of HDRC impact on decision-making, including HDRC-supported evaluation reports/presentations, business cases, and board papers triangulated with LA board-level discussions of the HDRC's perceived impact.
- Questions in the staff survey and interviews described above specifically about the perceived impact of the HDRC on decision-making.

3. Wider influence

a) Clear channels and mechanisms for audience appropriate dissemination, including evidence of how we have expanded and diversified the profile of people with whom we engage.
b) Research outputs presented to Islington residents, LA staff, members, and ICS partners, and at national and international conferences, including joint delivery of findings with relevant academic/VCS/resident partners.
c) Research outputs published in peer-reviewed journals, including examples of academic colleagues additional to those named as co-applicants collaborating in delivery of research studies to completion.
d) Funding applied for and secured from external sources for multicentre health determinants research: Our LA as lead or key partner with LA staff named as the principal/co-investigator and Islington used as a research site.
e) Perceived impact of the HDRC in residents and outside of Islington.

These will be measured by:

- Tracking the dissemination outputs described above over time.
- Documenting HDRC-generated funding and Islington's involvement in external funding.
- Survey of stakeholders external to Islington for views on influence and impact.

Table 1. Summary of proposed success criteria and how these will be measured

Theme	Outcome	How it will be measured	Time points
Culture and leadership	An organisational culture where research is seen as everyone's business, & key HDRC functions shared across Islington	Quantitative surveys and qualitative interviews (LA staff partners, residents) using adaptation of validated tools Quantitative surveys	At three phases: Baseline (year 1) mid-point (~yr3) and late phase (year 5)
	Clear pathway to research	Surveys, audit of ethics submissions	
	Staff and partners can participate in research at different levels	Training process metrics recorded (e.g. numbers attending courses, feedback from courses)	Collated from regular performance monitoring & annual reports
	Resident research champions central to HDRC	Recording of champion recruitment (no and characteristics), recording of resident activities Quant surveys and qual interviews (LA partners, residents)	Baseline (year 1) mid-point (~yr3) and late phase (year 5)
	VCS orgs better connected to LA	Progress monitoring of VCS activities Quant surveys and qual interviews (LA staff partners, residents)	
Decision-making	Data and insights routinely mobilised when initiating LA projects	Documentary review and analysis to track how and where evidence (e.g. data, evaluations, peer-reviewed lit, resident insights) features in papers discussed at key council decision making forums, e.g. corporate management board, commissioning/procurement boards (sampling to be determined by coproduced evaluation protocol). Quantitative surveys and qualitative interviews (LA staff, councillors, partners, residents) & meeting observations	Baseline (year 1) mid-point (~yr3) and late phase (year 5)
	Evaluation standard practice for LA projects		
	Evidence (local evaluations, local data/insights & wider evidence) inform future decision making		
	Streamlined resident engagement mechanism		
	Data and insights used to identify measure and address inequalities in access to services and outcomes.		
Wider influence	Clear channels for audience appropriate dissemination and evidence of widening participation	Progress monitoring of dissemination outputs, funding secured	Baseline (year 1) mid-point (~yr3) and late phase (year 5)
	Presentation of research outputs locally, nationally and internationally		Collated as part of regular performance monitoring & annual reports
	Publication of research outputs in peer-reviewed journals		
	External funding secured for research, including multicentre research		
	Perceived impact in residents and outside Islington	External stakeholder interviews	Late phase (year 5)

Maximising learning across LAs. To maximise learning that can be applied elsewhere, our evaluation will focus on describing the existing context within Islington, the actions implemented as part of the HDRC, and the outputs and influence of the HDRC, drawing on process evaluation principles and tracing the processes through which research becomes embedded within decision-making culture. Furthermore, research projects conducted as part of the HDRC will be encouraged to adopt a mixed-methods approach where evidence on the magnitude of public health changes (quantitative) as well as the underlying reasons why change did/did not occur or are understood (qualitative) will be published to maximise learning available for other LAs to benefit. To help stakeholders understand how generalizable this evidence is to other contexts, information on the characteristics of the population/contexts involved will be published, (e.g. we will share information on PROGRESS-Plus characteristics [41]) building on the work described in 2.3 with DK.

3.0 Dissemination, outputs and anticipated impact

Dissemination strategy. During the development year, we have co-developed a resident and VCS engagement strategy . Fundamental to this will be a focus on widening participation so that dissemination activities are undertaken by a broad range of stakeholders, including residents, and tailoring our approach to ensure it is audience-appropriate. Both the Resident Response Network, and Community Research Team and VCS partners will support us in cascading findings to communities across Islington. As described in 2.4 and 2.5, resident training will include oral and visual presentation skills to facilitate their involvement in dissemination of outputs. Reciprocally, they will share with LA staff preferred ways to communicate research to different population groups (i.e. young/old/those with alternative learning needs). Although we will convene specific HDRC events, we anticipate that the majority of our activities will leverage existing spaces and networks, proactively seeking opportunities for dissemination rather than expecting people to come to us.

In the first year, the new communications officer will develop an overarching dissemination strategy, including tailored strategies for different internal LBI and external stakeholders, in addition to the resident-specific strategy already developed.

3.1 What do you intend to produce?

Academic outputs

- Presentations at local, national, and international academic or practitioner conferences.
- Peer-reviewed publications in academic and practice-relevant journals.
- Internal LA guidelines and briefing papers based on HDRC-led initiatives and citations of HDRC-led initiatives in systematic reviews, and regional and national guidelines.
- External funding applications as a lead partner or collaborator.

Wider outputs

- Presentations at non-academic events, including resident-led events in the community.
- Online blogs, podcasts, and video-logs, including on our LA's intranet and social media pages, informed by consultation with residents and VCS organisations.
- Publications and interviews with traditional (e.g. local newspapers) and social media.
- Annual conference (3.2)

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

Elected members and LA leadership. Progress on the HDRC will be shared with the LA CMB quarterly, and to the HWBB annually. Importantly, the delivery board includes representation from across the LA, and the HDRC implementation team will work across the LA, ensuring the HDRC is embedded across all functions and departments and that these departments are aware of ongoing HDRC activities (2.7). We will also organise member workshops, training for members (e.g. on how to interpret evidence, the hierarchy of evidence, and how evidence can be communicated as science), and member briefings on HDRC activities. Lead members will be identified for this, but for specific pieces of work engagement with multiple members will be part of the process. This

aims to ensure an ongoing dialogue with members that informs our communication and dissemination strategy by enhancing our understanding of how to make the HDRC more relevant to members, and their beliefs on the HDRC's strategic direction and priorities. We have a strong track record of engaging with members, who have positively commented during the development of this proposal how impressed they were with the accessibility of the public health data reporting during the pandemic.

Internal and regional meetings. We will share tailored findings in oral and written formats through our LA's internal and external networks including the monthly public health research seminars, newly formed HDRC lunchtime learning seminars, cross-LA and wider engagement groups (e.g. at parent champions and Youth Council meetings), LA 'communities of practice' and task forces, issue and population specific groups (e.g. cross-LA and cross-Islington staff working on homelessness), NCL ICS structures and staff members' professional networks, and the evolving pan-London LA/practitioner/academic network chaired by OHID. Our HDRC programme will report to the ARC NT Population and Social Care theme meetings and seek member input there. The existing work across the five boroughs of NCL provides a natural structure to extend HDRC capacity building, research, and dissemination. Finally, we will organise writeshops at least annually for LA and VCS staff and residents to develop their research findings, e.g. transform a conference presentation into a journal article [42]. This role is currently supported by DM & JS in an ad-hoc way, but the HDRC will enable a more consistent approach (e.g. DM mentors a PLAF Fellow and works with colleagues on ethical approval applications and manuscript preparation).

Islington annual HDRC conference. We will organise an annual Islington HDRC conference to showcase academic and wider outputs to all potential stakeholders. An active focus of this will be to widen participation by encouraging residents and partners in VCS organisations to both attend and present at this conference in ways that best fit their needs and preferences.

HDRC annual meetings. If successful, we will advocate for annual meetings with other funded HDRCs to share learning (rotating sites) and facilitate a collaborative environment where critical challenge is encouraged and used to inform strategic direction. We have already contacted representatives of Doncaster HDRC bid, who have agreed to partner with us if both HDRCs were to be funded (and will do the same with whomever is successful). These interactions would place HDRCs in a stronger position to jointly bid for multi-site research, during and following the five-year HDRC period. They also offer opportunities for peer learning among resident representatives**.**

3.3 How will your outputs enter society as a whole?

Pathway to impact. The dissemination activities described include a strong emphasis on ensuring that our outputs are shared with a broader range of audiences than traditional academic circles. This will ensure that residents and VCS organisations across Islington and further afield will benefit from our activities and findings. Currently, much of our local evaluations are only shared internally and not disseminated or published more widely (due to a lack of time/resource/staff capacity, not willingness). However, as described, the HDRC structure and dedicated funding will enable us to widely disseminate the HDRC research outputs and range of LA-research activities that will stem from the HDRC capacity building activities. We are confident that we will make a significant contribution to the published evidence base on inequalities and WDH and thus our research generation is more likely to be incorporated into practice and policy both within and beyond Islington. Importantly, our evaluation plans (2.8) involve documentary analysis and qualitative and quantitative surveys to assess how our activities have impacted our core functions, including procurement and service design, and how these activities have improved outcomes for residents.

Sustainability. The activities described in this proposal will have a transformative and lasting impact on the ways in which we work across Islington. By creating a centre of research excellence and sharing this learning we aim to encourage wider adoption and implementation. As we are already a proactive member of ARC NT, the capacity building activities described (2.4) will help make us stronger partners and provide us with a stronger position from which to better support ARC and HEI research activity. Importantly, how we build on the momentum of the initial funding

period to sustain impact so that HDRC activities can continue long-term is a challenge we are cognisant of. We believe that a robust evaluation mechanism, senior-level organisational buy-in of the proposal, and cross-partner ownership will deliver a positive movement organisationally to support these processes going forwards. We recognise the importance of maintaining senior-level commitment (2.2) and securing external funding described below.

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

Opportunities for external funding for HDRC-sponsored research will be identified in collaboration with academic and VCS partners and use platforms such as ResearchConnect, which brings together a spectrum of funding opportunities for researchers at all levels and all disciplines into a central database. For example, we have been approached about the Building Community Research Consortia to tackle Health Disparities call, and envisage the HDRC as being a key partner in such calls. We have also demonstrated above (1.2) that we are involved in several funding bids, so are well placed to capitalise on the opportunities that the HDRC would offer. A key function of the HDRC research officers will be to map the funding landscape and support staff to apply for specific funding opportunities, supported by Matthew Saunders, an NIHR Academic Clinical Fellow in Public Health, and JS and DM.

Fellowships. Concordant with our core aim of building research capacity and capability within the LA, we will support and encourage staff to develop their research careers by applying for pre- and post-doctoral fellowships, including the NIHR Local Authority Academic Fellowship (LAAF) Programme, and fellowships offered by partner organisations of UKRI (e.g. ESRC and MRC). Such fellowships would involve joint LA/HEI supervision.

Grants. External funding for specific research projects will be sought from NIHR (e.g. through the Health and Social Care Delivery Research and Public Health Research programmes); UKRI (e.g. the Public Health Intervention Development programme) and external charities and industries when specific calls are launched.

3.5 What are the possible barriers for long-term impact?

Possible barriers to long-term impact include: staff turnover and maintaining expertise; shifting LA priorities; elected member support as they change through electoral cycles; time and capacity, e.g. obtaining ethical approvals when other pressures are more present; financial challenge, e.g. how to keep the HDRC on the agenda as financial challenges becomes even greater; and how to clearly demonstrate that the HDRC is not “nice to have” but essential to our core functions. We believe that the activities described throughout this proposal including the proposal development consultations, and importantly the commitment to share ongoing findings of the evaluation, will help to embed a sustainable research culture across Islington that is resilient and adaptable to changing circumstances. Although ARC NT is currently funded until September 2024, it is committed to applying for renewal. In the unlikely event its funding is not renewed, the HDRC will be able to sustain the capacity building activities described because the focus of our partnership is to build sustainable links, skills, and networks with individuals and organisations that contribute to ARC. Other academic links are already built into the application with individuals and NIHR structures that have funding beyond Sept 2024.

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

See 2.8 for a full description of our anticipated impact and success criteria.

4.0 Project timetable

See Gantt chart for a detailed timetable including activities and milestones. Stop-go criteria are highlighted in red text. Evaluation commences at the start of the HDRC in order to ascertain baseline position to measure impact.

5.0 Approach to Collaborative Working

Our approach to collaborative working is described fully in 2.2, 2.4, and 2.5. In addition:

HEI. Our planned HDRC, ARC NT, the ARC academy, and UCL have close links (see ARC letter of support). Regular reporting and sharing of information will occur through the monthly ARC NT Public Health and Social Care theme meetings (co-chaired by DM), the training co-ordinator will be co-located between ARC NT and our LA, and SC and CA will meet regularly to shape the capacity building offer. JS will maintain the links between UCL and HDRC, and support Islington staff in linking to UCL and ARC academics, obtaining research career opportunities such as NIHR PLAF and SPARC, and where appropriate support for applying for honorary UCL contracts. Similarly, DM will signpost to LSHTM academics (through the LSHTM SPHR3 Management Board and ARC NT Board). DM will also support LA staff with PLAF, SPARC and similar career opportunities as well as offering opportunities to contribute to the LSHTM MSc in Public Health.

VCS. Healthwatch Islington and other key VCS organisations (i.e. Voluntary Action Islington, Octopus) are already members of our LA engagement networks, which hold regular meetings. Healthwatch Islington and Diverse Communities Health Voice have previously gathered resident insight, including as part of the recent Covid-19 and inequality (Let's Talk) surveys. HWI will draw in Diverse Communities Health Voice partners to ensure that the evidence from communities less often at the table is included. The group will meet up to eight times a year, facilitated by Healthwatch Islington's Partnerships and Engagement Manager to consider issues that need raising and to share existing data that partners hold. We have now budgeted for engagement with community partners and HWI will oversee this allocation.

Data sharing. We will build upon and formalise existing data access and sharing agreements to facilitate long-term two-way access.

6.0 Roles and responsibilities

The developmental year provided an opportunity to review our structures. As per the organogram, the HDRC is made up of a strategic delivery board, implementation groups and collaborators. The Strategic Delivery group will have multi-partner membership, steers strategy, makes decisions, allocates resources and disseminates key knowledge and insights. The implementation group will then operationalise this, working closely with others across the council and wider partners to deliver specific pieces of work. The roles are outlined in table below.

	Role	%FTE	Name	Primary Institution	Responsibility within HDRC	
Delivery Board	Director of PH	0.1	Jonathan O'Sullivan	Islington LA	• Embed priorities of their theme across the LA • Develop an approach which is integrated and sustainable • Maximise the benefits and opportunities of identified interdependencies to increase impact of the HDRC on supporting LA priorities and informing and supporting delivery of HDRC vision • Support dissemination across the LA, LBI, and beyond • Work closely as a connector with the delivery board and implementation team to translate priorities into effective implementation	Lead HDRC vision Embed HDRC in corporate decision making through CMB and Joint Board
	HDRC Director of Programme & Theme Lead Public Health and capacity building	0.5	Charlotte Ashton	Islington LA		Oversee governance and management delivery of vision, aims and objectives of the HDRC and the key deliverables and milestones Work across the LA and with ARC NT to identify opportunities for training, and development of courses (new courses, reviewing existing courses to ensure fit for purpose)
	Head of Health Intelligence	0.2	Mahnaz Shaukat	Islington LA		Lead all aspects of the proposed data/intelligence and infrastructure activities
	Head of Research	1	TBA	Islington LA		Building and delivering a council-wide research agenda, strengthening research quality.
	Theme Lead: VCS liaison	0.2	Emma Whitby	Healthwatch Islington		Act as a representative for VCS organisations and co-manage PPIE activities
	Theme Lead: ARC/LSHTM academic strategic liaison	0.2	Dalya Marks	LSHTM		Co-manage PPIE activities and act as a liaison between the LA and LSHTM/ARC NT
	Theme Lead: ARC/UCL academic strategic liaison	0.2	Jessica Sheringham	UCL		Lead the evaluation and act as a liaison between the LA and UCL/ARC NT
Implementation team	Programme administrator	1	TBA	Islington LA	Support the monitoring, reporting on, and delivery of the HDRC and work closely with theme leads to support the day-today operation of HDRC activities	
	Programme assistant	1	TBA	Islington LA	Administrative support across programme	
	HDRC embedded research associate (rotation)	0.5	TBA	Islington LA	Work across the LA to provide support for skills development, map existing research, support research design and implementation, navigate the funding landscape, and link LA staff with academics at partner HEI. Roles will spend time embedded within different parts of the council. Organise a central database to collate evidence of HDRC activities, and organise, lead, and disseminate the evaluation activities described	
	HDRC embedded research associate (rotation)	1	TBA	Islington LA		
	HDRC embedded research associate (rotation)	1	TBA	Islington LA		
	Training coordinator	0.8	TBA	Islington LA	Co-located across the HDRC and ARC academy to organise and lead the capacity building activities described	
	PPIE coordinator	1	TBA	Islington LA	Manage and mentor the ambassador panel and community research team (recruitment, retention, training, linking. scheduling, payment); liaise with LA colleagues involved in PPIE, including coordinating requests across the LA to VCS/residents; and train and mentor VCS and LA staff	

	Role	%FTE	Name	Primary Institution	Responsibility within HDRC
	Data manager	0.5	TBA	Islington LA	Work with data controllers and analysts to undertake data discovery exercises to create linked datasets that respond to research questions of the HDRC; checking and cleaning datasets; management, coordination, and drafting of data linkage specifications, including ensuring accuracy, completeness, consistency and compliance with data linkage guidelines; preparing rigorous and understandable documentation; development and management of a plan for data transfers and curation; contribute to the development of SOP, guidance and policies relevant for data linkage processes for research purposes; and assess data linkage progress and risks, discussing findings and potential solutions with HDRC
	Data quality officer	0.5	TBA	Islington LA	Support the data manager
	Comms Officer 0.5FTE	0.5	TBA	Islington LA	Development of communication strategy and dissemination of information/updates within the council and to partners
	VCS Operational Lead		TBA	Healthwatch Islington	Diverse Community Health Voice coordination and support
	VCS Comms support		TBA		Dissemination of messaging to residents, ensuring appropriate language and target
Collaborators	Capacity Building Consultant	0.05	Silvie Cooper	UCL	Providing strategic advice on capacity building, co-managing the training coordinator who will be co-located across both ARC and LBI, and overseeing ARC input into development of new training courses
	Research consultant	0.05	Dylan Kneale	UCL	Providing strategic advice on using evidence and working to implement/refine approaches to conceptualising generalisability and assessing generalisability of systematic review findings to Islington's context; and providing advice and training on reviewing the literature and evidence synthesis.
	Research consultant	Adhoc	Matthew Saunders	LSHTM	Providing strategic advice and research mentorship/supervision for junior researchers looking to undertake research projects and apply for research training fellowships.

Appendix: Log of changes made to business case

Section	Changes made	Rationale for change
1.2	Included information on Islington Together 2030 – the updated corporate plan.	Islington Together 2030 is the new corporate plan – the amends made reflects the development of this plan. There is no change to the HDRC approach. We see Islington 2030 as an excellent way of embedding and accelerating the work we plan through our HDRC programme.
2.2 & 2.5	· Expanded involvement of VCS · Removed development of PPIE strategy · Changed citizen ambassador panel to a resident response network	Following the co-design of the resident engagement strategy and discussions with VCS during the development year, and recent LBI investments to create a representative resident panel, the changes reflect the current institutional context, resident priorities for involvement and our increased understanding of the distinction and synergies between resident and VCS engagement. The total numbers we plan to recruit have been reduced slightly following the development year. In part to enable more VCS involvement (which in turn should lead to even greater resident involvement) and to fill gaps not covered by the new LBI citizens panel. Rather than breadth, our focus will be on depth and longevity of engagement.
2.2 HDRC strategic plan and research strategy.	Provided further detail around proposed plans around housing as a specific area of focus following the development year	Following the success in the development year, housing has been identified as one of our key areas of focus as we develop our five-year programme
2.3	We have reduced the amount of data manager time from 2 WTE posts to 0.5wte post, supported by a data quality officer role	Discussion and review with colleagues in our intelligence team indicates that the amount of input required to do this can be reduced, due to the development of wider systems and other pieces of work that are ongoing which dovetail to the proposals within the HRDC. In developing a sustainable approach to our HDRC programme we are aiming to embed and add value to existing teams this is reflected here.
2.3 Optimising dissemination and use of evidence	Increased focused on dissemination of findings	Experience from our development year has highlighted the importance of effective dissemination to staff and residents. This is an area we want to further develop over the full HDRC, noting, to be effective and meaningful the communications need to be nuanced and bespoke. We acknowledge that this is a gap in the original structure. As such we intend to recruit a communications officer (0.5wte) to support

		this area of delivery (with a particular focus on cross-council and partner dissemination). Additionally, we have costed in additional support from Healthwatch with a particular focus on resident dissemination.
2.3 Data and infrastructure: Data governance and ethics. & 2.7 leadership and governance	HRDC funded governance role – has been removed from proposed staffing structure	During our HDRC development year, data ethics has been more explicitly integrated into the Information Governance team and the role of head of information governance now includes ethics as a responsibility. A cross-council research ethics review process has been updated and reinstated. HDRC will help to further institutionalise these internal processes and standards and to discuss ethics concerns and LBI responses with residents. We do not see value in having a separate governance role within the HDRC.
2.4 capacity building	Updated text based on learning and work that has occurred during the development year	Based on work done in the development year we have identified the importance of bespoke and innovative approaches to maximise reach. Our plan has been updated to provide examples of some of the insights we have gained which are informing the development of the training offer.
2.4 Capacity Building HDRC Research Officers (embedded researchers)	Increased the number of these roles to 3, deleted evaluation lead role from structure. Research officer roles will be graded at a more senior level	Following reflection on the development year and work delivered through the CRN, we realise that for these roles to be truly impactful, they need to be graded at a higher level than initially planned. It is important that the research officers have the experience, competence, and confidence to work independently, particularly when embedded in another department. Additionally, we realise that a core part of the work of these roles is likely to encompass evaluation. We have therefore removed the evaluation lead role proposed in the original model and replaced this with a third embedded researcher role. This will mean evaluation is encompassed across a number of staff as opposed to sitting with one individual, increasing capacity in this important area as well as encouraging better cross organisational learning. In total there will be 3 WTE research officers. However, HDRC funding will be for 2.5 WTE roles, the remaining funding will come from the Public Health budget – this reflects the commitment to these roles which we see as key to supporting the intelligence/research led approach becoming embedded across the organisation.
2.7 leadership	Amendments to roles and responsibilities as follows:	A review of the original staffing model has taken place following the development year and lessons learn. Based on this, changes to the team are proposed, ensuring

and governance & 6.0 roles and responsibilities & Organogram	· JOS as Director of Public Health remains within the HDRC and will act as the HDRC champion of the Executive Management Team, the WTE contribution will be reduced to 0.1. · CA's commitment to HDRC has been increased. They will now contribute 0.5 WTE in the role of HDRC Director · A head of research role has been added to the staffing infrastructure · Reduction in data manager time, and inclusion of data quality officer · Increased embedded research roles (will also be advertised at higher grade) and to encompass role of evaluation coordinator. · Governance manager role and programme manager removed from structure. · Added 0.5 wte communications role. · VCS ops and comms lead added,	a clear focus on what staffing complement is required in order to facilitate the delivery of our five-year plan for HDRC. · The Director of HDRC (at 0.5 wte) and Head of research role reflect our direction following the first year and acknowledges the importance of providing research support across the council if we are to truly embed research across the organisation. Significant momentum and engagement have been achieved during the development year and this increased expert capacity will be used to further galvanise this - providing an excellent opportunity for HDRC to act as a driver for delivery of the Islington 2030 plan. · The programme manager role was recruited into during the development year. Having this role has been extremely valuable in terms of developing structures and processes for the programme. It is felt that once these are established and running the focus needs to shift to delivery of research activity (outlined above) and as such the ongoing oversite of systems and administration will be supported by a programme administrator and programme assistant. · Rationale for embedded researchers outlined in 2.4. · Removal of governance manager discussed in 2.3 and 2.7. · Changes to data manager discussed in 2.7. · The inclusion of a communications role discussed in 2.3. VCS operational and communications leads – see 2.2, 2.3. 2.5 for rationale for the inclusion of these roles
2.8 Evaluation and success measures	Supervision and lead for evaluation amended	This reflects the changes in roles within the HDRC as outlined in 2.7 and 6.0. We recognised there are two components we need to include in the evaluation. Firstly evaluation of the projects which have occurred because of HDRC. Secondly evaluation of HDRC as whole. We have split the leadership roles of these: the Head of Research will lead the project specific evaluations and JS will lead the evaluation of HDRC. The Head of Research will manage the embedded researchers. One of the embedded researchers will work under the guidance of JS in the delivery of the overarching evaluation of the Islington's HDRC.

2.8 Evaluation and success measures (including table 1)	Shift away from annual all staff surveys to 'regular surveys', some of which maybe bespoke and targeted. Includes more examples of types of approaches we will take to gather intelligence.	Repeated staff survey (quantitative) and staff interviews (qualitative) at approximately three key points in the programme (as opposed to annual surveys), aligned to LBI staff surveys, including for members of VCS organisations, to monitor changes in research culture and leadership, knowledge, attitudes and opportunities to participate in/contribute to research. We believe this will enable a higher quality approach that makes best use of people's time (both HDRC staff and those completing the survey) as it will enable a more thorough feedback loop of establishing status, adapting approach and evaluating impact. In recognition that a significant proportion of staff in Islington are not officed-based (e.g. street cleaners, repairs teams), a different approach to surveying staff will be undertaken to that used in public health, which may include discussions at team meetings, quick polls, outreach to service locations. We will also make use of LBI's polling technology, which can be targeted to particular groups of staff and residents for a quick 'pulse check on specific issues.
3.2 How will you inform and engage elected members, local authority staff and the wider population …	Removal of reference to the joint Camden and Islington public health department and 'Be Islington' strategic groups	No fundamental change to the our HDRC proposal – amendments reflects changes in council governance and structures. N.B similar changes have been made through the document
5.0 Approach of collaborative working	Diverse Communities Health Voice partners will be allocated a pot of funding to use to ensure that the evidence from communities less often at the table is included. The group will meet six times a year, facilitated by Healthwatch Islington's Partnerships and Engagement Manager to consider issues that need raising and to share existing data that partners hold.	This reflects our learning from the development year about how we engage with residents in a true and meaningful way which will support us in getting the impact we want