Version History

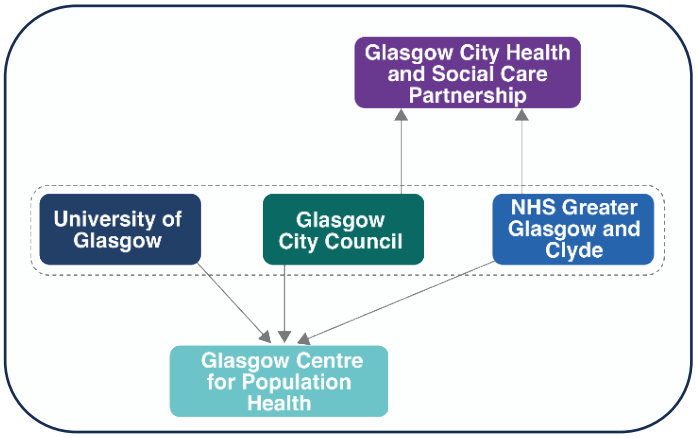
Version	Author	Date	Notes
1.0	Kimberley Hose	27/07/2023	First issue
1.1	Kimberley Hose	24/11/2023	Addition of Development Year tasks
1.2	Kimberley Hose	20/05/2024	Revisions to Development Year tasks

Full title: Glasgow Health Determinants Research Collaboration (GHDRC)

Background and rationale

For decades, Glasgow has experienced lower life expectancy rates than similarly deprived UK and European cities. Within Glasgow, there are substantial health inequalities and recent data indicates that the situation is deteriorating: life expectancy is stalling, healthy life expectancy is declining, and inequalities are increasing.(1-4) It is widely accepted that the key to improving this situation lies in addressing the wider determinants of health and inequality. There is a longstanding commitment in Glasgow to act on these determinants and a recognition that integration of research, policy and implementation is key to effective action. The opportunity to catalyse greater integration enabled through a Glasgow Health Determinants Research Collaboration (GHDRC) is timely and welcome.

The proposed GHDRC will be a collaboration of three organisations, Glasgow City Council (The Council), University of Glasgow (The University) and NHS Greater Glasgow and Clyde Health Board (The Health Board). In Scotland, directors of public health are not employed by local authorities but there is a very close relationship and lots of joint working between the Health Board and the Council. The GHDRC will build on two existing partnerships: the Glasgow City Health & Social Care Partnership (the Care Partnership), linking the Council and Health Board, and the Glasgow Centre for Population Health (The Centre), a partnership of all three organisations (Figure 1).



The GHDRC will also engage with other stakeholders across Glasgow, the wider city region and Scotland, placing emphasis on the inclusion of the public and communities. To set the context, we briefly describe each of the five organisations and existing collaborative research activities.

The Council is Scotland's largest local authority, leading and co-ordinating the provision of services to the city's diverse population. The Council is committed to the systematic use of evidence and data in policy making, priority setting, service (re)design and resource targeting to improve delivery. This work is led by the Chief Executive's Office where the policy development process is by necessity a complex mix of political, professional and operational considerations. To support strategic and operational decision making, the Council has invested in resources and leadership in two key areas, led from the Chief Executives Office by members of the proposed GHDRC delivery team:

Data and Intelligence: Working with other local authorities in the city region, the Council has created an Intelligence Hub that has transformed the quality, accessibility and usefulness of data and analysis on economic matters, which are feeding into policy and practice. The Council has been a member of the Open Government Partnership Local Programme since October 2020, working with local civil society organisations and other members to advance the open government agenda locally and transform the way the government serves its citizens. This core team includes members from the Council (including Hose and McGinty), Glasgow Chamber of Commerce, Glasgow Third Sector Interface Network, The Health Board, and Police Scotland. One of the key commitments is the co-creation of an Open Data Hub to make information about the Council and the city easier to access and understand, informing and empowering citizens to participate in democracy and key budgeting decisions. The Council works closely with other local authorities through links with the Scottish Local Government Digital Office and is particularly well connected into the data community across public and third sector.

Public and Community Engagement: The Council's Strategic Plan 2022-27(5) recognises that its decisions are best shaped in partnership with the communities it serves. Consequently, the Council is committed to improving and increasing the range of information available to citizens about their neighbourhoods and supporting ways in which they can get involved. This includes an emphasis on supporting community generated initiatives and seeing community organisations as genuine partners in the work of the council. Community Planning Partnerships operate at sector level (three sectors within Glasgow) and more local 'Area Partnerships', of which there are 23. A key mission in the Council's Strategic Plan is to roll-out a new model of Area Partnerships, to expand their membership, establish local community panels and make it easier for those with direct experience of inequality to be involved in making Council policy.

The Council's Strategic Plan has four Grand Challenges which are to:

- Reduce poverty and inequality in our communities;
- Increase opportunity and prosperity for all our citizens;
- Fight the climate emergency in a just transition to a net zero Glasgow; and
- Enable staff to deliver essential services in a sustainable, innovative and efficient way for our communities.

A common theme across these priorities is the interdependence of complex challenges such as inequality, climate resilience, economic growth and wellbeing, as emphasised by Glasgow's Circular Economy Route Map.(6) Each of these challenges has multiple independent and interdependent determinants cutting across Council departments and partner organisations. This highlights the importance of joined up working, with a need for research-informed practice and policy, co-produced with a diversity of stakeholders and with strong public and community involvement.

Public health in Glasgow is a shared statutory responsibility between the Council and the **Health Board**, with priorities and actions expressed in the Partnership Strategic Plan.(7) **The Care Partnership** provides a range of unified health and care services to children and families, through primary care, with vulnerable adults (including homeless) and older residents and includes the cities

health improvement function and workforce. Health Improvement staff work in each of the three localities in Glasgow on programmes to foster a healthy childhood, to reduce financial insecurity and mitigate poverty and to promote healthier lives and neighbourhoods. Staff work with all partners at a community level, often convening partnership meetings and events, enabling and supporting community involvement, fostering community decision making, e.g., participatory budgeting, sharing public health intelligence with partners and citizens and in delivering collaborative investments, e.g., employability and welfare advice support within primary care. The Health Board will also contribute to the GHDRC through the West of Scotland Safe Haven, a partnership between the Health Board and the University, providing safe, ethically approved access to NHS datasets on a secure ISO-accredited data analytical platform. The Safe Haven provides opportunities for GHDRC to investigate and collate further information on health inequalities and health determinants within Glasgow for research and delivery purposes. **The Centre** was established in 2004 as a setting where researchers, policymakers, practitioners and local people come together to understand and seek to improve population health in Glasgow. The Centre's work, delivered by a group of some 25 staff, has focussed on understanding the patterns and causes of Glasgow's health profile and working with partners to strengthen processes for better and more equal health.

The University places great emphasis on its distinctive ambition to be a leading Civic University while its research strategy prioritises interdisciplinary challenge focussed research, with health inequalities a priority University and College theme. The MRC/CSO Social and Public Health Sciences Unit in the School of Health and Wellbeing is an internationally recognised centre of excellence in research on the wider determinants of health, with an increased focus on identifying, appraising and evaluating policies and interventions on the wider determinants to improve health and reduce inequalities.

The opportunity and rationale for the GHDRC is to provide a focussed and resourced catalyst to drive forward action on the wider determinants of health, embedded within the structures, processes and priorities of the Council. This to be achieved through a collaboration that builds upon existing Council strengths in data, intelligence and community participation, and on strategic Council priorities that highlight the importance of concerted action across a diversity of wider determinants. The GDHRC will focus on the impacts on health and health inequality of policies and decisions taken across Council departments and on place-based interventions. It will be led from the Council's Chief Executive Office and delivered through collaboration with key academic and health sector partners.

The GHDRC will add value by significantly increasing the capacity of the Council, working with its partners, to impact at scale on place-related determinants where the Council has lead responsibility and to use its convening power to drive change in favour of better and more equal health. The GHDRC will build on a successful model of research-practice collaboration that has been used to create a Glasgow Child Poverty Pathfinder, funded by the Scottish Government. Closer partnership will foster culture change, surmounting barriers to partnership working that have limited the effectiveness of previous collaborations, combining the experience and expertise of researchers and practitioners to develop policies and implementation approaches that are well-evidenced and robust. Three key challenges to the goals of the GHDRC have shaped our plans. In the proposed stakeholder and mapping and leadership dialogues, we will identify further barriers and the means to overcome them, enabling us to co-produce refined plans by the end of our first year.

Leadership for population health in Glasgow: A universal problem for population health and health inequalities is that there is no one decision maker with control of the critical policy levers. Decisions on key determinants of health, such as transport, housing, or the economy, are made with a focus on sector-specific issues, rather than broader health impacts. In Glasgow, a Public Health Summit was held in 2019 where leaders from multiple agencies and sectors decided to focus

on health as an asset that brings social and economic benefits for families, communities, and the city as a whole. At the summit it was recognised that such ambitions could only be achieved through community planning partners working together. A specific proposal was the establishment of a Public Health Oversight Board, reporting to the Community Planning Partnership Strategy Board. The Board is jointly chaired by the Council and the Health Board and brings council departments, Glasgow Life (Leisure, culture, and wellbeing), the Care Partnership, the third sector, the Centre, Police Scotland and Public Health Scotland together to progress change. While this is a significant step forward, the academic sector is not yet successfully embedded in this crucial strategic mechanism to co-ordinate action on the wider determinants of health and this has limited the use and impact of data, evidence, and evaluation. The GHDRC would be a natural vehicle to do this and will report into the Public Health Oversight Board to embed its work within this, the principal Governance structure for cross-sectoral work on Public Health in Glasgow.

Capacity, skills and culture: In line with the NIHR Local Authority Research Systems project findings,(8) the Council does not have the research and development capacity that is more typical within the NHS, although as noted above has made great progress in its use of data, particularly in business intelligence with relation to the economy. Decision makers are understandably influenced by local factors and public and community voices. Research tends to be confined to using local data to identify priorities for action, and some literature reviews to identify what has worked elsewhere. Evaluation culture, capacity and skills to inform decisions to continue, modify or disinvest, are far less well-developed. Glasgow's significant academic capacity has led to some excellent collaborative projects, but often academic time horizons are too long, and local authority research demands too short to generate high quality evidence or to use that evidence to best effect. Increased collaboration and sharing of skills and assets with academia and the NHS via the GHDRC is a major opportunity for change, to catalyse and support the use of data, evidence and evaluation in policy across diverse sectors that have direct or indirect impacts on health. By locating the GHDRC in the Chief Executive's Office, led by the Head of Business Intelligence (Hose), the GHDRC will immediately be integrated with the Council's data team and assets, and to the hub of cross-Council policy development and community engagement. The GHDRC's resources will be embedded within these teams, providing opportunity and capacity to transform the profile, conduct and impact of research on the wider determinants of health.

Separation of academia from policy and practice: While there are notable examples of productive research collaborations between the University-based academic sector and Council and NHS partners, systems, relationships and incentives to embed research within policy and practice are underdeveloped. While there is demand for relevant and timely research evidence to support public health decision makers, academics are often unaware of these priorities and opportunities. Research funding and other academic incentives privilege rigorous intervention research that requires substantial funding and time and tends to be academic-led rather than embedded in practice. Moore and Craig have led or contributed to significant initiatives to facilitate the identification and implementation of opportunities for relevant, collaborative public health intervention research, including the Cardiff-based Centre for the Development and Evaluation of Complex Public Health Interventions (DECIPHer) and the use of evaluability assessment in Scottish Government and in the NIHR Public Health Intervention Responsive Studies Team (PHIRST Fusion).The GHDRC will build on this learning to improve the relevance, quality and timeliness of Council-led research through collaborative working on GHDRC strategy, priorities, project selection, delivery and dissemination.

Delivery plan - our approach to implementing and delivering the GHDRC.

Overarching vision, aims and objectives:

Our vision is to improve the health of the people of Glasgow by embedding research-practice collaboration across Glasgow City Council, its partners and communities.

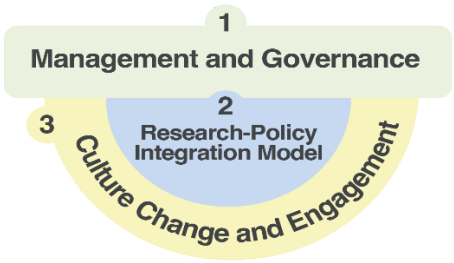
Our aim is to achieve a cultural shift in the Council towards evidence-informed decision-making in all areas of policy and practice that may have an influence on health inequalities and outcomes.

Objectives for the first five years are listed below. Please note some planned objectives for year 1 will now be carried out in our development year (see appendices for development plan year 0-1). A revised business plan will be submitted towards the end of the development year if we are successful in progressing to full HDRC status.

1. To develop a shared understanding, commitment and vision across the collaborators and partners for a research-informed prioritisation, design, development and implementation culture to drive forward action on health determinants.
2. To integrate investments in new capacity through placements, relationship building, training and collaborative projects.
3. To create a sustained, thriving collaboration, recognised as a model for wider implementation, with a pipeline of research-informed innovation in service delivery and research that positions partners to attract further research and development funding.
4. To design, implement, evaluate and refine a research-policy integration model, initially through application in prioritised pilot projects, and subsequently scaled out more widely.
5. To improve the quality, discoverability and accessibility of data to collaborators and partners to enable more effective use of data in prioritising, appraising and evaluating policy and practice.
6. To cultivate a research-led evaluative culture that drives health improvement by strengthening relationships between researchers, decision makers and communities and building the necessary capacity for cultural change.
7. To embed collaborative research capacity and processes within the wider community of stakeholders including elected members, public and community representatives and the Community Planning Partnership.

The work of the GHDRC over its first five years will be taken forward in three Workstreams, addressing management and governance, research-policy integration and engagement and culture change (Figure 2).

Figure 2 GHDRC Workstreams



WS1: Governance and Management
Led by GHDRC Director (Hose) supported by Academic Lead (Moore) and McGinty
Responsible for governance; management of programme and resources; reporting to NIHR; delivery of objectives 1-3.

WS2: Research-Policy Integration Model
Led by Moore and Hazle, supported by Hose and Craig
Responsible for design of Research-Policy Integration Model and its application to projects; data discovery, linkage and curation; delivery of objectives 4&5.

WS3: Engagement and Culture Change
Led by Hilton and McNulty, supported by Collins, Seaman and Moss
Responsible for stakeholder and system mapping, leadership dialogues; engagement and dissemination across Council and with partners, public and the community; delivery of objectives 6&7.

The workstreams are deliberately broad and each have mixed leadership teams from across the collaborating organisations. This is to maximise coherence and collaboration in the early stages of the GHDRC. The attached logic model (Attachment 3) sets out the key activities to be undertaken within each workstream. These map on to the mediators of change depicted in the logic model, and to the seven objectives listed above. Our progress over the first five years should be most readily assessed against these mediators and objectives. The vision and aim set out above and the intermediate outcomes and outcomes listed in the logic model are longer term and will be most useful in informing a five-year evaluation of progress. The Gantt chart (Attachment 2) indicates, for each of the activities in the logic model, when the activity will start and finish and within that period, the planned intensity of activity. This schematic representation conveys the planned activities and their variation over time. Detailed milestones are only given for the first six months. More detailed plans and milestones for Years 2-5 will be finalised after six-month review and our first-year mapping and refinement of plans is completed, finalised in consultation with NIHR and our Advisory Board.

Our delivery plan is underpinned by three broad principles:

1. To minimise the creation of new structures and processes and maximise the extent to which GHDRC is embedded within existing Council structures and priorities. This principle responds to stakeholder feedback that changing the ‘systems’ of influence in the city will hinder progress so new projects and collaborations are unlikely to achieve buy-in and sustainability if they are in addition to, rather than embedded within, existing structures, processes and priorities.
2. To continue to build on what citizens have already shared through progressive consultation in Year One, through a process of stakeholder mapping, system mapping interviews and workshops and leadership dialogues, before finalising plans for Years 2-5. To review plans and progress with NIHR and our Advisory Group regularly, and to do a further in-depth review across all activity in Year 5 prior to renewal.
3. To gradually scale up and scale out the work of the GHDRC over the initial five-year period. In the first two years, our work beyond the stakeholder and systems mapping will focus (i) on topics of high priority to the Council, related to key missions in the new Strategic Plan and/or (ii)

on selected area partnerships across the city. Our pilot projects will fit these criteria and initial criteria to determine which other projects we adopt in Years 2-4 will prioritise projects with this focus. Once proof of concept is achieved and initial mapping and engagement work restricted to these focus areas is established and evaluated, we will then scale out to a broader range of topics and areas, likely to include a wider range of health determinants. We anticipate that projects adopted in Years 2-4 will be delivered with GHDRC resources. Later in the period, it is intended that additional adopted projects will be developed into project funding proposals to NIHR and other funders, especially where new empirical data collection is required. Proceeding with this wider portfolio of projects will be contingent on securing additional funding.

Priorities for Initial Focus of Activity

Stakeholder and systems mapping in Year One will include broad coverage of research on the wider determinants of health and inclusive engagement. The identification of potential projects to be adopted by workstream 2 will focus (i) on topics of high priority to the Council, related to key missions in the new Strategic Plan and/or (ii) on selected area partnerships across the city. Thus, in its engagement work in Years One and Two, workstream 3 will also focus on identifying priorities for action and/or candidate interventions for potential adoption within these topics and through more intensive engagement with the selected localities. In the consultation work conducted in developing this proposal, and building on existing collaborative work on the Child Poverty Pathfinder, the following potential priority areas for early project identification and adoption have been identified, all of which are linked to the Council's strategic priority Grand Challenge Mission to 'end child poverty using early intervention to support families':

- **Financial security**, which comprises working to raise income above the established poverty threshold and supporting families to have the means for effectively managing their income and outgoings to meet their needs. Having a child significantly impacts on all aspects of financial security.
- **Employability** extends beyond "the ability of an (employed or unemployed) individual to move into or within employment" encompassing "the multifaceted and complex combination of factors affecting the labour market interactions of those in and out of work".(9)
- **Community spaces and groups** that strengthen social connection as well as wellbeing for parents and children.

This initial priority could be adapted or changed in the early months of GHDRC but any significant departure would need to be signed off by the Advisory Board and NIHR at the first six-month review. It includes many groups across the Council and other partners focusing on economic (welfare, skills and work), educational, environmental and social determinants of health among children, families and over the lifecourse and is a very high priority topic among the public and communities.

Workstream 1: Governance and Management

This workstream will be led by Hose, the GHDRC Director, supported by Moore, the academic lead and Deputy Director, and McGinty, the Council's Head of Corporate Policy and lead on citizen and community engagement. This leadership will ensure the work of the GHDRC is well embedded in the Chief Executives Office and in the wider Data and Intelligence functions of the Council. This workstream will oversee the management of the GHDRC, and thus overseeing the work of the other workstreams and all activity and expenditure across the GHDRC. Four of its six activities (as in the logic model Annex 3) are covered in the 'Governance and Management Structures' section below. The two additional specific activities in the logic model led by this workstream are:

Design and Implement Project Adoption Process: Through engagement with stakeholders across the Council, partner organisations and with the public and communities, it is likely that there will be a high volume of potential issues, interventions or actions which are identified as potentially requiring further research, for example data to assess need, evidence to identify potentially effective interventions, or evaluation of ongoing or proposed actions. While Workstream 3 team will

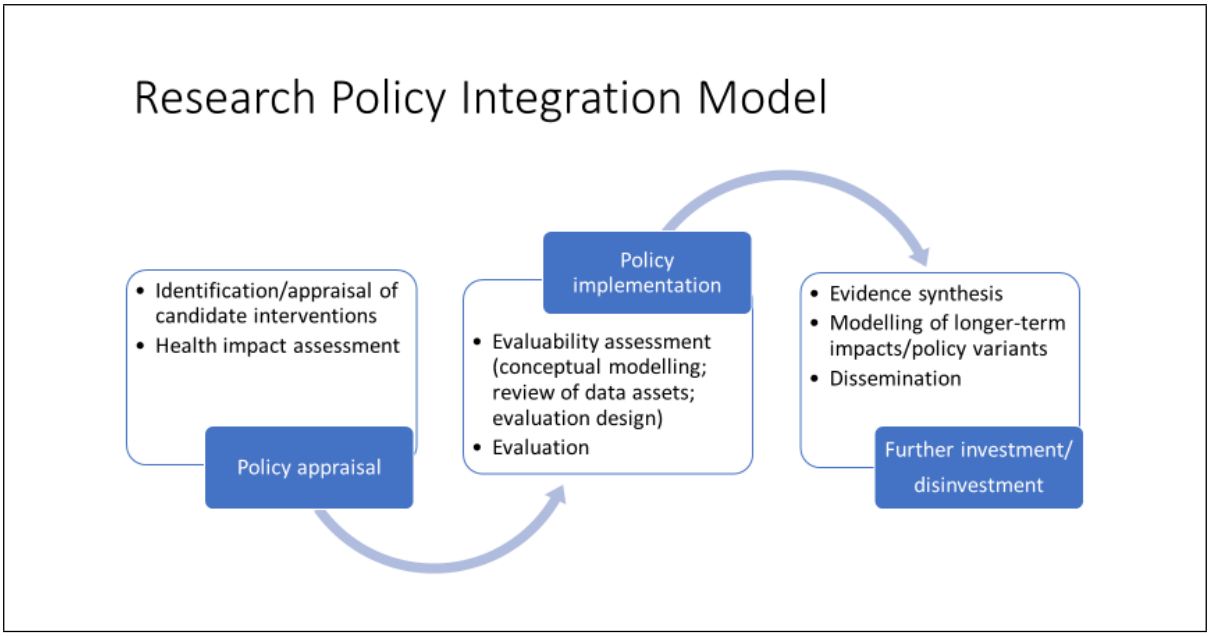
endeavour to respond to these requests where possible through GHDRC funded resources or through identifying resources, knowledge or expertise lying elsewhere in the partner organisations, only a subset of these potential projects will be ones where there is sufficient priority or potential for the GHDRC to take this on as a project to be adopted by the Workstream 2 Research-Policy Integration Model team. To ensure that the projects taken on by this team are the most appropriate ones, requires a transparent process through which potential projects are assessed. This process will need to capture diverse perspectives, and the process design and decisions made whether to adopt a project will need to be signed off by the GHDRC Advisory Group. During Year One, we will draft and consult on the details of this process, the key criteria to be applied and the process through which decisions are made. This will also include ongoing monitoring of the existing and planned workload of the Workstream 2 team, to ensure that the flow of projects is matched to the availability of resources. The adoption process will be evaluated and refined in Years Two to Four.

Develop and Implement Training Programme: As part of the stakeholder and systems mapping and leadership dialogues in Year One, and ongoing throughout engagement with stakeholders across the Council, partner organisations and with the public and communities, we will develop an education and training programme to enhance knowledge and skills relevant to the GHDRC mission. This will likely include training on research related topics including: how to search for, obtain and consume (critically appraise) research evidence; sources of data and expertise to help obtain and interpret data; data analysis and visualisation; evaluation, covering mixed methods, prospective evaluations and natural experiments; evaluability assessment; public involvement; dissemination and communication of research; knowledge exchange; applying for research funding; research ethics and safeguarding. There will also be training and research seminars on key topics related to the GHDRC, including the wider determinants of health and health inequality; key models underpinning our understanding of the wider determinants of health, including socio-ecological framework, complex systems theory, circular and wellbeing economy, place-based approaches to health improvement; topics related to Council priority areas and adopted priority projects. In-person and online training events and online modules will be developed, and appropriate means and methods will be used to target different professional and lay audiences. Action learning sets will be considered, as an effective means to develop relationships and collaborations, as well as develop multi-perspective understandings and solutions to focal problems. GHDRC staff from all workstreams will contribute to the training programme development and delivery, and we will also encourage participation as trainers from colleagues across the collaboration, partners and other relevant providers, including colleagues in the University of Glasgow and partners in the University of Strathclyde. We will also develop an online resource with links to relevant training materials for different purposes and audiences.

Workstream 2: Research-Policy Integration Model

This workstream will be co-led by Moore, the GHDRC academic lead and Deputy Director, and Hazle, the Council lead on data analysis and visualisation, with support from Craig and Hose. Moore and Craig have substantial experience of mixed methods pragmatic development and evaluation of interventions, evaluability assessment and evidence synthesis,(10-12) while Hazle and Hose are embedded within the Council Business Intelligence team that is responsible for the range, quality and accessibility of information available to elected members, staff and the wider public for use in service development and policy improvement.

This workstream will design, implement and refine the model depicted below (Figure 3) through a series of pilot projects, and subsequently apply it to further projects that are adopted by GDHRC. We believe that adapting and integrating this model is a critical step in changing the culture and impactful use of research.



The model identifies three stages where research evidence can support decision-making: 1) during policy appraisal to support identification of candidate interventions and health impact assessments; 2) during implementation to support evaluability assessment (determining whether and how a programme can be evaluated) and evaluation; and 3) to support decisions on further investment in policies, through evidence synthesis, modelling of longer-term impacts and dissemination. These stages are the key building blocks of an evaluative culture that generates context-specific evidence for local decision making while also contributing to the wider evidence base.

We plan that the process will work as follows: Through our engagement work, stakeholders across the Council and wider collaboration will be invited (and over time become aware of the ongoing opportunity) to put forward projects for adoption. Our community leads will promote dialogues among diverse stakeholders in communities to identify priority issues and potential projects that we will help develop. These may be specific candidate interventions, or specific areas of policy or service need where alternative interventions may have been or need to be identified. This may include existing practice where one or more interventions are being considered for disinvestment, continuation, or expansion. For adopted projects, a team will be established, overseen by one of the Delivery team, including stakeholders from the Council, public and other relevant perspectives and supported by University-based GHDRC staff. The candidate interventions will be appraised against RE-AIM criteria(13) (i.e., according to their expected reach, effect, adoption, implementation and maintenance), drawing on existing health impact assessments,(14) where available or conducting new ones if needed. Interventions that are assessed as having the potential to have a substantial and sustained impact on health and health inequalities across a sizeable population, will be prioritised for evaluation, with the final selection made by the Advisory Group

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We will develop evaluation proposals for the selected interventions (stage 2) by conducting evaluability assessments. An evaluability assessment is a systematic, collaborative way of formulating a conceptual model of how the intervention might achieve impact, determining which outcomes matter to stakeholders and what data sources can be used to capture change in those outcomes, and developing a list of evaluation options.(15-17) By engaging stakeholders throughout the process, evaluability assessments create a shared understanding of how the intervention works, and what an evaluation can and cannot deliver. The main formal output is an option appraisal, summarising the strengths, weaknesses and resource costs of different evaluation designs, and a

report summarising how these were derived, but the learning gained from engaging in the process is another key deliverable.

Decisions on which evaluations should proceed will be made by the Advisory group and signed off by the Public Health Oversight Board. We have allocated funds for relevant Council staff to have a placement with the University to bring their expertise to the team and enrich the Council-University collaboration. The team would produce a full report of each evaluation (stage 3), placing the results in the context of what is already known about the intervention. We would liaise with stakeholders to identify other formats which could be used to make the evidence accessible and useful, including lay summaries, animations, blogs, decision models, etc.

We acknowledge that this way of working is a step-change in the use of health outcome evaluation within the Council and will take time to become accepted. We will therefore undertake a series of additional steps to encourage embedding, based on established principles for building evaluation capability.(18) This will include the Leadership Dialogues in which we will engage with leaders across the Council to clarify expectations and build agreement around the goals of the GHDRC. The adoption process and associated governance arrangements will guarantee support and engagement with the Workstream outputs. Through training, shared appointments, placements, collaborative evaluation projects, supporting data access and other mechanisms, we aim to promote and refine this model, develop case studies of its successful application, and then apply to a wider range of applications that we would expect to be submitted to the adoption process in later years.

We anticipate that the typical cycle for the policy appraisal and evaluability assessment will be around 3-4 months. Evaluations where there are readily available data to retrospectively evaluate interventions may then be completed quite rapidly, while prospective evaluations may require more time or resources. Where new data will need to be collected, this will require additional resource and therefore lead to the development of grant funding applications by the team. However, when resources are available within the GHDRC, Council and partners to complete the evaluation using existing or low-cost data resources, then the whole evaluation cycle will be completed very rapidly, with immediate feedback to Council decision-makers.

Key activities recorded in the logic model for this Workstream are the design, implementation and ongoing refinement of the Research-Policy Integration Model and then, for each adopted project, to establish a project team and plan, and apply the model through each stage as appropriate.

An additional key activity of this Workstream will be to support data discovery, and data linkage, integration, curation and analysis where needed, both for adopted projects and also in response to requests for data that may emerge from across the GHDRC collaboration, particularly because of the engagement work of Workstream 3. This will be taken forward by establishing a GHDRC Data Discovery Hub, which will bring together key expertise from across the collaboration with knowledge of the administrative, economic, health and other datasets readily available within the collaboration (initially through links to the Glasgow Open Data Hub, the NHS Safe Haven, University-held datasets (e.g. Urban Big Data Centre) and national resources including Office for National Statistics, National Records of Scotland and commercial datasets (e.g. CACI and Consumer Data Research Centre)). The Hub would immediately be able to expedite the identification of datasets, either for adopted projects or other inquiries, through the collective knowledge of what datasets are available where.

Over the five-year period, the GHDRC Data Discovery Hub would take forward the following key elements in support of adopted projects and cumulatively over time to curate a comprehensive and flexible resource:

- Stakeholder Engagement: Interviews with key stakeholders involved in data discovery and curation, such as department heads, data owners, and analysts to better understand their data needs, challenges, and expectations.
- Data Mapping: Workshops and an ongoing process to co-create an inventory or map of available data sources, with a specific focus on GHDRC needs and complementary to Glasgow Open Data Hub.
- Data Validation and Preparation: Analysing data sources to understand their quality, completeness, accuracy, and potential limitations. Removing or correcting errors, inconsistencies, and duplications within datasets to enhance data quality. Converting data into standardised formats or structures to enable compatibility and interoperability across systems.
- Metadata Management and Data Classification: Documenting essential information about each data source, such as its origin, format, structure, and relevance to specific domains or projects. Organising data assets based on their type, purpose, and sensitivity to facilitate efficient data management and access.
- Data Integration and Matching: Combining data from multiple sources to create a unified and comprehensive view, enabling more comprehensive analyses.
- Data Security and Privacy: Implementing measures to protect sensitive data, comply with privacy regulations, and ensure secure access and sharing.
- Data Governance: Establishing policies, guidelines, and procedures for data management, including roles and responsibilities, data standards, and data lifecycle management.
- Community Engagement: Working with communities to understand their data needs and challenges and to explore how best to enhance access and data literacy skills.

Workstream 3 Engagement and Culture Change

This workstream will be co-led by Hilton (University) and McNulty (Council) with support from Moss (Care Partnership), Collins and Seaman (Centre). McNulty and Hilton both have substantial experience in engagement and collaboration across public, policy and third sector organisations and in championing public involvement and community voices. They are currently co-leading the stakeholder dialogues for the UKRI ESRC-funded Local Policy Innovation Partnership which has involved substantial engagement with Council Departments and stakeholders across the region. McNulty's pivotal role in the Child Poverty Pathfinder research-practice collaboration further solidifies their credentials. Meanwhile, Moss is the Care Partnership's Head of Health Improvement, Collins and Seaman, as Director and Associate Director of the Centre, have spearheaded community and partner engagement in major health inequality projects, fostering collaboration across the GHDRC community.

Key activities recorded in the logic model for this Workstream are to lead on the stakeholder mapping, systems mapping and leadership dialogues that will be conducted in Year One to raise awareness of and buy-into the GHDRC across stakeholders, and to the refinement of our vision and five year programme of work. The workstream will lead on public and community engagement across the GHDRC, with an initial focus on the Council priority missions and target Community Planning Partnership Areas, and support public involvement in each of the projects adopted in Workstream 2. As the GHDRC progresses, the Workstream will lead on scaling out stakeholder engagement to a broader range of topics linked to a wider range of health determinants and in additional areas. This Workstream will also anchor learning, reflection and refinement of engagement activity and progress towards embedded cultural change and focus on dissemination, transferability and impact across the collaboration and beyond, in part to facilitate continued progress by establishing recognition and perceived value of GHDRC to partners.

Within this workstream we will build upon existing partnerships involving the Council, city-wide collaborators and academics, notably the Child Poverty Pathfinder's embedded research-practice

collaboration, in which Delivery Team members are centrally involved. This context-specific, multidimensional research activity involves University researchers who have been actively embedded in a multi-agency change programme throughout its duration. These researchers have played a pivotal role in facilitating an enabling space for collaboration within a transdisciplinary team, fostering co-creation and implementation of research-informed activities. These activities are designed to support delivery objectives while promoting continuous learning, reflection, and collaborative knowledge creation and mobilisation across partner organisations. This approach has significantly bolstered the mobilisation of evidence and knowledge that has emerged from the research. The design of the pathfinder's programme acknowledged that the scale and complexity of the challenge of tackling child poverty meant its envisaged objectives could not be achieved by any individual organisations or sectors working in silos as they may have in the past. An awareness of the necessity of adopting a whole system approach, bolstered through intentional investments in a multi-agency collaboration and change capacity to drive forward the overall programme of work, was shared across the partnership and centrally informs the design of the GHDRC.

In Workstream 3 we will draw learning from the successful practices of the pathfinder research-practice collaboration to enable the GHDRC to benefit from conversation-led approaches to culture change and engagement, ensuring seamless integration between research and operational agendas across the partner organisations. Through these concerted efforts and partnerships, the GHDRC aims to make meaningful strides in addressing the determinants of health, fostering positive change, and promoting a healthier and more equitable future for the community. To ensure a sustainable and successful collaboration in the planning process, the GHDRC will adopt a participatory and inclusive approach.(19) This approach will facilitate the alignment of partner visions at each stage, enabling a smooth testing phase, establishing a well-informed research pipeline, whilst supporting culture change. The GHDRC aims to cultivate a research-led evaluative culture that drives health improvement through evidence, data and evaluation, strengthening relationships between researchers, decision-makers, and communities, and building the necessary capacity for culture change.

In the first year, the GHDRC will conduct several ***stakeholder mapping*** workshops to gain a comprehensive understanding of the local evaluative research landscape. By leveraging existing partnerships, we will identify a broad range of key ***stakeholders for interview*** across various determinants of health to gather valuable insights. Key stakeholders, such as public, community groups, policymakers, council members, service providers, evaluators, and relevant organisations, will be crucial to include. ***Participatory systems mapping*** workshops will help visualise the system, identify enablers and barriers, and explore opportunities for improvement in research practice on the wider determinants of health, working within the system's existing structures and mechanisms rather than developing competing processes and additional demands. This will have a focus on each of data, evidence and evaluation as critical components of research practice and culture. This mapping will then enable discussions to refine and finalise the GHDRC workplan and develop the GHDRC training plan.

Public and community involvement will be an integral part of GHDRC throughout its lifespan, with a strong emphasis on co-production and co-creation. We firmly believe in the principle of 'nothing about us without us,' and actively engaging with the community to understand their needs, preferences, and experiences.(20) By building on our longstanding connections with communities, we aim to generate meaningful outcomes, strengthen trust, and foster co-learning. Our approach to public and community engagement involves early dialogue sessions with stakeholders and families, integrating GHDRC within the city's existing engagement structures. Learnings from our bid PPI work suggest early engagement should also include dialogues to co-produce an agreed policy for payment and recognition of public involvement to minimise barriers to inclusion, especially for those with lived experience of inequality. This will include working with the Glasgow Equalities Forum to

convene sessions and events for the four networks they contain (Women, LGBT+, Disability and BME), both at this stage and throughout the GHDRC funding period. Leveraging platforms like the City Community Engagement Forum, Glasgow Equalities Forum and the Glasgow Health and Social Care Partnership's relevant networks will enable us to engage stakeholders and citizens effectively. We will also tap into successful neighbourhood- and home-level engagement practices that have shaped research and service delivery. Glasgow's three Community Planning Partnership Sectors (localities), each serving around 200,000 residents, have established Community Councils that converge in six to eight Area Partnerships. Additionally, locality community planning structures bring together elected members, third sector organisations, community networks, and other stakeholders. As part of the GHDRC, we will appoint a dedicated Lead for each locality to collaborate with and harness these existing networks. These Leads will gather intelligence, mobilise emerging evidence from the GHDRC, and facilitate ongoing feedback loops between local structures and the wider GHDRC team. This crucial component will bring the GHDRC to life at the local and city level, fostering high awareness, engagement, and impact. The Leads will receive training and support to work with stakeholders and work with them to identify priority issues for potential adoption by the GHDRC Research-Policy Integration Model. Where adopted, the project teams will continue to involve stakeholders, and then completed projects will feedback into knowledge and decision making. Whenever possible, we will utilise existing community infrastructures. However, for addressing specific areas of concern and interest for citizens and stakeholders, we may organise more structured dialogue sessions. By actively involving the public and communities, we aim to ensure that the GHDRC's efforts are closely aligned with the real needs of the people it serves, leading to more impactful and sustainable outcomes in improving public health and reducing health disparities. (20)

Throughout the process we will undertake ***reflective practice*** allowing partners to refine the model through a 'what worked' and 'what needs improvement' approach. Continuous feedback, reflection, and iteration will be used to refine the model based on new insights, changing contexts, and evolving needs. This continuous improvement approach ensures the model remains effective and aligned with our common objectives. This approach will also be used to help us capture insights and evidence from Council staff and staff of delivery partner organisations and to evaluate community and stakeholder engagement, and we will develop an evaluability plan as part of the HDRC. The evaluation will use various methods, including storytelling and metrics, to capture the journey and impact of participation. It will explore how community engagement has influenced achievements at both the HDRC team and broader programme levels, providing valuable insights to further enhance our approach. By fostering a culture of learning and adaptation and by rigorously evaluating our community and stakeholder engagement, we aim to ensure that the HDRC's efforts have a meaningful and positive impact, leading to improved public health outcomes and a stronger sense of ownership and collaboration within the community. At key points throughout the initial five-year period, we will host a leaders' round table event to gain buy-in, and develop actionable strategies for advocacy, leadership, and research-led decision-making on wider determinants of health within the Council. This strategy will be tailored to the specific local context and challenges the Council faces, ensuring it is sustainable, feasible, realistic, and aligned with our shared vision.

Transferability and impact**:** The GHDRC will leverage successful practices from the pathfinder research-practice collaboration, focusing on investing in capacity-building, coaching, and training to enhance the transferability of culture change and community engagement initiatives. We aim to develop tools and workflows that promote coherent transferable learning and sustainable evidence mobilisation. In this endeavour, mapping activities in Workstream 3 will play a vital role in identifying expertise, skills, networks, and successful practices within the system. This information will be used to create tailor-made capacity-building, coaching, and training programmes that address specific gaps or reinforce strengths. The goal is to foster more effective collaboration between the GHDRC

team, its partners at local and city levels, and to promote the successful practices that emerge from the project. Collaboration with partners, such as Public Health Scotland and others, will be instrumental in strengthening and expanding knowledge exchange networks within and beyond Glasgow. The HDRC team will actively work with citizens who contribute to the project, providing them with capacity-building opportunities. This approach ensures that their priorities and needs are considered throughout the programme's implementation. By focusing on capacity-building and knowledge exchange, the HDRC aims to create a more resilient and impactful approach to address determinants of health and drive positive change in Glasgow and beyond.

Culture

The Christie Commission on the future of public services, set up by the First Minister of Scotland in response to the pressures placed on public services by the financial crisis of 2008-9, reported that radical and sustained public service reform was needed, otherwise 'both budgets and services would buckle under the strain'.(21) Overlapping concerns included the persistence of social and economic inequalities; a 'fragmented, complex and opaque public service system' that was hampering the joint working considered by Christie to be essential; and a failure to prioritise preventative measures which might have avoided the need for more expensive interventions. The GHDRC will help the Council and its partners progress some of the key recommendations made by Christie: that individuals and communities receiving public services should be empowered by involving them in the design and delivery of the services they use and that public service providers should work much more closely in partnership to integrate service provision and thus improve the outcomes they achieve, by greatly improving the flow of information and the rigour of analysis, and by embedding research awareness, use of evidence and relevant skills within the practices of the organisation. The step change in culture needed is considerable, but through the Child Poverty Pathfinder, its support for vulnerable children, its enhanced use of data and its commitments to Open Government and the circular economy, the Council has been pioneering in its approach across the wider determinants of health. The GHDRC, through its workstreams will significantly enhance capacity to measure progress on the Christie recommendations not just in health but also in the related economic, environmental and social spheres and to drive forward the changes in mindset and practices that are essential components of culture change, while providing the feedback required to quickly identify and mitigate risks and ensure effective engagement.

Our success in engaging decision makers on the wider determinants of health can be assessed through the numbers of stakeholders from these wider domains who: (i) participate in our initial mapping and dialogues; (ii) engage with others to identify policy/intervention questions submitted for adoption; (iii) participate in engagement and training events; (iv) request data or evidence on health impacts of the determinants within their domain; (v) are involved in adopted projects; (vi) take policy decisions based on research outputs from GHDRC.

Collaborations

Recent projects between the Council and partner organisations have begun to develop strategic collaborations in areas related to health determinants, taking a longer term, systems informed approach that recognises the interdependence of health and other systems. As well as the Glasgow Child Poverty Pathfinder (Council, third sector, the Partnership, Scottish Government and University), relevant collaborative projects include the £10m UKRI NERC funded GALLANT Centre 'Glasgow As A Living Lab Accelerating Novel Transformation' (the Council, University and Centre); Glasgow Independent Commission for Economic Growth (the Council and University); Glasgow Thriving Cities Initiative and City Portrait project (Council, Care Partnership and University); Glasgow City Food Plan (all five partners); Glasgow Promise Project (Council, third sector and Partnership) and the UKRI ESRC-funded first stage Glasgow Aligning Local Policy Partnerships (GALoPP). These initiatives are developing long-term collaborations, relationships, shared

understandings, formal system maps, data sharing, etc., that will align with, benefit from and contribute to the key objectives of, the GHDRC.

There is developing coherence among these collaborations, the commitment to a Circular Glasgow, the centrality of community led planning and place-based intervention and the increasing appetite for greater use of data, evidence and evaluation for decision making in this context. The GHDRC will be working with rather than against these developments and will catalyse a focus on health and health inequality outcomes and policies across the wider determinants of health that influence them.

Active Learning: To succeed, the HDRC must successfully work with a range of partners, from Chief Executive and political leadership levels through to and including communities of place and of interest. Our Strategic Plan recognises that actions to support this aim are best shaped in partnership with the communities we serve. Consequently, the Council is committed to improving and increasing the range of information available to citizens about their neighbourhoods and how they can get involved. This will include an emphasis on supporting community generated initiatives and seeing them as genuine partners in the work of the council. The HDRC provides an opportunity to enhance this process, by providing them with information and analysis to set agendas on what matters to them and making a positive difference to their city.

Leadership and staffing structures
See Governance and management structures below.

Resource, Capacity and public involvement
Capacity building: As reflected in some of our objectives and in intermediate outcomes and outcomes in the logic model (Attachment 3), a principal intention of the GHDRC is to create sustainable capacity by the end of its first five years, through the culture, processes, relationships, skills and resources developed, embedded within the existing structures and processes of the Council and wider Community Planning Partnerships. Training will be led from Workstream 1 and the text above indicated the scope of activities that we plan to deliver through the GHDRC. This will be further refined and co-produced with stakeholders including public and community members in Year One before the training plan is finalised. The relationships, resources and processes we create will be a substantial driver of capacity building that will leverage staff and resources not directly funded by the GHDRC award into the wider set of activities and community of practice that the GHDRC will catalyse.

Shared learning: The Council works closely with other local authorities through links with the Scottish Local Government Digital Office and is particularly well connected into the data community across public and third sector. The Council would propose to utilise this network to help share the output and learnings from the GHDRC. Glasgow is also part of a UK cities network and has strong connections with other cities of similar size and challenges (including health inequalities) and would be keen to present the work of the GHDRC to this wider audience for dissemination as well as feedback.

Public involvement is central to our plans and has been detailed thoroughly in this document and other sections of the application form.

Governance and management structures
Workstream 1 will be responsible for Governance and Management and lead on these activities in addition to those detailed in the Workstream description provided above. The Workstream is led by Hose and supported by McGinty. McGinty is Head of Corporate Policy at the Council (also leading on citizen and community engagement) and Hose is Head of Business Intelligence. Both are based in the Chief Executive's Department and play key roles in driving and embedding change within the policy and service delivery spheres of the Council. Appendix One provides a governance organogram and details the staff roles within each workstream.

Advisory Group: Our principal governance group will be the GHDRC Advisory Board, which will include selected members of the Glasgow Public Health Oversight Board (PHOB), our partners (see Letters of Support from Glasgow Life, Public Health Scotland, Scottish Government, University of Strathclyde), two community/public representatives; invited NIHR representative and the Aberdeen HDRC Director, and will be attended by the GHDRC Director (Hose), Deputy Director (Moore), Hilton and McNulty. This will meet six-monthly and will sign off the detailed work plan as it is developed and revised and make decisions on which projects are adopted by the GHDRC. The GHDRC will report into the PHOB which is jointly chaired by the Council and the Health Board and brings council departments, Glasgow Life (Leisure, culture and wellbeing), the Partnership, the third sector, the Centre, Police Scotland and Public Health Scotland together to progress change. The PHOB was established, after a Public Health Summit in 2019, to provide leadership, co-ordination and oversight to action across multiple agencies and sectors, with a joint focus on health as an asset that brings social and economic benefits for families, communities and the city as a whole. Co-applicants McGinty, Collins, Moss are members of the Board. The Advisory Group membership and the reporting line into PHOB will ensure that the GHDRC is well embedded in the Council and key partners existing structures and processes, notably the Community Planning Partnerships, since the PHOB itself reports to the Community Planning Partnership Strategic Board. It also ensures there will be high awareness and support from across these structures and participating organisations in the work of the GHDRC, which will be embedded centrally in the wider strategy and routine working of the Council and its partners, rather than as a peripheral, stand-alone health-focussed group.

Delivery Group: This will meet monthly and be attended by all co-applicants, the project manager and administrator. This group will be responsible for delivery of the detailed work plan; ongoing reflection, refinement and evaluation of the work plan and monitoring of progress of each workstream; co-ordination of workstreams; ***resource management*** including budgetary monitoring; risk management and ***six-monthly reporting to the Advisory Group and funder***. Each workstream has a lead or co-leads and a group of 3-5 named members of the Delivery team responsible for delivery and management of staff and other resources. The workstream groups will meet at least monthly, attended by the GHDRC project manager, and report into the Delivery Group monthly meetings.

Project Governance: For each project adopted by the GHDRC for application of one or more stages of the Research-Practice Integration Model (see Project Adoption Process in Workstream 3 section above), a project team will be established that will include key Council and other stakeholders with an interest in the project, at least one community or public representative, two members of the Delivery Group, one of our GHDRC research team and a member of Council staff involved in the delivery of the project (who could be bought out full- or part-time with the GHDRC placement budget, thus providing a suitable management and delivery group for each project.

Justification of costs

A detailed justification of costs is provided elsewhere in the application form. Here we present a high-level overview of the resources requested. Delivery Group members based with the NHS in the Health Board, Centre and Partnership (Moss (10%), Seaman (10%), Collins (5%)) have contributed their time. Within the Council, Hose and Hazle have requested funds for 50% of their time. They are both based in the Intelligence and Data team in the Chief Executive's Office, and buying out half of their time will ensure they can provide substantial dedicated time to developing the GHDRC and embedding it in the Council. McGinty (10% contributed time), the Council's Head of Corporate Policy & Governance, will further ensure the GHDRC is embedded centrally within policy, decision making and community engagement structures and processes, while McNulty (30%) will build on the current work of the child Poverty Pathfinder to co-lead on engagement and culture change. The requested posts to be based in the Council will support project management (Workstream 1:

1.2FTE); data acquisition, linkage, analysis and curation (Workstream 2: 0.8FTE); and engagement and culture change (Workstream 3: 3.8FTE), embedded within existing partnerships and supported by staff based at the Centre (1FTE). There are also funds to allow the buy-out and placement of council staff to work on adopted projects. The University-based team consists of Moore (30% in Years 1&2; 20% in Years 3-5) and Craig (20% in Years 1 and 2), who will develop and oversee the initial implementation of the Research-Policy Integration Model supported by 2FTE research staff; and Hilton (20%) who will co-lead the engagement and culture change workstream. Additional funds are requested to support data and training activities and there is a substantial budget to support engagement, culture change and dissemination.

Over the initial 5-year course of the GHDRC, early work will focus on broad engagement with key Council staff, partners, communities and the public in co-producing the detailed plans. Initial priorities and subsequent adopted projects will be supported by the GHDRC resources and staff over Years 2-4. Some of these may require additional funding to be taken forward, while our expectation is that an increasing proportion of projects over time will be supported by resources embedded in the Council and the wider collaboration but require additional funding from NIHR and other funders in many cases. The work of the GHDRC would be sustainable beyond the initial five years with a lower level of core funding. This would require some continued support for engagement and data functions and a post to lead on the Research-Policy Integration Model, which we would anticipate being a progression for one of the University employed researchers (Baxter or TBC) who could progress towards this role in Year 4 or 5 of this funding period, seconded and then located within the Council. Sustainability in the absence of continued core funding (from NIHR or elsewhere) would depend on some underpinning funding from the Council and/or contributions from the other collaborating partners, and a pipeline of external funding applications to take forward larger projects and those requiring primary data collection. The successful embedding of the GHDRC in Council structures, processes and culture would likely lead to continue demand and support for its key functions, supporting policy development and decision making and continuing the collaboration.

Implementation, Milestones, KPIs & stop/go criteria

The activities listed in the logic model (Attachment 3) represent a detailed breakdown of planned activity and over the first two years, the main measures of ‘success’ will be the delivery of these activities. Over time, success will need to be measured more in terms of evidence of achieving our mediators of change and progress against our seven objectives. In Attachment 2, we indicate in our schematic five-year Gantt the planned flow of work across the planned activities, and we also set out milestones for the first six months. This includes establishing KPIs for the first year (which will relate to achieving key set-up targets and indicators of good engagement in our mapping and planning activities. These could be the focus of the first six-month review, while by the end of Year One we would plan to have completed a more detailed set of plans for the remaining four years, adapted to respond to the stakeholder engagement, mapping and consultation which we aim to have competed by then. Thus by Month 12, we would expect to have a revised logic model and Gantt chart and new KPIs including measures of success for each Year. We also plan to implement all our plans reflectively and flexibly and to publish and evaluate our model and progress, with those evaluation plans developed once the final plans are revised at end of Year One.

All our Delivery Team (including Director) are already in post and we have planned to have some key recruits in place by Month 4. We also aim to have the collaboration agreement in place by then.

Socioeconomic position and health inequalities

The Collaboration will concentrate on identifying and evaluating interventions with the potential to reduce health inequalities. Our initial focus will be on interventions to reduce child poverty by improving families’ financial security, employability and social connections. We will focus on the more deprived areas in Glasgow in our adoption of place-based projects. We will use health

inequalities impact assessments to identify candidate interventions with potential to make a real difference, drawing on previously under-used sources of data on variations in health and health determinants across Glasgow, such as the three yearly health survey commissioned by the Health Board and the school health census collected by the Council's education service (https://publichealth.nhsggc.org.uk/health-and-wellbeing/glasgow-city-schools-health-and-wellbeing-survey/). In our evaluability assessments we will involve people from the communities directly affected by the interventions so that we identify the outcomes that matter most to them. We will design evaluations that can capture distributional consequences rather than simply estimate average effects. We will make the health inequalities impacts of further investment or disinvestment clear when we pull the evidence together.

Dissemination, Outputs and anticipated impact

The outcomes indicated in our logic model represent the best summary of our current thinking is of what the key impacts of GHDRC should be:

- Glasgow recognised nationally as a centre of research-informed action on health determinants
- Thriving collaboration between Council, NHS, University and partner organisations with shared project teams
- Completed and ongoing projects, including those funded by NIHR and other research funders
- Demonstrable impacts on Council policies and actions
- Improved engagement, satisfaction and benefits for public and communities
- Improved health outcomes and reduced inequalities
- Contribution to wider evidence base

These vary in terms of the nature of the output and the scale of context in which they would be achieved (from communities in Glasgow to the international evidence base. Thus, there are many different pathways and dissemination strategies to assist in securing these impacts.

Our principal focus will be to ensure that GHDRC stakeholders are actively engaged in and informed about the research progress and findings throughout our work, and that our work is useful to decision makers and directly or indirectly influences Council policies and actions. We have set out a collaborative model of evidence generation in which policy appraisal and evaluation will be conducted in partnership, so that knowledge exchange, capacity building and culture change will take place continuously. We will initially prioritise audiences within the partners and the broader network of collaborators to ensure that our approach is effectively socialised within these organisations. We have established a comprehensive communication strategy using various channels. Firstly, we will produce accessible summaries for lay and practitioner audiences, drawing on our extensive experience of producing infographics, animations and other accessible formats. We will also produce a formal report of each evaluation, summarising the methodology and the findings from each stage of the process, from appraisal through to the modelling of future policy options. These reports will serve as reference documents so that learning is captured and available for future evaluations, as well as forming the basis for academic publications that will contribute to the wider evidence base.

As we refine our model, we will widen the focus of our dissemination to share learning with organisations elsewhere in Scotland and the UK, using our links with the Improvement Service, Scottish Local Government Digital Office, Scottish Government and other bodies. We will link with the Aberdeen HDRC to share progress and learning, and have invited their Director to sit on our Advisory Board. We will also write newsletters and maintain a dedicated website exclusively for GHDRC. This website will be easily accessible and available in multiple formats, including talking head video clips and social media content. We understand the significance of accessibility, so we will cater to individual needs by providing language and format translations as required. This will

ensure our network can readily access the GHDRC's progress and outcomes. In addition to these efforts, we will invite key stakeholders to attend relevant dissemination events where they will receive updates on the research progress and findings. Furthermore, the results will be disseminated through peer-reviewed publications, conference presentations, and media coverage. The planning and execution of these dissemination events will be done in close consultation with our local policy, practice and community stakeholders and partners, supported by The Council and University communications teams. We will leverage their insights and existing consultation and communication infrastructures to ensure that the dissemination events are well-organised and impactful. By implementing this comprehensive communication and engagement strategy, we will offer a range of stakeholders with real-time updates and valuable insights, fostering a strong sense of involvement and shared responsibility in shaping the outcomes of the GHDRC.

Project timetable (see Attachment 3, Implementation, Milestones, KPIs & stop/go criteria above)

Approach to Collaborative Working

In current collaborations and in the development of this proposal, we have used various tools (notably MS Teams, sharepoint etc) to share files and work collaboratively in a seamless manner. Flexible working and hot-desking are supported by all organisations. Both the Partnership and The Centre are long-standing have worked effectively across the Council, Health Board and University for many years. We welcome the HDRC agenda and the way we have developed our plans to maximise the alignment of academic and policy/practice agendas and incentives, through novel collaborative processes embedded in The Council and partnership organisations.

Robust technical, legal and ethical data sharing arrangements between the Council and the Health Board already exist to ensure that individuals receive the care services they require. Responding to covid-19 brought this data sharing to a new level as it necessitated a coordinated response to identify and protect vulnerable citizens outwith the normal care arrangements. To achieve this, the legal and technical requirements to combine a number of additional data sets were achieved, creating a solid platform on which the GHDRC can be established.

There is significant experience within the collaboration of the challenges of data sharing and this has proven to be a major obstacle in the past. Learning from that experience and building on the experience of the Business Intelligence team and the Open Government partnership, we have included in our team a Data Protection Legal Specialist. The additional challenges for health data mean that we have also included a data manager at the NHS Safe Haven, which can facilitate the matching of health and non-health data for subsequent analysis of anonymised data.

Safeguarding and ethics

Any primary data collection or secondary data analysis undertaken for research purposes by the GHDRC would be submitted for ethical review by the University of Glasgow Ethics Committees, or NHS Research Ethics Service if appropriate. This would include the systems mapping and leadership dialogues in Year One, as the results of this will be written up and disseminated as a published rationale for our subsequent detailed plans. The main safeguarding issue we anticipate relates to preserving confidentiality and anonymity of data. This may relate to primary data we collect, including qualitative data where we will safeguard the privacy of participants by ensuring their personal information and responses are kept confidential and anonymous by using pseudonyms instead of using real names in reports or publications.

Much of our work will be with secondary data, where any research work undertaken as part of the GHDRC would follow the Council's Data Protection Impact Assessment (DPIA) process to assess the necessity and scale of the processing of personal information and identify the steps that must be taken to safeguard that data and comply with the requirements of the Data Protection Act 2018 and

GDPR. The DPIA is undertaken at the early stages of all initiatives rather than at the end and is seen as a way of designing privacy measures into proposals at the outset ('privacy by design').

In addition, we include a part time data protection specialist in the project team. Incorporating a dedicated legal expert has allowed the Child Poverty Pathfinder to identify bottlenecks in data access and to address them. The additional advantage of embedding this expertise is that the specialist becomes conversant with the non-legal barriers that may play an equally important role in obtaining access to relevant data. Furthermore, we will utilise the NHSGGC Safe Haven, enabling data from multiple organisations to be extracted, linked, and analysed while protecting privacy or other sensitivity concerns. The protections that would be accorded to the data are outlined in the Safe Haven Charter.(22) For any evaluation projects where other potential safeguarding risks may arise these will be considered by Ethics Committees and project teams as required.

Expertise

In this section we detail the expertise and contribution to GHDRC of the co-applicants. For the employed staff, details of posts are in the Justification of Costs section in the application form.

Hose, Director, WS1 Lead (fte 0.5), The Council. The Director will be ultimately accountable for delivering the vision of the HDRC and managing the delivery team. Crucially, the post resides within the Council, where it will facilitate the culture change required to embed research competencies and expertise at every level and to ensure the effectiveness of dissemination approaches. The post will be taken up by the existing Head of Business Intelligence at the Council who already has the remit for helping the Council make better use of data in the delivery of services, ultimately to improve the outcomes (and health) of the citizens of Glasgow. In only a few years, the Head of Business Intelligence has developed stronger relationships between the Council and researchers from key academic partners to facilitate collaborations that balance the agendas and priorities of all partners more effectively. These collaborations have resulted in an excellent working relationship and underpins this application. The post will be 0.5FTE charged to the NIHR while the other 0.5FTE will allow for the continuation of aligned tasks performed by the Head of Business Intelligence. It is believed that having a single person responsible for both the HDRC and for the wider council commitment to better use of data and research will result in better integration from an early stage, ensuring it is easier to support sustainable growth in HDRC capacity and capability.

McGinty WS1 Deputy (fte 0.1), The Council. Required to promote and embed a shared understanding of the place of evidence within policy and planning and to ensure research and evaluation is co-produced with and effectively communicated to the public and key stakeholders.

Moore, Co-Director, WS2 co-lead, WS1 Deputy (fte 0.3 in Y1/2; 20% in Y3-5), The University. Moore has substantial experience in leading major research investments including Centres and networks, including initiatives to promote evaluation embedded in public health policy and practice. He has successfully led rigorous evaluations of interventions and policies in schools, local and national government. He is committed to transdisciplinary collaboration and the usefulness and timeliness of research for decision makers. He will support Hose in overall management and governance and will lead Workstream 2.

Hazle, WS2 Co-Lead (fte0.5), The Council. Data Analytics and Visualisation Manager who will be responsible for the creation and development of a common data platform for the use of all partners. With a remit focussing on the policy and organisational change aspects of data, they will provide a strategic coordination role for GHDRC partners, and liaise with external organisations where negotiation to access data is required.

Craig, WS2 Deputy (fte0.2), The University. Professor of Public Health Evaluation who has substantial experience in the application of evaluability assessment, including as art of the NIHR PHIRST Fusion team. Craig has led many evaluation studies, notably using secondary data linkage

to conduct natural experiments of policy interventions. He will play a major role in design and implementation of the Research-Policy Integration Model.

McNulty, WS3 Co-Lead (fte0.3), The Council Lead investigator, Child Poverty Pathfinder research practice collaboration, Chair academic advisory group (Community Planning Strategy Board), Des has substantial experience as a public policy professional and as a knowledge broker, working at senior levels in government and the university sector.

Hilton, WS3 Co-Lead (fte0.2), The University. Professor of Public Health Policy. Shona has substantial experience in co-creation and co-production of projects to generate evidence that can be used to shape policies.

McNulty and Hilton will work together to oversee and direct the work of the Research-Practice Collaboration Manager and that of the Locality Health Determinants Leads who will work alongside the team headed by Glasgow's Head of Health Improvement and Equalities.

Moss, WS3 Deputy (fte0.1), The Partnership. Head of Health Improvement and Equalities. Required for project delivery and reporting to NIHR, aligning capacity and HSCP support to achieve this and ensuring the direct delivery of components of the project.

Collins, WS3 Deputy (fte0.1), The Centre. Prof. Collins is the Director of Glasgow Centre for Population Health. He will ensure the continuing work programme of The Centre is aligned to and supports the work of GHDRC.

Seaman, WS3 Deputy (fte0.1), The Centre. Dr Seaman, Associate Director of Glasgow Centre for Population Health, required to leverage their previous leadership in the design of PPI components of both NIHR-funded and the Centre's wider work. Dr Seaman also connects.

Partners: Key additional partners outside the collaboration who have provided letters of support are Public Health Scotland, the University of Strathclyde and Glasgow Life. Other letters of support are from collaborating organisations including the Council, Health Board and University. Public Health Scotland were particularly involved in discussions to develop our proposal. A wider range of organisations and many stakeholders from across the Council and the other collaborating organisations participated in the June/July workshops that shaped our plans.

Roles in application development: The application development was led by Hose and Moore. All co-applicants participated in two workshops and other meetings to develop the bid, although over the Scottish holiday period there were no meetings where all applicants could be present. Workstream leads led the drafting of their respective sections, supported by their co-leads. Hose led on the agreement of resources. Final stages of the submission through REALMS were supported by the University research team who have significant experience with NIHR grant submissions.

Appendix 1 – Development Year Plan

In the Development Year we will start work, in each of our three workstreams respectively, to: (i) establish the Glasgow HDRC (GHDRC), its management and governance and its profile and relationships in the council and collaborating organisations; (ii) develop and pilot key elements of the Research-Policy Integration Model and (iii) undertake substantial work to develop a shared understanding and vision for the HDRC including stakeholder relationships and public partnership.

Consistent with our Stage 2 proposal, we have identified and, in some cases, disaggregated activities that we included in our logic model and six-month milestones, which we propose to bring forward into the Development Year. These are depicted in the Development Year Work Plan Gantt chart below, along with proposed Milestones that we suggest can be used by NIHR to review progress and inform a Stop/Go review proposed for month 10.

Glasgow HDRC DEVELOPMENT YEAR WORK PLAN - Gantt and Milestones

	Activity	2024 J	F	M	A	M	J	J	A	S	O	N	D	Milestone(s)
Workstream 1: Management and Governance														
1	Delivery Group monthly meetings and action log													
2	Public Health Oversight Group (PHOG)			♦			♦			♦			♦	Updates to PHOG
3	PHOG Advisory Subgroup Meetings (Quarterly)				♦									Membership agreed, 1st meeting
4	Communications			♦			♦			♦				Comms & engagement; branding; website live.
5	Collaboration agreement									♦				Agreement signed
6	Project Adoption Process Design							♦						Signed Off by Advisory Subgroup
7	Recruitment		♦							♦				Staff in post; JDs for full HDRC written
8	Engagement with NIHR and HDRC peer community							♦		♦				Stop/go review report; Revised plan Y2-6
9	Data & research Governance		♦										♦	Dev year ethical approval; Apply for full ethical approval
Workstream 2: Research-Policy Integration Model														
10	Data Discovery Community					♦						♦		Membership agreed, 1st meeting, 2nd meeting
11	Research-Policy Integration Model							♦		♦				Signed Off by Advisory Subgroup; Pilot commenced
12	Data mapping and linkage													
Workstream 3: Culture Change & Engagement														
13	Stakeholder mapping				♦									Identify key participants and relationships for inclusion
14	Stakeholder interviews						♦							Collate views on context, enablers, barriers, opportunities
15	Systems mapping workshops (Wave 1 & 2)									♦				Shared understanding and co-created vision for HDRC
16	Community engagement and lived experience dialogues							♦						Recommendations for HDRC public partnerships plans
17	Leaders roundtable event									♦				Senior Leader's Endorsement of HDRC vision and plans
18	Learning events and capacity building													

We provide further detail of these proposed activities below by Workstream, with particular emphasis on the Culture Change and Engagement activities included in Workstream 3, which are most strongly related to the concerns raised in the Funding Committee Feedback.

Workstream 1: Governance and Management

Delivery Group meetings will be monthly, attended by all co-applicants and Development Year staff. Workstream groups will meet separately, attended by the project manager and report to the Delivery Group. The Advisory Subgroup membership will be established to include members of the Public Health Oversight Group (PHOG), And key partners and public/community representativesand will be attended by HDRC workstream leads. NIHR will also be invited to attend these meetings..

This workstream will also ensure that the establishment of GHDRC is communicated across many channels within the Council and collaborating organisations and partners, through website and promotion of opportunities and invitations to engage. We will present papers to the PHOG and the Wellbeing, Equalities, Communities, Culture and Engagement City Policy Committee (WECCE) and the Council Management Team (CMT), which will support Senior Council Executive and Elected

Member awareness of and engagement with GHDRC, its governance and the culture change and engagement activities.

The workstream will lead on the Collaboration Agreement, the design of the project adoption process and the management of resources including recruitment. We plan to have in post by February 2024 a project manager and qualitative researcher, with a community engagement lead in that latter stages of the year. Job descriptions and recruitment plans for the 'full' HDRC will be finalised in time for the month 10 progression decision point.

This workstream will lead on engagement with the NIHR and the wider HDRC peer community.

Workstream 2: Research-Policy Integration Model
In the Development Year this Workstream will establish the Data Discovery Community, with members recruited by April, and will further refine the Research-Policy Integration Model, for sign-off by the Advisory Subgroup in July. This workstream will also plan to adopt on a pilot basis its first project with the intention of completing at least an evaluability assessment, including identification of a candidate intervention, co-production of a programme theory and mapping of relevant data sources, given the outcomes identified as priorities in the programme theory. This will help to further refine the model and develop a proof-of-concept case study to help demonstrate the process and value to stakeholders across the Collaboration.

Workstream 3: Culture Change & Engagement
This workstream will lead on five linked activities that will together generate a shared understanding of the vision for GHDRC including a co-produced understanding of the culture change we are aiming to achieve, who needs to be involved, how we should go about this and what the key enablers, barriers and opportunities might be. This will culminate in a finalised Vision and work plan for GHDRC which will be endorsed by senior leaders from across the collaboration and partners (September) and signed off by the Advisory Subgroup (October) as a key component of Stop/go review and progression decision by NIHR (October). The proposed activities are as follows:

Stakeholder Mapping and Interviews (months 1-6): To gain a shared vision of what a cultural shift looks like, we will conduct up to 50 recorded stakeholder interviews (online and/or in-person) exploring 'what would a good research culture looks like?', 'Where are we now?', 'What needs to change and what levers for change do we have?', 'how will we assess that there has been change' and 'how do we ensure change is enduring'?' In keeping with our GHDRC principles, we will minimise the creation of new structures and maximise the extent to which our engagement is embedded within existing Council and community structures, priorities and workplans. We will use respondent-driven ('snowballing') techniques to leverage existing networks, gather information, and identify key stakeholders to invite to these interviews, the later workshops and/or future GHDRC activities. Stakeholder identification and mapping will commence in January with interviews planned to commence in February, once Ethics Approval is achieved (University of Glasgow Ethics). Stakeholder identification will include the Community Planning Partnerships and involve elected members, third sector organisations, community networks, service providers and other relevant stakeholders such as evaluators. We will also leverage existing connections with Glasgow Life and use platforms like the City Community Engagement Forum, and Glasgow Equalities Forum to identify and engage a diverse range of community stakeholders. These interviews will help us to:

- Identify who are the change makers and key actors that we should build relationships with, especially those with power over the wider determinants of health but perhaps not yet closely involved in health-related discussions.
- Refine critical questions for the workshops to understand how we can bring about and embed cultural change.
- Explore views on existing enablers, barriers, and opportunities that drives health improvement through evidence, data and evaluation related to the wider determinants of health.

- Identify potential 'early adopters' of or key advocates for this cultural change.
- Inform our engagement plans, strengthening existing relationships and building new links between researchers, decision-makers, and communities for the GHDRC.

Hosting a number of System Mapping Workshops (months 5-8)*:* We will adopt a participatory approach for these workshops which will each bring between 8 and 15 stakeholders together to map out the current evaluation ecosystem, and a possible future one that will drive forward health improvement through interventions that address the wider determinants of health. These in-person workshops will be recorded and use creative methods to:

- Help visualise the current eco-system (or potential components thereof, such as commissioners, producers and users of evaluation evidence), identifying enablers and barriers.
- Explore opportunities for improvement in research practice on the wider determinants of health within the system's existing structures and mechanisms rather than developing competing processes and additional demands.
- Co-create a vision underpinned by shared goals for what a research-led evaluative culture and ecosystem which drives forward health improvement looks like.
- Identify opportunities for our GHDRC to catalyse and support the use of data, evidence and evaluation in policy across diverse sectors that have direct or indirect impacts on health.

Hosting a Leaders Roundtable Event (month 9): Towards the end of the development phase, we will invite senior leaders and change makers from across the Collaboration and partner institutions to a Leaders Roundtable Event hosted at Glasgow City Chambers. This high-profile event will showcase the GHDRC and the results of the development work. It will aim to embed shared ownership and build connections with the policy and delivery agendas of our major stakeholders. The event will be co-hosted by the Leader of Glasgow City Council (Susan Aitken) and the Vice Principal for Research & Knowledge Exchange at the University of Glasgow (UoG) (Chris Pearce). Up to 25 senior Glasgow leaders from key departments across the Council, collaborators and partner institutions, government officials, community leaders, business leaders and academics will be invited. This event will aim to enhance awareness about GHDRC, gain early buy-in, and help strengthen collaborations between the University-based academic sector and Council and NHS partners to deliver GHDRC objectives with policy and practice. This event will be an opportunity to have feedback on our proposed plans, agree the shared vision, priorities and actions for the GHDRC going forward to establish Glasgow as working towards becoming recognised nationally as a centre of research-informed action on health determinants.

Dialogues with people with lived experience of deprivation and/or poor health (months 6-12): As stated in the GHDRC proposal, we firmly believe in the principle of 'nothing about us without us,' and actively engaging with the community to understand their needs, preferences, and experiences. By building on our longstanding connections with communities, we aim to generate meaningful outcomes, strengthen or establish trust, and foster co-learning. We will seek to identify established and effective mechanisms/spaces in communities where trust and open dialogue have already been established with citizens with lived and felt experience of deprivation and poor health. The imperative would be to, wherever possible, engage individuals in spaces or networks where they are already connected and secure, drawing on ethnographic approaches to learn about their experiences, priorities, needs, resources and capabilities in navigating both the challenges they face and the aspirations they have for themselves and their families.

This work will help us to:

- Enhance GHDRC awareness, engagement, and buy-in at the community level to help us adopt a collaborative, conversation-led and inclusive approach to delivering our overarching objectives.
- Obtain a holistic, nuanced understanding of people's experiences and priorities related to health inequalities.
- Capture learning and successful practice to inform the GHDRC's approaches to the ongoing integration of lived and felt experiences of deprivation and health inequalities over the 5 years, ensuring that these approaches are sense-checked and triangulated with the efforts of strategic partners to avoid duplication and to harness synergies.

Justification for Resources

We plan to start our Development Year on January 1st 2024 with the Delivery Group already meeting regularly to prepare and gather momentum. Our intention is for contracting to be completed before Christmas 2023 but to mitigate against the risk of a delay, we have costed the budget based on the assumption that activity will be charged to NIHR from Feb 1st 2024. The total funds requested for the Development Year are £249,701 (£277,445 FEC).

From 1st February, Kimberley Hose, Laurence Moore and Shona Hilton (lead, co-lead and Workstream 3 co-lead respectively) will each commit 20% FTE to GHDRC. For KH and LM, half of their time will be contributed in kind, by the Council and University respectively. Moss (10%), McGinty (10%), Seaman (5%), Collins (5%) will contribute their time in kind. Craig, McNulty and Hazle each have 10% of their time charged to GHDRC.

Research staff will be Cruywagen (Research-Practice Collaboration - 40% - to support Workstream 3) and TBC (Research Associate - 50% - to support Workstreams 2 and 3), both for 11months from February, and TBC (Locality Health Determinants Lead – 100% - Workstream 3 public dialogues, from June). Other staff will be a Project Manager (50%), Administrator (10%) and Communications Manager (10%) to support Workstream 1, all starting in February.

Non-staff costs are included to cover visits to other HDRCs (£2,400) and community engagement/public involvement reimbursement (£6,250).

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