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Cumberland Council

Cumberland Council's Research Plan

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Contents

Executive Summary

Cumberland Council's Health Determinants Research Collaboration (HDRC) is a five-year project funded by the National Institute for Health and Care Research (NIHR). It has a core aim to increase research capacity within the council and facilitate research in Cumberland to address health inequalities and the wider determinants of health. As part of this, the HDRC has produced a Cumberland Council Research Plan. This research plan will enable Cumberland Council to focus on key research priorities to address collaboratively, both as an organisation and across the community. This document provides background and rationale for the development of the research plan, identifying a distinct strategic research area broken down into, context, aims and objectives; and potential research questions relevant to Cumberland's health inequalities.

The Determinants of Health Context

Whilst access to high-quality health care is a determinant of health most determinants of health lie outside the health system. They include things like education, employment, working conditions, housing, and income. This is why the HDRC is a cross-cutting team situated in the Strategy, Policy and Performance directorate in the Council. Every directorate has some influence over one or more determinants of health. Ensuring health and wellbeing for all means we need to understand which of the determinants of health are affecting which health inequalities the most, and this might vary community to community.

Supporting individuals to make changes in their behaviour (for example adopting healthier lifestyles) is one part of the answer, but expecting this alone to improve health inequalities fails to recognise the root causes of these behaviours. Addressing the determinants of health means we work on the causes of the causes of ill health and wellbeing.

Sir Michael Marmot set out the evidence base linking determinants of health, to health inequalities in 2010 in the Fair Society, Healthy Lives report. A decade later, further evidence was presented in his report Health Equity in England: The Marmot Review Ten Years On (2020). Sadly, this also documented how little had been done in the decade between the report to tackle the determinants of health despite the wealth of evidence as to how to do so. Cumbria and Lancashire benefitted from a local Marmot report in 2022. This report, titled A Hopeful Future: Equity and the Social Determinants of Health in Lancashire and Cumbria set out the evidence of inequality in these local authorities along with case studies of what is working and recommendations for policy change. The HDRC project is our opportunity to focus

this ‘Marmot approach’ on Cumberland and its particular health inequalities. The Marmot principles are:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and to have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role of ill health prevention
7. Tackle discrimination, racism and their outcomes
8. Pursue environmental sustainability and health equity together.

The 2010 and 2020 Marmot reports also recommend adopting a proportionate universalism approach whereby universal polices and interventions are delivered more intensely where there is the most need. This approach ensures that everyone’s health improves whilst also levelling out the health gradient.

This research is grounded in the work of Marmot’s work and supported by his Institute for Health Equity.

Purpose

Cumberland Council’s vision is to put health and wellbeing into the heart of everything we do. This research plan will enable Cumberland Council to generate evidence of how this can be achieved and to evaluate initiatives to improve the determinants of health in the region. This delivers on Cumberland Council’s central aim in the council plan, of improving health and wellbeing, addressing inequalities and delivering excellent public services. The plan will be delivered in accordance with the Cumberland Approach.

The range of health inequalities that exist is well evidenced and much is also known about where and for whom inequalities are most prevalent, locally and nationally. Less data exists on which factors are the most significant drivers of health inequalities. Developing further understanding of how existing services affect these determinants of health together, and systematically drawing on national or international evidence of what works, would underpin future initiatives. Understanding how these determinants intersect with Cumberland’s geography, and each other as determinants is also crucial to improving health inequalities for Cumberland Council[1].

[1] Can intersectionality help with understanding and tackling health inequalities? Perspectives of professional stakeholders | Health Research Policy and Systems

This research plan will enable us to collectively research determinants of health that drive our most significant health inequalities to inform service design and continuous quality improvement across all directorates. The research plan was developed through a small-scale consultation to quickly ascertain whether the research priorities were identified in the HDRC Business Plan, drafted in 2023, were still relevant and whether anything had been missed. Whilst limited, the consultation process has confirmed the breadth of research areas that need to be addressed and has enabled identification of immediate research priorities.

The areas of research that are not prioritised for immediate action can be addressed by the research representatives and interns in each directorate, community co-researchers in each community panel, and by wider partners who have capacity to address them.

Health and wellbeing are the responsibility of all organisations in Cumberland and this plan will enable statutory, third sector and commercial sector organisations to jointly research and implement the findings from research in a system wide approach.

Scope

The research plan encompasses the work of everyone in the Council and our collective agenda with wider partners and stakeholders. It provides a strategic overview of the evidence we need to collectively compile, understand and act on. Whilst the research plan articulates our shared priorities, it is not, however exclusive and other research can be conducted, but should wherever possible link to this plan. The relationship between the Cumberland Council Research Plan, directorate research plans and community research plans is shown in figure 1 below.

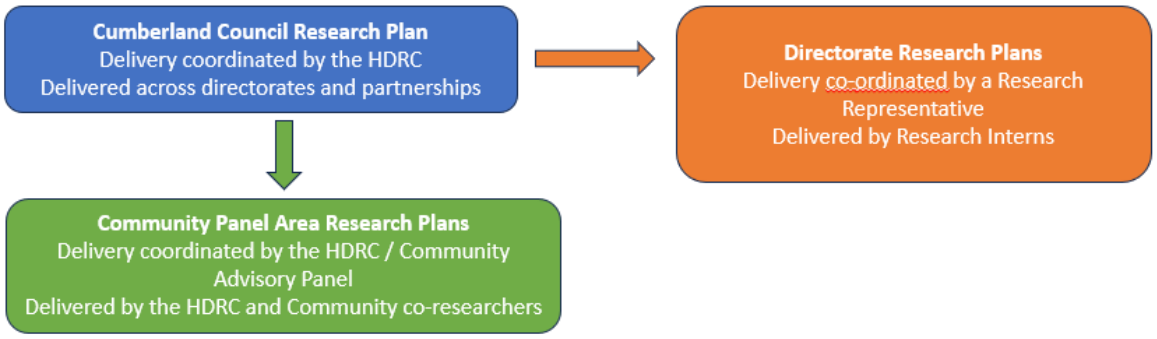

Figure 1: Relationship between research plans.

Directorates across the Council will develop their own Directorate Research Plan. This will articulate how they will support the delivery of the Council Research Plan priorities and any other research priorities they have as a directorate. The research

representative in a directorate will have ownership of this plan which will be delivered by the directorate research intern, both supported by the HDRC team.

Each Community Panel area will also have a Community Research Plan, where the overarching Council research priorities are translated into a local context and supplemented with other local priority research questions. Community co-researchers will be supported by the HDRC team to undertake this research.

The research is cross cutting and will involve multiple directorates and wider Council partners working together to achieve change.

The Cumberland Council Research Plan has a four-year life span, however there will be an annual review of research achievements that may lead to a refresh of the plan and that will be shared across the Council and its partners.

Roles

The HDRC is responsible for writing and reviewing Cumberland Council's Research Plan and for co-ordinating delivery of its activities.

Directors and Assistant Directors are responsible for ensuring relevant staff and / or projects are supporting achievement of the Research Plan and for designing and delivering their own directorate level research plan with the support of the HDRC team.

The HDRC Community Engagement Team are responsible for ensuring each Community Panel area has interpreted the Research Plan into a local context. The HDRC Community engagement team will support community co-researchers to deliver these plans.

Research representatives and interns, with the support of the HDRC team, will tailor the Research Plan priorities into a directorate context and will also ensure directorate priorities are addressed.

Community co-researchers, with the support of the HDRC team, will tailor the Research Plan priorities into their local context and ensure lived experience is a central pillar of evidence.

How the plan was developed

The research priorities for Cumberland Council have been developed through a robust four step process, informed by the World Health Organisation guidance on the systematic approach for undertaking research priority setting. This is outlined below.

Whilst the process was robust in its systematic collection, collation and scoring of priorities it was limited by two important factors. Firstly, the consultation was time-bound and practical rather than comprehensive and representative as set out in step one. Secondly, scoring research priorities as set out in step three is subjective and challenging when thinking about a particular issue across the entire geography of Cumberland. As such the scoring offers a useful guide to indicate priorities but should not be read as a scientific or definitive process. Future iterations of this plan will have a full consultation process and a refined scoring system.

Despite its limitations the process has assured us of a wide array of issues that need to be addressed that are all of significance to people living across Cumberland and enabled us to prioritise a strategic research area, and potential research questions.

Step one: Review and consultation.

A range of ten local reports and policies were reviewed and key recommendations drawn out and translated into research questions.

The HDRC team met with all seven Directorate Management Teams to ascertain their evidence gaps and research priorities. These led to a range of five additional follow up meetings where signposted to speak to more relevant colleagues or teams.

The HDRC team also attended all three elected member briefing sessions in September 2024 to elicit Community Panel priorities.

Representatives from our Academic Partnership Meetings provided their views and added wider consultation results into the process.

Community organisations contributed their ideas through one-to-one meetings and a webinar hosted by Cumbria Voluntary Services.

In total 107 people contributed research priorities and evidence gaps to the process as shown in the pie chart below.

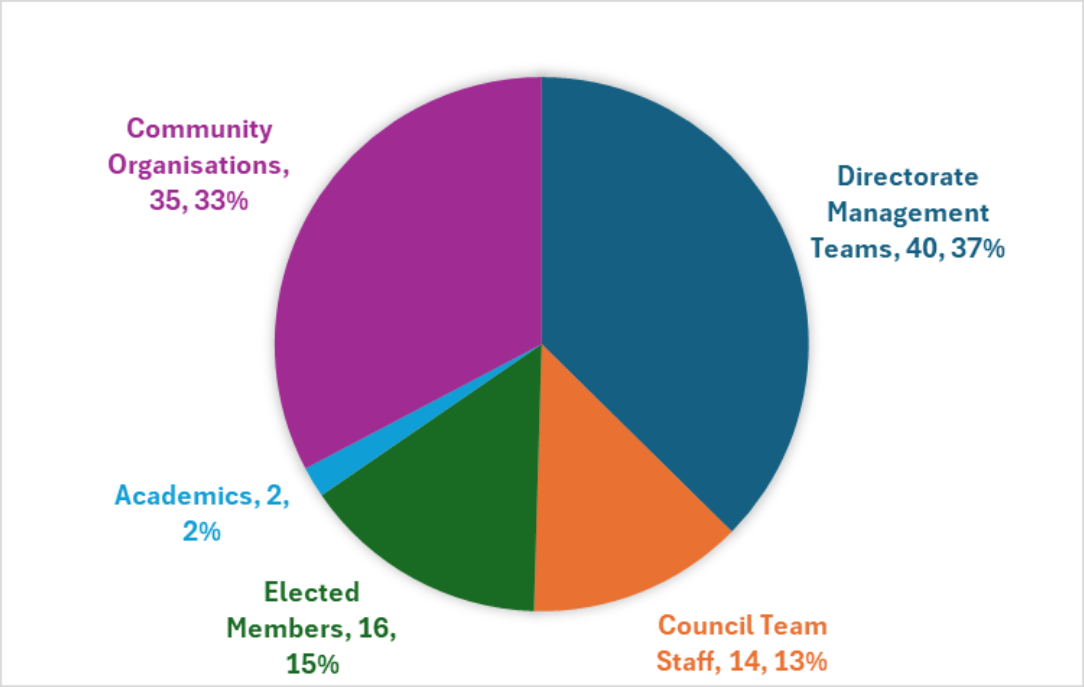

Figure 2: Total Number of Consultation Participants

Step Two: Collation

A total of 211 separate evidence gaps and research questions were collected from the participants. These were collated under the eight categories of the Dahlgren and Whitehead Determinants of Health model in order to create cross-Directorate themes. This model is shown in the diagram below. The source of the suggestion was noted alongside the question in order to understand how many different types of participants or documents perceived this as an important evidence gap.

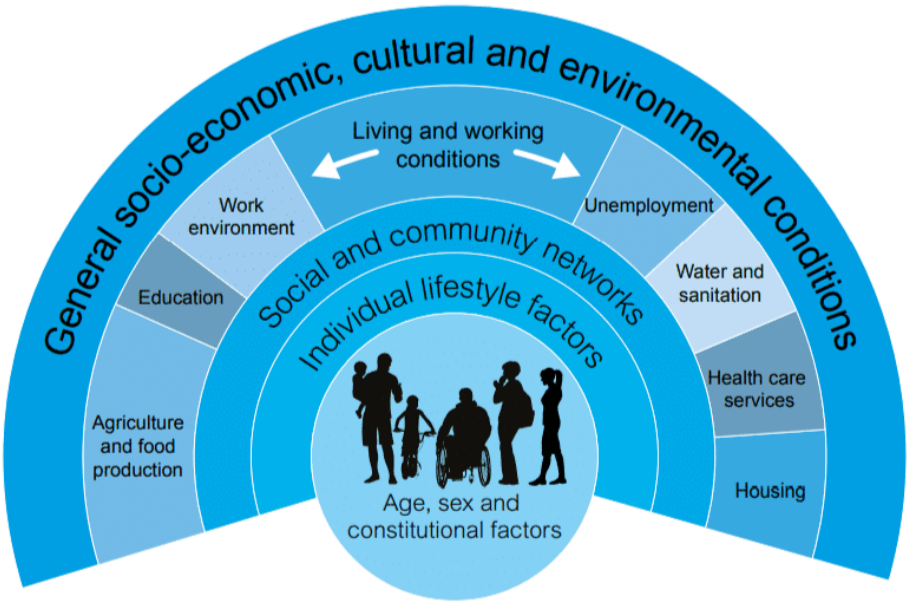

Figure 3: Dahlgren and Whitehead Determinants of Health (1992).

Once these were sorted by determinant of health, a second sorting was conducted in order to group them into broader areas of research and to remove any duplicate questions. At the end of this process there was a total of 40 areas of research and 157 research questions as shown in the table below. It was not possible to classify all the questions under these headings and two additional categories were added: connectivity (transport and digital) and Council processes.

Determinant	**Number of Research Questions**	**Number of Areas of Research**
Housing and Communities	18	5
Health and social care services	70	12
Living conditions	7	2
Education	16	5
Employment / unemployment	6	3
Working conditions	4	4
Food production and access	3	2
Connectivity	12	3
Council processes	21	4
TOTAL	**157**	**40**

Table 1: Total research areas and questions

It is also recognised this categorisation is not extensive, and does not explicitly consider every determinant of health, such as the commercial determinants[2]. The model however provides a clear picture of the wide and varied nature of determinants of health, highlighting that determinants of health can be affected by all areas of Council activity.

Step Three: Prioritisation

Once categorised all the research areas were scored using a priority matrix. The matrix provided five scores for each research area each on a one to five scale. This approach enabled differentiation between research priorities and was time efficient. The scores ensured that the areas of research prioritised:

- Fit to the Council's strategic plan
- Within the Council's scope of influence
- Open to change in the next five years
- Genuine evidence gap
- Valued by the community.

[2] The commercial determinants of health - The Lancet Global Health

The scoring matrix is shown in table two below.

	1	2	3	4	5
Fit to the Council's strategic plan	Irrelevant to plan	Weak link to plan	Relevant to some aspect of the plan	Related to one part of the plan	Strongly linked to plan
In the Council's scope of influence	Council cannot influence	Council has slight influence	Council can influence some parts	Council can influence most of this	Entirely within Council's field of influence
Potential to impact on health and wellbeing in five years	No link to HI / can't move in 5 years	Weak link to HI / hard to move in 5 years	Some potential to improve HI / some change expected in 5 years	Clear potential to improve HI and scope in 5 years	Strong link to HI's in 5 years
Evidence gap / uncertainty in this area	Plenty of evidence exists nationally and locally	Good evidence exists but not locally	National and local evidence is weak	Little national evidence	No evidence
Considered a priority by the community	Of no value to the community	Of little value to the community	Of some value to the community	Valued by the community	Community think this issue is significant

Table 2: Priority Scoring Matrix

The HDRC team conducted the scoring for items one to three, our academic partner scored area four and our community advisory panel scored area five. The total scores for each research area were then totalled.

Some issues occurred in the scoring of the research areas:

- Presenting a single score for an area with a range of questions was problematic and resulted in averaging upward to ensure no questions were scored down.
- Scoring evidence was complex as some areas of need and best practices were well evidenced, but that evidence was not being used. A more nuanced dual score may be used in the future to overcome this problem.
- The community organisations in the Community Advisory Panel did not want to value the different priorities on behalf of residents and only three returned

completed scores. We tested the impact of removing the community value score and the top ten priorities did not change, and they were left in place.

Scoring ranged from 5 to 25. The number of research areas with each score is shown in the chart below. More than half of the research areas (26 in total) were scored in the range of 16-20. Less than a quarter of the areas were scored in the 11-15 range (6 research areas) and 21 to 25 range (8 research areas). No project scored lower than 11 indicating all areas of research are important.

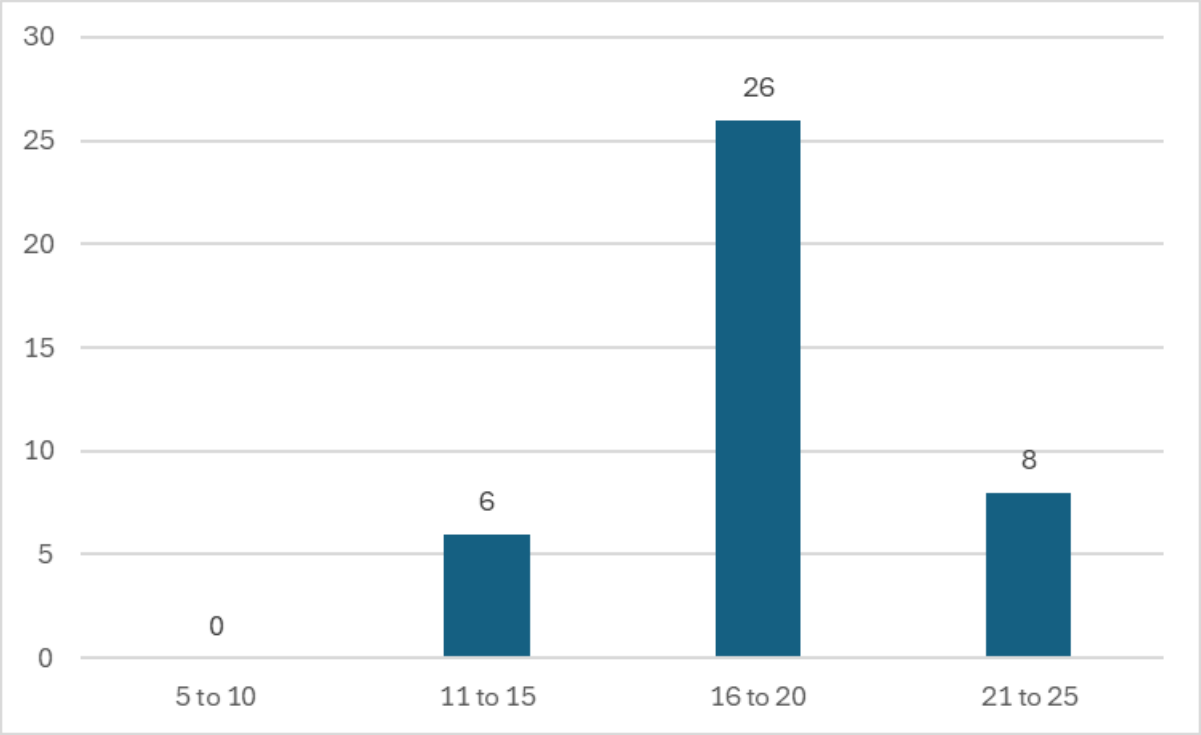

Figure 4: Number of Research Areas with Each Priority Score.

All research areas scoring 21 or above were taken forward as Cumberland Council's strategic areas for research, as set out in the next section. This yielded a total of eight priority areas:

- Integrated housing support
- Understanding the negative impacts of housing
- Pathways to employment for children in care
- Mental health
- Responses to emergency events
- Coastal and rural community needs
- Staff wellbeing
- Use of data in the Council.

These were shared with the Cumberland Council Extended Leadership Team and decisions on what to include and how to structure the project were made in the light of their advice and the latest data on priority inequalities. The final decisions on what to include were informed by the scoring exercise undertaken, the priorities of directorates and data on key health inequalities provided by Cumberland Council's Performance and Insights team informed the development of research questions relating to Cumberland's health inequalities.

Decisions on the Priority Research Areas

The first two research priority areas (integrated housing support and understanding the negative impacts of housing) were amalgamated as they relate to the same area.

Pathways to employment for children in care encapsulated two important areas – pathways to employment, and the high number of children cared for by Cumberland Council. These were retained as separate important lines of enquiry.

Mental health is a concern in Cumberland across age ranges and with particularly high levels of suicide and so was kept in the plan.

Responses to emergency events is consistently under review by the Council informed by reviews of responses to past flooding locally and the pandemic locally and nationally. This was therefore removed from the priority list as it is an existing strand of work in the Council.

Coastal and rural community needs was considered an under-researched area that provided a framework for all the other lines of enquiry. The coastal and rural needs can only be understood in comparison to urban areas and this was adopted as the overarching theme of the research project in which all other strands of enquiry would be embedded.

Staff wellbeing is both well understood, particularly in the light of the recent Pulse Survey, and best practices to improve staff wellbeing are well evidenced and in progress. As such, this was deemed to be a delivery project rather than a research project and was taken off the list.

Use of data was removed from the list as this is the core work of the Health Determinant Research Collaboration.

Two additional areas which were not scored as priorities were added into the research plan. The first of these is obesity and food insecurity. This was one of the areas of research included in the HDRC business plan and data shows it remains a

high priority[3]. Drug and alcohol use was also added as a strand of enquiry as data indicates use of these substances is significantly higher than national averages[4].

Areas not prioritised for immediate action are still of significant importance, but it is not possible to tackle all 40 research areas at once. Directorates can also address these areas themselves with their directorate research plans led by their directorate research representatives and interns. Alongside tailoring the Council research priorities at a local level, community panels areas may add research questions particular to their locality in their Community Research Plans. Partner organisations with a particular expertise or interest in these areas may also have capacity to undertake research in these areas.

In summary the consultation process assured us of a comprehensive list of research. The priority scoring system provided a pragmatic way to select which research questions had to be addressed before others. The formulaic approach was useful in narrowing down a huge field of possible questions and was then refined through discussion with the Extended Leadership Team and review of data on health inequalities in the area.

Step Four: Dissemination

The research plan will be disseminated across directorates, elected members, partners, community-based organisations and community panels to enable transparency in our processes and maximum potential for cross-organisation research.

Step Five: Review

The HDRC team will undertake an annual review of the delivery of the Research Plan reporting on the effectiveness of the process and the outputs and outcomes achieved. The review will seek to understand what research has been done, what it has found, how that knowledge is being implemented and, most importantly, the impact it is having on health inequalities. The annual review of Cumberland Council's Research Priority Areas will be published and available to the public.

At the practice level, Cumberland Council's new Gathering Evidence Safely: Research Governance Framework ensures the progress of all research projects are registered and regularly monitored by the Health Determinants Research Collaboration providing a detailed understanding of the progress of individual projects.

[3] Obesity Profile - Data | Fingertips | Department of Health and Social Care
[4] Alcohol Profile - Data | Fingertips | Department of Health and Social Care

Cumberland Council's Strategic Research Area

This research plan focusses on findings ways to lever the determinants of health within the Council's control that will reduce health inequalities. Much is known about what health inequalities exist but less is understood about how they are distributed through Cumberland's geography, what drives or determines them, and how those factors interrelate. As such this research plan will constitute a comparative study exploring the prevalence and reasons for Cumberland's most significant health inequalities across its coastal, rural and urban communities. This geographical and cultural landscape is one of Cumberland's unique and defining factors which, paradoxically, is not well-evidenced. Whilst data at a ward level and at a Local Super Output Area exists, it often masks the specific needs of small communities which disappear when aggregated into larger geographic areas. For this reason, a hyper local approach will be adopted in this this research plan.

Health inequalities can be viewed as 'wicked issues[5]'. This terminology is used to characterise complex problems that hold a multitude of other problems within them. There is no known or single solution to these issues, and they need to be solved through a system approach, with leadership that involves everyone, and approaches that look into everything and every possibility. Health inequalities are 'wicked issues' in that they are complex phenomena with multiple interrelated factors. They exist in complex chains of cause and effect where, for example, being a drug and alcohol user is simultaneously the result of a range of determinants and a determinant of later health outcomes itself. This research aims to tease out these different factors in a range of hyper local communities in order to reveal the different system levers that might be used to achieve positive change.

Health inequalities need to be viewed with a life-course perspective for two reasons. Firstly, it is important to know how health inequalities are distributed across different stages of life in order to understand how to prevent them from arising in the first place[6]. Secondly, health inequalities have a life-long impact and understanding how they then become determinants of poor later life outcomes is part of the complexity of the issue.

This comparative study of variations in health inequalities and their determinants across coastal, rural and urban communities in Cumberland aims to tease out the determinants and to reveal possibilities for concrete actions by the Council to improve health and wellbeing for all. The determinants and inequalities that are most significant for Cumberland are:

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[5] Grint K (2005) Problems, problems, problems: The social construction of leadership. *Human Relations* 58(11): 1467–1494.

[6] Health matters: Prevention - a life course approach - GOV.UK

- Poverty
- Routes to employment and education
- Cared for children
- Mental health
- Housing need
- Substance misuse
- Obesity and food insecurity

The development of community area and directorate research plans will allow for a collaborative hyper local approach to evidencing and addressing determinants of health in Cumberland.

Variations in Determinants of Health across Coastal, Rural and Urban Communities in Cumberland

Research Context

Coastal areas can be broadly defined as those that fall near the coast, and rural areas are those that fall outside of settlements with more than 10,000 resident population[7].

Coastal communities have complex overlapping issues created by their geography and socio-economic use of the space. De-industrialisation is common, and Cumberland's coastal communities have lost most of their fishing, shipping and mining industries and are economically 'left behind' and unemployment remains high in these areas[8].

The position of Cumberland's coastal communities on the west coast makes them 'peripheral' and 'remote' in many respects, with significant travel needed to connect to resources available in conurbations and limited transport links. This can also exacerbate lack of skills and access to employment opportunities in rural and coastal areas[9].

Some coastal communities are sparsely populated, further intensifying isolation and disconnection from services and difficulties in achieving scales of economy in service delivery. These contextual and geographical determinants may also intersect with other determinants of health in Cumberland, such as the increasing and significantly higher rates of cared for children; 93 per 10,000, compared to the national average of

[7] Defining_rural_areas__Mar_2017_.pdf
[8] Coastal towns as 'left-behind places': economy, environment and planning | Cambridge Journal of Regions, Economy and Society | Oxford Academic
[9] Skills, transport and economic development: evidence from a rural area in England - ScienceDirect

73 per 10,000[10]. Or attainment rates for disadvantaged pupils in Cumberland, which have fallen across all headline measures in 2023 since 2019[11].

Coastal communities are also documented nationally to have a higher prevalence of ill health than other geographies[12].

Cumberland's coastal communities have some distinct characteristics which differentiate them from some other coastal towns nationally. They have been thriving towns in the past, initially with import trade and later with local fishing trade. These are no longer present in these communities and have not been replaced by other employment opportunities creating particularly low employment opportunities.

Rural communities may have higher rates of older people and access to health and care services is particularly important in these areas. Social isolation in rural areas can negatively impact on mental health.

Indices of multiple deprivation frequently mask pockets of deprivation in rural communities, resulting in their needs being overlooked[13]. As a result of these issues, younger people may consider leaving rural areas creating staffing issues for local employers[14]. And in Cumberland there is a notably different employment structure compared to national standards, with higher proportions of agricultural and manufacturing work[15]. Indicating research and interventions in employment and education will need to have a hyper local and Cumberland context focus.

Rurality also has a particular characteristic in Cumberland, defined by its mountain and lake geography. Akin to other mountainous regions of the UK, the physical landmass and layout of lakes means it is not possible to connect some communities. There are tangible physical barriers to accessing them. Solutions, such as new roads, may therefore be impossible to implement.

A lack of digital inclusion is a concern for both coastal and rural communities due to poor internet and mobile signal coverage which reduce the ability of those in coastal and rural areas to access vital services. As such, these areas are struggling to attract knowledge-based industries, such as the tech sector, which are linked to higher salaries and productivity[16].

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[10] Children looked after in England including adoptions, Reporting year 2024 - Explore education statistics - GOV.UK

[11] https://explore-education-statistics.service.gov.uk/data-tables/education-and-training-statistics-for-the-uk

[12] The health of coastal communities: a national problem - The BMJ

[13] A Hopeful Future: Equity and the social determinants of health in Lancashire and Cumbria - IHE

[14] Rural communities: Issues and support - House of Lords Library

[15] Business Register and Employment Survey : open access - Nomis - Official Census and Labour Market Statistics

[16] Digital exclusion is leaving coastal communities behind

In recognition of the unique coastal and rural geography of Cumberland, there are also several disparities that can occur across urban areas in Cumberland. Health outcomes can vary greatly among urban communities, depending on air quality, access to healthcare services and commercial determinants[17].

The geography of Cumberland cannot be changed. Mountains and lakes cannot be moved, coastal towns will remain on the coast. The geographical constraints have to be worked with, which is why understanding the particular ways in which determinants of health play out across them is so vitally important. Crucially, some areas and communities in Cumberland may be positioned where urban, coastal and rural factors intersect. A hyper local approach to understanding determinants is needed.

Research Aim

This research aims to evidence the range of factors influencing health inequalities in Cumberland's coastal, rural and urban areas. This evidence should enable the Council's leadership teams to select and implement actions to improve health and wellbeing for all.

Research Objectives

The objectives of the research are to:

1. Establish the scale and nature of the most significant health inequalities between and within coastal, rural and urban communities in Cumberland.
2. Establish all the factors (determinants of health) that are driving disparities.
3. Document existing best practice across the Local Authority.
4. Recommend where Cumberland Council can act to improve the determinants of health and so improve health and wellbeing for all residents.

Research Questions

For each hyper local community, the research seeks to understand:

Poverty and deprivation	How many people / households experience poverty? How does this vary? How severe is the poverty? What factors create the poverty, why does it have these characteristics in this community? How many people do not claim their benefits and why? What consequences does poverty have in these people's current and future lives? What would reduce poverty in this community?

[17] Environmental determinants of population health in urban settings. A systematic review | BMC Public Health

Pathways to employment	What pathways to employment are there in this community? How many people access them? How does this vary? Why / when do they work or not? What barriers are there to employment and why do they exist? What consequences does un/employment have for these people's current and future lives? What would improve pathways to improvement for this community?
Cared for children and young people	How many children and young people are cared for in this community? Why are these children and young people cared for, what factors led to this experience? What consequences does being cared for have for their current and future lives? What would reduce the number of children and young people in care? What would improve the lives of children and young people in care?
Mental health	How many people have positive mental health in this community? Why do some people experience positive or poor mental health in this community, what drives these outcomes? What types of mental health issues do people experience and how are they distributed? Why are they distributed in this way? What consequences does poor mental health have for have for their current and future lives? What would reduce the prevalence of mental health issues?
Access to housing	What is the characteristic of housing in this community? How are housing situations and needs distributed in this community? Why do these needs and issue exist? What consequences does poor or insecure housing have for people's current and future lives? What would improve access to / housing in this community?
Drug and alcohol use	How many people use drugs and alcohol in this community? Why do some people experience poor relationships with drugs and alcohol, what drives this? What types of drug and alcohol issues do people experience and how are they distributed? Why are they distributed in this way?

	What consequences does drug and alcohol use have for have for their current and future lives? What would reduce the prevalence of drug and alcohol issues?
Obesity and food insecurity	How many people experience obesity in this community? Why do some people experience obesity, what contributes to it? What consequences does food insecurity have for individuals current and future lives? What would reduce the prevalence of obesity in this community?

Method

A full research methodology will be written in a research proposal for each phase of the research and a short overview is provided here to provide some insight into how the research objectives will be achieved.

The research seeks to understand how health inequalities and their determinants vary by coastal, rural and urban communities. A first step in achieving this is to develop a sampling framework which identifies what we refer to as hyper local communities and which ones will be within the scope of the research project as there will be too many to study each one meaningfully.

Data collected to inform our understanding of these hyper local health inequalities and determinants of health include:

- Literature reviews of what has worked to improve each of the health inequalities we are studying
- National and local data on the prevalence, variance and depth of each
- Resident's experiences of issues, barriers, enablers and examples of good practice
- Practitioner perspectives on the issues, barriers, enablers and examples of good practice
- System leader perspectives on addressing each health inequality hyper locally and within their footprint
- Case studies of best practice.

Outputs from the research will include literature reviews, data summaries, hyper local place-based reports, reports on each health inequality across places, and a summary report of all findings across coastal, rural and urban communities.

Phases of Research

There is an overarching four-year plan for this research, however, from the onset and throughout all four years of research there will be smaller projects that explore, test

and report on interventions that improve the determinants of health. These will have more immediate impact than the overall research project and will be integrated into the findings of the overall project.

Phase 1 – Secondary research establishing what is known

January-December 2025

- Local data
- National data
- Literature reviews – what works
- Creating a sampling framework of coastal, rural and urban communities
- Recruitment and induction of community co-researchers and wider partners
- Applications for additional research grants.

Phase 2 – Primary research in hyper local communities

January-December 2026

- Local lived experience
- Local practitioners
- System overviews
- Case studies co-designed and delivered with co-researchers

Phase 3 – Intervention testing

January – December 2027

- Pilot and test small scale interventions at hyper local level.

Phase 4 – Sustainability

January – December 2028

- Roll out of successful interventions across relevant hyper local communities
- Development of second phase of research (post HDRC).

How the plan will consider impact

Cumberland Council and the HDRC team also consider impact as a crucial factor in the designing and delivery of research. Designing for impactful research will ensure projects are planned to contribute to a change or benefit to society, culture, public policy or services, health, the environment or quality of life, beyond the ‘knowledge enhancement’ purpose of research or evidence gathering.

As such, this plan outlines three key approaches to ensure research will be designed for impact:

1. Community co-research
2. Use of findings and knowledge exchange
3. Sustainability.

Community co-research

Community co-produced evidence and research will ensure that the evidence or findings are placed in the context of communities and the priorities that are important to them. Co-produced forms of research allow for a collaborative and iterative process of shared learning[18]. Furthermore, the involvement of community co-researchers will be critical in widening potential audiences for research and impact for their community[19]. As such, research conducted will:

- Utilise established or purpose made networks to involve those with lived experience in the design and delivery of research
- Collaborate with colleagues in academic and community organisations
- Involve community co-researchers and aim to address priorities from community area research plans.

Implementation of evidence and knowledge exchange

Research delivered as part of this plan will aim to achieve conceptual and practical impact, contributing to both the understanding of determinants of health in Cumberland and influencing and shaping of policy and practice. The HDRC team will aim to promote the uptake and implementation of evidence, developing co-research and collaborations to build capacity for change[20].

As such, research conducted will:

- Ensure appropriate practice and policy leads are involved in to ensure findings and/or evidence contributes to a tangible change in practice, policy or strategic planning. The HDRC team will also aim to work jointly with Cumberland Council's Performance and Insight team to foster evidence, data and research informed decision making.
- Be shared internally through accessible means; staff seminars and workshops, communications and an evidence hub, acting as a register for ongoing and completed projects
- Work with Cumberland council's existing community engagement strategies, and Cumberland HDRC's community engagement team will work with

[18] Defining impact – UKRI
[19] Towards Co-Production in Research with Communities
[20] Fuse open science blog: Four practical steps to increase knowledge exchange between researchers and policymakers

communities to enable clear communication and engagement in research decision making.

Sustainability

Cumberland Council and Cumberland HDRC are committed to supporting a sustainable research culture in Cumberland council and the wider community. Designing impactful research should also consider how stakeholders and participants can be equipped with skills and tools, achieving sustained impact[21].

As such, research conducted will:

- Ensure council staff and co-researchers are involved in all stages of the research process and are provided training opportunities to develop skills in research, continuous quality improvement, evaluation etc.
- Incorporate Theory of Change[22] and/or appropriate evaluation plans to monitor whether projects are achieving impact for stakeholders.

Conclusions and Next Steps

Developing this plan has provided insight into the research needs of Cumberland Council and the evidence sought to inform decisions, practice and policies. The process has forced us to make uncomfortable and unsatisfactory decisions about what to prioritise as it is not possible to do everything at once. The geography of Cumberland and the way it affects services to improve health and wellbeing outcomes has become the primary frame for the research programme for the Council, and the most significant health inequalities, as indicated by national data sets, structure the enquiry across a range of coastal, rural and urban areas.

The HDRC will write detailed research proposals for each phase of the research and will co-ordinate research activity across directorates and community panel areas, with internal and external partners. The HDRC will provide six-monthly progress reports to the HDRC Oversight Board, Cumberland Council's Extended Leadership Team and the Health and Wellbeing Board.

At the end of each year the HDRC team will review the process of collaborative research as set out in this plan and the progress achieved.

In future years a more extensive consultation and revised scoring process will be deployed to overcome some of the limitations encountered in this iteration of the plan.

[21] Creating positive change in children's social care – UKRI
[22] What is Theory of Change? - Theory of Change Community

Appendix 1: All Research Areas and Questions

Determinant 1	Housing and Communities	Score
Integration	How can we better join up services to tackle housing, social care and health needs holistically?	22
Access to housing	Can we review the equity of the housing allocations policy?	15
	How do we create enough housing in the LA?	
	How do we ensure housing is affordable for everyone?	
	How do we enable 'Waiting Well' for housing to become available?	
Quality of housing	How can we ensure all housing is of a high enough standard?	14
	How do we better manage neighbour disputes and complaints?	
Planning	How do we design communities and houses that meet local needs?	16
	How do we plan more sustainable housing?	
	How do we ensure local plans consider local needs and DoH?	
Negative impact of housing	What are the impacts of housing poverty, particularly for working families who may be on the edges of homelessness, also the impacts of overcrowding due to affordable housing issues?	22
	What is the impact of emergency and supported accommodation placements on residents wider health issues – including families and children; impact of fleeing domestic abuse to safe accommodation etc.?	
Coastal / Rural Communities	Do our coastal towns have disproportionately worse health and wellbeing outcomes than non-coastal towns in Cumberland?	22
	How do those outcomes intersect, and which determinants are driving them?	
	Do our coastal towns have disproportionately fewer health and wellbeing resources / HSC worker deployment than non-coastal towns in Cumberland?	
	Do transport links make our coastal communities more peripheral?	
	How can we develop multi-disciplinary research to understand the multiple drivers of poor health outcomes in coastal communities and test effective interventions and solutions?	
	Do we split data by rural and urban so we can understand the issues.	

Determinant 2	Living Conditions	Score
Climate change	How do we manage the impact of extreme weather events on residents lives?	17
Finance	How do we ensure everyone has a basic standard of living?	17
	How do we support those most affected by the cost of living crisis?	
	How do we level up income inequality and reduce poverty? (child poverty, financial poverty, energy poverty, hygiene poverty, furniture poverty, clothing poverty, maternity poverty and generational poverty)	
	How do we reduce household debt?	
	How do we tackle intergenerational deprivation?	
	IMD Scores- these show that people who have the least are often the most generous in giving and volunteering, why?	

Determinant 3	Education	Score
Early Years	How do we improve children's access to play facilities?	19
	how do we ensure children are school ready?	
	How do we make access to childcare equitable?	
	How can we ensure life starts well with early intervention and think family models?	
	How can we further develop environmental sustainability in early years practice?	
	Can we develop an emotional wellbeing service for 0-5 year olds?	
Primary	Children have escalating statements of need and SEND - do we understand why this is?	20
	How can we address gaps in oracy skills?	
Secondary	How do we improve educational attainment for all young people across Cumberland?	18
	Are career and educational aspirations of pre- 16 children the same across the Cumberland area? Geographical or socio-economic variations? (economic development/ equalities)	
	Why are homeschooling levels in Cumberland comparatively high? Detail behind this?	
Teacher / school development	How do we invest in ongoing professional development as well as the widespread adoption of Universal Design for Learning principles?	18
	How do we infuse Trauma-informed principles in all schools?	
	How do we poverty proof all schools?	
	How do we improve mental health support in all schools?	
Youth work	How can we add mental health support into youth services?	19

Determinant 4	Employment	Score
Access	What mechanisms support people into employment?	16
	What would improve access to employment look like?	
Children in Care	How do we support children in care into the Council as a workplace?	21
	What is best practice for work experience, recruitment and retention of Children in Care in employment?	
Unemployment	What works to support people into employment?	16
	How do we improve access routes to employment?	

Determinant 5	Working Conditions	Score
Wages	Median household income is £28,794, lower than the national average - how can we increase it?	12
Workplace	How do we improve working benefits? (reduce zero hour contracts, in-work benefits, provide advice and support via the workplace, on the job education and training, no gender pay gap, increased adult education, incentivise recruitment of vulnerable groups).	15
Economy	We want to enable the move to an economy that builds wealth locally and offers opportunities for everyone and people have the skills to take them - how?	12
Childcare	How do we make childcare more affordable so parents can work?	15

Determinant 6	Food Production and Access to Food	Score
Access to food	How do we make sure each resident has adequate, available and accessible food and does not experience food poverty?	17
	How do we develop sustainable food systems?	
School food	How do we extend school holiday food programmes?	18

Determinant 7	Digital and Transport Connections (new)	Score
Transport	How do we connect rural communities to services better?	18
	How do we reduce the number of road casualties?	
	How do we improve transport systems and links - what is best practice?	
	How do we reduce transport poverty?	
	How do we ensure special educational needs pupils can easily get to school?	
Digital	How do we reduce digital poverty?	17
	What is best practice on digital connectivity and how can we use it?	
	Who are the excluded communities?	
	What online solutions work for people?	
	What digital skills and capabilities do communities and resident need to access services?	
Artificial intelligence used in the Council	How can Artificial Intelligence help us as an organisation - what is best practice?	18
	How can we use it to enable us without becoming reliant on it?	

Determinant 8	Health and Social Care Provision	Score
Integrated care	How do we make the lives of people in care more meaningful through integrated care offers?	18
	How do we ensure people get the right care, at the right time, in the right place?	
	What does place based integrated care look like?	
	How do we account for digital and physical connection in care planning?	
	How do we create a preventative health and social care system? Who are the customers, what are our services, how do we become effective? What are out outcomes? Who should we partner with?	
Ageing population	Do we know how to support our increasingly ageing population at a policy and practice level?	20
	How do we support people to age well?	
	How do we support people to die well?	
Emergency	What would an integrated emergency response look like - what have we learned?	21
Mental Health	How do we better support MH and WB as issues are escalating?	21
	What are the root causes of MH issues and how do we get ahead of the curve.	
	How do we reduce loneliness?	
	What is driving high suicide rates and how do we address them?	
	How do we invest in more resilience programmes?	
	How do we roll out trauma informed practice in all services?	
	How do we increase specialised responses to trauma?	
	How do we transform local approach to identifying and supporting mental health problems with the Power/Threat/Meaning Framework	
	How do we support a change in diagnosis from diagnostic labels to Social Determinants of Health?	
	How can we invest in more personal strengths-based approaches like coaching?	
	How do we promote mental wellness as well as dealing with mental ill health?	
	How do we increase the capacity of Lived Experience Recovery Organisations and the Recovery College to provide community-based opportunities for people to take greater control of their own recovery.	
	How do we support MH issues caused by the use of social media?	
	Do we understand the MH impact of young people's use of screens at home, school and work?	
	What emotional mental health unmet needs has Covid created for young people?	
	Can we generate more evidence that talking therapies work e.g. Growing Well?	
	How can we reposition the language around maternal mental health and illness and to reduce its stigma.	
	How can we improve the way police manage people with mental health issues (can we decriminalise it)?	

	How do we begin to support all the people with undiagnosed and unsupported neurodiversity's and understand how these intersect with other issues such as homelessness and addiction?	
	Seeking advice correlates with mental health issues and vice versa. It's a viscous cycle – how can we break it?	
Preventative work	How do we increase take up of screening and vaccinations?	20
	How do we better support families to have good attachments and parenting skills?	
	How do we normalise neurodiversity in communities, so people belong more?	
	How can we invest in more personal strengths-based approaches like coaching?	
	How can we tackle racism and discrimination across all services?	
	What best practice models can inform pre-front door services?	
	Do we know what local needs should be supported by Community Hubs and how they vary by place?	
	How do we measure the outcomes of Family Hubs?	
	Co-locating staff in food banks where people have the most need is a great way to reach them - how can we learn from this model?	
	Can we reduce the number of CYP in care by improving parental health?	
	There's a growing need for befrienders for various reasons - e.g. reduce social isolation, give carers a break. However, there are not enough befrienders to meet the demand. CVS wants to work collaboratively in helping to address this gap.	
Social Prescribing	Do we know if different models of social prescribing are working?	18
	What difference can social prescribing make to people, particularly marginalised or disadvantaged groups.	
	Social prescribing sometimes reaches rural communities can we make this more consistent?	
Autonomy	How do we support people to help themselves and manage their issues / conditions with autonomy?	18
	There are unacceptable and unpalatable health inequalities in Maryport – how do we even begin to discuss these with the community?	
Service improvement	Who do services reach and / or miss?	16
	Where are the gaps in services, what else do people need?	
	How can tech and AI further enable services?	
	What are the lived experiences of residents, do we assume we know? What do people want? What outcomes would they set for themselves and how would we measure them?	
	How do we manage to try things out and test transformations whilst upholding our statutory duties and not exposing staff and customers to any risks?	
	We use these words blithely, but do we really have trauma informed practice? And what would it take to create a trauma informed service? Many of our services traumatise, rather than being trauma informed. How do we move to a more genuinely trauma informed council?	
	How can we ensure parents are trauma informed?	

	Some services will not work with people with other issues e.g. mental health support only provided if not using substances / alcohol – how can we work more holistically with people's issues?	
Health care	How do we increase GP appointments?	16
	Can sommatic exercise programmes reduce chronic pain and frailty?	
	How can we tackle obesity, particularly for young people?	
	Do we know how and why learning disabilities and heal health outcomes intersect and how we can address them?	
	There is still the legacy of Long Covid and how long-term health effects play out in communities – do we really understand this and how to support them?	
	How do we reduce the differences in health life expectancy across the LA?	
Community engagement	Is community engagement a determinant of health itself?	16
	How can we increase community engagement in all services?	
	Do we know what is of interest and importance to young people as starting points for research and planning?	
Vulnerable Groups	Carers - so many are hidden, who identifies and who does not and why, what are experiences of being carers, journey's of caring, boundaries of care, how can we provide early intervention, so people come forward before they are in crisis, how do we create a preventative service for them?	20
	How do we better support perpetrators of DA to stop as it leads to so many other negative outcomes for families and children?	
	How do we tackle addiction and drug use as these drive so many other issues?	
	We know those on Probation struggle with various factors such as addiction, mental health, deprivation etc all of which have a huge impact on health and wellbeing, and accessing healthcare can be difficult at times (inflexible appts, transport, digi skills, remote). How can we reduce these barriers for this group of people?	
	How can we increase health promotion, prevention and management in the justice / probation services?	
	How can we collaboratively increase understanding of the importance of health and wellbeing and possible links to offending behaviour and how improving health and wellbeing may reduce risk of reoffending?	
	The majority of child protection plans are for neglect, and we treat families punitively for this, but generational neglect and poverty sit behind the neglect. How can we better understand and assess neglect in a holistic way to reduce child protection cases and to better support families?	
	There are huge issues with child obesity and malnutrition linked to poverty – do we understand how these affect children's outcomes and how do we tackle this in various community panels?	

Determinant 9	Council Processes (new)	Score
Innovation	Are financial constraints always the blockers to innovation?	18
	How do we innovate whilst still keeping people safe?	
	Can we find out how people experience our services and what they want from them?	
	Does community engagement improve services?	
	How do we achieve staff putting health and wellbeing at the heart of everything we do?	
	How do we make every decision count?	
Commissioning	There are a range of market categories and some of them are real pressure points for CYP and ASC. How can we ease this?	20
	How can we avoid suppliers and providers being monopolistic?	
	How can we understand deprivation in order to inform our commissioning processes?	
	How can we develop a more collaborative culture?	
	Can we ensure longer term funding for the voluntary sector?	
	Do we understand how the constant collapse of VCSE services and piloting of new services impacts on people?	
	How do we ensure equitable divide/ distribution of services in local/ rural areas?	
	There are a few contracts coming up for renewal in March 25 – the 0-19 Healthy Child contract and the addictions contract. How can we underpin the recommissioning of these services with research?	
Staff	How do we ensure all staff are well and able to contribute effectively at work?	21
	To what extent are we making people sick and increasing H&WB issues?	
	Can Swartz rounds and clinical supervision support staff wellbeing and retention?	
	How, as a rural local authority do we attract services and staff (e.g. health) into the area? This links with the lack of access in rural areas (e.g. nearest dentist for Millom residents is in Barrow)?	
Use of data	We shouldn't have to make participatory findings fit service review structures. How can we help them to use more holistic evidence?	21
	How can we respond quickly with research? Rather than it taking such a long time for analysis and reporting, when the participants want to see change quickly?	
	C&F WB has been planning where to put family hubs on the basis of data on deprivation, birth rates, frequency of care plans, number of benefit claimants. How else / where else can we use this data in the Council?	

Appendix 2: Glossary

Communities – these are groups of people who share common characteristics. The definition encompasses three broad but distinct types of community, such as:

- **Communities of place**: those defined by a geographical area
- **Communities of interest**: those with a shared interest or experience. This could include tenants/ residents' groups, allotment holders, people involved in environmental projects, or people who come together to use services.
- **Communities of identity**: people who share characteristics, or who share experience of, or a stake in, a particular issue. Examples might be young people, older people, disabled people, ethnic groups, or LGBTQIA+ people.

Coastal Community - a settlement that is on the edge of the sea or an estuary.

Determinants of Health – these are the social and environmental conditions in which people are born, grow, live work and age, which shape and drive health and wellbeing. The social determinants of health include: education, employment and quality of work, income, housing, build and natural environments. Access to good quality care is also a determinant of health*.

Health Inequality – the systemic differences in health between groups of people. They are avoidable and unfair. For example, people living in the poorest areas die earlier than those in wealthier areas*.

Cumberland HDRC – Cumberland Council's health determinants research collaboration team.

Hyperlocal - focusing on matters concerning a small community or geographical area.

Index of Multiple Deprivation (IMD) - This is the most common measure of the socioeconomic circumstances of the place in which people live. The IMD summarised how 'deprived' as area is based on a set of factors that includes: levels of income, employment, education and local levels of crime. The IMD is mapped on lower-layer super output areas (LSOA's), which though small, may include areas of high and low deprivation. Deciles of deprivation are calculated by ranking the LSOIA's from 'most deprived' to least deprived' and dividing them into five equal groups. These range from the most deprived 10 percent of small areas in England (Decile 1) to the least deprived 10 percent of small areas in England (Decile 10).

Proportionate Universalism – the aim of a proportionate universalist approach is to raise overall levels of health at the same time as flattening the gradient in health by improving the health and wellbeing at pace where the need is higher*.

Rural Community - Rural Urban Classification defines areas as rural if they fall outside of settlements with more than 10,000 resident population.

Social Gradient in Health – The relationship between social circumstances and health is graded, health is progressively better the higher the socioeconomic position of people and communities*[23].

Sustained Impact – Ongoing demonstrable contribution that evidence and research is making to policy, practice and communities.

Third Sector – voluntary, community, faith and social enterprise organisations that are not statutory or private profit making.

Urban Community - A settlement of more than 10,000 resident population.

Wicked Issues – these are complex problems that hold a multitude of other problems within them. There is no known or single solution to these issues. These problems need to be solved through a system approach, with leadership that involves everyone, and approaches that look into everything and every possibility.

[23] * Denotes definitions taken from A Hopeful Future by the Institute of Health Equity.