Supporting and enabling health research in a local authority (SERLA): an exploratory study

Dr Ciara McGee[1]*, Megan Barlow-Pay[2], Dr Ivaylo Vassilev[3], Professor Janis Baird[4], Professor Lee-Ann Fenge[5], Dr Debbie Chase[6] & Professor Julie Parkes[7]*

[1]Clinical Research Network Wessex, Southampton, UK

[2]NIHR Research Design Service South Central, Southampton, UK

[3]MRC Lifecourse Epidemiology Unit, University of Southampton, UK

[4]Health Sciences, Environmental and Life Sciences, University of Southampton, UK

[5]Faculty of Health and Social Sciences, Bournemouth University, UK

[6]Public Health, Southampton City Council, UK

[7]School of Primary Care, Population Sciences and Medical Education, University of Southampton UK

*Corresponding authors

Competing interests: none declared

21 December 2020

Table of Contents

1. Introduction

Over seven years ago the responsibility for public health was transferred back to Local Authorities (LAs) in England as part of the Government's health and social care reforms (1). LAs were given legal responsibility to improve local public health and reduce health inequalities (2), with elected councillors inheriting ultimate decision-making powers for public health priority setting and commissioning (2). LA public health is a legal duty underpinned by an annual public health grant from the Department of Health and Social Care (DHSC). In 2019/20 the total public health grant for LAs was £3.13 billion (3) but this grant has been significantly cut by £200 million in recent years (4). Continuous cuts to public services pose significant challenges for LAs, increasing the need for reliable and timely evidence to optimise the use of resources to improve population health (5).

Using research evidence to improve public health outcomes is widely recommended as it supports decision and policy maker understanding by framing options and addressing implementation considerations (6). Academics seek to produce usable evidence to inform public health practice (7) but a recent systematic scoping review found that research evidence is underutilised in LAs because it is not always relevant to the local context due to its global nature (8). Consequently, decision makers may turn to other sources, such as expert opinion, anecdotal information, and local intelligence and evaluations of unknown quality (8, 9). Barriers to research use in local public health practice include time constraints, capacity and expertise, mismatched timescales of policy and academic research, access and availability of research, the role of evidence within a political organisation and lack of ring-fenced research budgets (9-12). Nevertheless, there is an appetite for using research evidence to inform public health which demonstrates local salience (9-11).

Current literature postulates that researchers need to understand and respond to the local priority evidence needs of public health decision makers (8, 10, 11, 13). Collaboration between researchers and practitioners is key in creating relevant evidence for local needs (9, 10). Co-production between academia and LAs through joint appointments and or embedding researchers in the LA may support more meaningful outcomes but flexible research funding is needed to support such models (14, 15). The Academy of Medical Sciences calls for

transdisciplinary research to tackle future public health challenges (16) and involving LAs in the creation of public health evidence may better inform local public health actions (17).

The National Institute for Health Research (NIHR) has a long history of significant funding for National Health Service (NHS) research and research infrastructure, developing a skilled workforce and pledging to extend support into non-NHS public health and social care sectors (18). Building an evidence-base for LA interventions is a high priority to improve population health (6). It has been recommended that the NIHR provide relevant mirroring of NHS research infrastructure for non-NHS environments to inform public health actions (17) but LAs are complex systems with internal (staff, structures, cultural values) and external (political environment, national directive) influences (14). This study therefore aims to develop understanding of the factors, relationships and processes that contribute towards accessing, using, and generating research evidence that is relevant to LA public health and social care and shapes its practice.

2. Key Objectives

1. Understand the process of accessing and using evidence in Southampton City Council (SCC).
2. Explore the attitudes and perceptions among officers and councillors of research and evaluation within a LA environment.
3. Develop understanding about what is necessary to create a research system to sustainably create influential and innovative research activity within a LA environment.
4. Explore how community groups and the public are currently involved with SCC services and their views about how processes could be developed to embed greater involvement in future research and evaluation.

3. Methods

3.1.1 Design

Qualitative semi-structured interviews were conducted with officers, elected councillors, and community members identified through a PPI outreach programme. Ethical approval was granted by the University of Southampton Faculty of Medicine Research Ethics Committee [61111.R5]. All interviewees gave informed consent for the study.

3.1.2 Sampling and participants

SCC was conveniently selected for this study based on existing professional networks and previously having a researcher (CM) embedded within the public health team. The sample includes people in different roles and levels of seniority. The Director of Public Health (DPH) identified participants whose work related to public health and social care. Community participants identified via PPI convenience sampling represent a range of demographics, particularly communities experiencing health inequalities and poor health outcomes. Potential participants were invited by email with an enclosed information sheet and consent form. Community participants received a £20 voucher.

3.1.3 Interviews

Due to COVID-19 social distancing, audio-recorded interviews were conducted using Microsoft Teams (n=11) and telephone (n=3), between September and October 2020. Interviews with SCC participants and community members were conducted by members of the research team (see Appendices for interview guides).

3.1.4 Data analysis

Interview audio recordings were transcribed verbatim, entered into NVivo 12 software and thematically analysed (19). Interviewers undertook initial coding using a combination of inductive and deductive techniques to generate codes. Broad codes were collapsed into higher and lower order themes to develop descriptive and interpretive summaries. To aid credibility and trustworthiness of results, analyses and interpretation were discussed and checked with the research team. Findings are presented with a wide range of anonymised quotations under thematic categories.

4. Results

4.1.1 Participants

Interviews with SCC staff (n=14) and community members (n=3) were conducted (n=1 withdrew and n=2 did not respond). Participants included the Elected Member Lead, Ward Councillor, Deputy Chief Executive, DPH, Consultants in Public Health, Senior Public Health Practitioners, Executive Director for Adults and Health, Service Lead for Adult Social Care, and Community Members. (see Appendices Tables 1 and 2).

4.1.2 LA response to childhood obesity and Covid-19

Childhood obesity is an important public health and government priority, but most study participants focused on COVID-19 as a priority response due to its high visibility, and prioritisation nationally and locally. Few participants were directly involved in the childhood obesity response, aside from the DPH, a Senior Public Health Practitioner and the Ward Councillor on the Scrutiny Panel. Childhood obesity is a strategic priority for Southampton. A recent scrutiny inquiry, led by a panel of elected councillors, reviewed a range of stakeholder and expert witness responses to how evidence shaped the council response to childhood obesity. Tackling childhood obesity was seen as 'everybody's business'. The inquiry raised awareness of the issue among other departments and elected members, highlighting the need for a long-term commitment and willingness for flexibility across council functions, and with partners, including the Government.

> *"What I hope will come out of the scrutiny is more joined up working between the city council and the university, more understanding of the drivers on both sides, accepting what needs to be done in an academic sense… but to actually say that sometimes this may not result in a Lancet publication, but if it helps the delivery of services or stopping services that are not working or helps us to evaluate. So I hope that because of the juxtaposition of the university and me being a councillor and having that overlap we may be able to... take advantage of the expertise of how to do proper research."*

COVID-19 responses are strategic, with operational support from Consultants in Public Health, and a cascade of support through Outbreak Control Plans, COVID-19 Community Champions, and Information Cell provision. COVID-19 has led to a move away from operational silos, increasing partnership working between Public Health and Adult Social Care to deal with PPE procurement, and prevention and management of COVID-19 outbreaks within care homes. Social Care professionals commended public health guidance and support which enhanced their responses.

> *"Adult social care had some connect points with public health, but never like this… They [public health] gave us the information and data, the likely trajectory and what was going to happen, the number of people that you were going to see within hospitals and the impact on local communities, which enabled us to move our resources to the most appropriate places. That was very key."*

4.1.3 Participants social networks

Six participants completed the social network mapping indicating a wide range of information sources relevant to the childhood obesity scrutiny inquiry and COVID-19 response. The DPH was the most frequently cited source of information and support, alongside other LA staff and elected members.

Outside the LA, local networks of Directors of Public Health, the Association of Directors of Adult Social Services, Hampshire and Isle of Wight Local Resilience Forum and the Clinical Commissioning Group were cited as sources of information in the COVID-19 response, alongside senior academic involvement in the COVID-19 Health Protection Board and COVID-19 Saliva Testing Programme. Childhood obesity networks include the 0-19 years partnership and practitioner forums, and links with Universities via academic presentations at the childhood obesity scrutiny inquiry. Academic research did not explicitly feature during the network mapping exercise but was accessed through NICE, PHE, ONS, LGA bulletins and government websites.

Participants highlighted that understanding and accessing evidence, and its interpretation and contextualisation alongside experiential knowledge and peer learning was treated and experienced as individual responsibility.

> *"In terms of understanding the evidence, I would say that is our role to understand the evidence."*

> *"The ADASS, you need your own networks to help inform decisions and conversations, so if you've got queries, you can put that out to that wider group."*

> "*I'm in a network of Directors of Public Health and we come together on a weekly basis... that's important from a peer support perspective."*

4.1.4 Multiple concepts of and priorities of evidence use

Participants provided broad definitions of what counts as evidence and its use within a LA context.

> *"It's looking at international and national evidence. The other type of evidence is data. We run city surveys to understand what the public are doing, what they are thinking, how they are interacting."*

> *"If it's evidence it's data, or it could be anecdotal but gathered in a meaningful way that demonstrates how residents are feeling or demonstrates the impact of an intervention or an activity."*

Emphasis is placed on quantitative rather than qualitative sources, although a lack of coherent strategy across departments on evidence use lead to frustration.

> *"I couldn't say hand-on-heart that every single council service does that well. There are some that are doing it well like the integrated commissioning unit because they straddle the health service and the council operations. Adult social care I'd say are doing it to a degree, but it could be strengthened, and public health do it…. that is part of our culture."*

> *"If I'm absolutely honest, with our LA I would say that we don't' have one version of the truth. We have lots of different versions… everyone's got a different version of what their evidence is."*

Some councillors prefer anecdotal evidence from constituents, but local government officers are perceived as having responsibility to present evidence to support councillor decision-making.

> *"Each individual councillor will look at evidence very differently. There are some who will only work anecdotally."*

> *"It's not necessarily the priority of the councillor to look at the evidence, its incumbent on the persons who is championing that topic to make sure that they present the evidence in a way that resonates with the councillor."*

Priority of evidence differs across LA and NHS organisations, and LAs exist within a wider socio-political context requiring a balance between evidence within these wider requirements.

> *"In the NHS, it's almost easier because you're in a health environment and you're thinking, what is this health intervention? What does the evidence show us…? When you work in a political environment, you're balancing that evidence with a political approach to support society for a population."*

4.1.5 Access to and use of evidence

A wide range of evidence is accessed including online and local data, peers, networks, and social media to keep abreast of emerging COVID-19 evidence. Few accessed academic research evidence directly even though public health participants have free open access to academic journal databases via visitor status at one local University. Participants from adult social care rely on other sources to collate and synthesise available research evidence including the Social Care Institute for Excellence (SICE) and Research in Practice for Adults (RIPFA) which triangulate academic research, practice expertise, and service user insights. Triangulating evidence is integral for public health and social care to a create a rich and relevant knowledge base.

4.1.6 Barriers to and solutions for evidence use

Barriers for evidence use relate to access (except for public health participants) and accessibility; time and timeliness of research evidence; the political process; lack of relevant research applicable to the local context; and competence to find, analyse and interpret evidence (see Appendices Table 3).

Public health participants require timely evidence that is relevant to their real-world practice settings, as academic research often lags behind urgent decision-making processes.

> *"We need to make decisions quickly… Public health intervention doesn't fit an evidence-based model well because of this whole system approach that's needed… With childhood obesity we've got great evidence that you can do pockets of things, but what we don't have and need more of is evidence of whole systems approaches."*

Social care participants highlighted how COVID-19 increased pressure in adult social care and the need for evidence to forecast future demands.

> *"There's a huge amount of work that we need to do collectively in the system to properly understand the impact of COVID. I want a demand model for adult social care, based on the health of the population and what that means... There's a need to properly consider the impact of COVID and how we measure that."*

Training was identified as one solution for improving competencies and overcoming '*fears*' of using evidence, particularly in adult social care to support engagement with a range of evidence including grey literature, practice guidance, service user perspectives and academic research.

> *"It's breaking down barriers of fear around evidence because it feels scary… My assumption is that it's really difficult to do, to look for research, I don't really know where to go to or how to do it and then what to do with it."*

> *"What [University name] have is an arrangement that all Public Health teams in the South West can attend modules for free. It's not that they [practitioners] don't want to have those skills, it's just they haven't necessarily had the opportunity."*

4.1.7 LA role in research and evaluation

There was much enthusiasm for LA involvement in generating public health and social care research. However, teams are currently not research active or research ready. Major barriers exist due to the socio-political context of LAs. Research evidence is just one source of information for policy makers, and engagement is restricted due to limited resources and organisational capacity, local priorities, time constraints and political short-termism.

> *"I see that [research] as a great opportunity. Particularly with COVID, I've seen a shift in understanding the value and importance of an evidence-based approach… Money, resources, that's the massive challenge. It's the elephant in the room. LAs have been cut right back."*

> *"It's a question of how we make sure it [research] is relevant to what we want to do and the pressure that colleagues might feel about it. I think that's one of the challenges of [political] short-termism."*

Participants suggest LA research could boost investment and funding to challenge the "*Cinderella Service*" mindset. COVID-19 presented opportunities to establish a research climate within the LA, but unless supported by additional resources this is likely time-limited.

> *"If there was a greater body of research in local authorities, then that might get properly resourced, funded, and looked at in different way rather than just it's a bit of Cinderella service."*

> *"Particularly with COVID, the time is right to set-up that culture, the policies to enable us to do that. The problem is people. Its resources to support it, and without that I'm afraid it won't happen."*

4.1.8 Supporting and enabling LA research

Suggested solutions for supporting research capacity within the LA include recruiting people with skills in research methodology, data analysis and evaluation to better inform practice.

> *"I would recruit people skilled in research and evaluation and embed them in teams."*

> *"We need methodologists to take us with them. So they lead and inform and support us in the methods and approaches we take within our local authorities."*

Developing academic support to formulate research and evaluation questions, alongside co-production with diverse communities, would enable more effective local community responses.

> *"There's a host of questions that as a public health consultant we have but turning that into research question is a different thing… so I need a university to help pull that out."*

> *"There are particular groups of the community and vulnerable people that we need to pay particular attention to and do things slightly different for and its thinking about who those groups might be…. it's about ensuring we have a two-way process with the community."*

Strategic development of appropriate infrastructure for LA research activity, alongside leadership support and commitment for research, are crucial.

> *"My suggestion is to take someone at the level of [person's name] from the NIHR and they work a day a week working through what this infrastructure looks like and what resources would be made available to better support us."*

> *"I'd like to think this structure that we're developing secures from the LA leaders itself a commitment to research and evaluation... there needs to be supportive structures… from leadership, as well as operationally."*

Councillors echoed this through recognition of the importance of linking research to council priorities to reinforce the value of research to the administration.

> *"Saying [to politicians] I can see this is what you want to do. We could evaluate that, and that evaluation could lead to it being made bigger, being rolled out across the country… That's how you get politicians to understand research."*

4.1.9 Academic relationships and collaborations

The value of collaborative relationships with universities was recognised but these are opportunistic rather than strategic.

> *"It is opportunistic, I'm afraid. It's about relationships. It's about the links that people have previously had."*

Wider academic networks across Higher Education Institutions (HEIs) could strengthen support for LAs.

> *"The DPH previously done a day a week at the university and already had been strong links there. At practitioner level there have been fewer opportunities to develop links."*

> *"The Wessex forum supports us to create that link with the University. I'd argue we're not doing that well enough across all Universities… there is a need for Universities to come together in their own network, so they can strengthen what that academic offer is."*

Major barriers to forming and maintaining academic links relate to timing, differences in thinking, the financial costs of academic involvement, and knowing who to connect with.

> *"They've stalled because of timing or a slight mismatch between what LA people are thinking and what academic people are thinking…"*

> *"I know there are universities, but I don't know how you would make those initial links. I don't know how to develop that relationship with an evidence organisation."*

4.1.10 Improving and strengthening academic links

Improved communication around culture and priorities could strengthen links with academia by identifying mutual interests and research opportunities.

> *"I think it would be helpful for universities to have an appreciation of the political environment… then they would be able to work out how to influence LAs and get that research."*

> *"I guess universities just letting LAs know what research they are doing and giving them the opportunity to get involved... having discussions about what would be helpful for both sides."*

Embedded researchers, joint appointments, and models of support between the LA and academia can bridge the gap between research and practice.

> *"Having that embedded researcher role has been crucial in keeping this going. You are almost like a little bit of thread holding us together... we need to strengthen that link."*

> *"They [researchers] could be the leads in terms of stakeholder relationships with universities and making connections and bridging the gap between research and practice. A joint post would be a lovely way of doing it."*

Working within practice can inform teaching about public health issues, and LA student placements provide a balance between theoretical knowledge and real-world problems.

> *"I can bring real-life stuff to them [students] … I would love to get to a stage where we are utilising students and getting them into work that is really needed… I think there would be huge opportunities there."*

Social work teaching partnerships offer an example of LA and HEI collaboration and a step towards improving evidence-based practice.

5. Findings from community interviews

5.1.1 Community involvement in the LA

Different ways of engaging with SCC include through tenant's panels, although the effectiveness of these were questioned.

> *"I think you should bear in mind is that I reckon that the average age of people on tenant panels is going to be over 60 because they're the only people that have got the time."*

One participant, representing a local mosque, spoke about council members attending the mosque to share information.

> *"Well, when we opened up the centre, I remember lots of council used to come because we invited the mayor and others to open up different events."*

5.1.2 Engaging and involving wider community members

All community interviewees were active and engaged members of their community but are not representative and activity is largely driven by a few motivated individuals.

> *"What a lot of people have got to realise is unfortunately a lot of people don't want to do anything for their community, they rely on people like me."*

> *"It does depend on how it's presented. I find it very difficult because I've made a conscious decision to get involved in whatever it might be… there's only one way to change it, and that's to get involved, not sit back and moan and complain."*

It is challenging to engage wider community members with activities which require longer-term commitments.

> *"When they [the council] set up panels, okay, they said that nobody should stay on a panel for more than five years... because they believe that they will be inundated with people…. it hasn't happened like that. You're not getting enough people on the panels."*

A mosque volunteer recommended trying more ad hoc flexible approaches of engagement in spaces already attended (in this case at Friday prayers).

> *"Oh yes, they will talk about things, but if you want them to participate to write things out or to join something or do something, that's not that easy. On a Friday, for example, if you come and you want to do a quick research by questionnaire type of thing… but to do something substantial, yes, they usually switch off.*

5.1.3 Barriers to and facilitators for involving communities

A primary barrier related to a lack of long-term commitment, compounded by cultural or language barriers which may deter people from certain BAME backgrounds and disproportionately affect women from some communities.

> *"Obviously, language barriers are there sometimes if you are trying to get to different sections of the community, like ladies and things like that."*

Barriers can be systemic resulting from a lack of understanding or bias by researchers about community needs.

> *"Sometimes it's imagined barriers. You might think oh I'm English, or I'm something, if I go there, I have to be this, that or maybe they don't like. It's not like that, you should try to come and participate now. I'm not just talking about the Muslim community, go into other communities as well."*

The use of incentives could motivate people to take part in research, although financial remuneration should not affect benefit entitlement.

> *"I don't know whether you can actually pay them because you have to consider the fact that some… If you paid me, right, I don't know. I'm on Pension Credit."*

Vouchers, small gifts, thank you cards, and recognition may incentivise involvement.

> *"I think that will work very well. I don't think people do it for a lot of money and things, but recognition and thank you it's something that always helps."*

Preventing logistical barriers is important, including using accessible locations or paying for transport.

> *"You were never going to get people to go out unless you can arrange transit. That would be an incentive, and then financial incentive or a voucher for whatever."*

5.1.4 Learning from existing community and religious groups

All participants positively referenced projects undertaken in communities by Non-Governmental Organisations and community groups, highlighting the importance of local knowledge and existing relationships and trust (see Appendices Table 4, ref 1). Religious organisations engage with a wide range of external stakeholders (see Appendices Table 4, ref 2), and their networks offer access opportunities to different people (see Appendices Table 4, ref 3).

5.1.5 Motivations and attitudes to research

Participants appear motivated by issues which directly affect them or their community (see Appendices Table 5, ref 1). Health and social care research are considered something that happens 'somewhere else' resulting in a lack of understanding (see Appendices, Table 5, ref 2). For example, a participant described a previous research group that tried to recruit through their community but struggled as it was perceived as too complicated and not directly relevant (see Appendices Table 5, ref 3).

6. Discussion

Research and evaluation are not a high priority for local government and budgets cuts contribute to a lack of research capacity. Enthusiasm for LA research exists in principle and interviews highlight the value of research evidence to inform practice. However, barriers include time constraints, resources and capacity, organisational priorities, and political short-termism. Findings concur with previous studies highlighting barriers to evidence use, including access (not reported among public health participants), timeliness of research evidence, and competence in finding and appraising evidence and the political context of LAs (6, 8-10). Multiple perspectives on what counts as evidence exist; local knowledge and evidence is prioritised, and anecdotal evidence is valued (9, 12, 20). Evidence use varied between individuals and departments, with wider engagement among Public Health specialists reflecting an existing research culture (20). COVID-19 disrupted established ways of working, opening potential collaborations within LAs. This changed perspectives about the value of research but is likely time-limited unless underpinned by sustainable funding. Additionally, access to publications (13, 20) and confidence in using academic databases by LA staff are unlikely to improve the use of evidence without additional support. Even where such access was available it was sources such as NICE, PHE, ONS, government websites and opinions by PH professionals, especially the DPH, that were prioritised. Academics were rarely mentioned as information sources (21) and their involvement was mostly ad hoc or through invitation to specific forums.

Our findings suggest a need to commit at a strategic level to joint appointments and new research roles embedded within the LA (14, 15). Such appointments will help make the use of research evidence normal practice in LAs, support research staff to use existing evidence in a manner that is realistic and adds value to their work and help build sustainable links with existing research infrastructure through their understanding of existing practice in both contexts such as identifying projects with mutual local benefit. Further research is required to explore sustainability and how this would work for different contexts and role priorities.

Challenges to engaging diverse communities were identified. Much activity is driven by too few key motivated individuals. Barriers to wider community involvement include structures requiring too much commitment, the timing and location of meetings resulting in less diversity of representation. Bias and assumptions by researchers may compound lack of

engagement due to perceived difficulties in accessing seldom heard groups. Developing enthusiasm and commitment is key if research is to be seen as meaningful by community participants. Providing relevant, clear, and meaningful feedback may improve engagement, alongside flexible ad hoc opportunities, and incentives for involvement.

6.1.1. Recommendations to support and enable research activity within the LA

- Embed strategic level appointments within the public team in the LA to work with the DPH to champion the research agenda and value of research, build links to existing research infrastructure. This could include joint appointments across HEIs and the LA.
- Embed researchers within the LA to (I) aid the delivery of meaningful evidence within LAs (II) help staff to work with existing data (III) upskill staff through short courses and one-to-one tutoring (e.g. evidence synthesis; rapid reviews) (IV) facilitate the generation of local research and evaluation by supporting LA staff (V) expand links within the LA across teams and (VI) support LA researchers in developing partnerships with HEIs working on common projects or funding bids.
- An open data repository platform to bring together LA public Health, social Care, and other LA research evidence to eliminate duplication to create holistic approaches for tackling population health needs. Encourage LA staff to use the platform to generate research questions and ideas of relevance to LAs and engage the embedded researcher and strategic research lead to explore potential links to academics in HEIs.

6.1.2. Considerations for community involvement and engagement (developed with members of the community participation network):

- Harness existing community knowledge by building relationships with individuals and NGOs already working in the community.
- Develop meaningful ways of involving communities.
- Consider communities as ‘under-represented’ rather than ‘hard to reach’ to counteract systemic barriers. Explore incentives for involvement.
- Ensure PPI involvement in health/social care research is presented in relevant and meaningful ways to reflect individuals’ lived experiences. Provide feedback on involvement.
- Explore inclusive modes of involvement, with appropriate training.

7. Limitations

Limitations include the relatively small sample from one region in England which may limit generalisability to other LAs across the UK. Data gathered from local Councillors were the opinions of one political party and may not represent other opinions. Despite efforts to limit methodological bias, results are based on qualitative research which is by nature subjective. Despite these limitations, a range of views are represented, and it is unlikely that these limitations compromise the integrity of the study.

8. Acknowledgements

We express our gratitude to all the participants who gave their time to share their views and experiences with the research team. We thank Dr Debbie Chase and PPI representatives for their assistance in identifying and recruiting participants. We would also like to thank Professor Issy Reading, Dr Caroline Eyles and Ravita Taheem for their support and feedback on the study protocol.

9. Funding and Disclaimer

This study is funded by the National Institute for Health Research (NIHR) Public Health Research Programme (NIHR131747). The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

10. References

1. Department of Health. Public Health in Local Government 2011.
2. Gorsky M, Lock K, Hogarth S. Public health and English local government: historical perspectives on the impact of 'returning home'. J Public Health (Oxf). 2014;36(4):546-51.
3. Care DoHS. Public Health ring-enced grant 2019/20 circular. . 2018.
4. TheKingsFund. Chickens coming home to roost: local government public health budgets for 2017/18. 2017.
5. Dorling H, Cook A, Ollerhead L, Westmore M. The NIHR Public Health Research Programme: responding to local authority research needs in the United Kingdom. Health Res Policy Syst. 2015;13:77.
6. Brownson RC, Fielding JE, Maylahn CM. Evidence-based public health: a fundamental concept for public health practice. Annu Rev Public Health. 2009;30:175-201.
7. Whitty CJ. What makes an academic paper useful for health policy? BMC Med. 2015;13:301.
8. Kneale D, Rojas-García A, Raine R, Thomas J. The use of evidence in English local public health decision-making: a systematic scoping review. Implement Sci. 2017;12(1):53.
9. Kneale D, Rojas-García A, Thomas J. Obstacles and opportunities to using research evidence in local public health decision-making in England. Health Res Policy Syst. 2019;17(1):61.
10. Atkins L, Kelly MP, Littleford C, Leng G, Michie S. Reversing the pipeline? Implementing public health evidence-based guidance in english local government. Implement Sci. 2017;12(1):63.
11. Curtis K, Fulton E, Brown K. Factors influencing application of behavioural science evidence by public health decision-makers and practitioners, and implications for practice. Prev Med Rep. 2018;12:106-15.
12. Kneale D, Rojas-García A, Thomas J. Exploring the importance of evidence in local health and wellbeing strategies. J Public Health (Oxf). 2018;40(suppl_1):i13-i23.
13. van der Graaf P, Cheetham M, McCabe K, Rushmer R. Localising and tailoring research evidence helps public health decision making. Health Info Libr J. 2018;35(3):202-12.
14. Cheetham M, Redgate S, Van der Graaf P, Hunter R, L. R. Local Authority Champtions of Research Project: A Report for the Health Foundation 2019.

15. Cheetham M, Wiseman A, Khazaeli B, Gibson E, Gray P, Van der Graaf P, et al. Embedded research: a promising way to create evidence-informed impact in public health? J Public Health (Oxf). 2018;40(suppl_1):i64-i70.
16. The Academy of Medical Sciences. Improving the health of the public by 2040. Optimising the research environment for a healthier, fairer future 2016.
17. Lockwood A, Walters H. Making the most of public health research. J Public Health (Oxf). 2018;40(4):673-4.
18. Departement of Health and Social Care)2018). Eligiblity Criteria for NIHR Clinical Research Network Support.
19. Marshall C & Rossman GB. Designing Qualitative Research. London: Sage; 2006.
20. South E, Lorenc T. Use and value of systematic reviews in English local authority public health: a qualitative study. BMC Public Health. 2020;20(1):1100.
21. Oliver KA, de Vocht F, Money A, Everett M. Identifying public health policymakers' sources of information: comparing survey and network analyses. Eur J Public Health. 2017;27(suppl_2):118-23.

Appendices

11.1.1 **Appendix A:** Table 1. Summary of key findings from LA interviews

Thematic category	**Key findings**
LA response to childhood obesity & COVID-19	• Childhood obesity is a strategic priority for SCC, but most participants focused on COVID-19 as a priority response. • The DPH, a Senior Public Health Practitioner and Ward Councillor were involved in the childhood obesity response. • Scrutiny inquiry raised awareness and highlighted the need for long-term commitment and flexibility across council functions, partners, and the Government. • Phenomenal health burden and challenges brough by COVID-19. COVID-19 responses were strategic with operational support from Consultants in Public Health. • COVID-19 led to a move away from operational silos, increasing partnership working between Public Health and Social Care teams to address population needs.
LA social networks	• The DPH was the most frequently cited source of information and support, alongside other LA staff and elected members. • Academics were rarely mentioned as information sources and their involvement was mostly ad hoc or through invitation to specific forums.
Multiple concepts of and priorities of evidence use	• There were broad definitions of what counts as evidence and how it is used within a local government context. • Greater emphasis is on quantitative data rather than use of qualitative sources. • Senior Public Health professionals viewed evidence as a specialism which is deployed differently across departments and individuals. • Some councillors prefer anecdotal evidence from their constituents. • Officers are perceived to have the responsibility to present evidence to councillors to support informed decision making. • Local authorities exist within a wider socio-political context requiring a balance between evidence within these wider requirements.
Access to and use of evidence	• A range of evidence was accessed and included online and local data, peers, networks, and social media to keep abreast of emerging COVID-19 evidence. • Few accessed academic research even though public health participants had free access to journal databases via visitor status at one local University. • Adult Social Care staff relied on other sources to collate and synthesise research evidence such as the Social Care Institute for Excellence, and the Research in Practice for Adults. Triangulating evidence was integral for public health and social care to create a rich and relevant knowledge base.
Barriers to and solutions for evidence use	• Range of barriers related to access (except for public health participants); time constraints and the timeliness of evidence for decision-making; lack of relevant research; competence to find, access, analyse and interpret evidence and the role of evidence in a local authority environment. • Workforce development training. Important to consider a range of evidence which may include grey literature or different ways of sharing findings to inform practice which might not be in the gold standard of published academic research. • The local authority requires relevant and timely (rapid) evidence review outputs to inform practice and decisions. • Demand for whole systems approaches and Data/evidence to understand health of local population and the impact of COVID on future adult social care services.

11.1.2 **Appendix B:** Table 1 cont. Summary of key findings from LA interviews

Thematic category	**Key findings**
LA role in research and evaluation	• LA public health and social care are not research active or research ready. • Enthusiasm for research exists in principle and the value of research evidence to inform practice. • Limited resources and organisational capacity due to budget cuts and austerity are major barriers for LA research. • Other barriers include time constraints, research relevance to organisational priories and political short-termism. • COVID-19 has presented an opportunity to establish a culture of research but unless supported by additional resources it is likely to be time-limited.
Supporting and enabling LA research	• Build capacity for research within the LA, specifically embedding people with skills in research methodology, data analysis and evaluation. • Academic support to formulate suitable research questions and evaluation questions, alongside co-production with diverse communities, would enable more effective local community responses. • Senior strategic input required to help develop appropriate infrastructure for LA research activity, alongside leadership support and commitment for research. Clearly articulate the benefit and value of research to the administration.
Academic links	• Academic relationships are valued but are opportunistic rather than strategic. • Wider academic networks across Higher Education Institutions could strengthen support for local authorities. • Major barriers include timing, differences in thinking, the financial costs of academic involvement and knowing who to connect with.
Improving and strengthening academic links	• Improved communication around culture and priorities within respective organisations and identifying mutual interests and research opportunities. Early LA involvement in the academic research development process. • Embedded researchers/joint appointments and models of support can bridge the gap between research and practice. • Working within practice can provide a balance between theoretical knowledge and real-world problems. • Social work teaching partnerships are an example of local authority and Higher Education Institution collaborations and a step towards improving evidence.

11.1.3 **Appendix C:** Table 2. Summary of key findings from community interviews

Thematic category	**Key findings**
Engaging and involving wider community members	• Different ways of engaging with council services through tenant panels, although effectiveness was questioned. • Active and engaged members of their community, but are not representative, and activity is driven by a few motivated individuals. • Challenging to engage wider community members with activities which require long-term commitment. • Participants suggested trying more ad hoc and flexible approaches of engagement in spaces already attended (e.g. Friday prayers).
Barriers to and facilitators for involving communities	• Major barriers related to lack of long-term commitment compounded by cultural and language barriers which may deter people from certain BAME backgrounds and disproportionately affect women from some communities. • A lack of understanding or bias by researchers about community needs. • Providing incentives could motivate people to take part in research, although financial remuneration should not affect benefit entitlement. Vouchers, small gifts, thank you cards, and recognition may incentivise involvement. • Using accessible locations and providing transport.
Motivations and attitudes to research	• Participants appeared to be motivated by issues which directly affect them or their community. • A lack of understanding about health and social care research and belief that it is complicated and not directly relevant.

11.1.4 **Appendix D:** Table 3. Barriers to evidence use in the LA

Theme	***Quote***
Access and accessibility	*"The question is how would be get access to [academic research] and how accessible is it for the non-scientists among us?"*
Time constraints	*"The key one is time… people have different time pressures."*
Timeliness of research	*"Sometimes people like PHE collate rapidly pull evidence together and that's really helpful, but often it takes a long time to do it. You [Public Health] want it now. They're [academics] going to bring research in six months or next year… so there is something about the timeliness of evidence."*
Political processes	*"I don't feel like we [politicians] are often making good decisions based on good evidence. I think a lot of the decision making is driven by will it look good, can we put it on a leaflet that we can go out and get people to vote for us, because the primary driver for politicians is to stay in power."*
Research relevance	*"I think there's something about pragmatism… so we can look at the most thorough trials… but can you apply that to our local context, given our population needs? I think that's challenging."*
Competencies	*"I don't feel very skilled to be able to look for research evidence and interpreting some of it because I don't regularly do that… I would definitely need some training."*

11.1.5 **Appendix E**: Table 4. Learning from existing groups

Ref	*Quote*
1	*"I got involved a little bit with SO18 Big Local… they're a great organisation. They do loads of stuff and their latest thing is their mosaics… which was on the news the other day."*
2	*"We have sometimes non-Muslims or visitors... they used to come and learn about our culture and our religion, and things like that."*
3	*"We basically provided facilities where they could distribute the leaflets and come and say a few words or have a stand on Friday. They really quite enjoyed it, seeing across so many people."*

11.1.6 Table 5. Motivations and perceptions about health research

Ref	*Quote*
1	*"Green spaces, yes, it's to do with my neighbourhood. Cleansing is to do with my neighbourhood. Repairs is to do with the building, but obviously affect my neighbourhood. I do walkabouts with the neighbourhood warden which is right outside my house and everything else… That's the way it works."*
2	*"I've not seen any health research. My understanding, I'm not sure… health research, that's like somebody in a… you've got cancer research and heart research and it is something that happens in a laboratory somewhere. It's normally run by a charity, British Heart Foundation, or various charities... There are so many different diseases and they've set up so many different groups… It's normally privately funded."*
3	*"But I think they made it too complicated. People didn't really understand what was going on, and what they were trying to achieve. I think you've got to keep it very simple, and obviously to highlight the benefits to them and to the community as well after the research that is going on."*

11.1.7 **Appendix F:** Local authority interview topic guide

- Explain aims of study
- Reminder there are no right or wrong answers
- Talk through PIS and consent
- Check if there are any questions

Questions about role

1. Can you tell me a little bit about your role in the LA and how long you been in this role for?
2. How does your role relate to Public Health / Social Care?
3. Have you been involved in the LA response to childhood obesity / covid-19?

Responses to childhood obesity and covid-19

4. Can you tell me a little bit about your involvement in the LA response to childhood obesity?
5. Were you involved in the recent childhood obesity scrutiny inquiry? If yes, can you briefly explain the purpose of the inquiry and your role in that process?
6. Were you involved in the COVID-19 response? If yes, can you tell me about your involvement?
7. Have you been involved in supporting the wider social care sector in their COVID-19 response? If yes, how? If no, why not? What gets in the way?

Role and use of evidence

8. Can you tell me how you would define evidence in a local government context?
9. What types of evidence is prioritised in the work that you do? What evidence to you draw on to inform decisions? Does this differ between people and stakeholders? How?
10. What types of evidence was used to inform the LA response to childhood obesity AND COVID-19? Could you provide an example?
11. What makes it difficult to engage and apply research evidence in the work that you do?
12. How could research evidence be made more accessible and useable by you? What is important?

Local authority research and evaluation

13. What are your thoughts about the LA having a role in generating research evidence?
14. What is currently in place to support research and evaluation in the local authority?
15. What do you think makes it difficult to undertake research and evaluation in the local authority?
    - What gets in the way? [prompt – interpersonal relationships; political; commitments?]
    - What kinds of solutions do you think would address these?
16. What do you think it would take for this LA to be more effective / better at generating research evidence to inform practice and decisions?

Relationships and collaborations with academia

17. What are examples of local authority-academic research collaborations? if no academic links, why not? prompt what gets in the way?
18. What has helped you to engage and develop links with academic researchers?
19. What makes it difficult to link in and collaborate with academic researchers?
20. What do you think is needed to build more effective or better links with academia? (how would you like to work with universities to develop an evidence-base?)

Social Network Mapping in the LA Childhood Obesity and COVID-19 response

21. When you think about COVID-19 / Childhood Obesity, we are interested in finding out who were the people, organisations, and sources of information that were important to you in developing your understanding and position.
    - Who were the key contacts most important to you in developing your understanding and position in childhood obesity / COVID-19 response?
    - Why have you put these people in the circle closet to you? What is important about them?
    - Why have you put these people in the outer circle (least important) and not in the other one (important/most important)? What is different about them?

    Is there anything else you would like to add that you think is important?
    Is there anything that you would like to ask me?

11.1.8 **Appendix G:** Community interview topic guide

- Explain aims of study
- Reminder there are no right or wrong answers
- Talk through PIS and consent
- Check if there are any questions

About your role in the community

1. Can you tell me a little bit about the community(s) in Southampton you feel you are part of or involved in?
2. Can you briefly explain your role in this community and how long you have been involved?
3. Can you tell me what motivates you to be involved in your community?
4. How much do you think the local communities in Southampton have been able to influence city council services?
5. How has COVID-19 impacted on you or members of your community to engage in activities? Probe the preferred ways of working without face-face contact? Telephone; internet (access?).

Involvement in research / evaluation

6. What do you understand about research / evaluation?
7. Through links to your community group have there ever been opportunities to contribute to health research as a partner or collaborator?
   a) If yes, what / who was involved? What do you think motivated people to be involved?
   b) If no, do you think this is something that would be of interest? What do you think would motivate people to get involved?

Enablers and barriers

8. What would you say helps / hinders communities to try to influence local council and health services? Probe individual, organisational and cultural issues.

Incentives / rewards

9. Have you or your community received any incentives to help contribute to city council services or research/evaluation?
   a) If yes, what? Was this appropriate? Is there something better that could have been considered?
   b) If no, what incentives do you think would encourage involvement?

Recommendations

10. What do you think could be done better to engage people in Southampton in city council services and in local research/evaluation?
11. Do you have any suggestions on how research in Southampton could be developed to embed greater community involvement in future research/evaluation projects?

Is there anything else you would like to add that you think is important?
Is there anything that you would like to ask me?