

NIHR Policy Research Programme (NIHR PRP)

Research Specification

Research call on

“Health Inequalities Research Initiative: Call 2”

Timetable and Budget

- Deadline for stage 1 applications: **21 May 2019**
- Notification of outcome of stage 1: **July 2019**
- Deadline for stage 2 application: **17 September 2019**
- Notification of outcome of stage 2: **November 2019**
- Project start: **January 2020**
- Budget: **£250,000 to £750,000 per project**

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Introduction

1. The National Institute for Health Research (NIHR) Policy Research Programme (PRP) invites applications to undertake health inequalities research to support policy makers in the Department of Health and Social Care (DHSC) in the following areas:
 - Assessing how to improve existing population wide policies aimed at improving health outcomes so that they so they also reduce health inequalities and/or do not exacerbate inequalities
 - Identifying which existing health system interventions that are specifically designed to reduce socio-economic health inequalities are effective and cost-effective
 - Assessing the effectiveness in reducing health inequalities of whole system approaches to improving the health of deprived communities;
 - Identifying opportunities and risks presented by advancements in digital technology, and practical measures to ensure such technology does not exacerbate socio-economic health inequalities.

There is an overarching interest in understanding how to maximise the effectiveness of existing policies so that they can improve the health of the poorest fastest, as well as understanding the reasons why some local areas do well, and some less well, on health inequality measures.

2. Projects may draw on a range of methodologies, which may include, but not limited to: documentary analysis, evidence reviews, secondary analysis of quantitative and qualitative data, and primary data collection e.g. qualitative research with stakeholders and users.

Background

3. The DHSC single departmental plan includes a commitment to 'Reduce health inequalities across the health and care system to reduce unjustified variations in physical and mental health outcomes'. The health and care system relates to services that are available from health and social care providers and refers to the whole of the healthcare provision infrastructure, public and private sector. The Department is supported by 15 arm's length bodies (ALBs) and a number of other agencies and public bodies, in particular NHS England, NHS Improvement and Public Health England (PHE).
4. A critical aspect of the health and care system is Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) whose purpose is to improve the health and wellbeing results of the local community and reduce inequalities for all ages. JSNAs and JHWSs form the basis of clinical commissioning groups (CCGs), NHS England and Local Authority commissioning plans, across all local health, social care, public health and children's services. There is increasing traction for what is sometimes referred to as a 'health in all policies' or a 'place based' approach as a way of achieving demonstrable improvements in reducing the health inequality gap at a community level.
5. There are a number of tools that show local variations to help inform commissioning decisions. In addition, there is a significant body of evidence that describes the scale and nature of health inequalities in England, and how they compare to the rest of the UK and other countries, e.g. the Public Health Outcomes Framework. The purpose of this call is to provide further evidence to inform policy aimed at reducing health inequalities; specifically,

to focus on understanding where health and social care policy action can make a difference by either improving access and uptake of existing programmes and services, and/or making changes to other aspects of their implementation and delivery.

6. Socio-economic inequalities in health outcomes are of particular interest. There is a social gradient in the distribution of good health, with those in the most deprived neighbourhoods, on average, dying 7 years earlier, and enjoying 16 fewer years of disability free life than those in the least deprived. The gradient is particularly steep in the poorest 3 deciles of the population, with markedly worse mortality rates for diseases considered to be avoidable through appropriate interventions.¹
7. Inequalities in the distribution of good health result from a wide range of social inequalities; nevertheless, the health system has its part to play in addressing health inequalities, and mitigating the effects on health of these wider social inequalities.
8. Evidence-based strategies for reducing health inequalities in England were proposed in the Marmot Review (Fair Society, Healthy Lives)². It recommended a 'proportionate universalism' approach where service design, volume and delivery are tailored to those with the highest needs.
9. This call is funded by the NIHR PRP which commissions research to inform Ministers and senior policy makers. Researchers should demonstrate the relevance of their proposed research to evidence-users, i.e. how it will produce recommendations for action.

Areas Outside the Programme

10. This call does not cover research that solely describes the scale of health inequalities, how they affect different population groups, or how health inequalities manifest themselves in different settings. The focus of this call is on existing interventions, and is not requesting research to develop new interventions to reduce health inequalities.
11. Applicants should be aware of the current NIHR call for research proposals in tobacco cessation, control and harm reduction interventions, here: <https://www.nihr.ac.uk/funding-and-support/funding-opportunities/18164-tobacco-cessation-control-and-harm-reduction-interventions-hsandr-programme/9376>. DHSC are keen to create synergies between this call and the Health Inequalities call.
12. While addressing health inequalities requires action across all the wider determinants of health, this call focuses on those that are actionable by the health and social care system including those led by Local Authorities; including but not exclusively public health actions. Actions outside the health and care system are out of scope for this call.

¹ Avoidable mortality in the UK 2016. ONS.

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2016>

² Marmot, M. Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010.

Research Priorities

A. Assessing how to improve existing population wide policies that are aimed at improving health outcomes so they also reduce socio-economic health inequalities

13. Services and programmes intended to benefit the whole population e.g. immunisation programmes, excise taxes on cigarettes and alcohol, seat belt laws, water fluoridation, and restaurant menu labelling can have differential impacts on different population groups, so that while overall population health may improve, health inequalities may be exacerbated, i.e. the health of higher socio-economic groups improves more than that of lower groups. Research is needed that demonstrates how this may be reversed so that the health of poorest can be improved the fastest. This priority involves identifying characteristics of service design, delivery and implementation of programmes which impact directly on socio-economic health inequalities. Research may include:

- Identifying the critical factors in achieving high uptake of prevention programmes (e.g. screening, smoking cessation) in the most deprived 30% of the population
- Identifying behaviour change approaches that are effective for the most deprived 30% of the population, especially those with multiple behavioural risk factors
- Skills, knowledge and behaviour change needed of health care professionals and managers to deliver reductions in inequalities
- Identifying the critical factors essential to ensuring:
 - a) high rates of diagnosis of medical conditions in the most deprived 30% of the population, and
 - b) high percentages of these patients are managed according to NICE guidelines (e.g. for diabetes, cardiovascular disease risk, mental health, musculoskeletal conditions, chronic obstructive pulmonary disease, cancers). Including managing these patients with co-morbidities.
- Designing targets and incentives in the health and care system to ensure that services meet the health needs of people in the most deprived 30% of the population
- Identifying mechanisms and data systems that can inform better targeting of those from more deprived circumstances

B. Identifying which existing health system interventions specifically designed to reduce socio-economic health inequalities are effective and cost-effective

14. Health inequalities arise from social inequalities that occur across the life course, for example, inequalities in living conditions, wealth, income, education, and the interactions between them. Health and care services often attempt to prevent or mitigate the negative effects on health of these social inequalities, for example parenting programmes, smoking cessation services targeted at deprived communities, or community engagement/outreach activity designed to improve access to health services for deprived groups. Such interventions to address health inequalities exist in different parts of the health care system (e.g. public health, acute care, primary care, secondary care), and may target inequalities in access to health services, or inequalities in health outcomes. Research is needed to identify which interventions, in which parts of the health system, for which groups, are effective and

cost-effective. This may include evaluation of/ drawing together evidence from evaluations of:

- Interventions that aim to reduce health inequalities
- Interventions that aim to prevent health inequalities
- Interventions that aim to prevent or reduce health inequalities at different stages of the life course, particularly in the early years (on, for example, speech and language development, school readiness); and in the working age population (on musculoskeletal health and on mental health).
- Interventions implemented in England to prevent or reduce health inequalities compared to those implemented in other UK member states post devolution.
- Interventions that target, or service models that support, disadvantaged population groups, such as BAME groups, socially excluded groups or those with multiple complex needs.

C. Assessing the effectiveness in reducing health inequalities of whole system approaches to improving the health of deprived communities

15. Commissioning and delivering interventions that will generate measurable change at population level is challenging, and requires a range of approaches, tools and techniques. In recent years, there has been a steady move towards a place-based approach to health, where local commissioners and providers across sectors work together with local communities to meet the specific needs of that geographical locality. Developing integrated place-based systems is considered to be important for ensuring the long-term sustainability of health and care services. Research may include:

- Mapping the range of place-based approaches and their key features, Identifying and reviewing evaluations or research into existing approaches and drawing together key lessons learned, including what's working, where, why and for whom
- Evaluation of co-produced, and community led and delivered programmes on health inequalities
- Assessing the impact of cross-sector collaboration on health inequalities

D. Identifying opportunities and risks presented by advancements in digital technology, and practical measures to ensure such technology does not exacerbate socio-economic health inequalities

16. There is an expectation that advancements in digital technology will bring improvements to the healthcare system, however, the benefits of these advancements may not be equally distributed across the population, as reliable and stable access to digital technology is unequally distributed. There is evidence that low-income populations are more likely to require healthcare, but that they are also more likely to have unreliable or unstable access to technology. Further investigation of the potential role that technological innovations may play in influencing social inequalities in health is needed, and what practically can be done to ensure that health inequalities are not worsened by technological change. This may include:

- Identifying and mapping the opportunities and risks for health inequalities that are presented by advancements in digital technology

- Understanding how to leverage technology to improve health inequalities by improving the health of the poorest fastest
- Data systems that can assist with identifying more accurately those who are not reaching optimal treatment goals across the social gradient

Budget and Duration

17. Funding will be available for at least two commissioning rounds and will be allocated flexibly across projects working across disciplines and health systems on a broad range of themes. The Department is expecting to fund up to 10 projects in total at a cost of between £250,000 and £750,000 per project although lower cost projects are also encouraged. However, there is no guarantee that studies from each of the priority areas will be funded. Funding to that level will only be available if there are suitable high quality and relevant studies. In all cases, projects are expected to last no longer than 36 months.
18. In assessing proposals, the Department will be seeking value for money as well as scientific excellence and, in particular, the potential for policy impact which is key.
19. Costings can include up to 100% full economic costing (FEC) but should exclude output VAT. Applicants are advised that value for money is one of the key criteria that peer reviewers and commissioning panel members will assess applications against.
20. In order to maximise the benefit from the findings, the research will need to commence as soon as possible following selection of the successful bid and placing of a contract. Capability to start promptly will be an advantage and for this Commissioning Round, applicants should demonstrate that projects can start by January 2020.

Governance and Research Requirements

21. Applicants will need to describe how proposed studies will inform policy development in the area of health inequalities.
22. Lower cost projects are also encouraged as DHSC is keen to develop a mixed portfolio of projects in terms of scale and duration.
23. The NIHR may approach one of the successful applicants to act as a co-ordinator for the programme as a whole, in terms of setting up an annual research presentation meeting in conjunction with DHSC and its partners. Please do not cost for this activity; an additional sum will be allocated for this during pre-contract negotiation.
24. The successful applicants for this research may be required to review research objectives with an established research advisory group including representatives of relevant stakeholders and arm's length bodies and to share emerging findings on an ongoing basis. You may be expected to:
 - provide regular feedback on progress
 - produce timely reports to the advisory group
 - produce a final report for sign off

25. Key documents including reports must be provided to DHSC in draft form allowing sufficient time for review.

Key Documents

26. Public Health Outcomes Framework
<https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>
27. DHSC single departmental plan 2018
<https://www.gov.uk/government/publications/department-of-health-single-departmental-plan>
28. Health Inequalities support for CCGs
<https://www.england.nhs.uk/publication/challenging-health-inequalities-support-for-ccgs/> ;
<https://www.gov.uk/government/publications/reducing-health-inequalities-in-local-areas>
29. Secretary of State Priorities for the Health and Social Care System, July 2018
<https://www.gov.uk/government/speeches/matt-hancock-my-priorities-for-the-health-and-social-care-system>
30. Prevention is better than cure: our vision to help you live well for longer, November 2018.
<https://www.gov.uk/government/publications/prevention-is-better-than-cure-our-vision-to-help-you-live-well-for-longer>
31. Technological innovations and the rise of social inequalities in health, D Weiss 2017
<http://journals.sagepub.com/doi/abs/10.1177/1403494817711371>

Standard Information for Applicants

1. The sections below provide standard information on different aspects of NIHR PRP funding and will contain details relevant to your application.

General Comments About Applications

2. The National Institute for Health Research Policy Research Programme (NIHR PRP) is a national programme of research dedicated to providing an evidence base for policy-making through the Department of Health and Social Care. It provides information to the Secretary of State for Health and his Ministers directly and through policy directorates in the Department of Health and Social Care and covers all aspects of the Department's policy-making activity.
3. Applications will be considered from other UK countries (Scotland, Wales and Northern Ireland) provided they address the priority areas in a way that is relevant to the needs of the Department of Health and Social Care (England) and meet all other selection criteria.
4. Applicants are encouraged to submit multidisciplinary applications.
5. Applicants should consider the full range of potential audiences and describe how the research findings could be disseminated most effectively to ensure that the lessons from this research impact on policy and practice.

Research Management

6. Day-to-day management of this research will be provided by the principal investigator. They and their employers should ensure that they identify, and are able to discharge effectively, their respective responsibilities under the Health Research Authority (HRA) UK Policy Framework for Health and Social Care Research (Health Research Authority, 2018)³, which sets out the broad principles of good research governance.
7. All successful research involving National Health Service (NHS) and social care users, carers, staff, data and/or premises must be approved by the appropriate research ethics committee (REC) or social care research ethics committee (SCREC). For further information on RECs, please visit the Health Research Authority website: <http://www.hra.nhs.uk/>⁴
8. The successful research team must adhere to the General Data Protection Regulation and the new Data Protection Act (2018)⁵ and the Freedom of Information Act (2000). Effective security management, and ensuring personal information and assessment data are kept secure, will be essential. In particular:
 - The research team shall, at all times, be responsible for ensuring that data (including data in any electronic format) are stored securely. The research team shall take appropriate measures to ensure the security of such data, and guard against unauthorised access thereto, disclosure thereof, or loss or destruction while in its custody.
 - Personal data shall not be made available to anyone other than those employed directly on the project by the research team, to the extent that they need access to such information for the performance of their duties.
9. For any research involving clinical trials, the successful team will be expected to be familiar with the Medical Research Council (MRC) Framework for Evaluating Complex Interventions, and to follow the principles of the MRC Guidelines for Good Clinical Practice in Clinical Trials in proposing structures for oversight of such trials and comply with the Medicines for Human Use (Clinical Trials) Regulations 2004.
10. The Institution leading the proposal should confirm that it has the capacity and is prepared to take on sponsorship responsibilities for clinical trials undertaken as part of the programme. Where the proposal includes a proposal for multi-site clinical trial activities, the research unit should demonstrate that they have the experience of governance and management of clinical trials across multiple clinical trial sites.

Risk Management

11. Applicants should submit, as part of their proposal, a summary explaining what they believe will be the key risks to delivering their research, and what contingencies they will put in place

³ Available from URL:

<https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/>

⁴

<https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/>

⁵ <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/>

to deal with them. Please ensure this is detailed in the Management and Governance section of the online application form.

12. A risk is defined as any factor which may delay, disrupt or prevent the full achievement of a project objective. All risks should be identified. The summary should include an assessment of each risk, together with a rating of the risks likelihood and its impact on a project objective (using a high, medium or low classification for both). The risk assessment should also identify appropriate actions that would reduce or eliminate each risk, or its impact.
13. Typical areas of risk for an evaluation study might include ethical approval, site variation in data gathering, staffing, resource constraints, technical constraints, data access and quality, timing, management and operational issues; however, please note this is not an exhaustive list.

Patient and Public Involvement (PPI)

14. The NIHR Policy Research Programme expects the active involvement of patients and the public (e.g. service users and carers) in the research that it supports, where appropriate. However, the nature and extent of patient and public involvement (PPI) is likely to vary depending on the context of the study. Applicants should describe how the issue of PPI will be addressed throughout the research process. For example, this could include patient and public involvement in refining research questions, designing research instruments, advising on approaches to recruitment, assisting in the collection and analysis of data, participation or chairing advisory and steering groups, and in the dissemination of research findings.
15. Applicants are required to detail what active involvement is planned, how it will benefit the research and the rationale for their approach. PPI needs to be undertaken in a manner that acknowledges that some people may need additional support, or to acquire new knowledge or skills to enable them to become involved effectively (see INVOLVE publications for guides for researchers). Applicants should therefore provide information on arrangements for training and support. In addition, applicants should note that a budget line for the costs of PPI is included in the finance form. **Where no PPI is proposed, a rationale for this decision must be given.**
16. For further information and guidance about PPI, please visit the INVOLVE website: <http://www.invo.org.uk/>.

Outputs and Reporting Arrangements

17. The research team will be expected to provide regular progress reports over the lifetime of the research and will be provided with a progress report template to complete at regular intervals. In addition to describing progress, these reports will allow researchers to indicate any significant changes to the agreed protocol, as well as setting down milestones for the next reporting period, giving an update on PPI and any publications or other outputs. Information on emergent findings that can feed more immediately into policy development will be encouraged and should be made available as appropriate.
18. A final report on the research, with an accessible executive summary, will be required within one month following completion of the research. The report will be peer reviewed and may be circulated among relevant stakeholders within the Department of Health and Social Care

and its partners. Once the study is completed, a summary of the final report will be placed in the public domain, on the Policy Research Programme web pages found at: <http://www.nihr.ac.uk/prp>. This is where the outputs resulting from expenditure of public funds are made available for public scrutiny so it is important that the summary of your final report is easily accessible to the lay reader.

19. Research contractors are obliged to give at least 28 days notice before submission of any publication arising from research funded by the NIHR Policy Research Programme. In this instance, 'publication' concerns any presentation, paper, press release, report or other output for public dissemination arising from a research project funded by the PRP. Research contractors remain under an obligation to provide notice even after the contract has ended. Publication of PRP-commissioned research is subject to prior consent of the Secretary of State, which will not be withheld unreasonably and cannot be withheld for more than three months from the time the publication is submitted.

Dissemination

20. Applicants should describe how the research findings could be disseminated most effectively, ensuring that results of this research impact on policy and practice in the NHS, DHSC, and/or in social care.
21. Publication of scientifically robust research results is encouraged. This could include plans to submit papers to peer reviewed journals, national and regional conferences aimed at service providers, professional bodies and professional leaders. It might also include distribution of executive summaries and newsletters. Less traditional dissemination routes are also welcomed for consideration.

Transparency

22. In line with the government's transparency agenda, any contract resulting from this tender may be published in its entirety to the general public. Further information on the transparency agenda is at: <https://www.gov.uk/government/publications/procurement-and-contracting-transparency-requirements-guidance>.
23. If you wish to view the standard terms and conditions of the NIHR Policy Research Programme contract, please go to: <https://www.nihr.ac.uk/funding-and-support/funding-for-research-studies/manage-my-study/contracts-and-intellectual-property.htm>.

Application Process

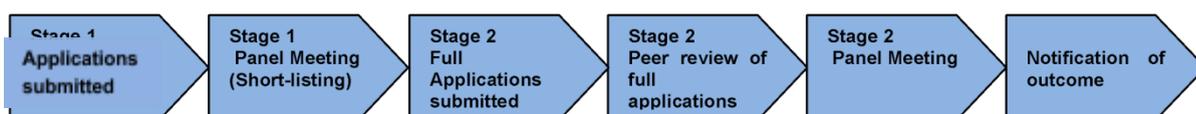
24. To access the research specification and application form, please visit the NIHR Policy Research Programme Central Commissioning Facility (NIHR PRP CCF) website at or visit <http://www.nihr.ac.uk/prp>
25. The NIHR CCF runs an online application process and all applications must be submitted electronically. No applications will be accepted that are submitted by any means other than the online process. **Deadlines for the submission of outline and full research**

applications occur at 1.00 pm on the day indicated and no applications can be accepted after this deadline.

26. We strongly recommend that you submit your application on the day before. Once the 1.00 pm deadline passes, the system shuts down automatically and CCF Programme Managers are unable to re-open it. If you are experiencing any technical difficulties submitting your application, please contact the CCF on 0208 843 8027 in good time, before 1.00 pm on a closing date.
27. Applicants are expected, before submitting applications, to have discussed their applications with their own and any other body whose cooperation will be required in conducting the research.
28. In order for your full application to be validated and submitted you are required to gain electronic approval from the relevant authorities **before the application deadline**. The Declarations page must be approved:
 - a) by the **Lead Applicant** to confirm that the content of the application is complete and correct.
 - b) by an **administrative or finance officer for the contracting (host) institution** to confirm that the financial details of the application are correct and that the host institution agrees to administer the award if made.
 - c) by a **Head of Department or Senior Manager** to confirm that they have read the application and that, if funded, the work will be accommodated and administered in the named institution and that the applicants may undertake the work.
29. Until this is completed the lead applicant is unable to validate and submit the application.

Commissioning Process

30. The standard NIHR PRP commissioning cycle includes the following steps:



31. In the standard 2 Stages' Commissioning, **Stage 1 applications** will be short-listed by a Commissioning Panel. Applications too remote from the issues set out in the research specification, or applications that have clearly inadequate presentation or methods may be rejected at this stage.
32. Applications that are successfully short-listed by the Commissioning Panel will proceed to Stage 2 of the application process and will be invited to submit a Stage 2 full application for consideration.
33. All full applications submitted to NIHR PRP will be peer-reviewed by both stakeholder and independent academic referees. Wherever time permits, applicants will be given one week to respond to the peer reviewers' comments.
34. Full applications, peer reviewers' comments and any responses to those comments will then be considered by the Commissioning Panel, which is comprised of independent experts

(possibly with observers from other government departments and executive agencies), who will advise the NIHR on which applications are most suited to receive funding. The Panel will be informed by the reviewers' comments and any responses made to these comments by the researchers. However, it is ultimately the responsibility of the Panel to make any funding recommendations to the Department of Health and Social Care.

Selection Criteria

35. The Commissioning Panel members are directed to consider applications against the criteria stated in this research specification as well as selection criteria detailed below:

- **RELEVANCE** of the proposed research to the research specification
- **QUALITY** of the research design
- **QUALITY** of the work plan and proposed management arrangements
- **STRENGTH** of the research team
- **IMPACT** of the proposed work
- **VALUE** for money (justification of the proposed costs)
- **INVOLVEMENT** of patients and the public

Contacts

36. General enquiries regarding the application and commissioning process can be directed to the PRP CCF Help Desk by telephone at 020 8843 8027 or by email to prp@nihr.ac.uk.