Order Schedule 20 (Order Specification)

Attachment 3 Statement of Requirements

Department for Work & Pensions

Bid Pack

Attachment 3 – Statement of Requirements

Contract Reference:

25494 Occupational Health Provider Survey

ITT_14021

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1. PURPOSE

1.1 The Department for Work and Pensions (DWP) hereafter referred to as 'the Authority' wishes to commission a supplier to undertake research with occupational health providers to understand the structure, attitudes, and behaviour of the occupational health/ vocational rehabilitation market in relation to the following areas:

1.1.1 Market capacity, workforce composition, skills shortages and enablers of/ barriers to recruiting multi-disciplinary teams and working with small and medium enterprises (SMEs) and the self-employed

1.1.2 Delivery models and extent of/ enablers for/ barriers to innovation amongst providers

1.1.3 Pricing strategies and levels

2. BACKGROUND TO THE CONTRACTING aUTHORITY

2.1 The Department for Work and Pensions (DWP) is the contracting Authority. The DWP is responsible for welfare, pensions and child maintenance policy. As the UK's biggest public service Department it administers the State Pension and a range of working age, disability and ill health benefits to around 20 million claimants and customers.

2.2 For more information on the work and overall objectives of the Department, please follow the links to the gov.uk website and single Departmental Plan 2018-22:2.2.1

https://www.gov.uk/government/organisations/department-for-work-pensions/about

2.2.2 https://www.gov.uk/government/publications/department-for-work-and-pensions-single-departmental-plan

2.5 The Occupational Health Analysis team, as part of the Employers, Health and Inclusive Employment Analysis Division (EHIEAD), will be managing the research project.

3. BACKGROUND TO REQUIREMENT/OVERVIEW OF REQUIREMENT

3.1 Occupational health services provide expert support to employers, employees, and self-employed people to promote and maintain (a) a healthy working environment; and (b) the health and functional capability of employees. Vocational rehabilitation services focus specifically on supporting employees or self-employed people with health conditions to return to or retain work, usually following a spell of sickness absence. Vocational rehabilitation providers tend to use a less medicalised and more holistic approach by considering the full range of physical, psychological, and/or social barriers to work.

3.2 In the UK, occupational health services are mainly provided through a private market of providers and purchased by employers. A small number of large employers employ in-house occupational health teams. NHS occupational health providers primarily support the NHS workforce, though they are often also sold commercially. Vocational rehabilitation services are also mainly provided by private providers and are often offered through employee health insurance services.

3.3 Both occupational health and vocational rehabilitation services can play an important role in employers' efforts to reduce sickness absence, improve job retention and increase productivity.

3.4 However, previous research shows that small and medium enterprises provide access to occupational health much less than large employers and self-employed people access OH much less. Surveys and qualitative research with employers suggest under-utilisation amongst small-medium enterprises and self-employed people is due to: (a) a limited understanding of the purpose and benefits of occupational health; (b) difficulties navigating the market to locate the information they need and this requiring significant time investment; and (c) cost and funding constraints in purchasing occupational health services[1,2].

[1] DWP/DHSC, 2019. Employers' motivations and practices: A study of the use of occupational health services.
[2] DWP, 2021. Sickness absence and health in the workplace: understanding employer behaviour and practice.

3.5 In addition, a 2019 survey with occupational health providers[3] found the sector was running at 89% of capacity. We believe it may now be closer to, or at, full capacity as some evidence[4] suggests demand may have since increased due to COVID and we know providers struggle to expand due to difficulties recruiting. For example, in the 2019 survey, 44% of providers reported having roles they were unable to fill, mainly for occupational health-trained doctors and nurses. 64% of staff working for providers who responded to the previous survey were occupational health doctors or occupational health nurses. However, the number of doctors with a specialism in occupational medicine has fallen by 24% since 2012[5] and the number of occupational health/ vocational rehabilitation specialist nurses has fallen by 8% since 2015[6].

3.6 The government's response to the Health is Everyone's Business consultation, published in July 2019[7], proposed a range of policies to reform the occupational health market. These aimed to improve access to occupational health/ vocational rehabilitation services for small-medium enterprises and self-employed people, with the ultimate goal of reducing ill-health related job loss. These policies broadly included:

3.6.1 Testing a financial incentive for small medium enterprises and self-employed people to access occupational health/ vocational rehabilitation

3.6.2 Providing small-medium enterprises and self-employed people with improved information about occupational health/ vocational rehabilitation and how to navigate the market

3.6.3 Supporting occupational health/ vocational rehabilitation providers to innovate

3.6.4 Improving work and health research infrastructure

3.6.5 Ensuring the right training and support is available to build a sustainable multidisciplinary workforce for the future

3.7 In order to monitor changes in the outcomes intended by these policies over time, we need to collect baseline outcomes data from providers now. One aim of this research project is to provide some of this baseline data for use from 2023.

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[3] DWP/DHSC, 2020. Full report: Understanding the provision of occupational health and work-related musculoskeletal services.
[4] GMC, 2020. The state of medical education and practice in the UK.
[5] GMC, 2021. The state of medical education and practice in the UK data tables.
[6] NMC, 2021. Permanent register data tables, annual registration report.
[7] DWP/DHSC, 2021. 'Government response: Health is everyone's business'.

3.8 **In addition, more and up-to-date evidence on the structure, attitudes, and behaviour of occupational health providers is required to support the ongoing development and delivery of these policies to reform the occupational health market. A second aim of this research project is therefore to provide this evidence to support policy development. The following is a non-exhaustive list of examples about how this research could support policy development:**

3.8.1 **Testing our assumptions about occupational health market failures, e.g., the occupational health sector is heavily reliant on NHS-trained occupational health doctors and nurses but these numbers are declining. This may be helped by the promotion of using multi-disciplinary teams and promotion of occupational health/ vocational rehabilitation as a career. Testing these assumptions will help to build a clearer case for intervention and ensure our policy interventions are right for the market failures.**

3.8.2 **Understanding where occupational health workforce shortages lie, how occupational health providers are dealing with them, and where they see a need for support, so that policy interventions to deal with the declining occupational health workforce are efficient and effective. Knowing which jobs are most difficult to recruit for, why, and what impact this has on service delivery. This can help us to target workforce policies to help occupational health providers expand more easily or improve quality of their services.**

3.8.3 **Understanding the extent of, barriers to, and enablers for providers using fewer clinical and more multi-disciplinary teams will enable us to identify a) whether we need/should do anything to encourage more multidisciplinary teams; and b) what support or incentives are necessary to support providers to take on more multidisciplinary teams. This could also help us to identify risks of not encouraging the use of more multidisciplinary teams, such as whether using fewer clinicians is perceived by occupational health services as risking a reduction in the quality of services.**

3.8.4 **We also need evidence from providers about their willingness and the extent to which they work with small and medium enterprises and the self-employed, and any barriers to doing so. This will inform the design of effective policies that encourage and support providers to assist smaller employers and the self-employed.**

3.8.5 Building data on pricing of occupational health services will enable us to a) more accurately estimate the cost of policies and b) analyse the costs and benefits of occupational health services.

4. DEFINITIONS

Expression or Acronym	Definition
DWP	Means: The Department for Work and Pensions
DHSC	Means: The Department of Health and Social Care
OH	Means: Occupational Health
SMEs	Means: Small and Medium Enterprises
MDTs	Means: Multidisciplinary Teams
The Authority	Means: The Department for Work and Pensions
GDS	**Means: Government Digital Service**
EHIE	Means: Employers, Health and Inclusive Employment
EHIEAD	Means: Employers, Health and Inclusive Employment Analysis Division
VR	Means: Vocational Rehabilitation
SE	Means: Self-employed
SEQOHS	Safe, Effective, Quality Occupational Health Service
COHPA	Commercial Occupational Health Providers Association
HiEB	Means: Health is Everyone's Business (a Government consultation published in 2019)

5. scope of requirement

5.1 The Authority seeks proposals from suitably qualified and experienced organisations to design and deliver a quantitative and qualitative research project across Great Britain to provide insight into OH/VR provision. This research includes understanding OH workforce recruitment, demand for services, pricing strategies, working with SMEs and the self-employed, use of multidisciplinary teams (MDTs) and provider views on data collection, innovation and accreditation services.

5.2 In scope for this research is:

- Provide project management of the research, including: any required administration, inviting participants to take part in the research, regular reporting of progress and findings, and attending meetings with the Authority as required, including an inception meeting.
- Set up an expert steering group with OH stakeholders to support with sampling, developing survey questions, deciding who is best placed at the provider company to answer the survey, and survey response options and interview topic guides. The Authority can assist with the steering group where necessary.
- Produce draft and final versions of survey questions and the topic guide, in collaboration with the Authority.
- Provide cognitive testing of survey questions and questions in the topic guide where appropriate.
- Organise and conduct the telephone survey, including sampling, survey distribution and collection and analysis of responses.
- Organise and conduct qualitative fieldwork, including sampling, audio recording and transcription where appropriate to research method chosen.
- Full analysis and reporting on outcomes of the research.
- Presentation of initial findings to the Authority three months into project.
- Full timetable of research programme, including key outcomes.
- Produce draft and final reports with findings from both the quantitative and qualitative phases of the research.

5.3 The following is not in scope for this research:

- Formal evaluation of HiEB policies
- Development of a theory of change for OH policies

6 THE REQUIREMENT

ALL PARTS OF THE REQUIREMENTS ARE MUST HAVES FOR THIS RESEARCH AND NONE OF THE FOLLOWING ARE OPTIONAL ELEMENTS.

6.1 Part 1: Telephone Survey

6.1.1 The first part of this research is planned to consist of 50-minute semi-structured telephone surveys with NHS, and in-house Occupational Health (OH) and vocational rehabilitation (VR) providers. The survey will aim to speak to as many OH/VR providers as possible, as an attempted census. The Authority will offer support with sampling, utilising our pre-existing connections within the OH community, but the Supplier is also expected to utilise snowball sampling where appropriate and suggest innovative sampling methods to maximise responses. We expect the survey to include at least 200 respondents. The survey will be aimed at senior decision-makers in these organisations, but we will welcome advice on which roles would be best able to accurately complete the survey.

6.1.2 This survey will consist of a mix of closed and open-ended questions to obtain both quantitative measures of capacity, pricing etc. within OH and VR provision, as well as the attitudes and perceptions that underly these measures. The survey may be piloted to attain which (if not all) questions can be asked within the 50 minutes.

6.1.3 This survey will aim to explore the structure of the OH/VR workforce, the current demand for OH/VR services and capacity to respond to this demand, how OH/VR providers determine their pricing, the characteristics of OH/VR customers, how providers can be encouraged to offer more services to SMEs and SE people, what data providers collect, provider approaches to innovation, attitudes to accreditation services and the use of MDTs in OH/VR (frequency of use, team composition etc.).

6.2 Part 2: Qualitative Research

6.2.1 Following the survey, the supplier will use initial findings that have emerged from the survey responses to inform the development of a guide for the qualitative component of this research. This could be either a topic guide to be used for interviews with OH/VR providers, or questions to focus on during case studies. The supplier will conduct in-depth qualitative interviews or case studies (to be discussed further with the contractor) over the telephone with approximately 20 OH/VR providers who use MDTs. These will aim to provide rich, detailed examples of pricing strategies, experiences of working with SMEs and the self-employed and using MDTs in practice, including how different skills, professions, and roles interact to deliver OH/VR services.

6.3 Taken together, the survey and qualitative research aims to address the following overarching questions:

- What is the current situation with workforce recruitment with OH/VR providers?
- How is the general OH/VR workforce currently made up?
- What is the current demand for OH/VR services and has this changed?
- Where is this demand focused?
- What is the pricing strategy for OH/VR services?
- How do OH/VR providers approach data collection and innovation?
- How do OH/VR providers view accreditation services?
- How does OH/VR provision differ for SMEs and the self-employed?
- How are OH/VR providers using MDTs?

6.4 In particular, we wish to understand and explore:

What is the current situation with workforce recruitment with OH/VR providers/ How is the general OH/VR workforce currently made up?

- **What percentages of different types of professions (for instance: nurses, doctors) make up providers' workforces?**
  - How easy do providers find to recruit each profession type?
  - What roles do different types of professionals have and what tasks do they carry out?
  - What are the barriers and enablers of recruitment in the OH/VR sector?
  - What is the current capacity of OH/VR providers?
  - To what extent do OH/VR providers use multi-disciplinary teams to deliver services?
  - What are the attitudes, barriers to, and enablers, of OH/VR providers using multi-disciplinary teams?

- Where multi-disciplinary teams are used, what mix of skills and professions do they involve and how do they work together to deliver OH/VR services?
- Do providers provide any training or qualifications for their staff? If so
    - What types of training?
    - Who do they offer it to?
    - How much do they provide?
    - How is it funded?
- What are providers' attitudes, barriers and enablers, to offering training and qualifications for their staff?
- What needs to change for providers to provide more training?
- Are providers looking for the formal certificate for doctors or are they open to more flexible routes into OH?

What is the current demand for OH/VR services and has this changed? Where is this demand focused?

- What types of services do providers offer?
- How do provides interact with the NHS and government services like Access to Work?
- Who are providers' main customers and what are their characteristics (e.g. employers, self-employed, insurance companies? Employer size? Sector?)
- How does demand for providers' services compare to their capacity?
- What are the implications if demand exceeds capacity? How do providers manage this?
- What are the waiting times for OH/VR services, if any?
- What are the providers' attitudes, barriers and enablers to expanding capacity?
- Do providers advertise their services? In what ways, and to what extent?
- Has there been any change in demand from employers over the Covid period, and post-Covid?
- How do growing OH providers expand with a declining workforce?

How does OH/VR provision differ for SMEs and the self-employed?

- What proportion of customers are SMEs?
- What proportion of customers are self-employed?
- What are providers' attitudes, barriers, and enablers to working with SMEs?
- What are providers' attitudes, barriers, and enablers to working with the self-employed?
- How does demand from employees influence provision of OH/VR services?

What is the pricing strategy for OH/VR services?

- What are the key factors that are considered when pricing OH services?
- How do providers charge customers for services?
- What prices do OH/VR providers set for different services?
- What are the determinants of pricing for OH/VR services?
- For SME's and the SE who have limited budgets, what pricing model could work allowing them to purchase the service they need and at no loss to the providers

How do OH/VR providers approach data collection?

- What are the outcomes that providers collect data on?
- Is there a cost burden when collecting outcomes?
- What data do providers collect?
- Do providers collect data on service outcomes?
- Is this data shared or cross referenced with anyone outside their organisation? If not, why not?

How do OH/ VR providers approach innovation?

- What proportion of provider time is spent on innovation, research and development?
- What proportion of provider money is spent on innovation, research and development?
- In what ways do providers innovate, if any?
- Has this changed due to the move to homeworking, and if so, how?
- What is the approach of providers to knowledge development?
- Do providers keep up-to-date with new OH/ VR research? How, and in what ways does it affect their service?

How do OH/VR providers view accreditation services?

- What is the awareness of providers regarding OH/VR accreditation services, e.g. SEQOHS?
- What are providers' attitudes, barriers, and enablers to gaining SEQOHS accreditation?
- To what extent do providers engage with these services?
- What do they see as the benefits of accreditation, if any?

How does OH/VR provision differ for SMEs and the self-employed?

- What proportion of customers are SMEs and Self-Employed people?
- What is provider willingness to work with SMEs and the self-employed?
- What are the barriers and enablers to serving SMEs and the Self-Employed?
- How does demand from employees influence provision of OH/VR services?
- What would OH/VR providers need from the government in order to provide more services to the self-employed and SMEs, in particular small and micro employers?

How are OH/VR providers using MDTs?

- To what extent do OH/VR providers use multi-disciplinary teams to deliver services?
- Where multi-disciplinary teams are used, what mix of skills and professions do they involve and how do they work together to deliver OH/VR services?
- What are the attitudes, barriers to, and enablers, of OH/VR providers using multi-disciplinary teams?
- Are there examples of effective approaches to using MDTs that OH/VR providers can share?

- **The exact research questions the Authority wishes to include will reflect the policy priorities at the time and will be agreed in collaboration with the Supplier and other OH stakeholders once the contract is in place.**

6.5 Sampling

6.5.1 The Supplier is responsible for identifying and carrying out sampling methods. As there is no single list of all OH and VR providers in the UK, we expect the provider to use multiple sources and where appropriate utilise snowball sampling in order to a) achieve as high a number of survey respondents as possible, and b) include respondents from each of the following groups in both the quantitative and qualitative parts of the research:

i. Private outsourced OH providers
ii. In-house OH departments (within large organisations)
iii. NHS OH providers
iv. VR providers

6.5.2 The contractor would like the supplier to reach as many OH providers from each group as possible, however, out of the providers surveyed the authority expects a minimum of 100 providers to be private, 50 to be NHS, 25 to be in-house and 25 to be VR providers.

6.5.3 The Supplier may consider sources used in the 2019 OH provider survey, which included:

i. A sample purchased from *Market Location*.
ii. Publicly available lists of OH providers who had or were working towards a SEQOHS accreditation.
iii. Publicly available lists of OH providers registered with Commercial Occupational Health Providers Association (COHPA).
iv. Publicly available contact details for NHS OH providers from the NHS Health at Work website.

6.5.4 However, we also expect the Supplier to consider additional sources, especially for in-house OH departments and VR providers, who were not targeted in the previous survey.

6.5.5 Suppliers should set out in their proposal any particular challenges they foresee in recruiting participants for this research and how they will address this to ensure that they successfully recruit the required number of participants.

6.6 Incentives

6.6.1 The Authority deems the case for use of incentives in the form of a £25 voucher to be reasonable as the target sample includes healthcare professionals, a group which has been difficult to reach in previous research. In this instance, the Supplier must take into account any restrictions that the Authority and the recipients may be subject to, for example, the NHS gift register. The Supplier must work in conjunction with the Authority to agree the recruitment strategy.

6.7 Reporting

6.7.1 Full discussion with the Authority of timing and reporting of key and interim outcomes.

6.7.2 Presentation to the Authority of initial findings once quantitative fieldwork is complete, for internal purposes following completion of quantitative research.

6.7.3 The drafts and final report should include a full report of methods, issues, analysis and outcomes, and where appropriate potential policy implications. The final report is expected to be of publishable quality and include findings from the quantitative and qualitative fieldwork and sent to the supplier in September 2023. The final report should be accompanied by a technical report and executive summary. The final report should be written to DWP standards (as set out in the DWP style guide, to publishable quality) with drafts as necessary.

6.8 WELSH LANGUAGE SCHEME

6.8.1 The Supplier should be aware that the Department has signed up to the Welsh Language Scheme. Where it conducts public business in Wales, it treats the English and Welsh languages equally.

6.8.2 The specific geographical coverage of the research has yet to be confirmed but the Supplier that must be aware of the provisions of the Welsh Language Scheme and the implications if the intervention is tested in Wales:

6.8.2.1 In practice, this means the Supplier must ensure:

6.8.2.1.1 Invitation letters to Welsh participants are issued in both English and Welsh.

6.8.2.1.2 Interview / survey/ research materials for Welsh participants are made available in Welsh, where requested.

6.8.2.1.3 Interviews are conducted in Welsh, where requested.

6.8.2.1.4 Any telephone or postal queries from Welsh participants are answered in Welsh, where requested.

6.9 Ethical Considerations

6.9.1 The Supplier is required to consider ethical issues in relation to the research (see the guidelines on Ethical Assurance for Social Research in Government) including the following ethical considerations:

6.9.2 It is essential that the research allows all participants to partake fully. Research instruments should be designed to be accessible if required.

6.9.3 It is the responsibility of the Supplier to ensure the research is conducted ethically. The Supplier will be expected to assess whether ethical approval is necessary. Where ethical approval is required, it will be the responsibility of the Suppliers to seek and gain ethical approval before the research commences.

6.9.4 All participants must give their full consent prior to taking part in the research. This consent must be informed, specific and freely given. Explicit verbal consent must be obtained and recorded by the interviewer, in cases of telephone interviews and electronic consent must be obtained in the cases of online interviews.

6.9.5 The Supplier should ensure that there is minimum burden placed on OH/VR providers.

6.9.6 The Authority will provide the Supplier with a template for obtaining informed consent from participants to ensure it is compliant with DWP standards and processes.

7 key milestones and Deliverables

7.1 The following Contract milestones/deliverables shall apply:

Milestone/ Deliverable	Description	Timeframe or Delivery Date
1	Confirmation of roles and responsibilities within the suppliers' project team	Within week 1 of Contract Award
2	Project inception meeting with EHIEAD analysts	Within week 1 of Contract Award
3	Delivery of work plan	Within 2 weeks of contract Award
4	Authority sign off research methodology and instruments	Within 5 weeks of contract award
5	Quantitative fieldwork to begin	April 2023
6	Weekly email updates to be sent from the Supplier to the Authority's contract manager, with update meetings to be scheduled when the Authority deems appropriate.	Weekly
7	Initial findings presentation & topic guide adjustment	Early June 2023
8	Qualitative fieldwork begins	June 2023
9	Fieldwork analysis & draft report	Mid September 2023
10	Final report	End September 2023

7.2 Note that the milestones are estimates and may be subject to change. Any changes will be communicated to the Supplier and discussed beforehand.

7.3 The Supplier shall perform its obligations so as to achieve each Milestone by the Milestone Date.

7.4 The Authority will ensure that the successful Supplier has access to relevant information to allow for a suitable understanding of the policy area prior to commencing the work.

7.5 The Supplier will inform the customer of changes to risk which will impact upon delivery to time, cost or quality.

8 MANAGEMENT INFORMATION/reporting

8.1 The Supplier (as represented by a senior research manager, associate director or equivalent) will report directly to the Authority's Contract Manager at regular update meetings and further report to EHIEAD analysts where the Authority requires.

8.2 The supplier is required to work with the authority and set up an expert steering group with OH stakeholders to support with sampling, developing survey questions, response options, interview topic guides and deciding who is best placed at the provider company to answer the survey.

8.3 If required, the authority will help the supplier to set up a steering group using their stakeholder links.

8.4 The Authority will require the Supplier to submit a final report and technical report as part of this research project. Draft versions of all reports must be provided by the Supplier for quality assurance by the Authority. Comments must be considered and used to inform the final version. The supplier should be aware that they may be required to produce multiple draft copies before a final version is accepted.

8.5 The Authority will also require at the end of the project, anonymised dataset(s) with data from the quantitative research component(s) to be transferred back to the Authority.

8.6 The Provider must delete the data securely at the agreed end of the project and provide a written confirmation of the destruction to the Authority.

8.7 The Supplier and the Authority will agree research outputs to include a minimum of:

- Fieldwork materials to be signed off by the Authority
- Regular reporting of key findings to the Authority throughout quantitative and qualitative fieldwork stages
- A presentation of initial findings upon completion of quantitative research, in a format to be agreed
- A final, full report by end of September 2023 which includes a separate executive summary and technical report written to DWP standards (as set out in the DWP style guide, to publishable quality) with drafts as necessary
- Coding framework for quantitative and qualitative datasets to be provided with fieldwork data when sent to the Authority

9 volumes

9.1 The quantitative research should aim to reach as many OH/VR providers as possible, but we expect a minimum sample size of 200 OH/VR providers. Surveys are expected to last around 50 minutes.

9.2 The qualitative research should have a sample size of 20 OH/VR providers who use MDT's. Length of time spent with each participant will depend on the methodology used for the qualitative part of this research project and will be discussed further with the Supplier.

10 continuous improvement

10.1 The Supplier will be expected to continually improve the way in which the required Services are to be delivered throughout the Contract duration.

10.2 Changes to the way in which the Services are to be delivered must be brought to the Authority's attention and agreed prior to any changes being implemented.

11 SUSTAINABILITY

12 QUALITY

12.1 The Supplier shall have sound processes for quality assurance in place and should demonstrate their internal procedures to assure and control quality in all aspects of the study within their proposal. This includes:

- Specified and clearly defined procedures for working closely with the Authority through regular updates.
- Specified and clearly defined procedures for quality assuring all research tools and analysis.
- Interview quality control procedures, including details of how the researchers conducting interviews have been trained and briefed.
- Specified and clearly defined procedures in place for handling complaints from potential and actual respondents.
- Specified and clearly defined procedures in place for handling contact from potential and actual respondents wanting legal advice or advice relating to employees.

12.2 Ethical issues should be considered **(see the guidelines on Ethical Assurance for Social Research in Government).**

12.3 Draft versions of all reports must be provided by the Supplier for quality assurance by the Authority. Comments must be considered and used to inform the final versions. The Supplier should be aware that they may be required to produce multiple draft copies before a final version is accepted.

12.4 The Supplier shall assess the key risks for this research. Bidders are expected to identify and set out the most significant risks for this research project and assess the degree of risk (likelihood and impact) and set out strategies for minimising these risks and managing the consequences if problems occur.

12.5 The Supplier will be required to work with the contract manager to complete a DWP Security Assurance for Research and Analysis (SARA) process. SARA will set out and clearly document what data will be collected, where it will be stored, who will have access, what data transfers will take place and between which parties.

13 PRICE

13.1 Responses should include a full cost breakdown including each element of the research and associated tasks (refer to Attachment 4 – Price Schedule via the e-Sourcing Suite).

1.1. **The Authority expects to be able to complete the survey requirement within their budget of £140,000 (excl. VAT). The maximum contract value for the initial period of 7 months is £140,000 (excl. VAT). There is an option to extend for up to a further 3 months at the sole discretion of the Authority. The maximum value of the extension period will be £70,000 for a 12-month period, the actual value to be confirmed by the Authority, subject to the requirements and length of the extension period, subject to budget approvals and governance**

13.2 For the bid evaluation bidders should price for:

- **Sampling and recruitment of participants**
- **50 minute telephone surveys for a target of at least 200 OH/VR providers.**
- **Qualitative follow up research on the use of MDT's, pricing strategies and working with SMEs and the self-employed with a target of 20 OH/VR providers.**
- **Data analysis for both phases of research, an initial findings presentation to the Authority, and writing of draft reports and the final report and technical report.**
- **Additionally: any costs associated with provision of anonymised dataset(s) in software formats required by Authority at the end of the project. Any datasets transferred to the Authority should be labelled and accompanied by the syntax used for the creation of any derived variables, a suitable explanatory data dictionary. Pricing should further incorporate the costs of project management and administrative support.**

14 STAFF AND CUSTOMER SERVICE

14.1 The Supplier shall provide a sufficient level of resource throughout the duration of the Contract in order to consistently deliver a quality service.

14.2 The Supplier's staff assigned to the Contract shall have the relevant qualifications and experience to deliver the Contract to the required standard outlined in the bid. The qualifications and experience of the staff who will be working on the project should be detailed by the Supplier in their bid.

14.3 The Potential Provider shall ensure that staff understand the Authority's vision and objectives and will provide excellent customer service to the Authority throughout the duration of the Contract.

15 service levels and performance

15.1 The Supplier will appoint a member of staff as a lead liaison to work closely with the research project manager to deliver the agreed key milestones on time. In addition, the lead liaison will work closely with nominated officials in the Authority to design and implement the research, keeping them informed of progress and involving them in key decisions.

15.2 The Authority will measure the quality of the Provider's delivery by completion of key milestones and project outputs to a publishable standard whilst meeting the specified timescales.

15.3 Progress and sign-off of products will be assessed by the Authority with representation including the Authority project managers, policy professionals and policy analysts from across Ministerial policy areas.

15.4 The Provider should demonstrate the internal quality assurance procedures that will be implemented during the project to ensure control quality throughout the project within their proposal. The Authority will measure the quality of the Supplier's delivery against all deliverables specified in Section 3 of this specification. This will include:

KPI/SLA	Service Area	KPI/SLA description
1	Service Delivery	Adherence to the milestones

2	Quality assurance	Specified procedures for quality assuring methodological design proposals. Take clear steps to ensure all analysis is quality assured and suitable for informing policy decisions and publications. The provider should set out these procedures and steps in their response to this statement of requirements. EHIEAD analysts will independently assess the quality and robustness of research designs and analysis.
3	Project management	Weekly progress updates by email
4	Project management	Respond to queries within 48 hours
5	Research Outputs - Analysis	**Robust analysis to be undertaken to a high standard meeting DWP requirements and to be quality assured before submission to the Authority.** **Clear steps must also be taken to ensure the accuracy and quality of the analysis does not suffer as a result of concurrent projects and high work volumes.** **The provider should set out the control procedures in their response to this statement of requirements. The provider should inform the Authority of any staff changes or other relevant issue that might impact on the production of analysis and reporting of findings.**
6	Research Outputs – Reporting	**Delivery of required reports/briefings/presentations to the Authority within timeframe set out in the milestones.** These should be of high quality and meet the requirements of the Authority including effectively addressing the agreed research questions. The final report should be of publishable standard.

15.5 Poor performance against the SLA's will be monitored, where there is an SLA failure for two consecutive months, the Supplier will be required to draft and implement a Service Improvement Plan. This plan will be agreed with the Authority and its implementation will be monitored.

16 Security and CONFIDENTIALITY requirements

16.1 Suppliers must adhere to all appropriate security requirements. They will work with the DWP Project Manager to ensure all security procedures are in compliance with Departmental standards.

16.2 The Supplier must provide detailed plans for how they will ensure participant data will be securely received, stored and destroyed. They will have an up-to-date Information Security Questionnaire (ISQ), as required by departmental security protocols.

16.3 All fieldwork must be gathered, transported and stored securely. **Any transfers to and from the Supplier to any subcontractors (for example, a transcription services provider) must also meet DWP standards, using PGP encryption software or equivalent.**

16.4 All transfers of personal data to and from the Authority must meet the Authority's security standards as agreed in the Information Security Questionnaire (ISQ).

16.5 The Supplier must securely store data in accordance with the General Data Protection Regulation. The Authority requires details from the Potential Provider on how this will be undertaken.

16.6 The Supplier is required to provide assurance to the Authority that all data will be securely destroyed within a reasonable timeframe, as per current Data Protection Regulations, following completion of the project.

16.7 In the case where the Supplier's staff are working from home, the Authority may require sight of the Supplier's working from home policy.

17 payment AND INVOICING

17.1 The Supplier will be paid in three increments by the Authority. The first payment shall be sent to the Supplier upon competition of the quantitative fieldwork and satisfactory presentation of initial findings to the Authority. The second payment shall be made upon completion of the qualitative fieldwork and the final payment will be made upon the Authority receiving the final report from the Supplier.

17.2 Before payment can be considered, each invoice must include a detailed elemental breakdown of work completed and the associated costs.

17.3 Invoices should be submitted to: SSCL, PO Box 406, Phoenix House, Celtic Springs, Newport NP10 8FZ. Electronic Invoices (attached to E-Mails) should be sent to APinvoices-DWP-U@gov.sscl.com . Shared Services Helpline: 0845 602 8244

18 CONTRACT MANAGEMENT

18.1 The Supplier will be responsible for providing overall oversight and management of both components of the research, with the Authority working with the Supplier to support with stakeholder engagement. This should include monitoring and mitigating for possible and emerging risks and issues which could impact on the successful completion of all aspects of the project. It is vital that the Supplier has a robust risk management plan/strategy which is agreed and shared with the Authority.

18.2 Attendance at any Contract Review meetings shall be at the Supplier's own expense.

19 LOCATION

19.1 The Supplier will be based in their offices but will be expected to attend Project Management meetings, including, if required travel to DWP Offices (London, Leeds or Sheffield). On-line meetings will be used where practicable.

19.2 All data processing, management and analysis will be undertaken in the United Kingdom. All servers must be located within the United Kingdom.

IFF RESEARCH PROPOSAL

Occupational Health Provider Survey

27 January 2023

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5 Methodology

5.1 Survey methodology

This is a really interesting study that we are delighted to tender for, and that's a good fit with our expertise in policy-relevant mixed method research, including previous studies within Occupational Health (OH).

Addressing the research questions: To provide reliable data to answer your research questions, we need to (a) ask the right questions, framed in appropriate language and with meaningful response options; and (b) ask them of a sufficiently large and representative sample. Our approaches to these are detailed below, but as the team delivering the 2019 OH Provider Survey, we're well-placed to 'get these right' by drawing on our expertise / experience, of what was then relatively uncharted territory.

Sampling approach: While there's an absence of reliable population data for OH and VR providers, the sector is known to be relatively small (confirmed by our 'sector expert interviews' and work on assembling a survey starting sample in 2019). We'll therefore need to conduct an attempted census, seeking an interview from all providers in our starting sample and achieving as many interviews as possible.

Within each provider, we propose to target a senior executive contact who can comment on the 'big picture' of issues such as capacity, approaches to recruitment and resourcing, pricing structures and marketing strategies, innovation and learning. This is consistent with the 2019 survey. When setting up the interview we could give examples of relevant roles but, more importantly, we should describe the kinds of topics we want to cover and emphasise that we want a strategic decision-maker working across these issues (rather than someone slightly more junior specialising in just one aspect).

Sample sources: In the absence of a single authoritative sample source, we propose blending sample sources to improve the sample coverage (individual sample sources may contain biases, such as providers reached via sector bodies being better-connected, but this can be compensated for by including other sources). We propose running our sample sources past the Steering Group, to seek further sources; but at this stage we suggest blending the following. We'd clean the starting sample to remove duplicates:

Source	Coverage	Number of providers
Market location sample	Businesses classed as "Occupational Health" Businesses classed as "Rehabilitation Centres" Large employers – *numbers TBD, subject to size chosen	260 records; 486 records; TBD*
SEQOHS public lists	OH providers with or working towards SEQOHS accreditation	155 records
COHPA public lists	OH providers registered with COHPA	60 records
NHS Health at Work	Network of Occupational Health teams working in the NHS	c.100 records
VRA Practitioner Directory	Members of the Vocational Rehabilitation Association	c.100 records
TOTAL		c.1,160 records

This emulates the 2019 approach, adding the VRA Practitioner Directory (as with others of our sample sources, a membership list in the public domain) to increase the coverage to include VR providers.

Approach to contacting participants, to maximise response rates and reach the participation target: We propose to use a combination of approaches to contact respondents and maximise response:

1. **Agreeing motivating lines to take:** Agreeing a persuasive rationale for participation in the survey can make more difference than anything else. We believe this study has just this strong rationale, as we are looking to create an updated picture of GB OH and VR provision, to shape UK government policy, and set a benchmark against which the effects of these policies can be measured. We'd hone this with the Steering Group, and then deploy these lines via (a) warm-up communications and (b) our survey introduction scripts.

2. **Warming up potential participants:** We'd use our agreed 'lines to take' within a warm-up email / letter (IFF-drafted and agreed with you), to be sent on behalf of DWP to our starting sample. We believe this will pay dividends in emphasising the survey importance and encourage potential participants to make time for it (it should have a senior DWP signatory to reinforce its status). It can also give **advance warning of any especially complex data**, that participants may wish to look up before their interview. We suggest we try to get news stories about the survey included in sector publications and on social media too; and encourage our Steering Group members to use their networks to spread the word.
3. **Our persuasive and experienced interviewers:** We have a team of telephone interviewers who spend their working lives recruiting and interviewing senior professionals; and we can 'cherry pick' individuals who delivered the 2019 OH provider survey, giving them familiarity with the topic and a more confident approach to a relatively technical subject. We feel this confidence will communicate itself to potential participants, when interviewers seek to gently persuade providers to take part.
4. **Flexibility in how we offer survey completion (our approach to survey delivery / mode):** The emphasis will firmly be on telephone completion (as the encouragement of an interviewer can help the participant see the survey through to completion, while also probing for more detail). That said, we'd be happy to offer an online completion option, free of charge, as a contingency (as it'd be better to get an online response from a provider than none at all). We'd also offer our telephone interviews at flexible times (day and evening, weekday and weekend) to suit providers' schedules; and we'd give providers the option of completing in several sittings, if 50 minutes is too much in one go. Finally, given the interview length, we'd mostly set up appointments in advance as we would with a qualitative discussion; and use a team of interviewers experienced in conducting both surveys *and* qualitative interviews (as they're more familiar / comfortable with maintaining engagement over a longer interview and probing for and capturing detail in response to open questions). All these are 'tried and tested' strategies that paid off when we ran the predecessor survey in 2019.
5. **Use of incentives:** We've assumed an incentive of £25 for each completed interview as you suggest. This can give potential participants another reason to say 'yes'. We'd discuss carefully with the Steering Group and yourselves, how to position this, but with a professional audience we'd tend to suggest it's framed as a donation to charity on the participant's behalf (which involves fewer ethical issues, and avoids a professional being offended by an incentive that's 'too small' in the context of the hourly rate for their time). We then let them accept it personally if they prefer, though (in the context of NHS Gift Register, NHS staff may be excluded from being able to take it personally as it's over £10, but we can still offer a charitable donation).

Overcoming challenges in collecting and surveying the sample: We've already touched on some of the challenges in collecting and surveying the sample above, but to summarise how we'd address these:

Challenge	Our strategy for overcoming this
Lack of a single authoritative sample source	Use a blended approach, as described above (this balances out any biases inherent in specific sample sources). Run proposed sources past the Steering Group, for advice on the best mix of sources. Final approach discussed and signed off with DWP.
Individual sample sources may contain inherent bias	
Providers not engaged with idea of taking part, so difficult to persuade	Agree with DWP, our lines to take to communicate the study relevance and importance (and get Steering Group input into this). Use warm up letters / emails and Steering Group networks to 'sell' study relevance, priming providers to be more open to taking part.
Providers feel too time-poor to take part in 50-minute interview	Give options for completion by phone at different times and in several sittings if needed. As a contingency, offer an online completion option.

Using these strategies, we'd target achieving a sample looking something like this:

Audience	Target sample size*:*	Margin of error at 95% confidence (assuming small population) – findings accurate to within:	Estimated response rate	Starting sample needed – estimates

Private outsourced OH providers	100	+/- 8.1 percentage points	32%	c.310
In-house OH departments	25	+/- 16.3 percentage points	32%	c.80
NHS OH providers	50	+/- 11.3 percentage points	32%	c.150
VR providers	25	+/- 16.3 percentage points	32%	c.80
TOTAL	**200**	**+/- 5.9 percentage points**		

While achieving the participation target cannot be guaranteed, we're confident of achieving a good response rate and delivering a robust sample for analysis: in 2019, we achieved 103 completed OH provider interviews from a starting sample of 322 contacts, a response rate of 32% (the basis for our estimates above). It's only NHS OH providers where our starting sample is smaller than ideal. We'd keep you informed of progress weekly and discuss transparently and collaboratively with you, what we can do to maximise response as we go. We've assumed, for costings, that the sample of 200 would include the 20 pilot interviews.

Developing, testing, prioritising and finalising survey questions and response options: Getting the questionnaire design right is one of the key project challenges. We need to make sure we address your priorities for updated evidence on the sector, both to shape policy and set a relevant benchmark against which the impacts of policy can be measured. The questions and response options need to be framed in language that resonates with providers and allows them to give us meaningful data. It also needs to be achievable within the 50-minute proposed survey duration. This will require a series of trade-offs. We successfully worked with you to develop the 2019 survey questionnaire from a 'blank sheet of paper', by drawing on our qualitive interviews with 'sector experts' and refining the design through small-scale cognitive testing among stakeholders. We therefore feel we're well-placed to design the 2022 survey.

We suggest the following iterative process to get us to the optimum questionnaire:

1. We meet with the DWP team, including key policy stakeholders, to **hear a detailed verbal brief** on your current data needs. This ensures we grasp the nuance and are all 'on the same page'. It also gives you the opportunity to update the ITT's research questions (the ITT notes these may evolve). We'd confirm our understanding of this in writing, particularly focusing on differences from the ITT.
2. We do some **initial development work** around your brief, for example, considering: which of your current research questions have been covered by the 2019 survey (giving us scope to emulate previous wordings, to give time-series data); how new questions might be phrased; which types of research questions might be 'headline' questions to capture big picture measures; and what further questions might be needed to add detail. You'd have the opportunity to comment on this work.
3. We suggest putting this initial work into a PowerPoint deck so that it can be **presented and discussed in a session with the Steering Group.** We suggest this session begin with a short briefing by DWP on current data needs and the rationale for these, so that the Group understands the parameters within which to give feedback. We'd then present the DWP research questions and our initial thinking on these, as the basis for exploring:

Steering Group session coverage ideas:

- Which of the 2022 research questions feel most important to include? Which are nice to have? (We can potentially run an exercise allocating 'stars' to questions, to clarify this.)
- Which 2019 survey questions might successfully meet a 2022 data requirement? Where would comparisons over time from 2019 to 2022 add most value?
- How well does our initial wording of new questions work for a provider audience? How might this be improved? What response options would be meaningful?
- Which research questions might benefit from 'hard measures' and which from the more qualitative detail of open-ended questions? (And which might benefit from being explored in more detail in a purely qualitative in-depth interview amongst a smaller sample?)

4. We'd briefly summarise the session take-outs in writing and would discuss them with you to explore your perspective. We'd then **work up a full questionnaire draft.** We suggest doing this initially in Excel, with full

question wordings and response options, one question per row, for you to review. We suggest this as it's easier for you (and us) to get an overview of how the suggested questions flow, and we can add a timing estimate in seconds for each question, so that you can see the overall interview length and how the time is being used (this can be invaluable for prioritising questions for inclusion and achieving a logical question sequence). We'd revise this iteratively with you until you're happy with it; we also suggest sharing it with the Steering Group for further feedback by correspondence, as part of this process. Once agreed, we'd transfer the questions into Word, with full routing and programming instructions, and share it with you for final sign-off.

The questionnaire would also be **cognitively tested.** We agree a sample of **five cognitive interviews** should give us sufficient feedback to make revisions. We'd recruit a deliberate mix of providers across the four audience groups (OH private providers, in-house OH, NHS providers and VR providers), with our specialist in-house recruiters recruiting from our starting sample. We'd also be open to the DWP or the Steering Group suggesting some 'warm leads' for providers who might be open to taking part, which could pay dividends in setting up the cognitive interviews quickly. We suggest two of the five being VR providers, as the only group not included in the 2019 survey. We envisage each cognitive interview being conducted by the core research team, and lasting up to 90 minutes, ideally face-to-face or via videocall. They'd have the following structure:

Running through the questionnaire (c.50 minutes):	• We'd administer the survey as if 'for real'; but briefing the participant to 'think aloud' whenever they have any feelings about / reactions to the questions. • As well as recording the participants' answers, the researcher will note reactions to the questions (including facial expressions/other non-verbal cues).
Reflecting on the experience (c. 40 minutes):	• Once the interview run-through is completed, we'd discuss the interview experience with the participant; exploring their views on the interview overall (including how well it 'flowed'; whether they felt anything important is missing). • We'd then revisit the question-by-question content; particularly focusing on any specific questions that were ambiguous, difficult or confusing, or seemed inappropriately worded. In discussing these, the researcher would draw on their notes from the interview run-through, of points where the participant reacted to the questions. We'd explore solutions to any issues raised.

We'd summarise the outcomes of the cognitive interview testing in a short (c.5 page) paper, making concrete recommendations for refinements, accompanied by a tracked changes version of the questionnaire. To deliver to your end deadline of September, cognitive testing will need to be relatively agile and informal; taking place alongside the process of liaising with you to refine the questionnaire draft.

The final stage of development is for our in-house data services team to script the survey. The survey script is then checked sequentially by our researchers and signed off by the project manager. We then proceed to a full **pilot.** We agree that, following the cognitive testing, a pilot of c.20 interviews will be sufficient to check comprehension of the questions and interview flow, monitor response patterns and the overall interview length. Following the pilot, we'll produce a further short (c.5 page) paper on the outcomes and recommendations for changes, with a marked-up questionnaire showing how these changed would be implemented.

Within this questionnaire development process, we'll need to make judgements on, for example, which current research questions might attempt to provide time-series data building on the 2019 survey, which might be used for 'big picture' measures; and which might need (perhaps free text) detail. As an example of our thought process, we've applied this assessment to a sample of your research questions:

Examples of 2022-23 research questions:	Potential to track against a 2019 question?	Potential to act as a 'big picture' measure?	Potential to act as a supporting 'further detail' question?	Could benefit from a free text question?
What percentages of different professions make up providers' workforces?	F2: captures % medical professionals	Y – could add further % breakdown		

How easy do providers find it to recruit each profession type?	F5/F6: hard-to-fill roles	Y – could add scale, easy/difficult		
What roles do different professionals have and what tasks do they carry out?			Y – suggest developing pre-coded lists	
What are the barriers and enablers of OH / VR recruitment?			Y – suggest pre-coded lists	
What is current OH / VR provider capacity?	C1/C2: max. capacity; % of capacity used			
To what extent are providers using multi-disciplinary teams?		Y – % of work done via MDTs		
What are provider attitudes to using multi-disciplinary teams?				Y - more exploratory
What are the barriers and enablers of using multi-disciplinary teams?			Y – suggest pre-coded lists	

This is just an example that we hope makes our approach a little more tangible. It's also worth noting that your brief covers many topics, so some hard decisions around priorities will almost certainly need to be made.

The above questionnaire development process draws on the expertise of a **Steering Group**. We'd be happy to work with you to identify relevant individuals to take part in the Steering Group (drawing on our experience of conducting the 'expert' depths in 2019); and to suggest how best to make use of the Steering Group (though an invitation to join the Steering Group may have more 'weight' coming from DWP). We assume, for costing purposes, engaging with them via c.4 meetings. We recommend:

- Giving them clear terms of reference, setting out the study purpose and making it clear that they act in an 'advisory' capacity (requiring Steering Group sign-off can, in our experience, cause delays).
- Aligning the sessions to points where they can actively feed into the study (for example, development of the questionnaire and 'lines to take' in warm-up communications; development of topic guides for the qualitative work; refinement of our interpretation of findings).
- Exploring whether they are willing to reach out to contacts in the sector, to 'warm up' providers to take part in the survey, encourage sector news channels to positively mention the study, etc.

Analysis of responses to closed and open-ended questions: Due to a lack of reliable population data, it's probably not feasible to apply population-based **weights**. With our attempted census approach, we don't need 'design weights' to compensate for oversampling any subgroups. We could consider applying weights to correct for non-response bias if needed, i.e., comparing the profile of our starting sample to that of the achieved interviews and correcting for any differences, using the profile of the starting sample as a basis. We'd discuss this with you and confirm the approach in writing.

An analysis plan for the survey data will be drafted and agreed with DWP in advance, including key cross-breaks to be applied and a full specification for data tabulations. Directors will play a lead role in determining the analysis plan. The data outputs of each wave will be: computer tabulations (with full significance testing against all the analysis sub-groups) and an SPSS datafile (fully-labelled, with a data dictionary to explain any derived variables).

Given the complex nature of what we're asking OH and VR providers to comment on, and the sometimes exploratory nature of the research questions, free-text questions will play an important role within the survey. The response to free-text questions will be coded by our in-house coding specialists in collaboration with our core research team, to identify recurring themes and, ultimately, to assign percentage values to signal the frequency with which these themes recur within the total sample (in our final data tables, these recurring free-text themes will appear as codes, in a similar manner to the pre-coded questions). The IFF Project Manager will review the initial provider responses to these free-

text questions, once c.20 interviews (10% of the sample) are complete, making notes of recurring themes. They'll then brief our specialist coders who will expand these thematic suggestions into a draft coding frame for each question, by reviewing responses from our sample iteratively and assigning codes to each provider's response. Our Project Manager will review and feedback on the draft coding frames, and a revised version will be reviewed and signed off by the Directors. They'll then be passed to the DWP for comment and sign-off before full coding of the free-text questions is carried out. The coding manager will check a minimum of 5% of the work of each coder. The final coding frameworks will be shared with you as a study output.

We'll share emerging survey findings iteratively on a couple of occasions, giving you early sight of findings and allowing you to pose further questions, which can help us evolve the analysis approach. Once data reduction and preparation is completed, individual researchers work with the datasets and bring their initial interpretation of the survey findings to director-led analysis sessions for scrutiny and challenge; we welcome your participation in this process, to collaborate on our final interpretation.

Overall reporting approach: We can confirm we'd deliver the outputs in the ITT; that is, a debrief of survey findings and a final report of publication standard that draws the survey and qualitative findings together. We welcome the opportunity to use the debrief as a further chance to discuss the implications of the survey findings – given the debrief will precede the final report, we can use this discussion to inform the final report's messages.

In our debriefs and reports our guiding principle is to tell a clear 'story', highlighting the key points and their implications, and concluding with actionable recommendations. We use charts, diagrams, quotes, stories and pen portraits to bring the findings to life and add visual impact. Where we're dealing with multiple data sources (as we will in the final report here), our preference is to synthesise these so we deal with all the evidence on a topic in one place. The IFF Directors would be very 'hands on' in drafting key sections and reviewing the whole draft; and they would lead our presentations. We're very familiar with using our presentations as a starting point for discussion with senior audiences, including for the Cabinet Office, DHSC and the DWP, so we'd be happy to use the debrief session to more extensively 'workshop' the findings with you (setting a short agenda, if helpful).

The **outputs for this study would answer questions such as**:

- What is the current demand for OH and VR services? Where is this demand coming from, and what is driving this?
- What is the capacity of OH and VR providers to meet this demand, and why?
- How are OH and VR providers currently resourcing their services? To what extent does this involve multi-disciplinary teams, and why?
- What is the current situation re: staff recruitment; and what are the consequences of this?
- How are OH and VR services priced and marketed, and what's the rationale for this?
- To what extent, and in what ways, are providers working with SMEs and the self-employed, and how might uptake amongst these groups be improved in future?
- To what extent do providers monitor their service delivery, and what is done with this data?
- To what extent do providers engage in innovation and knowledge maintenance and sharing? In what ways do they do this, and what does this allow them to achieve?
- How do OH and VR providers view accreditation services; and to what extent are these used?
- Reflecting on this, where do the strengths and vulnerabilities of the sector seem to lie?
- What does all this mean for government policy to improve the efficacy of this sector in supporting employers and employees?

5.2 Qualitative methodology

Design considerations: We propose to prioritise resource towards the OH / VR provider survey, as this will give the most authoritative picture of the state of OH / VR provision. This means that, for the qualitative element, 20 in-depth interviews will be feasible to conduct (as opposed to more extensive case studies). In any case, we feel that in-depth interviews will be a better match for your objectives, which this time are mostly concerned with deepening understanding of specific provider issues or exploring reactions to potential enablers or solutions within the OH / VR space (by comparison, case studies tend to be better at illustrating how provision is playing out in practice between multiple parties, such as provider, employer and employee).

That said, we suggest that, in practice, we deliver 20 one-to-one in-depth interviews or, where relevant, pairs or triads. Pairs or triads would involve us speaking with multiple individuals within the same OH / VR provider organisation; these add value where the relevant knowledge within a provider is shared amongst multiple individuals. At recruitment we'd identify a lead contact, would explain to them the topics that we're seeking to cover, and would ask them whether it would be relevant to conduct the interview with one or two of their colleagues. We'd always check that the two or three colleagues that we're seeking to bring together have complementary perspectives and are comfortable speaking candidly in front of each other.

As with the survey, we propose to target a senior executive contact who can comment on the 'big picture' of issues such as capacity, approaches to recruitment and resourcing, pricing structures and marketing strategies, innovation and learning.

Developing, testing, prioritising and finalising topic guides: Discussions will be a fluid two-way dialogue in which our researchers respond to what participants tell us. This is underpinned by a discussion guide that ensures all the key questions are covered.

We've assumed that interviews would last **60-90 minutes** so that we have some flexibility to accommodate OH / VR providers who wish to talk for longer while avoiding creating participation barriers for those who can give less time. We suggest having a 'light touch' modular topic guide approach where certain questions are flagged as high priority and other questions or sections are flagged as ones to ideally cover if there's time.

The discussion coverage will be shaped by the early survey findings, as the intention is that it should complement the survey. We envisage using the following process to develop and test topic guides:

1. At the start of the study we'd meet with the DWP team, including key policy stakeholders, to **hear a detailed verbal brief** on your current insight needs, to ensure we understand the nuance and are all 'on the same page'.
2. We'd use this briefing to begin the process of thinking through which research questions might best be served through measurement in the survey; and **identifying which might benefit from a more in-depth exploratory approach** in the qualitative element. Of course, some research questions will require both – perhaps 'headline' measures in the survey accompanied by further discussion in the qualitative interviews to deepen our understanding or illustrate the theme through stories and examples. Our early, 'survey scoping' session with the **Steering Group** will add their perspective to this initial thinking.
3. Once we have early findings from the OH / VR provider survey, we'd **meet with the DWP team again to discuss the emerging survey insight**. We'd talk about both the interpretation of what's coming out of the survey, and what this means for how best to use the study's qualitative element. We'd consider, with you:
    a. Which of your original research questions still feel high priority and were not fully addressed by the survey design (e.g., for time reasons, or due to being ill-suited to a survey)?
    b. What important queries have the emerging survey findings thrown up, that the qualitative research might be able to answer?
    c. What themes are emerging from the survey, for which detailed provider examples or stories might be valuable in helping audiences to understand the theme?
    d. What emergent hypotheses or ideas for policies or interventions might we be able to test and refine, by exploring provider reactions qualitatively?
    e. Of these relevant questions, which ones are essential to cover, and which are 'nice to have' if a provider is open to speaking with us across a longer (90-minute) session?
4. We'd produce a short summary of the meeting take-outs in writing. We'd then **work up a full topic guide draft** in Word for you to review. We'd refine this using your comments.
5. We then suggest inviting **feedback on the draft from the Steering Group**. This could either be via a meeting or by correspondence, according to whether there seems to be enough 'meat' for it to be worth convening a meeting at this point, from the stakeholder point of view. We'd discuss with you how best to implement the Steering Group feedback (agreeing which elements of feedback are more / less practical to incorporate and which are higher or lower priority).
6. You'd then comment on the updated topic guide draft, and we'd **revise this iteratively with you** until you're happy to sign it off.

The first c.3 qualitative interviews will be conducted by senior members of the research team as an inform**al pilot** of the guide design. We'll summarise our feedback for you in writing; and provide tracked-changes versions of the updated topic guide if any changes are needed.

Although the above is our suggested formal process for topic guide development, in reality we're open to the topic guide evolving further as fieldwork progresses. With qualitative interviews, the goal isn't to make every interview as similar as possible, but to draw on each participant's experience and expertise so that we learn as much as possible across the sample of interviews as a whole. It may be that discussions with OH / VR providers early on inspire an idea for how we can tweak the discussion approach to push things further in the remaining interviews, and we'd always be alert to these possibilities.

While the topics to be focused on are still to be decided, below are some examples of how the qualitative phase could add value to some of your research questions, to illustrate our thinking:

Example research questions:	• ***To what extent are providers using multi-disciplinary teams?*** • ***What are provider attitudes to using multi-disciplinary teams?*** • ***What are the barriers and enablers of using multi-disciplinary teams?***	• ***What are providers' attitudes, barriers and enablers to working with SMEs / the self-employed?*** • ***What pricing models could encourage SME / SE uptake?*** • ***What else could the government do?***
A qualitative approach might explore:	• Examples / stories of setting up MDTs, perhaps including 'journeys' from scepticism to being an MDT convert • Descriptions of the benefits; and what MDTs allowed providers to achieve • Good practice tips for how to help MDTs work well • Stories of challenges and how these were overcome	• Views on how much scope there is to expand service delivery to SMEs / SE • Reasons for this assessment • Provider ideas for what would assist SME / SE service expansion (pricing and other steps) • Provider reactions to stimulus giving ideas for policy / interventions in this space around pricing / other steps – which have more potential; refinements

Qualitative research delivery / mode: We propose offering a **blend of discussions by videoconference and telephone**, as a cost-efficient way of delivering the qualitative discussions while also giving us the flexibility to schedule / reschedule interviews at short notice around provider availability. If DWP agrees, where possible we'd encourage providers to take part via **videoconference** as a way of enabling us to build rapport. We've been delivering qualitative fieldwork successfully via video throughout the pandemic, including among OH providers (as part of our qualitative research into provider innovation and knowledge-sharing); while our fast turnaround insight work for the Cabinet Office involved us convening groups of senior businesspeople via video on a regular basis.

Participants will be **recruited over the telephone by IFF's specialist in-house recruiters**, drawing principally – we suggest – on the pool of OH / VR providers who took part in the survey (we'd ask consent to recontact them to invite them to a qualitative interview at the end of the survey questionnaire). We'd of course also approach any relevant providers in our survey starting sample who didn't participate in the survey, but it's still likely that mostly qualitative participants will be the same organisations already surveyed (especially with the survey being an attempted census).

We will work closely with you to determine how to define the research audience, including understanding which factors are critical and which 'nice-to-have' so that different criteria can be prioritised if necessary. Following an initial briefing, we will design a **recruitment screener** – a short questionnaire that is used to establish whether an individual fits the profile of the relevant audience(s) for the research.

As is the case with the survey, we propose to **target a senior executive contact** who can comment on the 'big picture' of issues such as capacity, approaches to recruitment and resourcing, pricing structures and marketing strategies, innovation and learning. This *may* be the individual who responded to the survey, but we'll make sure that, at recruitment, we describe the kinds of topics we want to cover qualitatively, in case we need to speak with someone different or, alternatively, convene a discussion with the survey respondent *and* one or two colleagues. As this suggests,

where relevant, we'll encourage a lead participant to invite one or two colleagues within the same provider organisation, where the knowledge we need is shared and they're comfortable speaking candidly in front of each other. We'd therefore **deliver some of our discussions as pair or triad interviews at no extra cost** (we would need, though, to achieve a balance; ensuring that the drive to achieve pairs or triads doesn't get in the way of fieldwork progress).

Participants will be given an incentive payment (£25 per discussion, as per the survey) to thank them for their time (this also encourages participation from a more representative cross-section of participants than we might otherwise achieve). Given the relatively modest sum compared to individuals' likely hourly rates as professionals, we suggest positioning this as '£25 given to a charity of their choice' per discussion completed.

All those recruited will receive confirmation letters or emails – these will include contact details both for IFF and yourselves to enable any queries or concerns about the research to be resolved before the session. This – together with reminder calls made a couple of days beforehand – is effective in minimising drop-out.

OH and VR providers will always be asked at the recruitment stage whether they have any additional support needs to enable them to participate fully.

Sample structure: We'd discuss with you carefully, how best to structure the 20 in-depth interviews, pairs or triads by provider type and other characteristics. To some extent, the sample design we develop with you will need to be informed by the desired topic guide coverage; as we need to select a sample of providers who will be able to answer the research questions identified for the qualitative phase. Once we've agreed with you the types of providers who are relevant to answer your research questions, we can either:

- (A) Distribute the sample evenly between the provider types, to give equal coverage of each; or
- (B) Allocate more interviews to specific types of providers, on the grounds that they are, for example, more numerous within the whole provider population; more diverse in their behaviours and attitudes (and so needing more interviews to represent that diversity); or simply more relevant to the agreed research questions.

It's impossible to arrive at a final sample structure now, but **example sample structures** to illustrate these two approaches are shown below:

Audience	**Number of in-depth interviews/ pairs / triads – illustrative**		
	(A) Even distribution	**(B) Distribution by relevance –** *e.g., if private OH / VR providers more relevant to our agreed research questions*	**(B) Distribution by relevance and diversity –** *e.g., if in-house OH departments more relevant and more diverse*
Private outsourced OH providers	5	10	3
In-house OH departments	5		11
NHS OH providers	5		3
VR providers	5	10	3
TOTAL	**20**	20	20

With us recruiting providers from the pool of participants in the survey, we will also have the ability to **review the survey dataset** for characteristics, behaviours or attitudes that are relevant to the agreed qualitative research questions, and then 'cherry pick' OH / VR providers to invite to take part.

Analysis of responses:

Qualitative analysis begins within the discussion itself. Within the session, the researcher continually weighs up the implications of what the participant says – and devises relevant follow-up questions (where this helps us draw out additional insight to meet the study objectives). Through this process of active listening and 'weighing-up' of feedback, the researcher exits the session with an initial view on discussion implications.

Encrypted digital recorders are used to record discussions (with permission). These are summarised in detail to a standardised template. The researcher uses the recording, the summary and any notes for **personal analysis,** re-immersing themselves in the content of what the participant said; the way in which they said it etc., in order to revisit / challenge their initial view on the implications of the discussion.

This will involve **triangulating feedback from different sections of the interview** (for example, although they claim they would be likely to market more to SMEs if incentivised to do so, how does this compare with what they've told us the barriers have been to doing so, historically). Notes are made of key take-outs, illuminating quotations, and areas to explore further etc.

Individual analysis of each discussion is entered into an Excel-based **analysis framework**, under headings relating to the objectives – allowing sessions to be compared/judgements made about the commonality of experiences. The framework would contain 'demographic' variables (e.g., provider type, workforce size, services offered) to identify subgroup differences.

IFF then conducts a **Director-led analysis session**, in which researchers develop their thinking regarding the findings/their implications. Individual researchers bring to the session their tentative interpretation of the findings. This will be discussed, with careful reference to the evidence, to verify our thinking on the findings through researchers applying a degree of scrutiny and challenge to each other's perspectives. **We welcome your participation in this session, to collaborate on our final interpretation.**

We'll also **share headline emerging findings from the qualitative interviews with you iteratively**. Sharing these a couple of times during fieldwork gives you early sight of the findings and enables us to discuss the findings with you, which allows us to refine our interpretation and means that you can pose any questions (which in turn can inform 'tweaks' to the discussion approach, so that we collectively learn more).

We'd be happy to provide details of our **coding framework** used to identify themes in the qualitative data, as requested; within our fees we haven't included costs for sharing the full analysis framework including summaries of individual interviews, or transcripts of interviews (these are too disclosive of individual detail and would involve considerable additional costs to edit for the sake of anonymity; we'd also need to pre-warn participants if we intended to share these, which might reduce candour or deter providers from taking part).

Overall reporting approach: We can confirm we'd deliver the outputs in the ITT; that is, a debrief of findings (which we gather is intended to focus on the survey, though we're open to being flexible on this) and a final report of publication standard that draws the survey and qualitative findings together. In our debriefs and reports our guiding principle is to tell a clear 'story', highlighting the key points and their implications, and concluding with actionable recommendations. We use charts, diagrams, quotes, stories and pen portraits to bring the findings to life and add visual impact. Where we're dealing with multiple data sources (as we will in the final report here), our preference is to synthesise these so we deal with all the evidence on a topic in one place. The IFF Directors would be very 'hands on' in drafting key sections and reviewing the whole draft; and they would lead our presentations. We're very familiar with using our presentations as a starting point for discussion with senior audiences, including for the Cabinet Office, DHSC and the DWP, so we'd be happy to use the debrief session to more extensively 'workshop' the findings with you (setting a short agenda, if helpful).

The precise reporting coverage of the qualitative element will depend on what we agree with you as the focus for the qualitative phase. It's likely that the qualitative element will add particular value in terms of:

- Allowing us to more comprehensively explore and explain more complex, nuanced issues;
- Giving us OH and VR provider feedback on initial ideas for policy or interventions in this space;
- Generating quotes, examples or stories that will bring to life the report's themes.

6 Programme Delivery Support and Account Management

6.1 Quality assurance and mitigating risks

Our Directors will lead on ensuring quality. All methodological decisions, research tools, fieldwork materials and projects outputs are signed off by the Directors against the key research aims/objectives at each stage. They are then sent to DWP for comment; and we then work with you to refine drafts in an iterative way. IFF's written quality standards form part of our induction processes and inform a rolling programme of internal training/appraisal.

High quality methodological design: The IFF Director team will meet to discuss each aspect of the design, sense-checking each other's thinking. Where design decisions are challenging, they'll be **peer-reviewed** by another Director with relevant experience. Our design decisions will be confirmed in writing as we go, always including the rationale for key decisions.

High quality sampling strategy: As with the design overall, the two Directors will discuss the sampling strategy as a sense-check on our decision-making; and will set out the options for sampling in writing. This will describe the rationale for our proposed approach(es); including our assumptions about sample volumes and available contact details. We'd also note any potential causes of bias in who is likely to respond. Lorna (Director) specialises in complex sampling (with an extensive track record of DWP surveys) and would add particular value to this. Our proposals will be shared with you; we'd evolve them with you iteratively.

High quality data collection: High quality data collection is founded on strong **research instrument design:**

- Directors will lead the development of research instruments, ensuring these are informed by the objectives, and documentation around the interventions. First-draft materials will be planned by the project Director(s), drafted by the Project Manager, and then reviewed internally by the Director before they're sent to DWP for comment. We'll then work with you to refine drafts iteratively.
- Finalised materials will be tested via cognitive interviews and a formal pilot for the survey; and by using early qualitative discussions as an informal pilot. We'll provide DWP with a concise bullet-point note of pilot outcomes / suggested improvements; and revised 'tracked changes' drafts for DWP approval.

We ensure quality in **sampling-set** up through:

- Checking the sample to ensure it matches the specification in terms of volume and profile.
- Conducting basic data-cleaning processes – de-duplication, re-formatting of contact details where they are not split between required fields, tidying salutations for use in emails and rectifying any incomplete telephone numbers (e.g., where zeros are missing from area codes etc.)

Quality control of **telephone surveys** includes:

- Our telephone field-force is IQCS (Interviewer Quality Control Scheme) accredited.
- All telephone interviewers attend a 2-day training programme including a combination of classroom sessions, role-play and live trials; followed by one-to-one coaching for their first few shifts.
- The interviewing team will be briefed by one of the research team and the briefing will be recorded for reference. In additional all interviewers will be issued with full briefing notes and 'lines to take'.
- The telephone fieldwork will be delivered by a relatively small team of experienced interviewers who will be closely monitored and coached by an experienced team leader.
- We will ensure respondents give informed consent in accordance with MRS and GSR ethics guidelines.
- 5-10% of each interviewer's work will be quality assured either by listening in live or back-checking.

Quality control of **online surveys** (if used as a contingency option for providers) includes:

- Completes per day will be monitored by the Project Manager to look for any unusual patterns that might indicate problems with completion.
- The mailbox (that respondents send queries to) will be monitored daily for any issues encountered.
- Across both CATI/online surveys we will check topline data during fieldwork to check response patterns.

Strategies that we employ to reduce different types of **respondent error** in surveys include:

- **Comprehension errors.** We always ensure questionnaires are expressed in appropriate language for the audience. We use text substitutions to tailor wordings to different respondent types.

- **Lack of engagement.** This is where respondents make mistakes because they are bored or tired. We deliberately add interest to our surveys through incorporating different types of questions.
- **Accidental mis-entering.** As far as possible we try to ensure that scale questions run in the same direction to avoid confusion. We also use routing and response caps to prevent inconsistent answers).

Strategies to avoid **interviewer error** include:

- **Use of questionnaire conventions.** We use a number of questionnaire protocols that interviewers are trained in and familiar with to avoid error. This includes standard configurations of scale questions, placement of 'read out' and 'add if necessary' text etc.
- **Double entry of / checks on complex data:** For data such as postcodes or e-mail addresses interviewers need to enter the data identically twice otherwise an error message is triggered. Numeric questions (such as % of provider workforce from medical professions) have inbuilt logic checks to cross-reference respondents' answers against those to other questions; so we can check implausible values.
- **Interviewers being monitored and coached by an experienced team leader** (including back-checking of 5-10% of each interviewer's work). The research team also regularly check survey toplines, which can also identify any sources of interviewer error. Through these processes, feedback is given to interviewers on any areas of error; they're then monitored to ensure improvement.

Qualitative data collection is conducted by a small, experienced team. The IFF Directors and Project Managers lead verbal briefings of small groups of interviewers, covering both the overall objectives and the purpose of each individual section and question. These briefings are supported by written briefing notes, and also cover how to handle participant queries and concerns. We encourage DWP participation in briefings. Initial discussions by each researcher are reviewed for quality by the Project Manager and feedback given. The discussions are written up into an analysis framework while fieldwork is in progress, and the content reviewed iteratively by the Project Manager, allowing gaps or queries to be addressed.

Qualitative interviewer training and briefing includes: internal training courses on qualitative moderating, data management and analysis; accompanied by Disability Awareness training. We are an accredited member of the Interviewer Quality Control Scheme (IQCS), the industry mark of fieldwork excellence; and won the MRS Operational Excellence award in September 2020.

Working closely with the DWP, including regular updates: Our named project manager will be **Louis Horsley, Senior Research Manager**; with **Julia Rinne, Research Manager** as deputy. They'll lead on communication with the DWP, keeping in close contact informally (by telephone and email). We'll deliver **weekly email progress updates** (including project status, progress with document reviews / recruitment / interviewing; emerging findings, upcoming actions, risks). This will be supported by a (we suggest) fortnightly project catch-up videoconference. We'd agree a template for updates in a format that works for you.

High quality analysis that's suitable for informing policy: To assure quality, analysis plans will be finalised by the Project Manager then signed off by the Directors. Quantitative data files and qualitative analysis frameworks will be checked by multiple researchers sequentially, using documented quality assurance processes. The Directors will be hands-on throughout the project and will sense check the overall analysis and interpretation. The emerging 'story' from the mixed-mode sources will also be discussed in a Director-led analysis session, providing scrutiny and challenge to each individual researcher's interpretation, and highlighting further hypotheses to test. We welcome your participation in this. **We ensure our interpretation is suitable for policy decisions** through:

- The seniority and experience of our Director team, who will be hands-on throughout, sense-checking the overall analysis / interpretation. As well as scrutinising the detail, they'll 'step back' to consider the bigger policy picture, using their expertise to consider the implications of our findings.
- Discussing the emerging 'story' in a Director-led analysis session, giving scrutiny and challenge to each researcher's interpretation, and highlighting further hypotheses to test. We welcome your participation in this, as a further sense-check.
- Sharing our emerging findings with you iteratively, providing multiple occasions to discuss/refine the interpretation, using your feedback/questions as a sounding board.

Quality assurance of research outputs, including presentations and reports: We ensure **accuracy and high quality in our research outputs** through a high level of director input, with the IFF Directors writing all key sections,

reviewing/editing all others, and having final sign off before we send it to you. Outputs are peer-reviewed by a second director, for consistency / clarity of messages. Before we begin drafting, we'll confirm the required tone, length, style, content, and structure with you, sharing a blueprint for your sign-off. Our report blueprint will explicitly set out how the output will **answer your research questions;** this, and our iterative sharing of emerging research findings with you, will ensure our reporting is on-point in meeting your needs. Drafts are sense-checked against analysis frameworks and data tables by our Project manager. The entire draft will be proof-read for spelling, grammar, consistency and checked for DWP style-guide compliance and accessibility (including the use of Alternative Text).

We **ensure our analysis and reporting don't suffer from the demands of concurrent projects** by: ringfencing reporting time in individual researcher's workloads; each researcher plans their workloads across all projects for the next 4-6 weeks. For the next week it shows the specific tasks for each project. The Project Manager reviews the time allocated across the team and ensures each individual has sufficient time for 'their' sections of the reporting output; then a weekly Director meeting is used to resolve any issues or clashes. Time for analysis and reporting is prioritised.

Risks and mitigation strategies: We will maintain a live risk register throughout. We agree an initial draft with you at the outset and then add new risks as the project progresses. The risk register will be included in the project updates; and we will use diarised regular catch-up calls to **escalate any emerging relevant risks**, discussing these with you transparently. We see some of the key project risks as being as follows:

Risk	Likeli-hood	Potential impact	Mitigation
Lack of an authoritative sample source, so risk of an unrepresentative survey sample	High	Very high	Blend multiple sample sources together, to minimise the risk of any one source being incomplete or subject to bias. Attempted census approach to maximise participation by a broadly representative mix of providers. Monitor sample achieved against the starting sample profile, to prioritise under-represented providers as fieldwork progresses.
Difficulty recruiting time-poor providers to participate	High	High	Use our experienced in-house interviewing team who conducted provider interviews in 2019. Book in interviews in advance as if it's a qualitative study. Use incentive to encourage participation. Seek study endorsement from sector influencers via Steering Group, and use 'warm up' communication to encourage participation.
Providers reluctant to discuss commercially sensitive business issues	Medium	High	Reassure re: study purpose, anonymity and the fact that details will be reported in aggregate form; emphasise study importance to encourage buy-in; consider offering providers the chance to redact anything causing discomfort at the interview's end.
Providers struggle to understand a question or to give a meaningful response	High	Very high	Develop questionnaire and topic guide collaboratively with DWP and Steering Group. Cognitively test and pilot the survey and pilot the guide, making improvements to each. Give advance warning of particularly complex questions / data needs in our warm-up communication to providers.
Respondents request legal advice or advice re: employees	Medium	Medium	Agree with DWP at the study outset, how we'll handle requests from respondents for legal or other advice (including resources to signpost them to). Create a process document and brief all recruiters, interviewers and researchers on how to use this. Keep DWP updated on handling of these requests.

Handling complaints from (potential) respondents: In the event that a complaint is received:

- Complaints will be entered into a complaints log, which will be accessible to the DWP;
- If relating to an interview, we will listen to the full recording of the interview;
- We will contact the complainant within 24 hours and take down full details of their complaint;

- We will investigate the sequence of events leading to the complaint and consider any modifications that this suggests to processes and procedures. This might include disciplining interviewers;
- We'll propose a course of action to you, and will agree with you how to respond;
- Within 48 hours of the complaint being logged, the project director will send a formal apology to the complainant, documenting action taken. We will send a copy to the DWP.

6.2 Project management, project plan and team

Our proposed project team: We have assembled an expert project team with a strong track record of designing, conducting and analysing **survey and qualitative research to inform policy development**, including with **relevant audiences** and **within the Occupational Health market**. All **IFF researchers are skilled across both quantitative and qualitative methods,** allowing agility and coherence in delivery.

Lorna Adams and Angus Tindle (Directors, IFF, 24.5 days) would lead the study, particularly the methodological design; design of research instruments and analysis plans; drafting key sections of outputs and leading key meetings and presentations. They add value through their expertise in designing and leading studies for the Work and Health Unit to explore current Occupational Health and MSK Provision. One of these was the previous 2019 survey that you're now looking to update. This was part of a wider mixed method study encompassing qualitative fieldwork with OH experts, as well as case studies among OH providers, employers and employees; plus the aforementioned attempted-census survey of private and NHS OH providers. In the context of relatively little existing evidence, this study described the history and current state of the sector, as a foundation for policy development work. The other study in this space that Angus and Lorna designed and led was qualitative, using 20 in-depth interviews among private and NHS providers to examine innovation and learning within the sector – including testing the hypothesis that a cost sensitive customer base of employers was leading to under-investment in innovation in the sector. Angus and Lorna bring wider experience of studies that seek to capture the current status of provision and resourcing within a specialist sector, through their work on studies for the DWP (sample-building and semi-structured interviews with c.70 providers of both employment and dependency support services as well as representatives of local authorities and Public Health England, to map national provision of both employment and dependency support for individuals with drug and alcohol dependencies) and DfE and the Youth Endowment Fund (qualitative discussions amongst national policymakers, regional influencers, professionals, practitioners and service users, to map relationships and the system of provision for young people at risk of involvement in serious violence). Their wider expertise in mixed method policy research on the relationship between health and employment, includes an evaluation of Access to Work and a deep dive into the work aspirations of the ESA Support Group. Lorna adds value through her expertise in complex sampling and survey design, including the DWP Employer Engagement Survey and longitudinal surveys for the evaluation of Group Work / Jobs II. Lorna is an MRS member. Angus is an MRS/AQR/SRA member; and holds the MRS Certificate.

Louis Horsley (Senior Research Manager, IFF, 33.9 days) will be our lead project manager, liaising with DWP and internal departments to deliver to time. He'll also contribute to the development and testing of research instruments, our overall analysis and reporting of the findings. Louis brings expertise in healthcare research design and delivery, from 4 years of specialising in this at Traverse. He adds value through expertise in mixed-method fieldwork among providers and users of healthcare services, for clients including DHSC, NHSE, Healthwatch, Derbyshire ICS, Sussex CCG and Greater Manchester Health and Social Care Partnership, on topics including health/social care integration and pandemic impacts on services.

Louis will co-ordinate internal resource, allocating tasks to Julia and Chloe.

Julia Rinne (Research Manager, IFF, 28.6 days) brings 3 years' mixed method experience and adds value through her expertise in managing and delivering fieldwork and analysis among healthcare professionals. She's worked on the General Medical Council's SoMEP barometer survey amongst its members; and a mixed-mode study exploring the role of Resident Medical Officers. Her sector knowledge is further enhanced by a Department of Health study exploring green social prescribing with GPs and mental health specialists.

Chloe Allenby (Senior Research Executive, IFF, 14.6 days) joined IFF in 2022 from YouGov. She's an MRS Member with 3 years' mixed-method research experience. She adds value through her expertise in blending survey and qualitative evidence on healthcare topics, including tracking vaccine uptake for Public Health Wales, evaluating Community Vaccine Champions for DLUHC; and exploring the attitudes, beliefs, and behaviours of Jewish people in the UK towards Genetic Testing, for the NHS.

Emma Vernon (Research Executive, IFF, 23.9 days) completes the team and will support with project management, particularly desk research to assemble sample, administrative and liaison tasks.

All of the IFF team would be involved in interviewing, analysis and interpretation of findings. They'd be supported by **Andrew Connelly, Daniel Clough and Jake Maun, qualitative specialists**; each with over five years' experience of

qualitative interviews including among employers, employees and HCPs (for example, within our DWP Access to Work Evaluation; and our Work and Health Unit qualitative case studies and in-depth interviews among employers, employees/patients and Occupational Health providers).

We manage **resource demands** to ensure that the project has sufficient capacity, firstly, by **having a relatively large project team:** We build our teams to allow flexibility to adapt to fluctuating project needs, so we can accommodate changes in the demands of projects easily. Secondly, **our multi-skilled researchers** mean tasks can be moved between team members to accommodate competing demands, making us agile. Thirdly **our workload planning process,** designed specifically so that we do not have to compromise quality due to high or fluctuating workloads. All individuals in the research team complete a workload plan weekly, planning the time for each of their projects for the next 4-6 weeks. For the next week it shows the specific tasks to be conducted. The Project Manager reviews the time allocated to this project across the team and checks that all tasks are covered; then a weekly Director meeting is used to resolve any issues or clashes.

Delivering key requirements if key staff members unavailable: We've proposed a large enough team to keep everyone informed whilst giving scope to pick up tasks in the event of staff absence. Two Directors heading the team provides continuity. Our standardised file labelling / storage make it easy for team members to pick up work; and a team email makes it easier for you to reach the team. If needed, additional relevant staff can be drawn from our wider team of 86 researchers; **we'd share CVs for any replacement staff with DWP**.

Managing the relationship with the DWP: The relationship will begin with a **kick-off meeting** to finalise objectives, milestones and deliverables. We'll then refine the research proposal and draw up a **detailed project plan**, including who's responsible for milestones, so that all parties have a clear understanding of timings and outputs during each phase. Our named project manager will be **Louis Horsley, Senior Research Manager**; with **Julie Rinne, Research Manager** as deputy. They'll lead on communication with DWP, keeping in close contact informally (by telephone and email). We'll deliver **weekly email progress updates** (including project status, progress with document reviews / recruitment / interviewing; emerging findings, upcoming actions, risks). This will be supported by a (we suggest) fortnightly project catch-up videoconference.

We **ensure progress is maintained** across both strands by preparing a detailed project plan for each strand, setting out key milestones and interim steps, both internal and external, so that all parties know what is needed to deliver to time. We use this for internal resource planning and within catch-ups with DWP. This in turn allows our departments to resource accordingly and gives you advance warning of needing your input. Our Project Manager monitors fieldwork progress daily. If progress is concerning, we'd discuss this with you frankly and suggest options for action. Our wider research team of 86 researchers and award-winning telephone team of c.1,000 interviewers, gives us scope to increase resource if this is the issue.

Understanding the DWP's vision and objectives: We ensure our team **understands your vision and objectives**, through: the IFF Directors briefing the team on the study background; the whole team attending the kick-off meeting to hear a briefing from you; and further Director-led briefings (e.g. on analysis). Our researchers are organised into sector-based teams, giving repeated exposure to work in this policy space.

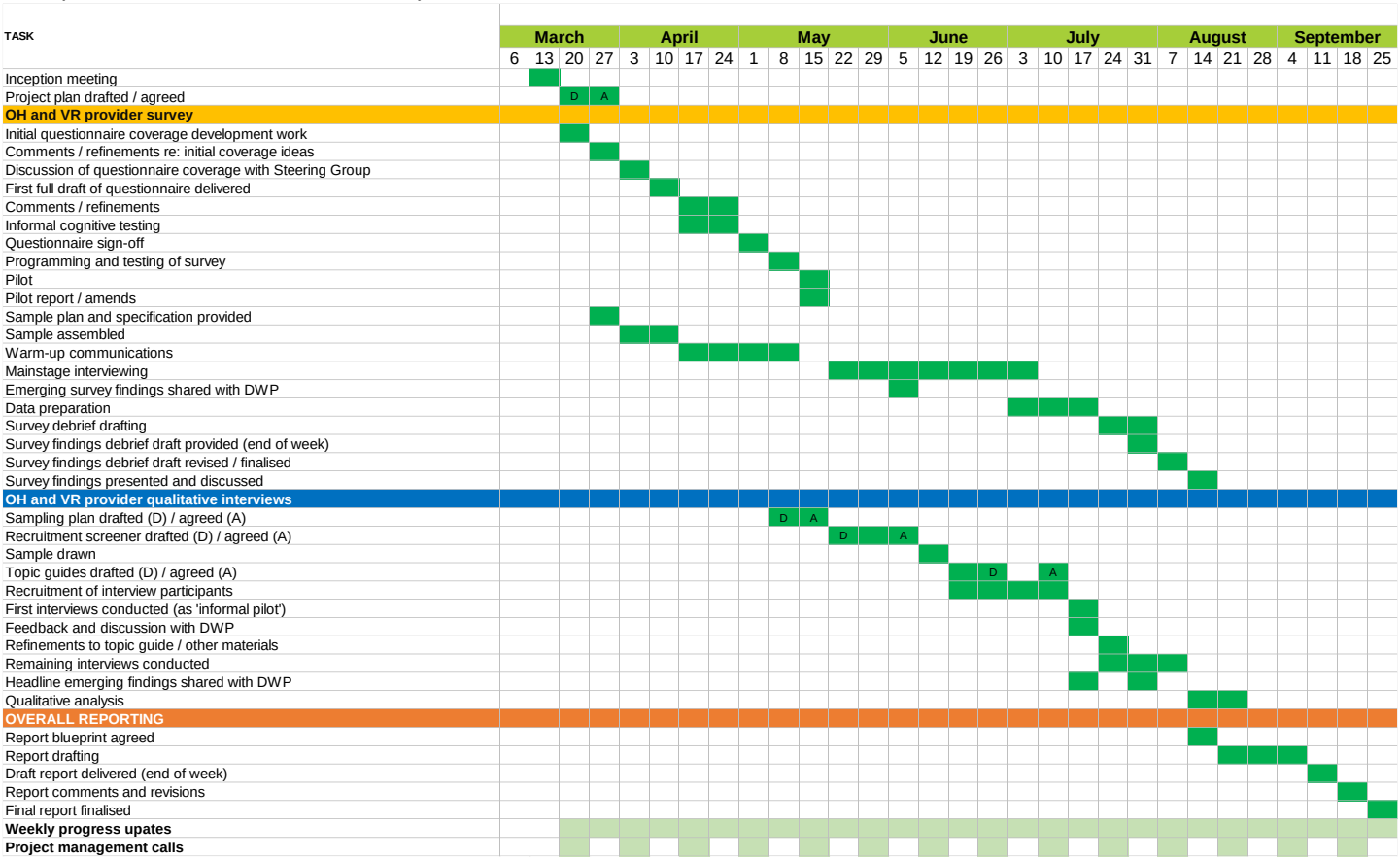
Continuous improvement and customer service excellence: We aim to have a transparent relationship; and encourage sharing of feedback between DWP and IFF throughout the project, to identify ways of working better (actions agreed on would be documented in writing, allowing us to revisit these at **quarterly review meetings**). We also, at the end of every project, convene a discussion between the IFF Director and the lead client contact, to identify lessons learned – this wider feedback supports continuous improvement.

Ethics and data protection: In our experience, this kind of study won't require formal ethical approval, as we aren't using NHS patient records and this isn't medical research (we've run the study requirements through HRA ethics checks, and this also suggests there's likely to be no need for formal ethical approval). However, our design, delivery and analysis will be in line with MRS guidelines and the GSR Code of Ethics:

Consent	We'll apply the principles of the GSR Code of Ethics throughout. We'll ensure **informed consent** through clear explanation of how findings are used and that taking part is voluntary in the recruitment script, on qualitative participant information sheets/consent forms and at the start of interviews. We'd be happy to use a **consent form template from DWP** if desired (or we can produce our own).
Overall approach	All interviews will be conducted with humanity and sensitivity. This means that interviews will be conducted at the participant's pace including over more than one session where appropriate; researchers will stop if the participant wishes; and if the researcher has concerns about a participant's wellbeing, then they will use established protocols to escalate the issue to the research team. As Corporate members of the MRS we have access to their ethics helpline which we consult on complex concerns. **Dealing with disclosure:** we've an established escalation process that we've used for other DWP studies and which gives guidance to interviewers on how to respond if a respondent should disclose that they/someone else is at risk of harm. We'll **minimise burden** on providers by working closely with the DWP and Steering Group to develop relevant and proportionate research instruments, and testing these with providers; offering an online survey completion option as a contingency; and offering to complete interviews in several sittings.
Access	We will produce **Welsh** versions of key communications and have Welsh-speaking interviewers. We'll use an open question at recruitment to establish any adjustments needed to participate. We'll ensure stated needs are met – e.g., varying discussion pace, arranging BSL/interpreters; supporting the participation of carers or supporters, if desired by the lead participant.
Data security	IFF's compliance with ISO27001 and Cyber Essentials will ensure we safeguard participants' personal data; and all outputs would be carefully checked by two researchers to ensure confidentiality is maintained. We employ a Compliance Manager. We'll ensure we have an up-to-date departmental Information Security Questionnaire in place for the project, setting out how we will safeguard personal data. We'll comply with your departmental protocols for the secure transfer of data (e.g., exchange of PGP encryption keys, transfer in encrypted format from one named individual to another). Personal data will be limited to names, job titles and contact details needed to set up and conduct interviews. Participants may share commercially sensitive information with us, in response to our questions; but this will be reported in aggregate, anonymized form; and we suggest giving providers the opportunity to redact details, if desired. All files containing personal or commercially sensitive data are saved to a project-specific secure folder on IFF's secure network which only the named project team can access.
GDPR	We explain to research participants, at recruitment and the start of interviews, their rights to see, modify or delete the personally identifiable data we hold. We give them a link to an FAQs page on our website which recaps these rights and supports them to make a request. We'll agree with you at the project inception how long we should retain personal data for; and will confirm when data has been securely destroyed. We can confirm that all evaluation data will be stored on servers based in the UK.

Our project plan: Below is the timetable that we suggest, to deliver a final report in September. We're open to refining this with you. It delivers survey fieldwork and findings later than your ITT outlines; however, this project plan factors in the need to work with the Steering Group, cognitively test the questionnaire and then pilot the questionnaire, which the ITT requests (and which we believe will pay dividends in delivering a better survey, ultimately). It also gives slightly more generous timescales for DWP to input into the development. We could pull forward the survey fieldwork, but realistically this would be at the expense of a collaborative development process. We'd be happy to discuss this further and adjust timescales to your preferences.

Occupational Health Provider Survey



7 Experience

7.1 Understanding the research need and policy area

The importance of Occupational Health (OH) and Vocational Rehabilitation (VR)

Long-term health conditions are keeping a significant number of people out of work, representing an ongoing challenge for government and the economy, as well as for individuals[1]. Expert support such as OH and VR services can be a critical component in helping individuals remain in and return to work, reducing unnecessary sickness absence, increasing productivity and enabling individuals to live better for longer[2]. OH can include fitness for work assessments, health surveillance, advice on return to work and reasonable adjustments, vocational rehabilitation, case management, biopsychosocial approaches, health and wellbeing services and signposting to services that treat specific conditions. VR providers deliver similar services albeit with a more holistic, less medicalised approach. Commercial providers dominate.

Long Covid is adding to the work and health challenge, with estimates this is costing UK workers a total of £1.5bn a month in lost earnings. According to research by the Institute for Fiscal Studies, 1 in 10 people who develop long COVID stop working, with sufferers generally going on sick leave (rather than losing their jobs altogether). Estimates suggest that the aggregate impact is equivalent to 110,000 workers being off sick[3] and recent research commissioned by DWP confirmed up to an additional 8% of businesses newly purchased OH during the pandemic specifically to help them deal with COVID-19-related OH issues[4].

The Occupational Health Market Reform Agenda: market challenges and consequences

'Health is everyone's business' identified several issues in the commercial OH market in terms of meeting demand. These included: cost and a lack of awareness/understanding as key barriers to procuring OH; shortages in the OH workforce, particularly clinical staff, which risk the future capacity of the OH providers to deliver services; and potential for more rapid innovation particularly for SMEs and self-employed people.

Sector workforce challenges: Experts and providers have both reported a threat to the future of OH provision in the reduction of qualified OH physicians and nurses in recent years. There is widespread concern over shortages of clinical staff. Combined with relatively small amounts of spare OH provider capacity, this risks limiting the market's ability to deliver services in the future, as 44% of OH providers report having roles that they are unable to fill (typically, OH nurses and OH doctors).

Suggestions to improve capacity at scale include creating additional routes into the specialism, through cross-cutting training within clinical programmes to aid transfer into OH. Current OH NHS training programmes do not always meet the needs of the commercial sector, making it difficult for the public and private sector to utilise OH specialists effectively and enable further expansion opportunities. Moving towards a biopsychosocial model which is multi professional (MSD) would help support the sustainability of the future OH workforce and enable cost-effective OH service provision. This approach would help properly utilise a wider range of skills, ease clinical pressures, enable greater access to OH services and support continuous professional development. Greater recognition of what other healthcare professionals, who are not OH doctors or nurses, could bring to the profession is required, with access to training placements.

We know from our own and others' research that Government is committed to supporting a sustainable OH workforce, recognising that immediate actions are required, alongside a longer-term strategy, which acknowledges cultural, behavioural and administrative changes needed[5].

Employer motivations and challenges: Employers currently dominate the commissioning of OH services, but SMEs are under-represented despite comprising 99.9% of 5.6 million enterprises[6], while the close to half-a-million self-employed are likely to access OH in a more utilitarian way. Overall, small employers are five times less likely to invest in OH services than large employers (18%, compared to 92%, invest in OH)[7].

[1] Health Foundation, The Continuing Impact of Covid-19 on health and inequalities https://www.health.org.uk/publications/long-reads/the-continuing-impact-of-covid-19-on-health-and-inequalities

[2] Health is Everyone's Business proposals to reduce ill-health-related job loss https://www.gov.uk/government/consultations/health-is-everyones-business-proposals-to-reduce-ill-health-related-job-loss/outcome/government-response-health-is-everyones-business#chapter-4-helping-employers-access-quality-occupational-health-oh-support

[3] Long Covid and the Labour Market https://ifs.org.uk/publications/long-covid-and-labour-market

[4] DWP Employer pulse survey interim report https://www.gov.uk/government/publications/dwp-covid-19-employer-pulse-survey-interim-summary-report

[5] Tindle et al., Understanding the provision of occupational health and musculoskeletal services (2020). DWP & DHSC https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/887926/RR985-understanding-the-provision-of-OH-and-work-related-MSK-services.pdf

[6] Business population estimates (2021). BEIS.

[7] Tu et al. (2021). Sickness absence and health in the workplace: understanding employer behaviour and practice. DWP/DHSC https://www.gov.uk/government/publications/sickness-absence-and-health-in-the-workplace-understanding-employer-behaviour-and-practice/sickness-absence-and-health-in-the-workplace-understanding-employer-behaviour-and-practice-summary

SMEs may lack the time / capacity (49%), capital (52%) or expertise (49%), to manage health events in the workplace, or to search for the most relevant guidance[8]. The current government information on offer, while valued, is fragmented and not always easy to apply to real-world problems. Employers across the board have asked for better integrated advice/information that's easier to find and act upon. Government intends to build on improved advice offered in response to the pandemic, by refining the information and advice on health, work and disability so it's easier to navigate and more readily usable, especially for SMEs.

Employers are likely access to OH services for three reasons overall: to comply with legal and regulatory obligations (legal); to reduce costs and improve business efficiency (cost/ financial); and to support and improve employee health and wellbeing (moral). Experts and OH providers also identify employers as most commonly motivated by legal obligation, with more 'aspirational' improvements to productivity and wellbeing being secondary motivations. Retention of employees has been identified as the single main reason why employers seek OH support: this encompasses all three of the motivations for providing OH services: cost (having to replace staff members), moral (employers valued their employees), and legal (ensure actions complied with employment law)[9]. Musculoskeletal and mental health problems dominate[10].

For employers without OH who are engaged in other health and wellbeing activities, barriers to purchasing services are financial, attitudinal and from lack of knowledge or misconceptions as to what OH involves. While employers recognise the cost of sickness absence, not all employers understand or consider the benefit of providing OH to reduce or prevent sickness absence[11].This is despite well-integrated evidence-based workplace health initiatives that are associated with improved employee health status and productivity in the workplace. Investments in occupational health add value through reduced costs associated with the prevention of ill health, improved productivity and a range of intangible benefits[12].

Our own studies of OH provision suggest employer under-utilisation of OH services may be contributing to a 'vicious circle', with the relatively small-scale capacity of UK OH provision being potentially reflective of the size of demand, with providers tending to not be at full capacity but also mostly feeling that it wasn't worthwhile to engage in targeted marketing.[13] IFF's work on this has also found indications that low demand for OH services amongst employers, combined with a marketplace where purchasers are often less informed, may have driven underinvestment in innovation in the OH provision sector.[14]

IFF's subject knowledge of this policy space

As references to our previous work suggests, we have expertise in qualitative and quantitative fieldwork to explore OH provision, including supply and demand issues; with relevant participant groups (employers and employees regarding uptake of OH; OH providers; and experts in the field):

- **Understanding Occupational Health and Related Services (the Work and Health Unit, 2018-19):** A mixed-method study using in-depth interviews with experts, a literature review, semi-structured surveys of OH providers and Clinical Commissioning Groups (CCGs), and case studies with OH providers, employers they work with and individual employees and line managers, to explore the state of current OH and work-related Musculoskeletal (MSK) provision in the UK. The study examined the history of UK provision and how this informs the status quo; how private OH provision and CCG-commissioned provision is designed, resourced, and delivered; and how private and NHS provision interact with the employer and the individual employee. The outputs include 20 detailed employer-provider-employee qualitative case studies and a conceptual systems map of provision. Each case study illustrated a different OH provision model that we had identified at the scoping stage.
- **Innovation and knowledge development amongst providers of occupational health (Work and Health Unit, 2019-20).** A qualitative to study to explore how occupational health providers innovate in their service delivery; and develop and maintain their professional knowledge. IFF used 15 qualitative interviews with OH providers (13 with private

[8] Ibid
[9] Fullick et al., (2019). Employers motivations and practices – a study of the use of occupational health services https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789894/employers-motivations-and-practices-a-study-of-the-use-of-occupational-health-services.pdf
[10] ONS sickness absence data, 2021: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/sicknessabsenceinthelabourmarket
[12] Nicholson, P. (2022). Occupational Health: the Value Proposition https://www.researchgate.net/publication/359440192_Occupational_Health_The_Value_Proposition

[13] Full report: Understanding the provision of occupational health and work-related musculoskeletal services - GOV.UK (www.gov.uk)
[14] Innovation and knowledge development amongst providers of occupational health - GOV.UK (www.gov.uk)

providers, and two with NHS providers that sell OH services commercially) to test the hypothesis that low demand for OH services amongst employers, combined with a marketplace where purchasers are often less informed, may have driven underinvestment in innovation in the market. This is the latest in a series of pieces of research that the IFF team has conducted on the state of occupational health provision in the UK, a previously little-researched topic. Fieldwork was completed despite the Covid-19 pandemic, and the later interviews explored whether the pandemic had contributed to driving innovation.

- **DWP and DHSC Fund to Stimulate Innovation: OHS Literature review (Innovate UK, 2022):** A rapid desk-based review of existing evidence on OH provision, across five themes, set out by Innovate UK, the DWP and the DHSC (including Innovation, Technology, Adoption and scale, and Market readiness). The findings formed part of a competition brief, on behalf of the Department for Work and Pensions (DWP) and the Department for Health and Social Care (DHSC), to award funding to encourage innovation that could ultimately improve OH provider capacity and improve employer and worker access to OH.

Our expertise in designing/delivering **employee research on work and health issues** also includes, for DWP, Understanding Sickness Absence, which used mixed-method fieldwork among employers, and employees to investigate the drivers of sickness absence. We've also conducted a recent BEIS study among 5,500 employees to examine awareness, knowledge and take-up of employee rights.

The aims of the Occupational Health Provider Survey

We understand the purpose of this survey is to further develop the evidence base and undertake research with occupational health providers to understand the structure, attitudes, and behaviour of the Occupational Health / Vocational Rehabilitation market in relation to the following areas:

- Market capacity, workforce composition, skills shortages and enablers of/ barriers to recruiting multi-disciplinary teams and working with SMEs and the self-employed
- Delivery models and extent of/ enablers for/ barriers to innovation amongst providers
- Pricing strategies and levels

We will cover the following key identified **research questions**:

- What is the current situation with workforce recruitment with OH/VR providers?
- How is the general OH/VR workforce currently made up?
- What is the current demand for OH/VR services and has this changed?
- Where is this demand focused?
- What is the pricing strategy for OH/VR services?
- How do OH/VR providers approach data collection and innovation?
- How do OH/VR providers view accreditation services?
- How does OH/VR provision differ for SMEs and the self-employed?
- How are OH/VR providers using Multi-Disciplinary Teams?

We will also consider the role of these questions in assessing the impact of the government's policy responses to the Health is Everyone's Business consultation (2019)[15] to reform the OH market: in order to monitor changes in the outcomes intended by these policies over time, this research is intended to collect baseline outcomes data from providers, for use from 2023. In addition, this research will explore the structure, attitudes, and behaviour of occupational health providers to gather evidence that can support the ongoing development and delivery of policies to reform the occupational health market, through:

- Testing assumptions about occupational health market failures, e.g., the OH sector reliant on NHS-trained occupational health doctors and nurses but these numbers are declining.
- Testing the potential for the promotion of multi-disciplinary teams and promotion of occupational health/ vocational rehabilitation as a career.
- Understanding where occupational health workforce shortages lie, how occupational health providers are dealing with them, and where they see a need for support (knowing which jobs are most difficult to recruit for, why, and what impact this has on service delivery).
- Understanding the extent of, barriers to, and enablers for providers using fewer clinical and more multi-disciplinary teams - to identify a) whether you need/should do anything to encourage more multidisciplinary teams; and b) what support or incentives are necessary to support providers to take on more multidisciplinary teams. This could also help

[15] DWP/DHSC, 2021. 'Government response: Health is everyone's business'.

you to identify risks of not encouraging the use of more multidisciplinary teams, such as whether using fewer clinicians is perceived by occupational health services as risking a reduction in the quality of services.

- Generating evidence from providers about their willingness and the extent to which they work with SMEs and the self-employed, and any barriers to doing so. This will inform the design of effective policies that encourage and support providers to assist smaller employers / the self-employed.
- Building data on pricing of occupational health services will enable you to a) more accurately estimate the cost of policies and b) analyse the costs and benefits of occupational health services.

7.2 Technical experience and expertise

IFF Research bring an extensive track record in combining high-quality findings from surveys, qualitative research and mixed method research among public and private service providers, often including analysis of administrative data. We are one of the UK's foremost agencies in delivering employer and occupational research, including the DfE Employer Skills Survey and the ONS Annual Survey of Goods and Services, DWP's Employer Engagement Survey and numerous qualitative and mixed method projects, including many on the relationship between health and work. Below we describe our expertise and experience in designing, conducting and analysing: surveys and administrative data to support policy development; qualitative research to support policy development; and mixed-method research. This includes two studies within the OH provision sector, of direct relevance to the proposed study.

Understanding Occupational Health and Related Services (DWP/DHSC Work and Health Unit, 2018-19). We delivered a mixed method study to help the Unit understand current OH and work-related Musculoskeletal (MSK) provision in the UK. The study included semi-structured telephone interviews with 108 private OH providers followed by a further survey examining providers' workforce compositions and issues, combining 156 private providers and NHS OH departments – in effect the predecessor to this proposed new survey. These surveys achieved 32% and 36% response rates respectively. We then conducted a further 87 telephone and online interviews with MSC leads in Clinical Commissioning Groups (CCGs). To achieve the best coverage and response we invested resource in building an accurate sample of named contacts and deploy telephone interviewers with deep experience in conducting this type of semi-structured provider survey. We offered interviews at flexible times and provided advance information of the more complex data that we needed to collect. We triangulated this evidence with expert interviews, a literature review and data gathered through 20 case studies with OH providers, employers they work with and individual employees and line managers. The findings identified areas for improvement and potential threats to OH resourcing and delivery, to shape policy development. We worked with sector bodies to disseminate messages around the importance of the study, which was effective in encouraging survey responses. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
	Y	**Y**	**Y**

Innovation and knowledge development amongst providers of occupational health (DWP/DHSC Work and Health Unit, 2019-20). This study helped the WHU understand how OH providers innovate in their service delivery, and develop and maintain their professional knowledge. We used 15 qualitative interviews with OH providers (13 with private providers, and two with NHS providers that sell OH services commercially) to test the hypothesis that low demand for OH services amongst employers, combined with a marketplace where purchasers are often less informed, may have driven underinvestment in innovation in the market. In this study we flexed the design and fieldwork to continue virtually following the Covid-19 lockdowns and adapt the research to provide insight into the impact of the on providers. Overall, the findings pointed to low demand for OH services amongst employers, combined with a marketplace where purchasers are often less informed, having driven underinvestment in innovation. There was little consensus on how best to address barriers to innovation or developing and maintaining knowledge, but some suggested that tackling wider OH sector issues (lack of employer buy-in to the value of OH, and shortages of skilled professionals) would pay dividends. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
		Y	

EU Exit Lines Narrative Testing (The Cabinet Office, 2020). Testing two policy narratives, to be used in the event of a deal or no-deal with the EU. We recruited and ran six focus groups with the public in England, Wales and Scotland, segmented by attitudes to Brexit. We targeted some individuals directly affected by Brexit (e.g. living near Channel Ports) while screening out those with the most extreme anti-Brexit feeling. The narrative was presented as if 'from a press conference by Number 10'. We explored overall feelings about each narrative, main take-out messages and implied secondary messages as well as testing use of terminology such as 'WTO terms' and examining feelings about specifics of phrasing. We examined tone of voice, perceived credibility, how inclusive the narratives felt and what it implied about UK government handling of negotiations. We also explored participants' feelings about Brexit, and their degree of confidence that the UK would 'be OK', to place responses in context. We fed back both 'big picture' insights and point-by-point analysis that shaped how Number 10 and Conservative MPs talked about the eventual deal. The project was turned around within 11 days from briefing to debriefing. A high level of Director involvement in analysis,

and the moderators developing a 'findings narrative' iteratively during fieldwork, allowed us to deliver policy-relevant recommendations, fast. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
		Y	

SME Re-emergence - Messaging Territories Testing (The Cabinet Office, 2021). We recruited and ran 8 focus groups and 18 depths with SMEs over an 8-day period, to explore their mindset and mood as they emerged from lockdown. A key element was to test strategic messaging territories and propositions within these, to validate whether the Cabinet Office was conceiving of these in the right way, to explore where current UK government messaging on policy was perceived to sit, and to investigate how far the UK government could go in using messaging talking about growth. SMEs were not shown the messaging territories or propositions, but instead discussed the tone/content of messages to date, and what types of messages would land more/less well in future (prompted by example messages). We used the feedback to assess the validity of the territories and propositions. Discussions were structured by nation, between sectors open and closed during lockdown, and between those with employees working on-site or from home. Our findings confirmed whether messages should address businesses and consumers together; whether businesses were ready for growth messages and when and how they might be ready to hear about this. Again, intensive Director involvement, and the moderators developing a 'findings narrative' iteratively, allowed us to deliver policy-relevant recommendations, fast. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
		Y	

Process Evaluation of Investment Package to Reduce Reoffending (Ministry of Justice, 2021-22). We've recently completed this process evaluation of a £50m investment package to reduce crime and improve public safety by tackling key drivers of reoffending. We stress-tested Theories of Change for each strand, via stakeholder discussions, and then used the findings to develop topic guides and survey questionnaires. Process evaluative feedback was gathered across two phases, to cover early and mature implementation. This was on a large scale, comprising c.300 qualitative discussions across prisons and Approved Premises; and surveys of c.400 staff and c.1,500 prisoners, prison leavers and residents. For work with prisoners, prison leavers and residents, we met the challenges of conducting face-to-face discussions and disseminating hard-copy surveys within the COVID-19 pandemic. Our findings highlighted what went well, challenges, lessons for future policy and further rollout, barriers and enablers, and progress made towards activities moving into 'business as usual. Findings were disseminated via a formal report, three presentations to stakeholders to give them early access to insights, and a series of short, fully-'designed' best practice guides, for practitioners. Findings were fully-synthesised to draw on all evidence on a theme, in once place. We liaised closely with leads in each region and at each prison / approved premises site to obtain 'buy in' to the study purpose, to get access to interview prisoners / residents and encourage a good response to staff and prisoner / resident surveys. **Angus led the design.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
	Y	**Y**	**Y**

Evaluation of the trial extension of SEND Tribunal powers (Department for Education, 2017-21). We led this mixed method evaluation of the trial extension of the powers of SEND Tribunals, to make non-binding recommendations on the health and social care aspects of Education Health and Care (EHC) plans for young people who require special educational provision. The findings were used to assess whether the policy had delivered better outcomes for SEND young people, and how the costs compared with the benefits. We used place-based qualitative case studies, surveys of young people and parents who had gone to tribunal and of local authorities and CCGs, and secondary data analysis to assess the trial process and its impact. IFF designed, managed and delivered the evaluation with support on modelling costs and benefits from economists, Belmana. We collected complex data from Tribunal appellants on their journey through the SEND system (to identify whether the Tribunal was duplicating other routes of redress) and collected complex cost data from both appellants and local authorities We worked closely to test and refine the findings with a cross-sector steering group of stakeholders to ensure the conclusions were well received, policy-relevant and

actionable. We were able to provide policy-relevant evidence that the trial powers were leading to a better appellant experience while being likely to be cost-neutral. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
	Y	**Y**	**Y**

Evaluation of Flexible Operating Hours (Ministry of Justice, 2018-20). IFF led this mixed-methods evaluation to examine the impact of alternative, extended hours for hearings on access to justice and the efficient use of courtrooms. Within this, we designed, conducted and analysed a process evaluation, using site visits to explore the intervention process among legal professionals involved in FOH hearings, court staff and members of the judiciary. Our process evaluation involved three phases, to capture learnings early in intervention delivery, once the intervention was 'mature' and then at its conclusion, to generate summative findings. We synthesised multiple strands of complex evidence into a two-page 'balanced scorecard' to summarise the impact of the policy, providing a clear assessment of whether the policy intent had been met, and to what extent this was viable to roll out in future. We liaised closely with leads at each courtroom site to obtain 'buy in' to the study purpose, to get access to staff and members of the judiciary and ensure public-facing staff understood how and why they needed to disseminate hard copy survey questionnaires to members of the public using the courts. We also administered cost datasheets within qualitative interviews to collect costs data from legal professionals and members of the judiciary. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
	Y	**Y**	**Y**

Mapping Systems of Support for Young People at Risk of Involvement in Serious Violence (DfE and Youth Endowment Fund, 2022). A study for the DfE and YEF to help understand the effectiveness of the system of provision for young people at risk of involvement in serious violence (whether as a victim or perpetrator). We are employing a system mapping approach (using 'Kumu' dynamic system maps), drawing on discussions and collaborative mapping exercises with national policymakers, regional commissioners, practitioners and young people themselves to create an overall picture of 'actors' in the system and the relationships between them. This is accompanied by a thematic analysis of what the system of provision means for young people at risk of involvement in serious violence. This is a foundational study to shape policy in this space and act as a starting point for further research. **Angus and Lorna are leading this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
		Y	

Evaluation of the two Drug and Alcohol Proofs of Concept (DWP, 2013-2016). This evaluation of two proof of concept schemes was used to identified work works in the design and implementation of support for drug and alcohol dependent participants and inform future policy. The evaluation included a review of pilot documentation and MI information; with depth interviews with pilot designers; three waves of in-depth face to face and telephone interviews with key stakeholders and pilot participants in the four areas in which the pilot models were applied. We achieved a high level of participation by being completely flexible around individuals' schedules and frequently rearranging interviews to accommodate them. In the interviews themselves we used journey mapping techniques to help plot out all of the support individuals had received in recent years, to help identify which were pilot-related and unpick which parts of the support were effective. This was accompanied by research to map national provision of both employment and dependency support for individuals with drug and alcohol dependencies, and describe the status of relationships between the employment support and dependency support sectors, as a resource for policy decisions. This involved sample-building and semi-structured interviews with c.70 providers of both employment and dependency support services, representatives of local authorities and Public Health England. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
	Y	**Y**	**Y**

Work aspirations and support needs of claimants in the ESA support group and Universal Credit equivalent (DWP, 2017-19). This was a mixed-method study among individuals on the Support Group element of ESA (as well as the equivalent group of Universal Credit claimants) to explore their work-related aspirations and support needs, in the context of relatively little being known about the experiences, needs and wants of these individuals. IFF undertook an extensive phase of qualitative research (50 in-depth interviews and six focus groups), and then used the qualitative findings to develop a survey of 2,012 claimants. The survey examined attitudes towards doing paid work and voluntary work in future; current take-up of support; perceived barriers and support needs around paid employment; attitudes towards communications from the DWP and JCP; communications preferences (frequency and channel); and degree of digital engagement/ capability. The survey allowed us to create a representative picture of this claimant group. We then used Latent Class Analysis to segment individuals by their attitudes to work, barriers and support needs. This placed each of our claimants into one of eight segments, which we then overlaid with further descriptive data to explain their demographic characteristics, attitudes and preferences regarding DWP communication; and what types of employment-related support might be most relevant for the DWP to tell them about. The findings were used to inform policy, support offers and communication about these. The study won the DWP's award for the most influential piece of research of 2019-20, reflecting – in the words of the DWP – that it both covered new ground and communicated its findings in a highly impactful and persuasive manner. This study included an insight tool to change how the client organisation thought about a group of its customers, as a foundation for policy-development. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
	Y	**Y**	**Y**

SEND Survey of Experiences of Education Health and Care Plans (EHCPs), the Department for Education (2016-18). A major mixed-mode (online, postal, telephone) survey of SEND young people, their parents and carers to assess experiences of / satisfaction with creating an Education Health and Care Plan. This major study involved an extensive phase of qualitative interviews with young people with special educational needs, and their parents and carers, in order to cognitively test the wording of questionnaires and accompanying communication materials, and check that the questionnaire is covering the correct issues. This was followed by a large-scale pilot to test survey contact strategies and response rates, prior to rolling-out the survey to achieve a nationally representative sample. The survey sample was drawn by IFF from the National Pupil Database (NPD) and the Individualised Learner Record (ILR), involving complex matching procedures to identify individuals with a 'new' EHCP in place in the 12 months preceding fieldwork. Over 13,000 young people, parents and carers were surveyed within the main stage – demonstrating that our cognitive testing of materials and piloting of contact strategies paid dividends in generating a good response. The study shows our expertise in designing surveys to capture niche and nuanced experiences on sensitive topics; to carry out complex sampling; and to make surveys accessible to vulnerable audiences. The findings were used to assess the effectiveness of the EHCP policy to date; and identify refinements. This was accompanied by 25 face-to-face in-depth interviews with parents, to explore factors that lead to satisfaction and dissatisfaction with the EHC plan process. As part of this, we collected sample EHC plans from 18 of the parents interviewed, which a panel of 10 SEND experts, convened by University of Derby, evaluated for quality, generating further best practice guidance on what makes a 'good' EHCP. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
	Y	**Y**	**Y**

Evaluation of Access to Work for DWP (2019). This process evaluation looked at the effectiveness of the Access to Work (AtW) scheme in helping those with disabilities and long-term health conditions secure the adjustments that they need

to be fully productive at work. The research included 60 in-depth interviews with approved AtW applicants with health conditions/disabilities; 25 in-depth interviews with employers with experience of AtW, two focus groups with specialist contracted providers of workplace assessments and two in-depth interviews with AtW staff responsible for making decisions. Our sample encompassed a range of disabilities and grant outcomes. Interviews explored how AtW awards were used, and the impacts of both the financial award and the related assessments and advice, on what individuals were able to do, as well as examining process improvements. The research report made recommendations for improvements to application process and information provided to assessors, and provided evidence to policymakers about the ongoing value of the scheme. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
		Y	

Evaluation of Employment Advisers in IAPT Mental Health Services, DWP/DHSC Work and Health Unit (2017-2020). This study helped DWP evaluate whether investment in Employment Advisers within Mental Health services delivered improved work and health outcomes to help shape policy and spending direction. The approach involved a thorough integration of findings from qualitative stakeholder interviews, case studies involving interviews and observations with patients, employment advisers and health professionals; and an impact evaluation using survey data comprising 1600 telephone interviews with clients. We combined this with administrative data collected alongside the evaluation to produce iterative reports from early process findings to the final impact evaluation synthesis at both national and regional level. **Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing, in support of policy development…	…surveys / admin data	…qual research	…mixed-methods
	Y	**Y**	**Y**

Many of the studies cited above culminated in us analysing and reporting survey, qualitative and/or administrative data. In doing so, we're careful to synthesise our sources so that we foreground the overall points being made (rather than writing up the analysis of data from our different sources in a 'silo-ed' way, unless this is what you specifically want). We seek to make our reporting of survey, qualitative and administrative data visually-engaging, for example, for the aforementioned **Evaluation of Flexible Operating Hours** we drew on our various data sources, including surveys and administrative data, to create a one-page 'balanced scorecard', that assessed the effect of the intervention against each of its intended impacts. Similarly, an IFF **Evaluation of the Integration Area Programme** presented our analysis of the administrative data for each strand in an infographic format, to make the findings more impactful and accessible.

7.3 Experience in research for policy development

IFF Research bring an extensive track record in delivering high-quality findings from surveys, qualitative research and mixed method research to develop policy. This includes policy-relevant research within the Occupational Health market specifically, and other studies examining the relationship between health and work. We also have considerable expertise in wider policy development research. This includes two studies within the OH provision sector, of direct relevance to the proposed study.

Understanding Occupational Health and Related Services (DWP/DHSC Work and Health Unit, 2018-19). We delivered a mixed method study to help the Unit understand current OH and work-related Musculoskeletal (MSK) provision in the UK. The study included semi-structured telephone interviews with 108 private OH providers followed by a further survey examining providers' workforce compositions and issues, combining 156 private providers and NHS OH departments – in effect the predecessor to this proposed new survey. These surveys achieved 32% and 36% response rates respectively. We then conducted a further 87 telephone and online interviews with MSC leads in Clinical Commissioning Groups (CCGs). To achieve the best coverage and response we invested resource in building an accurate sample of named contacts and deploy telephone interviewers with deep experience in conducting this type of semi-structured provider survey. We offered interviews at flexible times and provided advance information of the more complex data that we needed to collect. We triangulated this evidence with expert interviews, a literature review and data gathered through 20 case studies with OH providers, employers they work with and individual employees and line managers. The findings identified areas for improvement and potential threats to OH resourcing and delivery, to shape

policy development. We worked with sector bodies to disseminate messages around the importance of the study, which was effective in encouraging survey responses. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
	Y	**Y**	

Innovation and knowledge development amongst providers of occupational health (DWP/DHSC Work and Health Unit, 2019-20). This study helped the WHU understand how OH providers innovate in their service delivery, and develop and maintain their professional knowledge. We used 15 qualitative interviews with OH providers (13 with private providers, and two with NHS providers that sell OH services commercially) to test the hypothesis that low demand for OH services amongst employers, combined with a marketplace where purchasers are often less informed, may have driven underinvestment in innovation in the market. In this study we flexed the design and fieldwork to continue virtually following the Covid-19 lockdowns and adapt the research to provide insight into the impact of the on providers. Overall, the findings pointed to low demand for OH services amongst employers, combined with a marketplace where purchasers are often less informed, having driven underinvestment in innovation. There was little consensus on how best to address barriers to innovation or developing and maintaining knowledge, but some suggested that tackling wider OH sector issues (lack of employer buy-in to the value of OH, and shortages of skilled professionals) would pay dividends. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
	Y	**Y**	

Evaluation of Access to Work for DWP (2019). This process evaluation looked at the effectiveness of the Access to Work (AtW) scheme in helping those with disabilities and long-term health conditions secure the adjustments that they need to be fully productive at work. The research included 60 in-depth interviews with approved AtW applicants with health conditions/disabilities; 25 in-depth interviews with employers with experience of AtW, two focus groups with specialist contracted providers of workplace assessments and two in-depth interviews with AtW staff responsible for making decisions. Our sample encompassed a range of disabilities and grant outcomes. Interviews explored how AtW awards were used, and the impacts of both the financial award and the related assessments and advice, on what individuals were able to do, as well as examining process improvements. The research report made recommendations for improvements to application process and information provided to assessors, and provided evidence to policymakers about the ongoing value of the scheme. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
	(Y)	**Y**	**Y**

Research exploring perceptions and behaviours around Green Social Prescribing (DH, 2022). We designed, delivered and analysed 25 depth interviews with clinicians (both GPs and wider HCPs); 15 depth interviews with patients with mental health difficulties who'd spoken to a HCP and two focus groups individuals with mental health difficulties who'd not spoken to a HCP; to explore GP, HCP and patient perceptions of and engagement with Green Social Prescribing (GSP). Findings were synthesised with those of surveys of 501 clinicians and 4000 members of the public, to produce actionable recommendations on scaling up GSP. **Angus contributed to the design and reporting of this study.**

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
		Y	**Y**

Evaluation of the Primary Care Gambling Service (Gamble Aware, 2022). A mixed-method study including in-depth discussions with GPs, exploring attitudes towards protecting patients from gambling harms.

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
		Y	**Y**

Evaluation of the Interim Foundation Pharmacist Programme (Health Education England, 2020-21). Two waves of in-depth interviews among provisionally registered pharmacists, their supervisors and wider stakeholders, to evaluate HEE's Interim Foundation Pharmacist Programme, a support and educational programme for provisionally registered pharmacists unable to sit their registration exams due to Covid-19. Our fieldwork and analysis used the Programme to test some principles and practicalities which would inform the next stage of pharmacy education reform. It's already extensively influenced pharmacy education reform across a number of workstreams, with results shared at the Clinical Pharmacy Conference in May 2022.

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
		Y	**Y**

Scope of Practice Review (General Dental Council, 2020). An exploration of Scope of Practice guidance, exploring current working practices and how these overlap between job roles as well as how healthcare setting influences training and information needs. The study included focus groups with registrants and patients and the public as well as in-depth stakeholder interviews and a stakeholder workshop.

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
		Y	

Corporate Strategy and Stakeholder Research, General Medical Council (2018 and 2020): Two waves of Corporate Strategy and Stakeholder research involving online and telephone surveys among doctors, Responsible Officers, stakeholders, patients and the public. This research requires a good understanding of topical healthcare issues from a variety of perspectives.

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
		Y	

State of Medical Education and Practice Barometer Survey, General Medical Council (**2019, 2020, 2021):** Three waves of the State of Medical Education and Practice Barometer Survey, an online survey which explores core issues regarding doctors' working practices including, most recently, the impact of COVID-19.

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
		Y	

Evaluation of the two Drug and Alcohol Proofs of Concept (DWP, 2013-2016). This evaluation of two proof of concept schemes was used to identified work works in the design and implementation of support for drug and alcohol dependent participants and inform future policy. The evaluation included a review of pilot documentation and MI information; with depth interviews with pilot designers; three waves of in-depth face to face and telephone interviews with key stakeholders and pilot participants in the four areas in which the pilot models were applied. We achieved a high level of participation by being completely flexible around individuals' schedules and frequently rearranging interviews to accommodate them. In the interviews themselves we used journey mapping techniques to help plot out all of the support individuals had received in recent years, to help identify which were pilot-related and unpick which parts of the support were effective. This was accompanied by research to map national provision of both employment and dependency support for individuals with drug and alcohol dependencies, and describe the status of relationships between the employment support and dependency support sectors, as a resource for policy decisions. This involved sample-building and semi-structured interviews with c.70 providers of both employment and dependency support services, representatives of local authorities and Public Health England. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
		Y	**Y**

SME and General Public Economic Mood (The Cabinet Office, November 2021). 12 mini groups to understand the SME and general public mood around the UK's current economic challenges (e.g., supply chain issues, cost of living). Groups took place over a couple of weeks with a full debrief on each audience a couple of working days after fieldwork concluded. We 'free-found'-recruited a mix by UK nation, socio-economic group, life stage, ethnicity, sectors, sizes, attitudes to Brexit, financial impacts of COVID-19 on the business, importer / exporter status, and extent to which had experienced recent economic issues. Our findings gave the Cabinet Office a clear steer on which current economic issues were highest priority to small businesses and the public, to inform government policy. **Angus and Lorna led this study.**

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
			Y

Exploring Government Plan B narrative & policy with SMEs (Cabinet Office, Nov '21). Six mini-groups to explore Government narrative and policy for the autumn / winter 2021 Covid / Omicron response (Plan B) with SMEs. Groups took place 15th to 18th November with a full debrief on 25th November. We 'free-found'-recruited a mix of SMEs and customer-facing sole-traders and self-employed, with a mix of sectors and sizes. Groups were structured by the types of measures they would be affected by if Plan B were introduced as well as by their general outlook for their business (optimistic or pessimistic). The findings identified refinements to the policy narrative surrounding this very high profile national issue. **Angus contributed to the design and analysis / interpretation of this study.**

Demonstrates expertise in designing, conducting, analysing…	… policy development research in OH market	…research with relevant audiences	…wider policy development research
			Y

In 2023, we also delivered a rapid desk-based review of existing evidence on OH provision, across five themes, set out by Innovate UK, the DWP and the DHSC. The findings formed part of a competition brief, to award funding to encourage innovation that could ultimately improve OH provider capacity and improve employer and worker access to OH. **Angus and Lorna led this, with Louis contributing.**

8 Social Value – equal opportunities

Our method statement in relation to ***MAC 6.1 and MAC 6.2*** under the theme of **tackling workforce inequality** is provided below. All policy, plans and activities **directly affect the contract workforce**.

IFF Research is signed up to the **Market Research Society's Inclusion Pledge: A Manifesto for Opportunity**, a commitment to concrete steps to ensure the contract workforce represents the diversity of the UK; reviewing our recruitment practices across all areas of the business, redressing any practices or approaches that may be deflecting from these objectives and publishing diversity pay information alongside gender pay gap reporting. We've an **external EDI consultant** and an **internal EDI committee** to increase representation of Black and minority ethnic people and disabled people within our workforce. Line managers are given EDI and coaching training. We're part of the **10,000 black interns initiative** and have had two interns join us this year. We're a **Corporate Member of Disability Rights UK**, and work with them to ensure our staff recruitment and development, and research participant-facing materials, are accessible and inclusive. IFF are currently becoming a **Disability Confident Employer**, working towards level 1, with plans to work towards level 2 within the next 12 months. We are targeting a workforce profile that reflects the local community within all departments by ethnicity and disability and for no difference in retention rates by ethnicity and disability by the end of the 2022-23 financial year. We've removed restrictive academic grade requirements and introduced **aptitude testing** to reduce opportunity for unconscious bias, to promote inclusive and accessible recruitment. Recruitment processes for all levels involve **skill-based assessments** and **structured interviews**. We're beginning to post job advertisements on the government's **'Find a Job' page**, which is inclusive and reaches a wide range of different groups. We offer **apprenticeships** in our operations departments (IT and Accounts). We conduct **equal pay audits** and annually report on our gender pay gap (our pay gap across the whole company is -1% compared to a national average of 17.2%). Salary bandings for each role are transparent. Flexibility is at the core of our working practices, we implemented a **flexible and home working policy** in 2019, allowing individuals to work remotely for half of their working hours. We've implemented the **6 standards in the Mental Health at Work commitment** and have a team of **Mental Health First Aiders**. IFF have been a **living wage employer** for a numbers of years, however, in April 2022, we made the decision to pay the **London Living Wage to all employees** and workers in our organisation regardless of location. Our flexible working arrangements allow contracted employees to work remotely in a manner that suits them, without impacting their pay-level. **Retention rates** are monitored by gender, ethnicity and pregnancy/maternity within the contract workforce. **Influencing activities include:**

- We hosted an **industry event** in February 2021 looking at EDI in the research industry bringing together over 100 research commissioners (including DWP staff) to discuss tangible steps to positive change.
- All staff have 2 paid volunteering days annually. Additionally we participate in an annual career coaching programme for local disadvantaged young people run by Future Frontiers
- We have established a staff-led **Wellbeing Committee** that: runs **initiatives** and **regular events** that promote physical and mental wellbeing, underpinned by **senior level buy-in** with clear governance.

Within our **timed action plan**, monitoring looks at numbers and percentages of FTE employees, apprentices, and individuals on paid internships, who are young (under 25), BAME, disabled, carers, or retirees; as well as ratings from our staff survey on perceptions of our workplace:

	Jan-Mar 2023	Apr-Jun 2023	July – Sept 2023	Oct – Dec 2023
Monitor/ measure	• Staff survey • Diversity monitoring data from workforce in salaried and non-salaried teams • Review of Disability Confident Employer scheme	• Staff survey • Gender and ethnicity pay gap reporting across salaried and non-salaried teams	• Staff survey • Review outcomes of • Diversity monitoring data from recruitment processes	• Staff survey • Inclusive recruitment training for employees heavily involved in the recruitment process

Improve	• Review EDI policies and procedures	• Review of level 1 Disability Confident Scheme, actively working towards level 2. • Inclusive cultures training for those involved in hiring	• Inclusive recruitment training for all employees within the business	• Becoming a level 2 Disability Confident employer
Inform	• Share findings / actions (Mar)	• Share findings / actions (Jun)	• Share findings / actions (Sept)	• Share findings / actions (Dec) • Share feedback from Inclusive Cultures & Recruitment training
Report	• Report metrics (Mar)	• Report metrics (Jun)	• Report metrics (Sept)	• Report metrics (Dec)

“

IFF Research illuminates the world for organisations businesses and individuals helping them to make better-informed decisions.”

Our Values:

1. Being human first:

Whether employer or employee, client or collaborator, we are all humans first and foremost. Recognising this essential humanity is central to how we conduct our business, and how we lead our lives. We respect and accommodate each individual’s way of thinking, working and communicating, mindful of the fact that each has their own story and means of telling it.

2. Impartiality and independence:

IFF is a research-led organisation which believes in letting the evidence do the talking. We don’t undertake projects with a preconception of what “the answer” is, and we don’t hide from the truths that research reveals. We are independent, in the research we conduct, of political flavour or dogma. We are open-minded, imaginative and intellectually rigorous.

3. Making a difference:

At IFF, we want to make a difference to the clients we work with, and we work with clients who share our ambition for positive change. We expect all IFF staff to take personal responsibility for everything they do at work, which should always be the best they can deliver.