DPS FRAMEWORK SCHEDULE 4: LETTER OF APPOINTMENT AND CONTRACT TERMS

Part 1: Letter of Appointment

Dear Sirs

Letter of Appointment

This letter of Appointment dated 23rd August 2021 is issued in accordance with the provisions of the DPS Agreement (RM6018) between CCS and the Supplier.

Capitalised terms and expressions used in this letter have the same meanings as in the Contract Terms unless the context otherwise requires.

Order Number:	C36699
From:	National Health Service Commissioning Board (Operating as NHS England) ("Customer")
To:	NICHE HEALTH AND SOCIAL CARE CONSULTING LIMITED ("Supplier")

Effective Date:	23rd August 2021
Expiry Date:	End date of Initial Period 31st March 2022 End date of Maximum Extension Period 31st March 2023 Minimum written notice to Supplier in respect of extension:3 months

Services required:	Set out in Section 2, Part B (Specification) of the DPS Agreement and refined by: · The Customer's Project Specification attached at Annex A and the Supplier's Proposal attached at Annex B

Key Individuals:	James Fitton Susan Bagshaw
Guarantor(s)	N/A

Contract Charges (including any applicable discount(s), but excluding VAT):	Enhanced health and wellbeing in systems ***Suppliers are requested to provide a full breakdown of costs (including travel and expenses) exclusive of VAT for the delivery of all requirements as detailed within the statement of requirements.*** [redacted] Grand Total £159,500.00
Insurance Requirements	Additional insurance not required.
Liability Requirements	**Suppliers limitation of Liability (Clause 18.2 of the Contract Terms)**
Customer billing address for invoicing:	All invoices should be submitted electronically via Tradeshift. Tradeshift is a free to use service for suppliers, registration is completed directly by the supplier and is integrated with ISFE (Finance system). Full guidance for suppliers is available at: Welcome to NHS SBS's Tradeshift Network. Once registered suppliers will submit invoices directly to this platform. Note that any invoice submitted without a Purchase Order it will be rejected.

[redacted]	If you are an SME supplier or low volume supplier then the web-based portal at http://www.tradeshift.com/supplier/nhs-sbs/ is likely to be the best solution. If you are a high volume supplier, you may wish to integrate to the Tradeshift platform for invoice automation. If you are interested in integrating please contact SBS-W.e-invoicingqueries@nhs.net.

GDPR	N/A
Alternative and/or additional provisions (including Schedule 8(Additional clauses)):	N/A

FORMATION OF CONTRACT

BY SIGNING AND RETURNING THIS LETTER OF APPOINTMENT (which may be done by electronic means) the Supplier agrees to enter a Contract with the Customer to provide the Services in accordance with the terms of this letter and the Contract Terms.

The Parties hereby acknowledge and agree that they have read this letter and the Contract Terms.

The Parties hereby acknowledge and agree that this Contract shall be formed when the Customer acknowledges (which may be done by electronic means) the receipt of the signed copy of this letter from the Supplier within two (2) Working Days from such receipt

For and on behalf of the Supplier: **For and on behalf of the Customer:**

[redacted]

Service specification: Independent evaluation of enhanced health and wellbeing pilots

Background

As part of NHS England and NHS Improvement's (NHS E&I) ongoing work to support the health and wellbeing of all NHS colleagues through evidence based models, the national Health and Wellbeing team at NHS England and NHS Improvement have been allocated some non-recurrent funding in 2021/22 to share across a number of Integrated Care Systems (ICSs).

These two funding allocations (programmes) available this year are:

1. Enhanced health and wellbeing in systems - Invitations to apply for this funding was shared with ICS leads on 6 May, inviting colleagues to work collaboratively across their ICS to identify where support is needed, and how they would deliver a health and wellbeing offer for all colleagues working across their ICS (including hospital colleagues and community trusts etc).
2. Enhanced health and wellbeing in primary care - Invitations to apply for this funding was shared with ICS and primary care stakeholders on 6 May, inviting colleagues across the primary care landscape to work collaboratively to develop an offer that specifically supports the health and wellbeing of colleagues working across primary care (general practice, dentistry, optometry and pharmacy).

All ICSs wishing to bid for funding have been asked to submit their proposal to a panel (consisting of national and regional colleagues) for review by 7 June. The panel will review the bids over the month of June and confirm approved projects on 8 July. Funding will be allocated to a nominated CCG for each approved bid in Month 4 (July).

Aims and Objectives

NHS England and NHS Improvement have agreed to nationally support ICSs to evaluate the success of their projects by commissioning one or two independent evaluators to work in partnership with the national team and with named leads for each project to evaluate their support offers and monitor progress over the year, drawing conclusions and noting results.

The evaluation partner/s will be asked to deliver the following for each programme:

Lot 1

Enhanced health and wellbeing in systems: one interim national evaluation (due November 2021), one final national evaluation (due 31 March 2022), plus one individual evaluation per ICS project (due 31 March 2022)

Lot 2

Enhanced health and wellbeing in primary care: one interim national evaluation (due November 2021), one final national evaluation (due 31 March 2022), plus one individual evaluation per project (due 31 March 2022).

Evaluation Partner Requirements (In Scope)

The evaluation partner/s will need to share evidence that they:

1. Have extensive knowledge, expertise and experience within their team of data collection and evaluation on a large-scale basis.

2. Are able to build and maintain relationships and work collaboratively with a range of stakeholders, in this instance the national Health and Wellbeing team, regional colleagues and nominated leads for each project. The national team will co-ordinate the introductions between the project leads and evaluation partner.

3. Are able to agree a process with the national team and project leads for receiving and reviewing data on a regular basis, as well as identifying where there might be gaps in data (and how these gaps could be addressed).

4. Are able to co-ordinate staff feedback during the programme i.e. sending out staff satisfaction surveys at the start and again at the end, noting any impact.

5. Commit to attend regular meetings with the national team to present progress and findings.

6. Commit to delivering the evaluations on time, and therefore have sufficient capacity to provide the timely reports to set time scales (see "Timescales").

7. Are able to use innovative methods to ensure that each report will:
    - Measure the success of the overall programme and each individual project
    - Evidence value for money
    - Identify any impacts (both negative and positive)
    - Provide an evidence base of what works well
    - Identify where lessons have been learnt
    - Consider how specific elements of best practise can be shared and spread through a collaborative approach

Timescales

NHS England and NHS Improvement are keen to have appointed a supplier/s by 16th July. The contract term for the supplier/s will be from 16th July (depending on procurement timescales) until 31 March 2022.

NHS England and NHS Improvement will facilitate introductions between the evaluation supplier/s and individual project leads.

Deadlines for the reports (for both programmes) are as follows:

- One interim national evaluation (due November 2021)
- One final national evaluation (due 31 March 2022)
- One individual evaluation per pilot (due 31 March 2022)

For programme one, there will be a minimum of 7 and maximum of 14 system-level projects to evaluate. For programme two, there will likely be a minimum of 14 system-level projects to evaluate.

Evaluation Budget

Programme one (Lot 1) - Enhanced health and wellbeing in systems: £140k – £160k Exc VAT

Programme two (Lot 2) - Enhanced health and wellbeing in primary care: £180k – £200k Exc VAT

This is only an estimate, bidders will be expected to submit a competitive bid.

The funding allocation percentages for both programmes are as follows:

- One interim national evaluation (due November 2021) – 30%
- One final national evaluation (due 31 March 2022) – 30%
- One individual evaluation per pilot (due 31 March 2022) – 40%

The evaluation supplier will invoice NHS England and NHS Improvement for the allocated funding percentage once each report has been submitted, reviewed and agreed.

LOT 1 – ENHANCED HEALTH AND WELLBEING IN SYSTEMS

1. Please detail your systematic approach to the evaluation requirements *(3 sides – 14%)*

In overview, our approach would be based on four elements:

- Working with projects to develop a clear set of evaluation questions and metrics
- Evaluating both impact and process – the effect each project is achieving, and learning how best to implement it, including considerations of sustainability and scale
- Full consideration of projects' cost-effectiveness and social value
- A collaborative approach to the evaluation and to work on improvements in health and wellbeing

We would approach each of these four elements as follows:

Evaluation questions and metrics

As this evaluation will have both national and local elements, it will be essential for there to be some standardisation of the evaluation questions. We propose that the core questions could be:

1. What impact does project (x) have on: sickness absence, turnover rates, and self-reported wellbeing?
2. What is the cost-effectiveness of project (x)?
3. How can project (x) be effectively implemented?
4. How can project (x) be delivered sustainably, and at scale?

This pattern of questions is intended to balance pragmatically the various types of learning which this evaluation could generate, and to be useful both locally and nationally. We are, however, very happy to discuss and consider variations to these questions; we would facilitate a process for discussion and finalisation of the evaluation questions as the first step in the project. This would include agreement of the detail of instruments to be used, and data to be collected. (We would recommend standard and established instruments such as the Warwick and Edinburgh Mental Wellbeing Scale, or ONS4 if a simpler alternative is preferred.)

It may be that some projects would wish to collect metrics beyond the core questions; this will be for them to decide, but national summary reporting will be focussed on an agreed and standardised dataset.

Impact and process

There is an established literature on interventions to promote health and wellbeing of staff working in healthcare settings. This has substantially

influenced, for example the domains and structure of the NHS's current "Workforce health and wellbeing framework", which proposes and links to a wide range of projects across issues of leadership, data, the working environment, mental health, musculoskeletal problems, and healthy lifestyles.

Where projects are seeking to implement interventions of established effectiveness, the new learning as to that effectiveness may therefore, in some cases, be limited. Projects which are able to establish control groups will potentially be especially valuable. Some projects may be wholly innovative, and it will therefore be important to gather impact data. The literature is, however, less well developed as to how projects are most effectively implemented. What facilitates success? What hinders it? How can new sites be guided not only as to what to do, but how best to do it?

We therefore propose an evaluation which considers both impact and process and aims to improve our understanding of both.

Cost-effectiveness and social value

We are conscious that the NHS has high rates of sickness absence in comparison to other industries and employers; the Carter Review concluded in 2016 that a 1% improvement in sickness absence rates in the acute sector would equate to a saving of £280 million in staff costs, without including the cost of temporary staffing cover. It is therefore essential that we gather data as to both sickness absence, and the cost of projects, enabling a picture of their cost-effectiveness to be established, using a version of the CEA calculator developed via the Universities of Sheffield and East Anglia. Causality will not always be easy to attribute. We will therefore additionally consider the broader issue of social value – not simply the direct financial benefits accruing from reduced sickness absence, but the impact of health and wellbeing projects on wider organisational culture and wellbeing.

Collaborative working

From our previous experience of large-scale collaborative approaches, there are four ways in which independent evaluators can contribute to effective collaborative working across sites:

1. Ensuring compatibility of datasets and metrics. We will develop a standard guide as to the project's evaluation metrics, and offer advice as to its interpretation, so as to ensure that project data is as comparable as possible.
2. Compiling a simple directory of projects. It is often the case that sites might have shared understandings and learning earlier, had they known who was working on what. As evaluators we will need to compile such a directory, and we will make this available to all relevant stakeholders, with details of target groups, planned interventions, intended outcomes, and contact details. Depending on the nature of the projects, this may also permit a classification of project types to be tested and agreed prior to reporting.
3. Routine formative sharing of findings. We propose that all projects' data should be available to all sites throughout (once validated by the originating site). This will enable all site and project leads to be aware throughout as to how their local project is comparing.

4. Direct formative feedback. The exact approach to this will need to accommodate Covid constraints, but we would envisage facilitating some form of workshop event at the mid-point of the evaluation, to share lessons and ideas emerging by that stage.

This approach would therefore drive the following methods and deliverables:

	Question	Methods	Deliverables
1	What impact does project (x) have on sickness absence, turnover rates, and self-reported wellbeing?	• Summary description of projects via document review and baseline interviews • Analysis of sickness absence and turnover data • Analysis of participation data • Survey of self-reported wellbeing	• Directory of projects • Standard guide as to metrics • Formative and summative statistical reports, identifying both positive and negative impacts
2	What is the cost-effectiveness of project (x)?	• Analysis of input cost and outcome data • Formative and summative consideration of social value emerging – derived from qualitative interviews	• Summative cost-effectiveness and social value analysis, identifying both positive and negative impacts
3	How can project (x) be effectively implemented?	• Qualitative sample interview at baseline, interim and summatively • Thematic analysis	• Formative and summative assessment of implementation learning
4	How can project (x) be delivered sustainably, and at scale?	• Qualitative sample summative interview	• Summative assessment of sustainability learning

Sampling for the proposed self-reported wellbeing survey, and for qualitative interview, will be key considerations in this project. Depending on the agreed numbers of projects, and intended participants, we will need to agree an approach to sampling which is sufficiently representative of the full range of projects, but deliverable within the timescales and available project resources.

The pattern of interviews, whether as individual or small-group, will depend on the overall pattern of sites and projects. Our approach is based on up to 60 individual/small-group interviews at each of baseline, interim and summative stages. This will give a substantial national dataset of up to 180 qualitative interviews; we will spread these across sites and projects in a way which best reaches the various project and stakeholder groups.

Self-reported wellbeing surveys do not need to be limited in number; they will be limited only by the distribution and response rate we are able to achieve, working closely with site leads.

2. Please provide an overview of how you will resource your proposal, the proposed staffing structure, skills and experience that will help delivery of this contract *(2 sides – 10.5%)*

Our team would be:

Name	Position	Role
[redacted]	Partner	Senior Responsible Officer, with overall responsibility for delivery to time, budget, and client satisfaction.
	Senior Consultant	Site lead for 4-5 sites. Survey management, and lead on social value. Day-to-day contact for NHS England.
	Senior Consultant	Site lead for 4-5 sites. Project lead on organisational psychology and instrument choice.
	Senior Consultant	Site lead for 4-5 sites. Financial lead for cost-effectiveness analysis.
	Head of Analytics	Statistical analysis and advice.

Our team has a very extensive track record in large-scale multi-site evaluations. As a sample, drawn from fifteen such projects we have completed in recent years:

Project	Specific achievements in design and delivery	Volume of work undertaken, and audience(s) involved
New Care Models (NCM) Programme	A longitudinal evaluation of a complex, national pilot programme. Our mixed-methods approach included an extensive programme of interviews (via site visits), thematic analysis of interview findings, and statistical analysis of performance data.	Three formative rounds of qualitative interviews and quantitative analysis over a two-year period, with triangulated findings presented in a summative report to senior stakeholders at NHS England and the pilot sites (17 in total).
Specialist Community Forensic Team (SCFT) national pilot	A longitudinal evaluation of a complex, national pilot programme. Our mixed-methods approach included five rounds of interviews with staff, carers and service users alongside statistical analysis of activity, workforce, and financial data.	Five formative rounds of qualitative interviews and quantitative analysis over a two-year period, with triangulated findings presented in a summative report to senior stakeholders at NHS England and the pilot sites (three in total).
Women's Secure Blended Services (WSBS) national pilot	A longitudinal evaluation of a complex, national pilot programme. We visited all three sites to conduct formative rounds of interviews with staff, carers and service users. We also conducted an analysis of activity and workforce data from all three sites which included historical baseline data.	Three formative rounds of qualitative interviews and quantitative analysis over a two-year period, with triangulated findings presented in a summative report to senior stakeholders at NHS England and the pilot sites (three in total).

Project	Specific achievements in design and delivery	Volume of work undertaken, and audience(s) involved

National Suicide Prevention Programme	A longitudinal evaluation of a complex, national pilot programme. We collected data and conducted interviews at eight sites across England and collated our findings to provide an overall assessment of the efficacy of the programme. We also included financial data on the cost of the projects within the programme.	Formative rounds of interviews (including health, social care, public health and the third sector) and a summative data analysis, with triangulated findings presented to senior stakeholders at NHS England.
Care planning across eleven sites in the republic of Ireland	Very large-scale qualitative evaluation across 11 sites in the Republic of Ireland, including new partnerships with service user organisations across a wide range of Irish communities.	Sponsored and led by the Irish Mental Health Commission, working with a very wide range of statutory and independent sector providers.

All of these projects were led by [redacted] with other members of our team contributing to some or all of them. Our overall team is 23 strong, with access to a wide range of specialist associates in addition. We are therefore well placed to manage any unforeseen events which might arise, and to ensure continuity of service for you. Niche will bear the risk of ensuring we provide sufficient staff days with the right skills to provide all of the deliverables specified here to your requirements and timescales.

This range of experience demonstrates that we have a strong track record in:

- Method and evaluation design, across a wide variety of approaches.
- Stakeholder engagement, building effective relationships with national leads, local site leads, staff, and service user groups.
- Both qualitative and quantitative methods, including thematic and financial analysis.
- Evaluation work within the field of health and social care (which is our entire focus as an organisation).
- The particular issues which arise in considering mental health and wellbeing, a key driver of the nature of work-related pressures in the NHS.

3. Please provide details on how you will ensure that your proposal is inclusive, accessible and recognises the diverse demographic of the NHS workforce *(1 side – 7%)*

"Diversity" in this project will be understood broadly, considering issues of age, seniority and professional background alongside ethnicity and disability as the probable main relevant considerations. Risks to health and wellbeing are not equally distributed amongst these groups; broadly, more junior staff from ethnic minorities and/or with an existing disability are at greater risk of both physical and mental work-related health problems.

This consideration of diversity will affect our approach as follows:

Sampling

In our interviews and engagement work, we will ensure that we do not simply hear the views of project managers and senior staff. We will seek approaches to

sampling which ensure, across the full range of projects, we hear a balanced sample of views from intended beneficiaries, taking account of all of the aspects of diversity referred to above.

Data collection and analysis

Our quantitative work will include data-fields for each agreed aspect of diversity. This will permit us to investigate the extent to which:

- Projects are targeted at at-risk groups.
- Participants in projects are representative of the wider workforce.
- Participants in projects are representative of workforce cohorts at greater risk of work-related health problems.
- Outcomes (both positive and negative) are distributed in proportion to participant cohorts.

In undertaking such analyses, we are conscious that many projects may be relatively small, such that it may be difficult to draw out statistically significant findings – we will be careful to indicate the confidence with which any possible conclusions can be drawn. We are all conscious that some projects may be untargeted, whole-organisation initiatives, for which parts of this analysis will be less relevant.

Reporting and communications

In our reports, both formative and summative, we will draw out such diversity-related findings as appear justified by the full range of evidence. We will comment on the extent to which the programme appears to have led to appropriately-targeted projects, on the take-up of those projects, and on any significant differences in their impact across the workforce. Conscious of the wide intended audience for this work, we will present both our interim work and our project reports in non-technical language, such that the full range of the NHS workforce should be able to understand and interpret what we have found.

4. Please describe your project management arrangements and how you expect to work with the national team *(3 sides – 10.5%)*

Fuller details of our team's skills and experience are:

Name	Qualifications	Experience
[redacted]	MSc (Oxon); MA (Oxon); MBA; FRSA	James has 35 years' experience in healthcare management, half of that leading complex consultancy projects in a wide variety of settings, including all of the projects listed as examples under question 2. He has a Masters in evidence-based healthcare, and in business administration, and extensive experience in multi-site mixed methods evaluations.
[redacted]	MSc, BSc	Oliver is an experienced researcher, analyst and insight professional with extensive experience in conducting service evaluations and reviews, including the use of both quantitative and qualitative research methods.

[redacted]	MSc, MSc, BSc (Psychology) RGN, RMN	[redacted] is an experienced clinician and service manager, with experience and qualifications in a wide range of clinical specialties, and she has worked extensively in evaluation projects. She has an MSc in Organisational Psychology, and therefore leads on work of this nature within Niche.
[redacted]	BA, Chartered Accountant	[redacted] is a highly experienced finance professional with over 30 years' experience in finance, governance and performance roles in the public, private and third sector including a successful career in audit/assurance and advisory services. She has held senior finance and performance roles at a variety of NHS organisations.
[redacted]	PhD, BSc	[redacted] is a very experienced data analyst, both within the NHS and in consulting roles to the NHS. Prior to joining Niche, he has worked with the CQC, the King's Fund, and the Nuffield Trust.

We will work in the following ways to ensure effective management of this project with you:

Project initiation and mobilisation

Given the nature of the project, we envisage a detailed and carefully co-produced initiation and mobilisation process. This will review and finalise the timetable proposed here and agree who will do what at each stage of the project. This will then form the basis for all subsequent project management activities.

Evaluation steering group

We propose a small steering group will need to be established with your and our key project leads. This will need to meet fortnightly (or even weekly) in the project's early stages, but we expect this can move to monthly once the project is established. We will take full responsibility for the administration of these meetings (agendas, papers, notes etc). We propose that this steering group should meet on the large majority of occasions via Microsoft Teams; the past 18 months have taught us that this can be as effective, and is certainly more efficient, than face-to-face meetings.

Fortnightly project trackers

We will report progress to each steering group; we will in addition provide a regular fortnightly project tracker for the duration of the project. This will provide a single-side summary of work completed, plans for the coming fortnight, issues to be escalated, current deadlines, and project risks. It will therefore inform and drive day-to-day communications between our two teams.

Site liaison

We will identify a single member of our team as the lead for each site. This individual will lead on qualitative work for the site and be the immediate point of

[redacted] project communications. We have found this approach to be very successful in previous large multi-site evaluations.

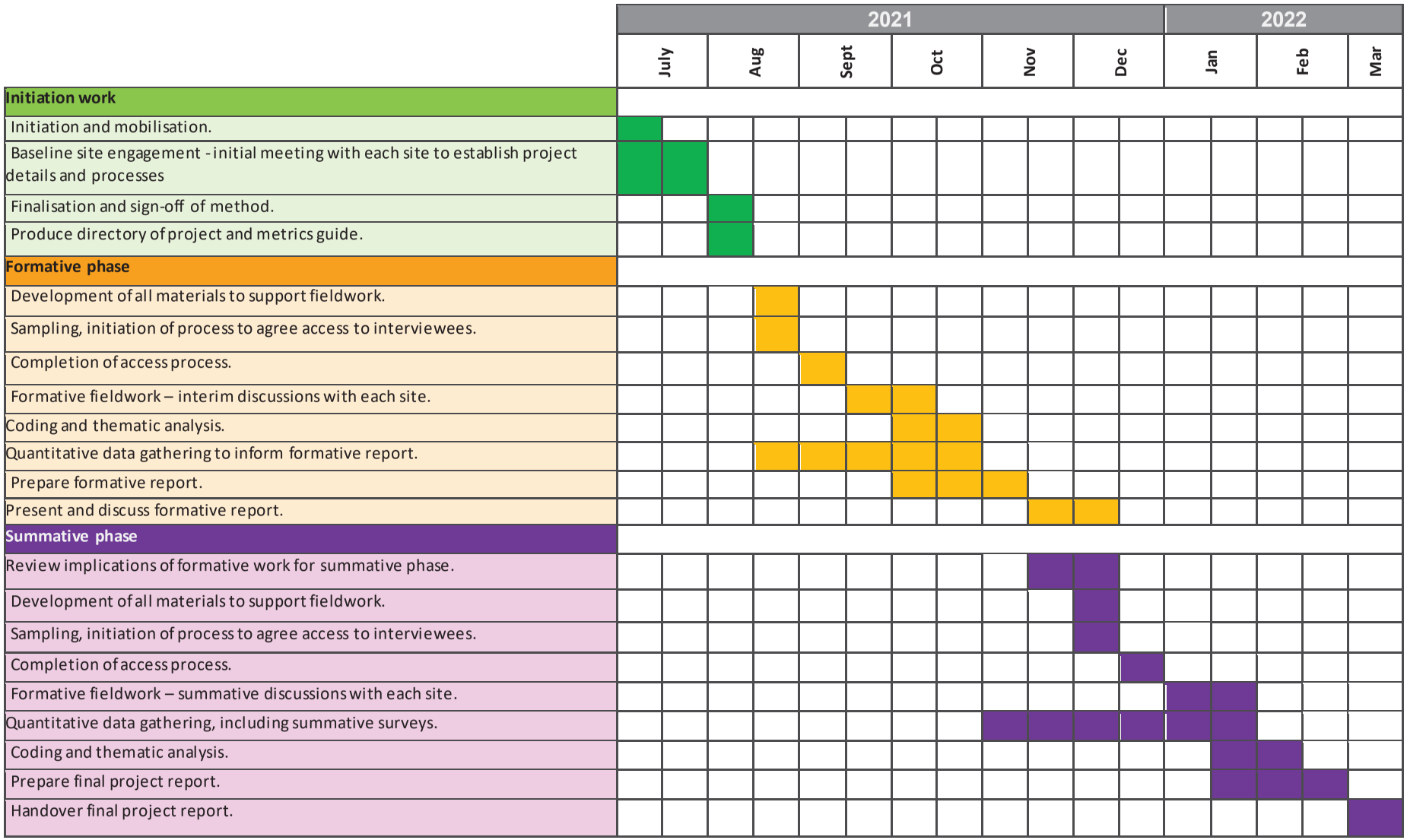
Data sharing and information governance

We do not envisage any transfers of identifiable and special categories of data during this project. No patient data will be involved; statistical staff data and survey results will all be anonymised; qualitative interview data will be reported in a non-identifiable format. Should any site nonetheless seek a formal data sharing agreement with us, we will be happy to pursue such arrangements. We are ISO 27001 and Cyber Essentials Plus certified and comply with all necessary information governance requirements.

Risk management

The main risks to this project we would expect to be delays in method agreement at its outset, and difficulties agreeing and accessing samples for survey or interview. Via the methods above, we will monitor progress against timetable throughout, and identify and escalate matters we have not been able to resolve directly with individual sites. We expect there to be few such requirements for escalation.

These activities, and our various delivery methods, will form a project timetable as proposed below. This timetable will be finalised at project initiation, and then monitored and adjusted as required throughout.



5. Please describe what data you will collect and how this will be used (2 sides - 14%)

Data schedule

We will prepare a full data schedule, based on the evaluation questions, and both site and central team feedback. In outline, we envisage the following types of data within that schedule:

Quantitative data	Qualitative data
Project participants – numbers, with diversity factors (where relevant).	Narrative description of projects' aims and intended outcomes.
Sickness absence – baseline data, context /control data (as a comparator), post-intervention data.	Implementation lessons – what helped, what hindered, lessons learned.
Turnover - baseline data, context/control data (as a comparator), post-intervention data.	Sustainability lessons – how the project could be sustained or expanded.
Self-reported wellbeing – sample survey.	Social value lessons – ways in which the project has had a wider impact on organisational culture.
Cost per project – planned and actual.	

Frequency

Qualitative data will be gathered three times: at baseline engagement in July/August, at the interim stage in October, and at summative engagement in February.

Quantitative data (with the exception of the self-reported wellbeing survey) will be gathered twice: for interim reporting in October, and for summative reporting in February. The interim reporting cycle will also include a request for baseline (historic) data.

The self-reported wellbeing survey will be conducted once, ideally including some form of control or contextual sample, in January/February 2022. Taking a positive psychology approach means that we believe we can have confidence in individuals' self-reported perspectives; we do not therefore propose a baseline survey with the same individuals, given the relatively short timescales over which this programme is being delivered.

Addressing gaps

Minimising gaps in data starts with clear data specifications, and clear guidance. We will not simply issue a data schedule; we will consult as to feasibility and desirability and provide guidance as to what exactly is expected by when. This is an approach we have applied successfully in numerous evaluation projects. We do expect, nevertheless, that across a multi-site project there will be some delays and difficulties in providing data.

Via our site leads and central analytical team we will ensure clear tracking of progress, and early awareness of difficulties which sites may be experiencing. We would always prefer incomplete or partial returns to completely absent ones, and we will work with sites to ensure as much as possible is available by the dates required.

Use and accessibility

We will prepare validation analyses of quantitative data, for confirmation by the relevant site, prior to inclusion of such data in our reports. Following validation, all such results will be shared across all project stakeholders.

Individual wellbeing survey responses, and notes of individual meetings or interviews, will not be shared outside the Niche evaluation team; these results will be shared only in non-attributable form, and in aggregate, following qualitative and thematic analysis.

Triangulation

Our mixed methods approach will enable us to test findings before drawing conclusions. We will do this in both directions between qualitative and quantitative data: where claims are made in discussion with interviewees, we will check whether (and to what extent) they appear supported by the statistical data; and where statistics suggest something may be happening, we will include this as a topic within our interviews. We will place most reliance on findings which are supported both qualitatively and quantitatively.

Reporting format

For both local and national reports, we are conscious that many readers will wish only to read a short-form summary. We therefore propose to prepare simple and short Powerpoint-based summary reports, with the main findings, and our judgement as to their implications. Full details of supporting evidence will then be cross-referenced and made available in supporting documents.

We will present statistical data via charts and tables, permitting readers to understand the full detail if they wish. Qualitative data will include (non-attributable) direct quotations, as we find these really important in bringing a project to life for a reader.

For the national report, we will aim to classify projects into types, to permit an overall understanding of impact and process learning. This will also assist local sites to understand their relative position, in comparison to other projects. We will base this classification on the emerging structure of the programme, but with regard to existing structures. We could, for example, structure our reporting around the six project types in the national workforce health and wellbeing framework: Leadership and management; Data and communication; Healthy working environment; Mental health; Musculoskeletal; Healthy lifestyles. We may also be able to distinguish preventative and treatment interventions.

6. Please describe your approach to effective stakeholder engagement *(2 sides – 14%)*

Five principles will be essential to effective stakeholder engagement:

- Clear structures and processes.
- Openness and transparency.
- Shared purpose.
- Evaluation benefits.
- Regular communications and responsiveness.

Clear structures and processes

This is the essential starting point for effective stakeholder engagement. Our approach to the evaluation will be based on a clear method and timetable, with statements of the respective responsibilities of Niche, the national Health and Wellbeing team, and local site leads. This will be made available for discussion with relevant stakeholders before being finalised and agreed.

Any changes to the method will likewise be agreed and communicated to everyone who needs to be aware of them.

There will be designated national project leads, and local site leads, so that everyone has a clear and single point of main contact with the evaluation; and there will be regular meetings and project updates.

Openness and transparency

We will work with the national Health and Wellbeing team to ensure that this evaluation is constructive, appreciative, and honest. Evaluation work always runs the risk as being seen as "another form of external criticism" or as a way of garnering praise for a national initiative, whether or not it is in fact proving successful. We will do neither of these things; our emphasis will be on identifying positive learning and successes wherever possible and noting challenges and problems only where necessary. But if a particular approach hasn't worked, we will say so, together with our view as to why, and as to what could be done to reduce the risk of that happening again. We aim to work as a trusted partner, an approach we have found successful in previous work of this nature.

Shared purpose

We start from the perspective that everyone involved in this programme shares an aspiration to improve the health and wellbeing of NHS staff. We have different roles and interests in that process, but it is "all of us against the problem" of staff struggling with their health, and the complexities of preventing or addressing those health difficulties. We will therefore consistently emphasise this as a shared purpose, and a shared endeavour, explain to people how what we are asking of

them can benefit both themselves and colleagues, and encourage participation in the project's various requirements on that basis.

This will be especially important in ensuring a good return rate for the proposed self-reported wellbeing survey, where we will aim to ensure that communications emphasise the importance of its data in understanding the impact of current projects, and in planning improvements in future.

Evaluation benefits

We have always found that evaluation brings secondary and unintended benefits. The questions we ask, and the data we request, promote reflection, improve clarity, and of themselves improve the likelihood of projects succeeding. In this particular case, we see potential benefits in:

- Seeking clarity from the outset as to the target groups for projects, and their intended benefits. We are happy to encourage and support the use of a logic model framework for this process, if sites find it helpful.
- Access to comparable data and to contacts for colleagues working on similar projects.
- Opportunities to reflect on learning as to implementation and sustainability, externally facilitated and guided.
- Formative feedback part-way through the implementation process.

We welcome and value this aspect of our role; it is always rewarding to hear feedback that our work has provoked useful reflection and change, and we will always work in a way which promotes relationships of this nature.

Regular communications, and responsiveness

Stakeholders will receive active communication from us regularly throughout the project.

National team members will see project trackers, steering group notes and papers, a method statement and associated detail of instruments and projects. Site leads will also see detail as to the project method, as well as the project directory, and regular detail about approaches to interviews and meetings, and survey sampling. These should ensure that all stakeholders are well aware of the evaluation, its questions, processes, and purpose.

We also expect to need to offer responsive communications. Stakeholders, both centrally and on sites will have queries about aspects of the evaluation; issues will arise which need discussion and resolution. All stakeholders will have the details of both their main point of access, and wider members of the Niche team; given the size of that time, we would expect to be able to resolve a query very quickly, even if the main point of contact is temporarily unavailable or on leave.

Project support staff in our offices are familiar with the full range of our work at any given time, and will always be accessible to handle enquiries, and to ensure a speedy response.

Part 2: Contract Terms

Contract Terms v6.0