Fostering an inclusive and impact-oriented mental health science field – Request for Proposals Questions and Answers

Overall

1. What gaps and silos in the Mental Health field has Wellcome already observed that you are most eager for this project to address?

   We want to address gaps and silos across biological-psychological-social research agendas and across different research disciplines, to which have multiple contributing factors ranging from researchers having limited time and opportunity to get exposure to different approaches, to more systemic factors like the way institutions are structured. We want the insight to help us identify which factors to focus on and can address through influencing.

2. Can you provide any specific examples of programme or organisations that you consider as leaders in ensuring research platforms are more inclusive and coherent, within the mental health space or beyond?

   We would like the landscape review to investigate this. A couple of examples might be Inspire the Mind, or Mental Elf. But we are conceptualising 'platforms' in the broadest sense possible for this project and are open to what that means.

3. Can you clarify your definition of what constitutes mental health for this RFP? Should it focus solely on the priority areas in your current strategy, depression, anxiety and psychosis?

   Yes, they should be on the priority areas in our current Mental Health strategy. The focus of the overall programme would be on early intervention in anxiety, depression, and psychosis.

4. We know from our engagement with the public engagement team that they are working on the development of Centres of Exchange (bringing researchers and communities together) to support participatory research and innovation. Would there be any expectation or interest in aligning with the frameworks/approaches that are being developed here?

   No expectations but the project team is open to learn from suppliers' knowledge and experience with other frameworks and approaches.

5. What do you think are biggest challenges and constraints to achieving your 30-year strategy especially in MH?

   There are many challenges and constraints given the scale of ambition in our endeavour, however we foresee the challenge of developing this mental health science community as a key one to overcome.

6. What existing milestones/other parallel pieces of work should we take into consideration when developing the workplan (e.g., that might influence the overall timeline and/or provide specific opportunities for engaging with Wellcome stakeholders)?

   There will need to be considerations given of not oversaturating Wellcome's stakeholders as sample and may need to be contacted centrally, although we would expect the supplier to

recruit majority of sample beyond Wellcome's immediate stakeholders. This can be discussed along with other work going on in more detail upon commission, and we would not envisage this affecting timeline.

RFP Process

7. If we were selected as your partner in this phase of work to help define the right solution then would we still be able to bid on any opportunities to then implement that solution, or would you see that as conflicted in some way?

   There is a barrier for the winning supplier to bid or be involved in any following work there might be following this project given the conflict of interest.

8. Can you confirm that the 20-page limit is only applicable to the core proposal for parts A/B/C/D and that information about team, relevant experience, budget and timelines can be submitted in addition?

   The 20-page limit is in total. Examples of similar types of work could be sent as a separate document/appendix to the proposal.

9. How many proposals will you be looking to shortlist to presentation stage?
   We are looking to shortlist 3 proposals.

10. To what extent does the ballpark budget included in this expression of interest factor into your selection criteria at this stage?

    We will consider value for money as one factor among many based on the budget provided in the final proposal.

11. What characteristics or attributes would you like to see in your ideal partner for this project?

    Inclusive, innovative, and expert.

12. We wanted to clarify on the 20-slide limit, is this total number of slides (including introduction/commercials)? The slide breakdown included in your brief totals 20 slides but focusses on the phases only so we wanted to double check.

    The 20 page limit is in total. Examples of similar types of work could be sent as a separate document/appendix to the proposal.

13. What are your expectations re costing structure?
    Are you planning to commission phases separately and therefore need each module to be costed individually?

    We would like a breakdown of costing at least by phase.

14. Do you have a proposed budget in mind for each section of the work?

    We are open to budgets but will account for value for money as one factor among many.

15. Should budget be inclusive or exclusive of VAT?

    The budget should be inclusive of VAT which should be shown as a breakdown. If you are not based in the UK, Wellcome will still have to self account for VAT at 20% so there should not be any additional local taxes included in your budget

16. Are you open to a proposal which only covers part A (audience insight analysis), or would you expect parts A and B to be proposed together at a minimum?

    We would be open to an only Part A proposal.

17. What format would supplier presentations take on w/c 24th April?

    Open to formats but most likely would expect a presentation of a slide deck and then a Q&A with a panel

18. Do you anticipate all agencies who have responded to the RFP will present proposals w/c 24th April?

    No, we will shortlist

    Equity, Diversity, and Inclusion

19. Incorporating an intersectionality approach – from our experience in mental health research there is a real focus and need to ensure that efforts in the mental health research space leverage an intersectional approach. E.g. considering gender equity, disability inclusion, intersection between climate and mental health, etc. Is this something we should consider incorporating, particularly in part C and D.

    Yes

    Lived Experience

20. Do you have specific criteria for the sort of Lived Experience experts you would like us to engage in Part A? And do you expect some of those experts to be represented in the co-creation community as well?

    At Wellcome we define Lived Experience as a unique form of person-centred knowledge, insights, and expertise that comes from having experience of mental health challenges. In mental health, it builds on the work of survivor and service-user activists, and people who have experienced mental health challenges and sometimes, though not always, clinical services.

    You can read more about it in the following articles:
    https://wellcome.org/news/lets-talk-about-lived-experiences-mental-health-challenges

https://www.linkedin.com/pulse/welcome-wellcome-what-you-need-know-lived-experience-our-kate-martin

We would expect some representation of Lived Experience experts in the co-creation community.

Audience insight analysis

21. Has Wellcome already identified potential Mental Health science community members in the nine target countries for Part A? If so, what is the nature of Wellcome's relationships with these individuals/organizations?

    No, we haven't identified potential members, but we envisage some of the members would also be our existing grant holders or individuals from our partner organisations.

22. The audiences you cite in the RFP could be construed as a list of researchers AND practitioners. How are you thinking about the balance between the two, and more broadly, what are your aims for a more cohesive / inclusive agenda to influence practice (and not just research)?

    At this stage, our focus would be primarily on researchers (this could include some practitioners who still conduct research around 50% of their time) rather than influencing practice per se - as we ultimately want to build a field that achieves step changes in understanding mental health and develops better interventions.

23. When you mention your ambition to make the insights publicly available, do you envisage for it to be formally peer-reviewed and published in academic journals and online resources?

    We would not expect these insights to be formally peer-reviewed for an academic journal, though may well provide an online resource - for other mental health research funders, for example.

24. In relation to the audience insights, is it your expectation that appx. 40 research area experts (as listed but not limited to those in section 2.2) are interviewed, or can we recommend other methods for capturing insights i.e. focus groups and surveys to optimise timelines and budget (in each market)?

    No, we are happy to be led by the supplier to recommend the best method to capture insights in the optimum and the most cost/time efficient way possible.

25. We would typically recommend a qualitative approach based on your objective and noticed your ambition re: publication – are there any specific requirements, related to publication, that we need to bear in mind to support this?

    No specific requirements.

26. To facilitate collaboration within and potentially across markets, it would be practical to use English as the primary language. Do you foresee any challenges with this approach?

Whilst feasibility is a key parameter when evaluating proposals, there could be challenges with this approach. It would be ideal to see risks associated with not using local languages and potential mitigations.

27. What does your network look like for recruitment purposes – any indication of size of panel? Are we able to contact people on your database for MR purposes? Do you typically reimburse respondents for their time for studies like this?

    We would reimburse respondents for time. While we have some contacts we can't guarantee a specific number nor have a specific panel, so would expect the majority of recruitment to be external

28. The RFP references 40 interviews per market – are you open to running fewer interviews per market, if we are confident the sample is robust enough to deliver on your needs? We believe 20 interviews will deliver a quality of insight, ensure participant seniority and expertise and ultimately deliver economies of scale.

    We would be open to fewer interviews suggested but would expect to see that reflected in cost and need to be assured it would deliver on our research objectives.

29. Of the markets in the RFP, are any considered priority markets, where we may bolster sample numbers or run fieldwork first (to build iterative learnings into later markets)?

    We would like to approach the 9 countries with equal priority initially.

30. What is the level of research / insights already gathered by Wellcome that this work will build upon, including on (a) the state of the Mental Health science field globally, and (b) the nine countries selected for Part A analysis?

    This is the first insight of the mental health science field being gathered in this way from these countries.

31. The RFP mentions that 'Some participant recruitment may be possible through Wellcome networks' (page 6). Can you give an indication of the main strengths and gaps of your networks in Mental Health science e.g., global vs. in-country and across the disciplines of Mental Health science listed in the RFP (pages 6 & 7)?

    We will be able to facilitate some contacts through our grantees but cannot give a guarantee of numbers and would expect the majority of recruitment to be undertaken by the supplier.

32. Do you have expectations that will help calibrate the breadth and depth of data-gathering activities with the Mental Health science community? Specifically, do you foresee an approach that includes active engagement (e.g., interviews, focus groups etc.) with ~40+ stakeholders/country (per the example shared in the RFP, page 7); or would you be open to a staged approach that would build upon different methods to optimize time & resources?

    We would be open to different approaches and methods that you wish to propose.

Scope design solution and setting up a co-creation community

33. Do you have any expectations for what the co-creation community will look like, in terms of engagement styles, virtual/in-person, and/or length of engagement? Do you expect it to draw primarily from the same 9 countries that you have defined for Part A?

    We don't have any rigid expectations for what the co-creation community will look like. We are happy to be led by the insights from Part A and the landscape review.

34. Have you had experience with this sort of co-creation model before?

    Yes, we have included co-creation models in previous projects.

35. For this kind of engagement, we would often take a systems thinking approach to identify gaps and opportunities, yet that is not directly referenced in the RFP. Is this something you would be open to?

    Yes, we would be open to this approach.

36. Have you already identified any promising solutions / platforms within the field of mental health?

    No, we haven't identified any promising solutions/platforms, we would envisage the landscape review part of the RFP to give that starting point.

37. Do you have expectations of Wellcome's role within this community? To what extent are you expecting Wellcome to be an active participant versus a sponsor in future solutions?

    Through this project we want to explore the best role for Wellcome - we are open to being an active participant or a sponsor, and recognise that we may not necessarily be best placed front and centre and may achieve more impact through enabling other organisations, for example

38. In part C, what role does the Wellcome team see cocreation/participatory design approaches playing in this aspect of the project? Whilst we recognise that stakeholder insights and whitespace analysis of existing approaches (Part A and B) might inform the initial designs, participatory approaches might be helpful in long-term validation of these designs and ensuring that the design of solutions is contextually appropriate.

    We envisage Part D (setting up a co-creation community) will play a key role in the solution scoping phase of this project. This is primarily to ensure long-term valudation and context-appropriate of the solution.

39. In Part D, what is the expectations from the community in terms of contribution and longevity of this commitment?

    This is open for development but would require more than a one-off engagement and need to avoid simply being extractive. Depending on the landscape review and the solution

scoping stages we would envisage the co-creation community to help inform the solution development.

40. Who do you envisage being part of the community group to input into Part C?

    A selection of researchers and Lived Experience experts, the exact make up of which is based on the findings of Part A&B and initial solution scoping.

41. Can you give us some more background into your suggestion for a co-creation community?

    What do you envisage this community to look like?

    What appeals about this approach? Where have you seen it work well? Has The Wellcome Trust used this approach previously?

    A selection of researchers and Lived Experience experts, the exact make up of which is based on the findings of Part A&B and initial solution scoping. Cocreation appeals as we believe it will make solutions more fit for purpose by inclusively involving wider perspectives. We have used cocreation models in previous projects.

42. Do you see the community as a long-term initiative that would continue to feed into ongoing solution development? Or a shorter-term solution that you may repeat at a later stage?

    This is open for development but would require more than a one-off engagement and need to avoid simply being extractive. Depending on the landscape review and the solution scoping stages we would envisage the co-creation community to help inform the solution development.

43. While we understand that the precise composition of this group will be informed by the work in Part A and B, can you share any prerequisites or expectations related to the configuration of the co-creation community (e.g., in terms of size / inclusion incl. Mental Health researchers vs. representatives with Lived Experience, Mental Health science disciplines, geographies)?

    There's no prerequisite for the cocreation community other than it involves meaningful involvement from researchers and lived experience experts, and the composition is led by the insights from Part A and B

    Collaboration with Wellcome

44. Who are the key internal stakeholders for this project?

    Wellcome's Mental Health team (particularly the Fieldbuilding and Lived Experience teams) and Corporate Affairs team

45. What will be the composition and set-up of the Wellcome team that will act as primary point of contact for this work (incl. participating in regular meetings)? How do you foresee their role and level of involvement/capacity?

The composition will be set up after the contract is awarded. There will be a point of contact and a wider team to be updated on the milestones. We would expect the Supplier to take on majority of the project management so the involvement from Wellcome Team is limited.

46. What will be the composition and set-up of the Wellcome decision-making body/bodies for this work (i.e., in reference to the 2-4 final stakeholder meetings mentioned in the RFP for Part A, B, and C)? How do you foresee their role and level of involvement (e.g., engage along the way vs. validation of final deliverables)?

    There will be individuals from Corporate Affairs and the Mental Health teams. We will develop the composition of these as we go but expect a small regular group for engagement along the way and wider groups less frequently for discussing deliverables.

47. How do you anticipate Wellcome's Lived Experience team will be involved in this project (especially for Part C & the co-creation of design solution ideas, as well as general decision-making)?

    Wellcome's Lived Experience team will be embedded in this project from the start and will identify opportunities throughout the project to inform outputs by Lived Experience of Mental Health

48. Does Wellcome have any specific policies or expectations/limitations related to engaging with external subject matter experts for consultation (e.g., stipends, fees)?

    We would expect some reimbursement for external experts giving time for consultation.

    Outcomes

49. You mention a written report / deck – can you confirm if a PPT deck will work or if you will need something more comprehensive for publication purposes?

    A PowerPoint deck would be sufficient.

50. What will success look like for this project?

    Success would be us understanding the perspectives of the mental health science community and the challenges they face, meaning we identify where we can make the most impact and are provided evidence based approach to developing influencing and engagement solutions which will be impactful.

51. Do you have expectations/examples of what the solutions would look like?

    No, we are completely open to what a solution would look like and happy to be guided by the insight.

52. On deliverables, at what stage in the fieldwork process would you expect interim findings to be shared? What is the key objective of an interim deliverable, is it a) to take stock of how fieldwork is going to build iterative learnings into the remaining interviews? Or b) to share insights from the first set of interviews? N.B we would anticipate all insights in an interim deliverable to be WIP until all interviews and analysis have been completed.

We would expect interim findings to be shared once fieldwork is around 60% complete, potentially both to guide remaining interview needs and to get an initial steer of insights, which would be understood as WIP