Independent evaluation of the Q Improvement Lab

Final Report

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Preface

Around the world, social labs are being established as a way of tackling complex challenges.¹ The aim of these labs is to work creatively and collaboratively to formulate and test new ideas. Most commonly the labs claim to support innovation (a step change in delivery and performance) in policy or delivery rather than improvement (incremental change in performance), but in practice there is considerable overlap. An early example of what a lab might look like was spun out of the Innovation Unit in the UK in 2008 as a ‘brokering institution’ to create networks that were more conducive to the development and spread of innovation.² Labs use various approaches, often rooted in the disciplines most relevant to their work, for example design or behavioural science.

The first Q Improvement Lab (‘Q Lab’), funded by the Health Foundation and NHS Improvement, was launched in the spring of 2017. The aim was to test whether the Q Lab approach is likely to become an effective, valuable way of developing ideas or interventions to support positive change at multiple levels of the health and care system in the United Kingdom. The Q Lab is distinctive not only for its focus on improvement but also for its concerns with UK health and social care issues.

RAND Europe and the University of Cambridge were commissioned by the Health Foundation to undertake a real-time, formative evaluation to support the Q Labs pilot. Starting in May 2017, the evaluation was conducted over 15 months. The evaluation team provided emerging findings and preliminary recommendations in an unpublished interim report in November 2017. In this final report, we draw on the interim report and consider the data collected since the beginning of the evaluation (from May 2017 to April 2018) to inform the findings and our recommendations.

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¹ See, for example: https://www.quora.com/What-are-examples-of-corporate-innovation-labs-for-a-collaborative-list-of-physical-innovation-spaces-worldwide-that-were-created-to-foster-product-or-process-innovation
² Horne (2008).
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# Definitions

| **Q** | The term *Q* refers to the Q initiative, led by the Health Foundation and supported and co-funded by NHS Improvement. It seeks to connect people skilled in improvement across the UK, with the aim of making it easier for people leading improvement initiatives to share ideas, enhance their skills and make changes that deliver improvements to health and care |
| **Q Lab** | The term *Q Lab* refers to the improvement approach that is the subject of this evaluation |
| **Q Lab team** | The core *Q Lab team* refers to the team that coordinated the pilot Q Lab, based in an office in London. Core team membership varied during the pilot Q Lab, but included the Head of Q Lab, a Programme Manager, an Insight Manager and an Office and Events Co-ordinator |
| **Q Lab participants** | The *Q Lab participants* are the people who the core Q Lab team seek to engage and who, to varying degrees, participate in the work of the Q Lab |
| **First Q Lab / Pilot Q Lab** | The *first Q Lab or pilot Q Lab* is the first attempt to put the approach into practice; it was launched in spring 2017, and it addresses the topic of peer support |
| **Second Q Lab / Q Lab 2** | The *second Q Lab or Q Lab 2* refers to the second challenge, which as of May 2018 was being decided |
| **Q Exchange** | A new funding programme within Q that invited people to submit bids by May 2018 for up to £30,000 funding to develop an improvement project or idea |
The Q Lab set out to test whether a Lab approach is likely to become an effective, valuable way of developing ideas or interventions to support positive change (Chapter 1)

The Q Lab improvement approach emerged from the Q community, an initiative led by the Health Foundation and NHS Improvement that brings together a community of people with experience and expertise in improving health and social care. The Q Lab provides a mechanism for bringing together relevant stakeholders (Q Lab participants) to work on a specific topic and challenge over the period of about 12 months. It was expected that the Q Lab would enable a deeper understanding of a particular issue, and the generation and testing of ideas and potential solutions to improve service users’ and providers’ experiences and outcomes. The Q Lab is coordinated by a core team based in London.

Launched in the spring of 2017, the first Q Lab (pilot Q Lab) addressed the topic of peer support in health and social care, focusing on the specific challenge: ‘What would it take for effective peer support to be available to everyone who wants it, to help manage their long-term health and wellbeing needs?’

A real-time formative evaluation began in May 2017 to address the overarching evaluation question: ‘Is the Q Lab approach likely to become an effective, valuable way of developing ideas or interventions to support positive change at multiple levels of the health and care system?’ Between May 2017 and April 2018, the evaluation team collected embedded qualitative data including ethnographic observations, semi-structured interviews and focus groups. The evaluation team also conducted surveys of Q Lab participants and a supplementary document review.

The Q Lab approach was consolidated during the pilot year (Chapter 2)

The ideas behind the Q Lab have deeper origins in the Health Foundation and beyond, but the Q Lab approach was developed in late 2015, with its main phases and activities being consolidated during the pilot year from May 2017 to May 2018. The pilot Q Lab comprised three phases defined by the Q Lab team, namely: the research and discovery phase, the developing and testing phase, and the distilling and sharing learning phase. The purpose of the research and discovery phase was to develop a better understanding of the problems and opportunities around peer support and to identify potential areas for improvement. The developing and testing phase focused on developing briefs for the three identified priority areas: access to peer support, evidence for peer support, and sharing what does and does not work. The distilling and sharing learning phase focused on completing the work on the briefs, wider discussions
and reflection (including various essays), and formally ending the challenge on peer support. All of this fed into further thinking and planning to set up the second Q Lab.

The Q Lab team worked to articulate the Q Lab’s programme theory, which evolved during the pilot year. This effort culminated in an ‘impact model’, which describes the Q Lab short-term and longer-term goals. Specifically, the Q Lab aimed to deeply analyse a topic to identify challenges and opportunities; generate and test ideas with the potential to improve; support people to take action; and disseminate and spread ideas locally and nationally. The impact model that Q Lab has taken forward is based on what was learned during the pilot year and also reflects the team’s aspirations going forward. In the longer term, the Q Lab hopes to achieve increased value placed on participatory design methods; new methods to spread and socialise learning and ideas; more people with the capability, confidence, motivation and support to lead change; and thriving communities that build resilience and cross-pollination of learning across health and social care.

The evaluation team has also articulated its understanding of the Q Lab programme theory, including its phases, mechanisms and principles. Thus the Q Lab’s phases include: topic selection; scoping the landscape; idea generation and support to implementation; and dissemination of learning. Its mechanisms are leveraging both formal knowledge and lived experience, convening a diverse group of stakeholders, and providing an effective and psychologically safe platform. Finally, the Q Lab abides by the principles of being inclusive, creative, people-centred, topic-specific and time-bounded. The evaluation team recognises that the programme theory is likely to evolve further in light of the second Q Lab cycle.

In its phases, mechanisms and principles, the Q Lab approach is distinct from other improvement efforts in health and social care (Section 3.1)

As discussed above, the Q Lab approach comprises four phases. From the topic selection phase through to completion, the Q Lab represents a distinctive approach apart from other improvement initiatives, such as Q. However, there was a suggestion from some stakeholders that the peer support challenge as articulated may have been too broad, and that future Labs may consider defining a narrower challenge.

The Q Lab’s mechanisms also helped to distinguish it from other improvement approaches. In particular, one of the defining mechanisms of the Q Lab is its convening function, which brings together a wide range of stakeholders with different roles, experience and professional backgrounds in the health and care sector. The Q Lab also draws from a balance of existing data and evidence, as well as service users’ lived experience, or ‘uncodified’ tacit knowledge. In its pilot year, the Q Lab was able to create an effective and safe platform for a range of stakeholders, with varied backgrounds and expertise, to meaningfully interact.

The Q Lab’s principles include being collaborative, creative, time-bounded and topic-specific. By themselves, these principles are not unique in the UK’s health and care improvement landscape, but the Q Lab’s particular combination of these principles distinguishes it from other improvement approaches.
For a Q Lab to be effectively delivered, it is important to have a dedicated Q Lab team, as well as a range of stakeholders focused on a topic that is relevant and timely (Section 3.2)

In the pilot year, having a dedicated Q Lab team was likely essential in creating the momentum around the generation of ideas that have the potential to impact peer support. The core Q Lab team had a diverse skillset, ranging from design thinking to improvement science, that enabled them to employ creative tools and approaches throughout the pilot year. The Q Lab was funded by the Health Foundation and NHS Improvement, which meant that the team was able to focus on delivering the pilot Lab without having to search for funding.

The ability of the Q Lab to engage a range of stakeholders, including patients and service users with ‘uncodified’ knowledge, was perceived by participants to have contributed to its success in achieving a holistic understanding of the peer support challenge. However, it was also felt that the Q Lab might not have included the stakeholders with the necessary agency, power and networks to impact the health and care system.

The Q Lab’s consultative, participative process for topic selection ensured that the topic selected was relevant to stakeholders. The association of the Health Foundation with the Q Lab also helped to legitimise and provide visibility for peer support.

The Q Lab used a varied engagement approach. Participants had different motivations and faced different barriers to engagement, but valued the relationships nurtured through the Q Lab (Section 3.3)

The Q Lab team used a deliberately varied engagement approach that included in-person (via workshops) and remote or online means (via an online space). In addition, the Q Lab team organised webinars and emailed fortnightly updates to participants. In general, participants felt that the Q Lab team had been successful at maintaining engagement throughout the pilot Lab.

Participants engaged with the Q Lab for different reasons, which is likely to have influenced their level of engagement. In addition, participants’ engagement was hindered by a lack of clarity about what was expected of them. During the pilot year, the Q Lab team recognised and tried to mitigate this issue.

The networking opportunities provided by the Q Lab were highly valued by participants. In particular, attending the face-to-face events (i.e. workshops) was an important way for participants to form new relationships.

There have been benefits as well as the potential for tension in the links between the Q Lab and Q. The Q Lab has benefited from the Health Foundation and NHS Improvement, but its place within the broader health and care system is still unclear (Section 3.4)

The tight link between the Q Lab and Q means that the former has been able to benefit from the latter’s community. However, there is a potential for tension between Q and Q Lab, given that membership for
both is not directly linked, and that becoming a Q member is a selective process while becoming a Q Lab participant is not.

The financial support to the Q Lab offered by the Health Foundation and NHS Improvement was vital to the Q Lab and the development of its approach. Being linked to the Health Foundation also provided the Q Lab with connections to relevant stakeholders as well as a repository of knowledge on healthcare services and improvement science.

The Q Lab is unique, but operates in a crowded health and care improvement space. In future cycles, the Q Lab may find its niche in either: refining but broadly replicating the approach taken in the pilot year; or more fully leveraging routes to impact and spread, for instance by working with a partner. The second Q Lab will provide more evidence on the feasibility of the latter option.

*It is not yet clear if the Q Lab approach is the most effective for achieving spread and impact in the health and care system, but the Q Lab has been able to consolidate learning and knowledge on, and raise the profile of, peer support, as well as drive participants to take action (Section 3.5)*

In its pilot year the Q Lab achieved a broad understanding of peer support, and made its findings more visible by, for instance, conducting and publishing the results of a survey to understand decision-making in peer support, as well as supporting the development of an Evidence Hub (to be run by National Voices) to provide accessible information and evidence on peer support. As discussed above, participants also felt that the Q Lab was able to create momentum around the topic of peer support, and legitimise it in the eyes of policy-makers and high-level stakeholders.

The Q Lab has also enabled and empowered participants. Participants stated that they felt they now had the skills and confidence to make an impact and drive change in their own contexts. However, participants and stakeholders also felt that the Q Lab may not have been able to achieve impact and spread locally and nationally – although this may in part be due to the wide scope of the challenge set by the Q Lab team.

*The Q Lab is likely to be an effective and valuable approach for addressing some, but not all, types of improvement challenges. Going forward the Q Lab team should retain many core elements of the Q Lab approach, but continue to review others (Chapter 4)*

In its pilot year, the Q Lab team developed and implemented an approach to addressing challenges in health and social care that hinged on developing a holistic understanding of that challenge, creating momentum around addressing the challenge, convening participants and stakeholders and empowering them to generate and act on ideas that are potential solutions. This is likely to be an effective and valuable approach for challenges where past efforts have been hampered by too narrow or too hurried an understanding of the problem, where not all the perspectives needed to develop solutions have been involved, and where securing collaboration across organisational and professional boundaries is key to success. However, learning from the pilot year suggests that the Q Lab approach needs to be clearer about its goals, scopes and boundaries. Importantly, the Q Lab should address whether its goal is to have
immediate impact on the health and care system, or if that goal is too ambitious, and undermines the unique contributions of the Q Lab in the improvement landscape.

The evaluation team suggests that, going forward, the Q Lab should retain many of its core elements, including its time-bound and topic-specific nature, as well as the tools and techniques that support the development of psychologically safe spaces for a wide range of stakeholders to meaningfully interact. The evaluation team also suggests a number of issues that the Q Lab team can reflect on and consider changing for the next cycle, including: the scope of its goals; the topic selection process; when and how it engages with different groups of stakeholders; and how to communicate what success looks like. In addition, the Q Lab has the opportunity to contribute to the evidence base, both of ideas and interventions that emerge from the Q Lab, but also of the effectiveness of the Q Lab approach itself. In the next cycle, the Q Lab should continue to reflect on its ways of working, in particular when working in partnership. It is also possible that working in partnership will change the balance of skills required in the core Q Lab team, and it would be helpful to conduct a skills audit early in the next cycle to identify any duplication of skills and ensure that the necessary skills are present.
We are grateful to all the individuals who have contributed to this evaluation and would like to acknowledge them in no particular order.

We thank the Q Lab participants and other stakeholders who agreed to donate their time to be interviewed, to take part in a focus group and/or to complete our surveys.

The participation of the Q Lab team in this evaluation has been invaluable and we would like to thank all team members for their time and openness, and for their practical support in our evaluation. We would also like to thank the Health Foundation and NHS Improvement for their support.

We would also like to thank the former members of our evaluation team, Kristy Kruithof, Bryn Garrod and Jenny Newbould, for their earlier inputs into the evaluation and the interim report, on which this final report draws.

Finally, we would like to thank Professor Mary Dixon-Woods (THIS Institute), and our quality assurance reviewers at RAND Europe, Dr Sonja Marjanovic and Dr Sarah Ball, for their helpful and constructive comments on draft versions of this report. We are also grateful to other colleagues who informally provided feedback throughout the evaluation.
1. Context, aims and methods of the evaluation

1.1. Introduction

The Q Lab improvement approach has emerged from the Q community, an initiative led by the Health Foundation and NHS Improvement that brings together a community of people with experience and expertise in improving health and care. The Lab provides a mechanism to bring together relevant stakeholders (both individuals and organisations, within and beyond the Q community) to work on a specific topic over the course of approximately 12 months. Within the topic area, the Q Lab articulates a specific challenge to address during this period. Focused on tackling complex and previously apparently intractable challenges in healthcare, the Q Lab approach is inspired in part by social innovation labs worldwide. The expectation is that successive challenges will be explored over a 9–12 month period, each involving a different and wide range of people in the United Kingdom (the Q Lab ‘participants’), with the aim of achieving a deep understanding of a particular issue, generating ideas and testing promising solutions for improving service users’ and providers’ experiences and outcomes. It is intended to introduce new spaces – both virtual and face-to-face – for bringing creative thinking, imaginative insights and tested solutions into the improvement landscape of the UK; the time-limited nature of the work is designed to create focus, energy and urgency.

The first Q Lab was launched in the spring of 2017; it was based in London and coordinated by a Q Lab core team, including the Head of Q Lab, a Programme Manager, an Insight Manager and an Office and Events Co-ordinator. The Q Lab team engaged with Q Lab participants from varied backgrounds in peer support and health and social care (numbering almost 200 across England, Scotland, Wales and Northern Ireland as of 4 May 2018). The first Q Lab addressed the topic of peer support in health and social care, which is where people with shared characteristics, contexts and/or experiences support one another to improve their health and wellbeing. The challenge was formulated as follows: ‘What would it take for effective peer support to be available to everyone who wants it, to help manage their long-term health and wellbeing needs?’ The Q Lab worked to tackle this challenge over a 12-month period, alternating periods of ‘opening up’ (thinking, development and discovery) with periods of ‘narrowing down’ to identify specific objectives and solutions (see Section 2.2).

The Q Lab is funded by the Health Foundation and NHS Improvement, with the aim of delivering improvement and learning lessons for the future development of an improvement lab approach. The first cycle of the Q Lab was therefore set up as a pilot: the funders and the Q Lab core team hoped to learn whether the Q Lab approach has potential for generating ideas and insights that can be used to improve healthcare throughout the UK. However, identifying the right lessons to be learned from this pilot is
inherently difficult; an innovative concept such as Q Lab is a quintessential example of the kind of complex improvement system where links between cause and effect are difficult to make (Van Winkelen 2016). Understanding the potential of the Q Lab approach and the issues involved in spreading the approach thus requires careful inquiry into both the Q Lab’s direct effects on the people involved in its work, and the indirect longer-term systemic outcomes. To this end, the Health Foundation commissioned a real-time, formative evaluation in January 2017 to support the Q Lab team in developing and applying the model.

Starting in May 2017, the evaluation was conducted over a 15-month period, with data collection taking place between May 2017 and April 2018. This document is the final report of the evaluation, offering the summative findings and recommendations of the evaluators, including those from an interim report, a final version of which was shared with the Q Lab team in November 2017 (Liberati et al. 2017).

The remainder of this chapter provides an overview of the evaluation aims and methodology. Chapter 2 describes in more detail the Q Lab approach and the implementation of the pilot year. Chapter 3 then describes the main findings for each evaluation question. Finally, Chapter 4 outlines the main reflections on key issues and challenges, and recommendations for the Q Lab going forward.

1.2. Aims of the evaluation

Our evaluation of the pilot year of Q Lab sought to:

- Determine, in so far as is possible given the time constraints of the evaluation, the extent to which the Lab approach has shown signs of achieving the desired outcomes.
- Explicate the mechanisms of change and contextual influences on success, using a programme theory-guided approach.
- Produce and share knowledge, learning and recommendations to inform future Q Labs.

These aims address the overarching evaluation question: ‘Is the Q Lab approach likely to become an effective, valuable way of developing ideas or interventions to support positive change at multiple levels of the health and care system?’ This is a central question for the Q Lab team, senior management at the Health Foundation and wider stakeholders. Initial discussions indicated that the pilot lab would help inform decisions as to both whether or not to continue funding and also whether or not (and the extent to which) other Q Labs should be funded in the future, in different locations or investigating different topics. Drawing from the overarching evaluation question, the specific evaluation questions were:

1. What are the distinguishing features of the Q Lab approach, and what are the mechanisms through which Labs work?
2. What resources, stakeholders, conditions and infrastructure are required to deliver a Q Lab effectively?³

³ Note that this question changed slightly during the course of the evaluation. The original formulation was: ‘What resources, conditions and infrastructure are required to deliver a Q Lab effectively?’
3. How does the Q Lab engage participants? How valuable have participants perceived their participation to be?¹

4. How does the Q Lab fit within Q more widely, the Health Foundation and the broader health and care system?

5. Does the Q Lab make a valuable contribution to achieving change alongside other approaches?

The evaluation used multiple methods to tackle these questions, with the aim of generating an in-depth understanding of how the Q Lab model worked during its pilot year and what would be required for it to achieve its desired aims. It is important to note that the evaluation team sought to distinguish, as much as possible, between the Q Lab approach/programme theory (i.e. the mechanisms and principles involved in achieving the desired change, and the interrelationships among them) on the one hand and implementation and delivery of the pilot project itself (i.e. the activities conducted by the Q Lab team between May 2017 and April 2018) on the other. We recognise that the emergent nature of the pilot Lab often blurred this distinction; however, we propose that this advances our understanding on the mechanisms of change underpinning the Q Lab approach and potential influencing factors.

1.3. Overview of evaluation methodology

In conducting the independent evaluation of the Q Lab pilot, we used a flexible approach. To address each evaluation question, a range of methods was used that seek to understand and explain both processes and outcomes. Table 1.1 summarises the different evaluation questions and accompanying data collection tools and sources analysed for the evaluation.

The evaluation commenced in May 2017, during a period named by the Q Lab team as a ‘research and discovery phase’ (see Section 2.2). Our data collection was broadly organised in two ‘rounds’. The first took place between May and August 2017 and contributed to the unpublished interim report in November 2017. The second round of data collection took place between December 2017 and April 2018. This final report draws on data collected in both rounds. An overview of the data sources, including the details of the observations, focus groups, interviews and surveys conducted, as well as the documents reviewed, is provided in Annex A.

¹ Note that this question changed slightly during the course of the evaluation. The original formulation was: ‘How valuable are the Labs to participants and other stakeholders?’
Table 1.1. Overview of evaluation questions and methods

<table>
<thead>
<tr>
<th>Evaluation question (EQ)</th>
<th>Data collected May 2017 – April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EQ0 (overarching EQ):</strong> Is the Q Lab approach likely to become an effective, valuable way of developing ideas or interventions to support positive change at multiple levels of the health and care system?</td>
<td>Synthesised analysis of all the data collected</td>
</tr>
<tr>
<td><strong>EQ1:</strong> What are the distinguishing features of the Q Lab approach, and what are the mechanisms through which Labs work?</td>
<td>Ethnographic observations, including attending workshops with participants; focus groups with Q Lab participants; interviews with Q Lab team, participants and other Q Lab stakeholders; surveys with Q Lab participants; supplementary document review</td>
</tr>
<tr>
<td><strong>EQ2:</strong> What resources, stakeholders, conditions and infrastructure are required to deliver a Q Lab effectively?</td>
<td>Focus groups with Q Lab participants; interviews with Q Lab team, participants and other Q Lab stakeholders; surveys with Q Lab participants</td>
</tr>
<tr>
<td><strong>EQ3:</strong> How does the Q Lab engage participants? How valuable have participants perceived their participation to be?</td>
<td>Ethnographic observations, including attending workshops with participants; focus groups with Q Lab participants; interviews with Q Lab team, participants and other Q Lab stakeholders; surveys with Q Lab participants; supplementary document review</td>
</tr>
<tr>
<td><strong>EQ4:</strong> How does the Q Lab fit within Q more widely, the Health Foundation and the broader health and care system?</td>
<td>Ethnographic observations, including attending workshops with participants; focus groups with Q Lab participants; interviews with Q Lab team, participants and other Q Lab stakeholders; surveys with Q Lab participants</td>
</tr>
<tr>
<td><strong>EQ5:</strong> Does the Q Lab make a valuable contribution to achieving change alongside other approaches?</td>
<td>Synthesising analysis drawing upon the impact model and the Q Lab’s intended outcomes (informed by multiple sources as listed under EQ1)</td>
</tr>
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</table>

1.3.1. Formative component of the evaluation

In order to ensure that the learning emerging from the embedded evaluation was captured in a timely way and put to use by the Q Lab team, the evaluation and Q Lab teams developed a cyclic methodology composed of five-weekly ‘blocks’. Each block included three data collection weeks, one data analysis week and one feedback and reflection week (Figure 1.1).

At the end of each block the evaluation team shared a short document (referred to as the ‘working document’) with the Q Lab team, reporting the main learning points from the ongoing embedded evaluation and providing a focus for discussion during the subsequent feedback meeting.
The Q Lab team reported that they valued this methodology and found it helpful to experience *reflection-in-action* (Shön 1983), i.e. use the learning from the evaluation to shape practice and decisions within the first Lab.

Eight evaluation cycles, including a kick-off meeting and a meeting focused on the interim report, were conducted up to April 2018.

**Figure 1.1. Five-weekly cycles**

1.3.2. Embedded qualitative data collection

The evaluation featured an embedded qualitative data collection component, including ethnographic observations at the Q Lab team’s office (Gobo 2008; Spradley 1980), semi-structured interviews, and focus groups that allowed us to capture the emergent nature of the Q Lab approach, and to shed light on ‘how the Q Lab works’ (the mechanisms and features of the approach that the team themselves may take for granted).

One member of the evaluation team visited the Q Lab team’s office regularly to observe the team’s meetings, briefings, after action reviews or other routine work activities. Observations were also conducted at key events organised by the Q Lab team, including the July 2017 deep-dive workshop in London, the December 2017 workshop in Birmingham and the March 2018 workshop in London.

The first site visits were aimed explicitly at establishing ground rules for the embedded evaluation and building a relationship of trust between the ethnographer and the Q Lab members. Verbal permission was

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5 ‘Reflection-in-action’ describes as the act of reflecting on an event or incident whilst it still happening and it can still be changed; the opposite, ‘reflection-on-action’, is the retrospective contemplation of practice in order to uncover knowledge used in a particular situation, and reflect on how things could be done differently in the future.
sought to take notes during meetings and, occasionally, to take photographs of the team visual outputs. Notes of the observations were written-up in full after each observation, and were discussed with the evaluation team and analysed in advance of the five-weekly meetings to inform the working documents (and in turn the interim and final reports).

The aim of the ethnographic observations was mainly to explore how the Q Lab approach worked in practice, to examine the Q Lab team working culture (e.g. how problems are identified, prioritised and selected, and what values and concerns underpin team members’ work), and to identify the contextual and infrastructural factors that supported or hindered the achievement of relevant objectives.

Alongside regular observations, the evaluation team conducted interviews with Q Lab team members (n=9), Q Lab participants (n=18) and other stakeholders who were, to varying degrees, involved in the work of the Lab (e.g. individuals from Q, the Health Foundation and NHS Improvement) (n=5) between May 2017 and April 2018.

To capture the variety and internal differentiation of the Q Lab participant group, in the second data collection round we sought to recruit both ‘highly engaged’ participants (i.e. those who were closely and consistently involved with Lab work and processes) and participants characterised by a more modest (or less consistent) degree of engagement and participation. To achieve this, we adopted three different routes to sampling and recruitment:

- **Participants selected purposively:** these individuals were identified by the Q Lab team as highly engaged participants;
- **Participants selected by stratified random sampling:** these individuals were randomly selected based on responses to two questions from the survey conducted in July–August 2017;
- **Participants selected completely at random:** to make sure that all Q Lab participants had a chance of being selected – even if the Q Lab team had not identified them as highly engaged or they had not responded to the first survey – we selected some participants completely at random.

The full protocol for participant selection is reported in Annex B.

The evaluation team also held focus groups with Q Lab participants, including one at the end of the second day of the July 2017 workshop, and four during the March 2018 workshop. Suggestions for participants for the first focus group were made by the Q Lab team, while all participants attending the March 2018 workshop were invited to take part in one of the four focus groups held concurrently during the workshop.

All data collection activities with Q Lab participants and other stakeholders focused on their perception and experience of the peer support Lab and the value they attributed to the Q Lab approach more broadly. Participants’ expectations, hopes and fears, as well as the potential risks of the approach, were also discussed. Upon consent, the interviews and focus group were audio-recorded. Proceedings were transcribed verbatim and analysed to inform the working documents and the interim and final reports. Data analysis was mainly inductive and based on a thematic approach (Miles et al. 2014). For the purposes of this report, themes were organised according to the evaluation questions (Section 1.2).
Annex A includes an overview of the observations, interviews and focus groups. The topic guides for the interviews and focus groups are reproduced in Annex C.

1.3.3. Surveys of Q Lab participants

The evaluation team conducted two surveys with Q Lab participants (see Annex A for an overview). The surveys, which took place at different points during the evaluation, were sent to all Q Lab participants at the time. The first survey, which was open between July and August 2017, comprised two parts (the full survey instrument is reproduced in Annex D). The first part was designed by the Q Lab team and asked for feedback on the Q Lab workshop. Respondents were told that this information would be shared with the Q Lab team and used in the evaluation. The second part was designed by the evaluation team and asked further questions to support the evaluation. The survey received 66 unique responses, giving a response rate of 50 per cent.

The second survey took place in March 2018 and was designed by the evaluation team (the full survey instrument is reproduced in Annex E). This survey focused on the nature and quality of the relationships generated by the Q Lab (both between the Lab team and the participants and among the participants), including barriers and enablers to participation, and sought respondents’ perspectives on the achievements of the Lab. The survey questions related to engagement, participation and relationships were informed by the findings from the interviews with Q Lab participants conducted between January and March 2018, who were recruited to include different experiences and level of engagement (see Section 1.3.2). The survey received 31 unique responses, giving a response rate of 16 per cent.

1.3.4. Document review

The aim of the supplementary document review was to support the other data collection and analysis activities of the evaluation. The evaluation team drew on a wide range of sources, including Q Lab documents from an online collaborative working portal used by the Q Lab team (Huddle), Q Lab blogs and materials prepared for workshops. Documents were either flagged by a member of the Q Lab team as important for the evaluation team to review, or were retrieved by the evaluation team on Huddle or the Q community website. In total, 56 documents were reviewed (listed in Annex A).

1.4. Strengths and limitations of this evaluation

One of the main strengths of the evaluation is its formative and embedded design. This allowed the evaluation team to directly observe the Q Lab as it developed, and to provide ongoing feedback to the Q Lab team. However, evaluating a pilot which itself is changing in response to experience and evidence has inevitable limitations. The Q Lab approach has evolved from how it was originally envisaged and the Q Lab team has re-articulated its goals, and it is therefore challenging for the evaluation to measure its achievements. A second tension is that while the evaluation clearly sets out to evaluate the Q Lab approach (as a distinct contribution to improvement), it has done so with evidence produced through a specific Q Lab on peer support. We can (and do) make judgements about the overall approach but it should be recognised that this depends upon building an argument that is based on one particular case.
A specific limitation relates to the second survey conducted as part of the evaluation. Due to the low number of responses, we limited our analysis of the survey to descriptive statistics (i.e. statistics that describe the main features of the sample of respondents, for example how many Q Lab participants were also Q members or worked in the field of peer support). These statistics were used to help enrich and provide supporting evidence to the findings of the evaluation team. Some cross-tabulations (i.e. statistics that analyse the relationship between multiple variables to understand the association between them) were possible. For example, the association between respondents levels of ‘free time’ and routes to engagement with the Q Lab were considered, as well as the association between attending face-to-face events and forming new relationships. However, a more in depth analysis, such as an attempt to identify the typical profile of a highly engaged individual, was not possible due to the lack of responses to the survey. For example, only ten responses were received from ‘very engaged’ participants and only one from an ‘extremely engaged’ participant.
2. The Q Lab approach: origins, phases and programme theory

This chapter describes in more detail the Q Lab approach, including its development and the implementation of the pilot year (main phases and activities) as well as an overview of the programme theory as articulated by the Q Lab team. The chapter concludes by presenting a revised programme theory, as proposed by the evaluation team.

We draw here on analysis of the data collected through observations (OBS), interviews (INT) and documents (DOC) between June 2017 and April 2018.

2.1. Development of the Q Lab approach

The Q Lab concept was developed in late 2014 and was initially introduced to and discussed with over two hundred Q members. It was further developed in 2015 and 2016 during a period known as the design phase, which focused mainly on: 1) explaining the concept to Q members and testing their appetite to proceed; and 2) establishing a small team to take the idea forward. In 2016, the Q Lab team further developed a proposal for a Q Lab through an iterative design approach, which involved in-depth research into other labs worldwide, determining the Q Lab’s goals and key questions, and the articulation and testing of a Q Lab approach with others (both within Q and the Health Foundation and with external stakeholders) (DOC 001). During this process, the team worked to clarify the key features of the Q Lab approach:

- A collaborative and inclusive improvement approach
- Grounded in design thinking and social innovation
- With a clear focus on action and solutions
- Setting out to tackle complex challenges where there is unlikely to be a simple solution.

2.1.1. Set-up and topic selection phase (December 2016–May 2017)

This phase included the development of the infrastructure for the first Q Lab (including secured funding), the recruitment of the members of the Q Lab core team, and the selection of a topic. The selection of the topic was a key concern for the pilot Q Lab (DOC 002). Firstly, from a practical perspective, choosing a topic that was too broad or too narrow might undermine the possibility of testing the whole approach.

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6 The recruitment phase started in December 2016 and finished in May 2017.
(i.e. if the topic was either too trivial or too unmanageably large). Secondly, from a symbolic point of
view, the Q Lab team were aware that the topic would send an important message about the Q Lab to
stakeholders, including signals about the Lab’s priorities and mode of operation. The topic selection
process was thus organised into a number of steps (Figure 2.1) (DOC 002).

**Figure 2.1. Topic selection process**

The Q Lab team (at the time composed of two core members) initially conducted a literature review to
generate a longlist of potential themes. This review included a range of sources (independent think tanks,
patient and user organisations, and NHS documents) that discussed the key challenges in healthcare
service use, access and experience. The final longlist was discussed with the management team of the
Health Foundation and with key sponsors at NHS Improvement (DOC 003).

All Q members were then invited to vote on the themes. Respondents were asked to rank the theme areas
in order of priority, explain why they thought the selected area was important and identify specific topics
that they would like the Q Lab to focus on. The theme ‘empowering people to manage their health and
care needs’ received the largest number of votes (40 per cent).

The Q Lab team then convened a workshop, inviting the 21 people who had ranked the theme area the
highest, and others who had experience in and expertise of this theme. The purpose of the workshop was
to discuss the broad theme of empowering people and to identify specific areas for the Q Lab to explore.

The process culminated with the selection of the topic of ‘Peer Support’ – the challenge being formulated
as follows: ‘What would it take for effective peer support to be available to everyone who wants it, to help
manage their long-term health and wellbeing needs?’

### 2.2. The Q Lab pilot year

The topic and challenge were publicly announced in April 2017 and, at the end of May, recruitment for
the Q Lab core team was completed. The core team contributed a variety of skills and expertise, such as
design, research, project management and communications.

The pilot Q Lab took place between May 2017 and May 2018 across three phases: research and discovery,
developing and testing, and distilling and sharing learning (see Figure 2.2). The following sections provide
an overview of each of these phases.
2.2.1. Research and discovery phase (May–September 2017)

With increased capacity and skillset, the Q Lab team embarked on a research and discovery phase for peer support. The purpose of this phase was to better understand the problems and opportunities around peer support and to identify some potential areas to improve the UK health and care sector. The Q Lab team employed structured desk research, a small number of qualitative semi-structured interviews and a survey in order to bring together existing evidence about the topic. A small number of ethnographic observations was mooted, but did not take place due to time constraints. The Q Lab team developed a list of Q Lab participants and engaged with them through a communication strategy that included a webinar, an online platform for participants’ use (‘online space’ – see Section 2.2.2), and fortnightly email updates.

The research and discovery phase highlighted four challenge areas in the field of peer support: evidence, workforce, access and buy-in, and culture. The Q Lab team presented the outputs of this phase in a two-day deep-dive workshop conducted in July 2017 at the Barbican, London. The workshop was attended by over 50 people and aimed to explore the key challenges in peer support and to identify opportunities for action to take forward into the ‘developing and testing’ phase of the Q Lab process. It further aimed to offer developmental opportunities to workshop participants, in order to enhance their skills in tackling complex problems and to foster meaningful connections and collaborations (DOC 004).

Following the workshop in July, the Q Lab engaged in a period of sense-making and prioritising that resulted in three priority areas being identified: access to peer support, evidence for peer support and culture and workforce (INT 013).

2.2.2. Developing and testing phase (September 2017–January 2018)

During the developing and testing phase, the Q Lab team developed three briefs (DOC 005):

1. *How can we improve the routine offering and promotion of peer support in primary care settings?* (access to peer support).
2. *How can we generate sources of evidence that capture the holistic impact that peer support can have on people’s lives?* (evidence of lived experience).
3. *How can we support the sharing of knowledge, experience and evidence of what does and does not work in peer support?* (sharing what does and does not work).
For access to peer support, the Q Lab team initially hoped to work with a small number of GP practices to understand and improve the routine offering and promotion of peer support as part of normal clinical consultations. Due to low take-up from GPs, the Q Lab team instead designed a survey to look at the issue of access on a larger scale, beyond the primary care context (the ‘access survey’; DOC 013).

In relation to understanding the evidence around peer support, the Q Lab team intended to work with people with lived experience and other experts in the field to identify, collate and promote evidence that was holistic and included stories of personal impact (DOC 009). The team conducted desk research into what was meant by, and the potential benefits of, storytelling and how organisations use evidence of lived experience. At the same time, Mind and National Voices initiated discussions with the Q Lab team to collaborate to launch an ‘Evidence Hub’ on peer support.

In terms of sharing what does and does not work, the Q Lab team aimed to develop ways for participants to share information. For instance, an online space was set up for Lab participants to interact virtually. This was intended as a platform for participants to share information, experiences and resources, as well as to post and respond to questions and comments from other participants (DOC 052). The Q Lab team also envisioned the online space as a means via which participants could keep up-to-date with the work of the Q Lab (OBS 009, early developing and testing phase).

During this phase, in December 2017 the Q Lab team held a workshop in Birmingham, attended by 41 Lab participants. The Q Lab team also held a workshop on peer support in Northern Ireland at the request of Q participants. The workshop was attended by representatives of each trust in Northern Ireland as well as senior leaders in Northern Ireland health and care, including Q and non-Q members.

Finally, Q Lab aimed to encourage participants to build their own improvement ideas and solutions in the field of peer support following participation in the Lab process. This stream of work was initially envisaged as the Lab team providing ‘light-touch’ support to participants’ ‘self-started’ projects; later in the year, when Q Exchange became available, participants were encouraged to take work forward through this funding programme. Q Exchange is a new funding programme within Q that invited people to bid for up to £30,000 funding to develop an improvement project or idea.

2.2.3. Distilling and sharing learning phase (February–May 2018)

The final phase of the pilot Q Lab focused on completing the work on the briefs, formally ending the Lab challenge on peer support, and setting up for Q Lab 2.

Finishing the work on the briefs covered four areas, namely the access survey, storytelling, the Evidence Hub, as described above, as well as tracking self-started projects. The access survey, which was run by YouGov, received 2,666 responses (DOC 048). The Q Lab team worked with Dr Christina Pagel at University College London to analyse the data; the findings were disseminated through a variety of

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7 The online space can be accessed by participants at: https://q.health.org.uk/community/groups/q-lab/
8 Submissions to the Q Exchange closed in May 2018, and projects were shortlisted between June and July 2018. While the Q Lab team encouraged Lab participants to take part in Q Exchange, the Q Exchange itself is outside the scope of this report.
methods, including a dedicated event organised by the Q Lab team in April 2018; publication, in May 2018, of an essay, publicly available to download (DOC 056); and presentation of the survey findings at conferences and events, such as the 2018 Health Services Research UK (HSRUK) Conference. The insights and learning on storytelling were integrated into other Lab products, including a blog post on how stories could be used to capture the impact of peer support (DOC 049). For the online Evidence Hub, the Q Lab team supported the design process, and in May 2018 the Health Foundation awarded funding to National Voices to develop and maintain this platform. Additionally, the Q Lab team planned to continue to develop relationships with participants undertaking self-started projects in peer support (DOC 029).

As part of formally ending the pilot Q Lab, the Q Lab team held a final workshop with 36 participants in March 2018 at the BMA House in London (DOC 048). The purpose of the workshop was to provide an opportunity for participants to reflect on the pilot Lab, to share what has been learned on peer support and to learn more about the opportunity for Lab participants wishing to sustain improvement activities relating to peer support to take part in the Q Exchange initiative (DOC 037). The Q Lab team separately published their insights and learning on peer support as an essay (DOC 029, 050, 055). Finally, the Lab initiated consultations and activities aimed at setting up Lab 2, which will see the Q Lab team working in partnership with an organisation with an established role and expertise in the topic area. Although this model of partnership working was not used in the pilot year, the Q Lab team noted that there had always been an intention to work with external partners in future cycles. The Q Lab team approached and held discussions with potential partners for Q Lab 2. The Q Lab announced in July 2018 that their partner for the next Q Lab cycle is the mental health charity Mind.

2.3. The Q Lab programme theory

Articulating the Q Lab’s programme theory has been a key part of the Lab team’s efforts throughout the pilot year. A programme theory outlines the components that are necessary and sufficient to accomplish the desired outcome: it provides a way of laying out the goals of a programme, its components, the mechanisms involved in achieving the desired change, and the interrelationships among them (Funnell & Rogers 2011). It should provide a set of statements that collectively describe why, and in what contexts, the programme will achieve its intended effects. A programme evaluation can then interrogate these

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9 This is the third in a series of six Q Lab essays, available at: https://qlabessays.health.org.uk/essay/how-do-people-make-decisions-in-peer-support/
10 HSRUK 2018 was held in Nottingham on 4–5 July of that year; see https://hsruk.org/members/events/hsruk-conference-2018
11 This was announced on the Q website on 17 May 2018. See: https://q.health.org.uk/news-story/building-an-online-evidence-hub-for-peer-support/?dm_i=4Y2.5N9H0,ROI606,LYGUH.1
12 This is the second in a series of six Q Lab essays, available at: https://qlabessays.health.org.uk/essay/learning-and-insights-on-peer-support/
13 This was announced on the Q website on 22 August 2018. See: https://q.health.org.uk/news-story/q-lab-where-next/
statements against the evidence and, usually, identify ways of improving outcomes while managing undesired and unintended consequences (Sidani & Sechrest 1999). There is no single best way to represent a programme theory (although a visual representation is almost always used) and it might be developed with different primary audiences in mind (for example, stakeholders, service users, funders or implementing teams). It is also important to recognise that a ‘programme’, as opposed to a ‘project’, is characterised by bringing a number of activities and projects together with the intention of creating benefits that could not have been achieved by running these activities separately. Aligning these various activities to create added synergies, a sense of purpose, and energy is important to most programmes and Q Lab in particular.

The programme theory underpinning the Q Lab approach evolved during the period of the evaluation. It is relevant that this evolution was not one in which the design of the Q Lab remained constant while the programme theory was adapted to become a better fit. Rather, it was one in which the Q Lab team learned, reflected and adapted the design and each iteration of the programme theory. This is why the Q Lab can properly be described as a complex intervention and why the iterations of the programme theory should be viewed as part of this complex adaptation. The first iteration of the Q Lab programme theory was set out in the evaluation team’s interim report (Liberati et al. 2017). This preliminary model described the Q Lab approach as step-wise, articulated into four phases of work (set up, research and discovery, developing and testing, and distilling and spreading), and aiming to achieve impact by: 1) supporting improvements within the current system; 2) facilitating new collaborations among those with a passion for improvement in the challenge area; and 3) re-imagining and influencing the future provision of care. The model also summarised the core values of the approach, such as using multiple perspectives, promoting collaborations across professional boundaries, and aiming towards usable solutions.

Throughout the pilot year, the Q Lab team continued to develop both the approach and the programme theory collaboratively with colleagues from the Health Foundation as well as the evaluation team, culminating in the development of a programme theory (which the team rebranded as an ‘impact model’14) that was presented to a group of Q Lab participants for their feedback in the March 2018 workshop, as part of focus groups conducted by the evaluators. The Q Lab team also received comments in March 2018 on the impact model from the Evaluation Advisory Group at the Health Foundation, which provides expert guidance for the evaluations of both Q and Q Lab. The development of the programme theory over time is therefore an important reflection of the collective learning that has taken place.

At time of writing, the Q Lab team was continuing to reflect on the feedback received both from the Evaluation Advisory Group and participants, and as a result the impact model was still evolving. Moreover, the evaluation team recognises that the impact model will continue to evolve as the Q Lab team test a new way of working (i.e. with a partner) in the second Q Lab. We report here on the most up-to-date version of the impact model.

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14 The Q Lab team was influenced by the impact model developed by Lifehack, a systems-level intervention in youth mental health and well-being in New Zealand (DOC 053). The Lifehack impact model is available here: https://lifehackhq.co/wp-content/uploads/2017/04/Lifehack-Impact-Model_March2017v1.5-2.pdf
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to-date draft from June 2018, which the Q lab team was planning to include in the final outputs of the first Lab, i.e. the six essays condensing the learning from the Q Lab pilot year on peer support. These were made public and disseminated to Q Lab participants between May and August 2018.

Figure 2.3. Programme theory as articulated by the Q Lab team

The impact model, as presented in Figure 2.3, describes the Q Lab phases and short-term goals, namely:
- deeply analysing a topic to identify challenges and opportunities
- generating and testing ideas with the potential to improve
- supporting people to take action
- disseminating and spreading ideas locally and nationally

The impact model also presents longer-term goals for the Q Lab (i.e. ‘Wider changes that we hope to see’), including:
- increased value placed on participatory design methods that impact on policy and improvement
- new approaches to spreading and socialising learning and ideas
- more people with the capability, confidence, motivation and support to lead change
- thriving communities that build resilience and cross-pollination of learning across the health and social care sector.

The Q Lab is inherently dynamic and relational. Within each topic there is an anticipated journey as we move from analysing problems through to spreading insights; each of these has different requirements if the anticipated transformations are to be achieved. In the wider literature there is interest in the potential for open innovation to attract new ideas (Mergel 2015), innovation and improvement intermediaries that help organisations transform their performance (Howells 2006), and the concepts of co-production and co-creation (Nesti 2015). However, hard evidence of how best to do this is limited (Feller et al. 2011) – especially in an improvement setting – and therefore inevitably the Q Lab is developing an approach in a context of uncertainty (and learning and adaptation has indeed been part of the Q Lab pilot phase).
Q Lab as an approach is therefore dynamic in the sense that the pilot topic was always intended to lead to stepping back and applying lessons learned before continuing, adapting or abandoning the approach. We anticipate that this dynamic process of reflection and adaptation would also characterise any future development of Q Lab.

The Q Lab is also concerned fundamentally with creating new relationships and consolidating existing relationships as a basis for improved trust, understanding and a capacity to deliver change. Much of the anticipated value created by Q Lab arises from these new and extended relationships. Part of Q Lab can therefore be seen as developing a very particular brokerage role requiring trust, integrity, facilitation skills and communication. The impact model as developed by the Q Lab team in June 2018 is a helpful tool for communicating the approach they take to stakeholders, especially regarding where and how stakeholders are being invited to participate. We also anticipate that the impact model will be helpful for communicating and explaining to funders, the team, potential participants, partners and others what the Q Lab is.

Given that the Q Lab is to continue, future evaluations should continue to contribute to reflection and learning, but as practices stabilise and routes to impact become more established so too will the evaluation need to adapt. This would most helpfully (in our view) take the form of a theory-based evaluation that could practically test the hypothesised model (Weiss 1997). In time, a theory-based evaluation would require more detail on how to operationalise measures of success, the specific components delivering change, and an understanding of the underlying mechanisms.

2.4. Programme theory as proposed by the evaluation team (for further development)

The programme theory developed by the Q Lab offers a clear description of its ways of working and the anticipated goals both in the short and long term. It constitutes a useful communication aid to illustrate the Q Lab approach to participants and other external stakeholders, and it will doubtless be adapted in the light of the experience of the next Q Lab cycle and will subsequently reflect how the model works in a growing variety of topic areas.

Yet, for the sake of this evaluation, and to secure full understanding and replicability of the approach, it is important to identify, and distinguish between, the different elements of a programme theory. Evaluation scholars generally agree that a programme theory should articulate at least two elements: 1) the essential components – what Lipsey (1993) calls ‘the critical inputs’ – that ensure the effectiveness of a programme; and 2) the processes (steps, phases or links) through which the programme accomplishes its work.

Figure 2.4 below represents the evaluation team’s attempt to capture (and distinguish between) the Q Lab’s dynamic life cycle phases (the steps and phases through which the approach works). Within and linking these phases, outcomes are achieved as a result of underlying mechanisms (understood as the means by which individuals and groups change their understanding and behaviour as a result of the programme). This might include, for example, the psychological mechanisms activated when bringing together clinicians, carers and service users. These mechanisms, we recognise, are context dependent and so any evaluation is also interested in the assumptions about this context. Future evaluations may find, for
example, that the mechanisms apparent in peer support are masked in other policy areas (that is to say, that although the mechanisms are real other more powerful mechanisms – such as professional power – drive behaviour). We also recognise that the Q Lab model is relational and it has established particular principles that should guide relationship building. This was shaped by many of the same insights that influenced the Q Lab’s articulated programme theory (Figure 2.3), but also reflects both the insights gained through the evaluation activities, and the needs of a theory-based evaluation. It also highlights the elements that make the approach distinct from other, existing improvement methodologies (for example leveraging and combining different types of knowledge). The impacts, as in Figure 2.3, reflect a focus on those things that the Q Lab can hope to directly influence.

**Figure 2.4. Programme theory as articulated by the evaluation team**

The individual components of the programme theory articulated by the evaluation team will be explained in detail in Chapter 3; specifically Section 3.1 will describe the phases, mechanisms and principles of the Q Lab approach as captured by the evaluation team, and Section 3.5 will focus on the outcomes.
3. Findings

This chapter addresses the evaluation questions 1 to 5, as described in Section 1.2. Although data were first analysed in an inductive manner to derive thematic findings, for the purposes of this report findings have been organised according to the evaluation questions. As such, where evaluation questions are interrelated and not mutually exclusive (e.g. the Q Lab distinguishing features and mechanisms, described in Section 3.1, and the contribution of the Q Lab, described in Section 3.5), thematic findings may be reiterated. Repetition is limited by clear signposting between sections.

We draw here on analysis of the data collected through observations (OBS), interviews (INT), focus groups (FG), documents (DOC), surveys (SUR), and attendance at five-weekly meetings with the Q Lab team, between June 2017 and April 2018, as well as our reflections as evaluators on such data. Each quote from interviewees and focus group or survey participants is labelled based on the phase of the Q Lab in which the data were collected (e.g. research and discovery phase, etc.).

The overarching evaluation question, ‘Is the Q Lab approach likely to become an effective, valuable way of developing ideas or interventions to support positive change at multiple levels of the health and care system?’, is addressed as part of the reflections and recommendations in Chapter 4.

3.1. What are the distinguishing features of the Q Lab approach, and what are the mechanisms through which Labs work?

This section describes the Q Lab approach as understood by the evaluation team and captured by the programme theory discussed in Section 2.4; it particularly focuses on what is distinctive about the Q Lab approach when compared with other efforts to support improvement in health and care settings. After describing the phases of Q Lab cycle, we discuss the Q Lab’s underlying mechanisms (which link the activities to the desired outcomes) and principles (i.e. the values and ethos that shape the overall approach).

3.1.1. The Q Lab cycle comprises four phases

Currently, the Q Lab team approach involves working in cycles of around 9 to 12 months, with each cycle focusing on a specific healthcare topic and being structured into four main phases: topic selection,  

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15 As of June 2018, the phases are listed on the Q Lab website: https://q.health.org.uk/q-improvement-lab/about-the-labs/
scoping of landscape, idea generation and support to implementation, and dissemination of learning. Though these phases should not be envisaged as entirely discrete entities with a linear relationship to each other (the boundaries between them may be somewhat blurred, with iterative feedback loops informing and shaping each phase), they are intended to be undertaken largely sequentially (DOC 054). For example, one of the main principles of the approach is that an in-depth and thorough understanding of the topic and of the relevant stakeholder network needs to precede any attempt to develop solutions (DOC 054). Similarly, although all phases are needed to achieve the desired outcomes, the length of each phase is likely to vary depending upon the topic selected for each life cycle.

**Topic selection**

The focus on a cyclical approach focussed on one topic at a time is one of the distinguishing features of the Lab approach (see Section 3.1.3), especially when compared to the broader Q improvement initiative. In line with the principles of the Lab approach, the selection of a topic is a consultative and participative process, with the Q Lab team retaining responsibility for managing the consultation process and making a final decision (DOC 002, 003). Overall, the process of topic selection can be understood as one of bounded engagement: the ‘bounding’ coming from the wider evidence of what works and the imperatives of the funders, and the ‘engagement’ coming from a non-systematic engagement that genuinely, and largely successfully, seeks to engage a wide range of opinions from those with relevant expertise.

Learning from the pilot year and evidence from the evaluation suggested that suitable topics for the Lab should be relevant to service users and the wider health and care system, amenable to further exploration, and complex and challenging but at the same time focused in scope. ‘Making effective peer support available to everyone who wants it’ may have constituted an excessively broad challenge for Q Lab, which suggests that future Labs could attempt to develop a narrower aim within the selected topic area.

*I think it’s such a massive subject for them to have chosen for the first [Lab], it was quite tricky [...]. I don’t think [you can] take a massive topic like this and get... I’m amazed they’ve got as far as they have in a year.* (INT 018, Q Lab participant, distilling and sharing learning phase)

*I’d almost be tempted to look at really one objective [...] and having one and saying what is the one thing we want to achieve out of this, and what would success look like, and really drive that forward. A specific or one narrow objective [...] because a year is a very short space of time if we’re trying to influence a culture, or a landscape. I mean a year isn’t time to do that.* (INT 021, Q Lab participant, distilling and sharing learning phase)

**Scoping the landscape**

The scoping the landscape phase (known as the ‘research and discovery phase’ in the pilot year) includes all the research activities, facilitated by the Q Lab team, that are needed to achieve a thorough understanding of at least two elements: 1) the topic area, its ingrained challenges and key opportunities for action; and 2) the key stakeholders to engage in the Lab life cycle, including service users, providers and individuals with lived experience on the topic (DOC 054, OBS 004, INT 005).

The outcome of the Scoping the Landscape phase should, therefore, be twofold:
• From a topic perspective, success would look like the identification and clarification of the cause and effects of the problem, of the reasons behind failure of previous improvement attempts, and of examples of success and good practice.
• From a stakeholder perspective, this phase should result in representatives from all relevant stakeholders groups feeling engaged in Q Lab process, and empowered to contribute to a deeper understanding of the challenge.

Idea generation and support to implementation
Leveraging the knowledge on the topic achieved through the previous phase, the idea generation phase focuses on developing opportunities for improvement within the topic area. In this phase, the Q Lab team plays a central and active role in the development of ideas (for example, through convening workshops and webinars and transforming the findings from the scoping phase into actionable improvement opportunities) and a supportive/facilitation role in the implementation of such ideas (for example, through the identification of funding bodies or suitable partners with the means and resources to take actions forward, and through leveraging the Q community). It is in this phase that the ‘convening’ function of the Q Lab approach (see Section 3.1.2) is leveraged in full.

Dissemination of learning
The closing phase of the Q Lab life cycle focuses on the sharing and dissemination of the impact achieved through the year, including new knowledge and learning on the topic, individual capabilities and social capital, and any active improvement initiative. In the pilot year, the output generated by the Lab was captured and disseminated in the form of essays (DOC 054, 055, 056) available online, and accessible to all those with an interest in the topic area.

3.1.2. The Q Lab works through three main mechanisms

Convening key stakeholders around a complex healthcare topic
One of the defining mechanisms of the Q Lab is its convening function: throughout its life cycle, the Q Lab brings together a wide range of stakeholders with different roles, expertise and professional backgrounds in the healthcare sector (including patients and service users, healthcare professionals and improvement experts), with the aim to collectively reflect, and take action, on a complex topic (INT 005, 017, 018, 022, 025, FG 004, DOC 054). The case for a sustained ‘creative abrasion’ of ideas within a supportive environment has been made by the Harvard Business Review (Hill & Davis 2017) among others. By engaging a diverse group with expertise and experience, Q Lab generates new ways of thinking about long-standing and substantial problems, identifies opportunities for action and develops innovative solutions. The convening function is made effective by the Health Foundation brand and the core team’s skills in planning and facilitating large events, and is amplified by exploiting other existing groups and networks, and in particular the Q community (INT 004, 005).

Our evaluation has shown that participants taking part in the pilot Lab were aware of, and placed great value on, the Q Lab’s convening function. Participants often emphasised the inherent value of bringing together a group of individuals characterised by a diversity of perspectives and expertise but commonality in aims and values.
I suppose it’s about bringing together people with experience and a passion, an expertise in peer support, too, to learn from each other. (INT 017, Q Lab participant, early distilling and sharing learning phase)

This was also recognised by senior leaders from Q and the Lab funders (the Health Foundation and NHS Improvement).

To convene people to work on a topic who were coming from lots of different backgrounds (is) something we really struggle with in the NHS in England, I can only speak for England, but I know that the other countries [...] have the same issue, how do you convene people. And the Lab seems like a really still exciting way of doing that for some common purpose. (INT 032, senior leader, distilling and sharing learning phase)

The Q Lab used a number of methods to engage a broad range of people working across the health and care system, including the organisation of full-day workshops, the creation of an online community, and targeted email and telephone communication (see Section 3.3 for the routes to engagement used by Q Lab). The impact of this engagement work is reflected in the diversity and size of the Q Lab participant group that the team developed.

**Drawing on multiple sources of data and evidence**

In analysing the current healthcare landscape and tackling complex challenges, the Q Lab draws on existing data and well as lived experience: it seeks to undertake both in-depth examination of the existing knowledge base (in the form of ‘codified’ knowledge on peer support) and an exploration of ‘un-codified’ tacit knowledge. In the words of a Q Lab participant:

> Q Lab brings together research and evidence. [...] It isn’t just clinically driven evidence, it’s also lived experience evidence and you know, they do… they do seem very open to that. (INT 009, Q Lab participant, early developing and testing phase)

Getting the balance right between these two types of knowledge is likely to be a significant enabler of the Q Lab’s success; presenting a sound ‘codified’ evidence-base on the topic selected is key to securing participants’ trust as well as the buy-in of important Lab stakeholders, while generating insight from people’s direct experience of healthcare services is key to maintaining fidelity to one of the defining features of the approach – its human-centred nature (Section 3.1.3).

The Q Lab team seemed mindful of this and worked hard to modify their approach to incorporate the feedback of relevant stakeholders during the pilot year. For example, following the July 2017 workshop, a number of Q Lab participants reported a desire to be involved more directly in shaping knowledge-creation and called for a more truly co-produced approach. This wish was expressed mainly by highly engaged participants with expertise on, and experience in, peer support.

> I think people were sort of being told what to think, what to aim for, and it had quite a ring of didacticism, in a sense, to it. That it was more a telling than it was a sharing [...] I was fairly vocal in expressing that that had not happened properly, which (is why) I think the first [workshop] was, relatively speaking, less productive. But those areas have been very significantly considered and addressed. (INT 015, Q Lab participant, early distilling and sharing learning phase)
[I would recommend] to involve a more diverse group in planning the Lab right from the outset, before [the Q Lab team] even get their pens out, and be open to different ideas. So that would be the first thing. [...] And when you get people in the room, use the expertise of the room and spend most of the time exploring the talent and the ideas and expertise in the room and less time on inputs from the core team. (INT 026, Q Lab participant, distilling and sharing learning phase)

The way subsequent workshops were organised, with participants being invited to give presentations and talk about their own experience with peer support, is evidence that this feedback was taken on board by the Q Lab team.

**Balancing effectiveness and psychological comfort**

Convening stakeholders with a range of backgrounds and expertise is only effective in the presence of a suitable platform; a defining mechanism of the Lab approach is the creation of a forum that is both effective (i.e. sufficiently structured to nurture fruitful and focused discussions) and psychologically comfortable (i.e. sufficiently open and flexible to encourage contributions from all involved). Underpinning this mechanism is the ability to identify both those individuals with an expertise in improvement and/or the topic, and the ‘quieter’ voices, typically harder to reach and engage, but equally important to fully understand complex challenges in health and care. It is this platform that fosters the ‘creative abrasion’ that helps generate innovative ideas.

The mechanism described above was visible throughout the Q Lab pilot year, and was reflected in the views of numerous Lab participants. They showed an appreciation of the increasingly wide-ranging and supportive platform created by Q Lab, where barriers between participants were gradually overcome to endorse a truly collaborative and multidisciplinary approach.

I’ve contributed more and more each time I’ve come [to a Lab workshop]; I’ve felt that I’ve had that platform, so I feel like others definitely feel that way as well. [...] In the first [Q Lab event], back a year ago… everyone arrived; there was a table of suits… there were a table of … and people naturally… gravitate towards what… we mirror, and then, by the end of that, ties were off, people were sat having dinner chatting about stuff, so… It’s just the way it’s set up. [...] Then everything went to zero, and everybody’s knowledge and contribution had the same value. And that’s how they [Q Lab team] did it; that’s how they broke it down. Because my voice was as loud as [others’] voice… There was no hierarchy (FG 004, Q Lab participant, March 2018 workshop)

It’s not all academic, it’s not all strategic, it’s also personal … it’s an opportunity to talk personally. There’s something for everybody, and I think that is a great leveller, if everybody feels that they can understand the topic and contribute. (FG 004, Q Lab participant, March 2018 workshop)

The various strands of work conducted by the Lab team in the pilot year have striven to nurture participation and psychological safety. For example, the communication strategy as formalised by the Lab team defined collaboration and user-centredness as the most important values and the team have sought to adopt a language that is encouraging and accessible. Some participants praised the Q Lab team for their
professionalism in delivering events, and described the ‘invisible’ work that made it possible for all participants to take an active role in the workshops.

It’s quite anxiety-inducing for me to turn up to an event like this, but knowing how well it’s run, and how the structure is, allows me to relax into it, and make a better contribution than I might otherwise do. (FG 004, Q Lab participant, March 2018 workshop)

Others particularly appreciated the Lab team’s flexible approach to interacting with participants remotely and their ability to customise their engagement strategy in order to accommodate people’s needs and preferences.

Although [for Q Lab], it was really important to bring people together into a room, they gave the flexibility to allow other people to input separately, for whatever reason that might be […] So I think the approach was quite inclusive. (INT 018, Q Lab participant, distilling and sharing learning phase)

Importantly, values of inclusivity and psychological safety were also highly visible in the way Q Lab team members worked and interacted with one another. The team leadership sought to nurture an ethos of openness, where speaking up was allowed and team members’ input was valued. They did so, for example, by explicitly welcoming constructive criticism and by seeking regular feedback by other team members.

There’s a real sense of open communication and freedom to speak that represent the Labs. […] There’s not much ego in the room, which is nice. (INT 003, Q Lab team member, early research and discovery phase)

[Observation of meeting, Q Lab office] [Person one] raised the question of how they were hoping to do something interactive with more than 50 people in the room; the comment was well received. During the meeting, I witnessed many other examples of team members raising doubts or concerns about what was being discussed and these were always well received. The team has a culture of openness and shows a learning attitude: divergent ideas are welcome, not discarded, even when they force the team to rethink, slow down progresses, make new plans or abandon potentially promising avenues. (OBS 008, developing and testing phase)

3.1.3. The Q Lab is distinguished by its combination of collaborative, creative, time-bounded and topic-specific working

Collaborative, participatory and ‘people-centred’

The Q Lab approach is collaborative and participatory, and emphasises the ‘human’ element of change and improvement. In this it is not unique (for example, the Flow Coaching Academy emphasizes the human aspect of improvement), but the importance given to brokering a network and creating a community is distinctive. It is underpinned by an attempt to rebalance the biomedical model and to give voice to a diverse group of stakeholders (including those who are often absent from improvement

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16 More information on the Flow Coaching Academy is available at: http://www.sheffieldmca.org.uk/flow
programmes). The approach is in contrast to a top-down model, in which the Lab’s activities and impact would be entirely dictated by the core team or by the funders.

So I think we’re definitely sort of people-centred. [...] I think our value statements are very linked to putting patients at the centre of improvement. [...] I don’t think it’s entirely driven on cost production, for example, because a lot of healthcare improvement initiatives are about very specific … costs, so improving efficiency. I think ours (…) is very people focused. (INT 003, Q Lab team member, early research and discovery phase)

If you’re bringing these people together it is that idea of participation I think, and treating everybody […] on that equal footing, that we are all there to feed into this mission. It’s not a kind of […] ‘we’re leading on it, we just want your input’… It does feel in many ways a much more collaborative approach. I mean although Q Lab, you know, and Health Foundation are leading on it […] it does feel like they are listening to what people are bringing to that table. (INT 021, Q Lab participant, early distilling and sharing learning phase)

Across the whole pilot year life cycle, particular effort went into identifying, developing and mobilising participants’ skillsets, and motivating and empowering people. This feature of the approach was also visible in the consistent use of user-centred methods adopted by the Q Lab team (INT 003, 004). As a result, Q Lab participants often described the approach as based on the values of collaboration and inclusivity, with an emphasis on equality and mutual support (INT 017, 020, 022).

Creative culture and diverse skillset

A second distinguishing feature of the Q Lab is the creative use of a set of improvement skills to address well-selected topics in order to un-package problems and develop solutions. Based on the hypothesis that complex challenges are better understood when people are able to tolerate uncertainty and embrace paradoxes, the Q Lab makes skilful use of creative tools that allow individuals to revisit their ideas and preconceptions, slow down their thinking processes and develop new ways of framing problems.

Consistent with this approach was the skillset and composition of the Lab team in the pilot Lab. Composed of seven individuals and based in an office in London, the core team showcased a diversity of skills and expertise, ranging from improvement science to research and design thinking. In their daily activities (e.g. meetings, briefings, report writing), the Q Lab team emphasised the creative aspect of their approach by adopting techniques and exercises derived by design thinking and accompanying written outputs (word documents, reports) with appealing materials, images and other visual outputs. The creative element was also exemplified in the methods the Q Lab team used in the research and discovery phase. This feature of the Q Lab approach was valued by most Lab participants.

What I found really helpful in the workshop was the people who had a design background and their different approach but it was so refreshing that that kind of different approach to problem-solving, I find that really helpful and having that different viewpoint and stance to look at addressing issues. (INT 012, Q Lab participant, early developing and testing phase)

However, we found that a few participants were sceptical about the creative methods adopted by the Q Lab team during the first workshop (July 2017). A small number of individuals suggested that an excess of creativity may result in participants struggling to understand the aim of the proposed exercises, thus
ultimately feeling disempowered. This risk was perceived as being particularly acute for patients and service users, who might not have extensive experience in design thinking and improvement methods more generally.

There is evidence that this feedback was taken very seriously by the Q Lab team. In later events, the team made a conscious effort to simplify the materials offered and exercises proposed to Q Lab participants, and moved towards an approach that gave voice to Lab participants more directly.

**Time-bounded and topic-specific**

The topic-specific and time-bounded nature of each Q Lab life cycle is also a key distinguishing feature of the approach – and, notably, one that makes it different from, and complementary to, the Q initiative. Once again, the Q Lab is not alone in seeing merit in creating energy and focus around a time-bounded approach (see, for example, Nesta’s People Powered Results\(^{17}\)), but linking this to a large-scale and inclusive community is different. According to some stakeholders who have taken part in the development of Q Lab, this feature was intended to provide focus to improvement work, encourage or intensify rapid learning, and nurture networks around important healthcare topics.

> Q Labs seemed like a great way of supporting a fixed term piece of work. So kind of the period of time. And that there would be a team of people working on this full time and supporting the process, the engagement. So it seemed to be a consistent way of trying to convene people to really get some insights and answers around, in this case, obviously peer support. (INT 032, senior leader, distilling and sharing learning phase)

However, the 9- to 12-month lifespan provisionally envisaged for each Lab makes the process fast-paced, and may have made it difficult for the Q Lab team to keep focus on both developing and implementing the Q Lab approach, on the one hand, and achieving the desired outcomes related to peer support, on the other. The Q Lab team attempted to mitigate this risk by constantly capturing learning from experience in written form (as witnessed by the documents regularly uploaded on the team online file-sharing platform) and by establishing regular formal and informal forums to discuss progress and reorient action. The Q Lab team’s reflexivity and tolerance for uncertainty also contributed to the sustainment of a flexible and adaptive approach over time.

> I think the pace does put an added pressure to try and either get things right first time or identify them and call them out and rectify them quickly. (INT 003, Q Lab team member, early research and discovery phase)

### 3.1.4. Balancing visible progress with emergence and uncertainty in the pilot year

One of the key characteristics of the Q Lab approach (particularly pronounced in the pilot year) is the emergent nature of the process.

\(^{17}\) More information on People Powered Results is available at: https://www.nesta.org.uk/project/people-powered-results/
Well, I think it’s a bit of an experiment, that’s the first thing to say. (INT 018, Q Lab participant, distilling and sharing learning phase)

Consistent with this, the improvement model underpinning Q Lab cannot be described as a simple step-wise toolkit, and outcomes will emerge from the (neither predictable nor tightly controlled) process of selecting complex healthcare issues, identifying and convening relevant stakeholders, discussing problems and opportunities and testing customised solutions. Around the core Lab team and participants sit the wider interests of the Health Foundation (including the Q leadership and senior management), NHS Improvement, and other interested parties. This wider group has also actively learned, discussed and derived lessons for the future.

Our evaluation suggests that some Lab participants saw value in this feature and hoped that the emergent, experimental and open-ended nature of Q Lab would result in the development of an improvement approach that builds on the expertise and capabilities currently available within the healthcare system, but untapped or under-utilised.

I don’t think [the mission of Q Lab] was very clear. And that is not a criticism, I think that sometimes is quite a strength, and quite a brave thing to do. [...] You know, quite often you come along to meetings where you’re asked for [input] but there’s already a very clear objective of what people want to do. [Whilst with Q Lab] it was to very much say to people ‘What do you think do we need to do to raise the profile of peer support?’ So, I suppose the mission was to raise the profile of peer support and really throwing it open about what is the best way to do that, and what are the mechanisms to do it. (INT 021, Q Lab participant, distilling and sharing learning phase)

The Q Lab’s agile and experimental qualities also enabled the identification of opportunities for new partnerships as they emerged; this resulted, for example, in the Q Lab working with National Voices on the development of a peer support online evidence portal (see Section 2.2).

Although there are benefits to this approach (e.g. solutions can be tailored to a particular topic), both Q Lab participants and the Q Lab team themselves acknowledged the challenges of an emergent and open-ended model. These include the risk of a loss of engagement from people throughout the project lifespan, or key stakeholders not trusting the process, perceiving it as too risky, or as lacking strong direction. Lack of clarity in the Q Lab objectives and impact measures may have resulted in some participants ‘dropping out’ or disengaging after the July 2017 workshop:

Yeah, I mean… It can be a bit difficult in at first because, you know, I remember the first event I went to, I was sitting in this room and going ‘What is it we’re actually doing here?’.

Yeah, it lacked clarity. But then again, I think that’s a challenge [...] [but is also] quite refreshing, and it’s quite new. [...] I think getting consensus has been a challenge, and I think some people have probably dropped off along the way because they’re not necessarily engaged in that. (INT 021, Q Lab participant, early distilling and sharing learning phase)

The emergent and flexible nature of Q Lab also had repercussions for how the team communicated with Q Lab participants as they continued to shape the Lab. Getting the balance right between engaging
participants and maintaining freedom to change and redesign was a consistent challenge for the Lab team in the pilot year.

An interesting point was about communicating with the Lab participants […] the team are very aware of the fact that Lab participants need to see some outcomes from the workshop to remain engaged with Lab. But Q Lab team also want to maintain some leeway to change the content or number of the ‘big ideas’ [later rebranded as briefs]. They talked about writing a blog post to be shared next week but trying to balance carefully how much information to give to participants. (OBS 008, developing and testing phase)

The Q Lab team were well aware of the challenges of an emergent approach and spoke openly about this with Lab participants; for example, during the July 2017 workshop, the presentation of the principles underpinning the Q Lab approach included a specific point on emergence:

And then, in presenting the workshop principles, [team member] added a really important point and said ‘Our time together might feel messy, ambiguous and unfinished but that is OK. Today is about progress not perfection’. (OBS 006, deep-dive workshop July 2017)

The team were aware that sometimes the only way to learn is by doing something and taking the risk, and they tried to balance these different strategies, keeping in mind that there is an ‘allowance’ for mistakes or elements not being ‘perfect’ yet in this pilot phase:

[The Q Lab is] high-paced and high-energy, with the ability to kind of readily reflect on where we’re going and pivot, depending on what opportunities arise. (INT 002, Q Lab team member, early research and discovery phase)

We learn more from doing than we do from kind of thinking through it… So yeah, it is the opportunity to learn in real time and we will learn so much more by doing this than we would have by sitting down and [writing a plan]. (INT 004, Q Lab team member, early research and discovery phase)

The team also navigated uncertainty by reflecting on their own work and by deliberately allocating time and energy to learn from experience. They always sought feedback from Lab participants and other stakeholders (including the evaluators) to identify potential areas for improvement and to redirect their work. For example, after the first workshop, the Lab team took on board feedback from Q Lab participants and evaluators that the expertise of the workshop attendees could have been more explicitly valued, and new ways of capturing ‘lived experience’ could be explored. In the December 2017 and March 2018 workshops, the team invited participants to give talks and reflect on their personal and professional involvement in peer support; this format worked much better and was highly appreciated by the workshop attendees.

The Lab’s team efforts to reflect and learn from experience were recognised by participants themselves, who valued the opportunity of ‘having a say’ and shaping the Lab throughout the pilot year.

I really think that the feedback element is so well conducted, at regular intervals, and I think it’s really encouraged the feedback, whether that’s positive, negative or anything in between, really. And I really do feel like it is acted upon and taken seriously, which is nice. Again, it doesn’t just feel like you … they’re saying stuff and it disappears. [...] Because it is an
The team also adopted a ‘learning log’, a document shared by the team where they captured learning and reflections throughout the pilot year, and monitored their progress against their expected aims and impact. This reflexivity-in-action was particularly notable in the light of the fast-paced and time-bounded nature of the Q Lab life cycle.

3.2. What resources, stakeholders, conditions and infrastructure are required to deliver a Q Lab effectively?

This section describes, in turn, our findings about what resources, stakeholders, conditions and infrastructure are required for the Q Lab approach, as described in detail in Section 3.1, to be effectively delivered. It is important to note that this evaluation question cannot be fully addressed at this stage, because the pilot year focused on shaping the Q Lab approach, rather than fully investigating and developing the resources, stakeholders, conditions and infrastructure underlying the Q Lab. As already discussed in Section 3.1, the fast-paced nature of the pilot year may have made it challenging for the Q Lab team to fully develop and implement the approach while also striving for outcomes related to peer support. Nevertheless as evaluators we present our findings on the characteristics that appear to be necessary for the Q Lab approach, as well as the considerations for future Lab cycles associated with these characteristics.

3.2.1. The Q Lab needs the support of a dedicated, core Q Lab team that employs tried-and-tested methods as well as being flexible and reflexive

The dedicated Q Lab team was crucial to the effectiveness of the Q Lab approach. Given the well-documented pressures on the health and social care system in England (Robertson et al. 2017), in particular on its staff (Vize 2018), the existence of a core team, whose sole remit was to harness the Q Lab mechanisms to address an articulated challenge in a specific topic area, helped to create the necessary momentum around ideas that have the potential for impact. The particular value of the core Q Lab team could be seen in the ‘Idea Generation and Support to Implementation’ phase of the programme theory as understood by the evaluation team (Figure 2.4). As discussed in Section 3.1.1, it is in this phase that the team actively supported the development and implementation of improvement ideas and options. This was recognised by participants as well as senior leaders from Q and the Lab funders:

I think what the Q Lab has the opportunity to do is to bring staff together who work in health and care to problem solve and to generate knowledge and to create momentum that can support them in their change effort. And I don’t think we should underestimate the potential of the lab to really help with some of those staff engagement, staff able to lead improvement type measures. Because they are very important. Because without those we don’t get change happening at a local level. (INT 032, senior leader, distilling and sharing learning phase)

Another resource implicit to the core Q Lab team was the diverse skillset of the team members, ranging from design thinking to improvement science. As discussed in Section 3.1.3, the skillset of the team
members was intertwined with the creative tools and approaches that the team employed throughout the pilot year. For a future Q Lab to be successful in convening a diverse group of stakeholders within a safe and effective platform to enable meaningful collaborations, it is likely that similar skills, tools and approaches will be vital. During the pilot year, the Q Lab team had already developed and applied particular tools, for instance, in participant engagement and workshop facilitation, that can be employed in future Q Lab cycles where appropriate.

A key resource underlying both the dedicated Q Lab team and its creative approach was the provision of funding from the Health Foundation and NHS Improvement (see also Section 3.4.2). Financial security (usually a major constraint for labs and start-ups worldwide) meant that the Q Lab team was able to dedicate their work and time entirely to the Lab’s core activities, rather than worrying about the funding.

*I think having the funding mechanism that we do is unique [...] and that means that you have a lot more time and space to just do your work if you’re constantly seeking funding, it changes the dynamic, it changes the length of the project cycle. We’re also, the way we’re funded [...] means you are free to do a little bit more creative thinking, so I think that is very unique.* (INT 002, Q Lab team member, early research and discovery phase)

3.2.2. The Q Lab requires a continuum of stakeholders ranging from informal experts with lived experience to those with system leverage

Section 3.1 described the convening function of the Q Lab in bringing together a wide and diverse range of stakeholders with different roles, expertise and professional background in the healthcare sector. The ability of the Q Lab to bring together and empower a range of relevant stakeholders was perceived by participants to be crucial to its success in contributing to a deeper, holistic understanding of the challenge. Importantly, stakeholders included patients and service users, or those with ‘uncodified’ tacit knowledge and lived experience, who are often not included in improvement programmes.

If the Q Lab intends to impact the health and care system, it is likely to also require the involvement of stakeholders with agency, power and the right networks within the system. The Q Lab team, participants and senior stakeholders noted that the Q Lab did not always include the optimal range of stakeholders with leverage in the area of peer support, and thus was not able to contribute to addressing the challenge to the full extent possible. Indeed, only three of the 28 respondents to the second evaluation survey were classified as senior (using income as a proxy for seniority, classifying those earning £80,000 or more per annum as senior), and none of the senior participants identified as being very or extremely engaged with the Q Lab (SUR 002).

*What I don’t know is how that then plays back in [...] how the social care system works, how that plays back into the wider system. [...] What I’m unable to answer at this stage is how far the distance travelled in terms of meeting that objective around making peer support available for everyone who needs it, wants it, I’m not able to answer that because I don’t know.* (INT 025, Q Lab participant, distilling and sharing learning phase)

The evaluation team acknowledges that it was not easy to identify these stakeholders in the particular area of peer support (as opposed to areas supported by national charities or medical Royal Colleges), and also that in the pilot year, the Q Lab team was as much defining and shaping the Q Lab approach as tackling
the peer support challenge. Moreover, it is likely that working with a partner in the next cycle will affect the range of stakeholders involved.

3.2.3. The Q Lab would be most effective tackling a topic that is relevant and timely for the health and social care system

The Q Lab exists within a health and care system that is under pressure (Robertson et al. 2017) and where priorities may come and go. Therefore, it may be that the Q Lab would be most effective – or have the most impact – when tackling a topic that is both relevant and timely. Such topics may be relevant to the wishes and desires of patients or service users, or they may address systemic issues, such as a lack of funding and capacity. The use of a consultative and participative process for topic selection (see Section 3.1.1) was one way to ensure its relevance.

It should also be acknowledged that, in the eyes of Q Lab participants, the Health Foundation’s association with Q Lab provided visibility and further legitimised the importance of peer support as a topic area. It is clearly perceived that the association of the Health Foundation with peer support has helped to create conditions that are more responsive towards impact in the area, though the extent of this effect is difficult to measure through this evaluation.

In future Q Lab cycles, this legitimising function may be further enhanced by the presence of a carefully chosen external partner with an established role and credibility in the topic area. The second Q Lab, in which the Q Lab team is partnering with the mental health charity Mind, will provide the opportunity to shed more light on this.

3.2.4. The Q Lab currently fits within the wider infrastructure of Q and the Health Foundation

In its pilot year, the Q Lab was strongly linked to both Q and the Health Foundation. The relationship between Q Lab, Q and the Health Foundation, as well as the broader health and care system, will be further discussed in Section 3.4 under the evaluation question ‘How does the Q Lab fit within Q more widely, the Health Foundation and the broader health and care system?’.
3.3. How does the Q Lab engage participants? How valuable have participants perceived their participation to be?

Understanding and describing the model for engaging stakeholders adopted by the Q Lab is a key aim of this evaluation. This section describes the Lab’s routes to engagements in the pilot year, i.e. the ways through which the Q Lab team identified and convened participants and attempted to keep them engaged in the first Lab life cycle. It also describes participants’ perceived drivers and barriers to engagement. Finally, the section reflects on the perceived value that taking part in Q Lab had for participants, with a specific focus on their professional networks and the impact on their work. Given that the ‘convening’ function of the Lab is one of the main mechanisms through which Lab works, this evaluation question presents clear links with EQ1, as addressed in Section 3.1.

The learning from the pilot year described in this section constitutes the basis for the evaluation team’s recommendations in relation to the Lab’s future engagement model and strategies; these are reported in Chapter 4.

3.3.1. The Q Lab used a varied engagement approach with some success in the pilot year

As discussed in Section 3.1.2, convening a range of diverse stakeholders to facilitate conversations and idea generation is one of the mechanisms through which the Q Lab accomplishes its work. Since the early days of the pilot Lab, the Q Lab team sought to identify relevant stakeholders by both leveraging the Q community and carrying out a customised stakeholder mapping. This task was made somewhat challenging by the team’s lack of previous experience of the topic, including knowledge of who the ‘relevant influencers’ are in the topic area.

I think […] the Q Lab team has to identify some of those key stakeholders and influences in whichever topic we’re working on, and be starting to try and engage them from a very early stage. And that’s quite a lot of relational work that needs to be done. […] And I think there are some existing mechanisms. Q obviously is a network of people who can receive information. But I think we need to think a little bit more tactically about some of the influential voices in the system. (INT 032, senior leader, distilling and sharing learning phase).

Recruitment of Lab participants was particularly prominent in, though not limited to, the setting up and early research and discovery phases, with the subsequent phases focusing more explicitly on developing an engagement strategy and monitoring changes in the group of participants.

The Q Lab team sought to engage stakeholders in two main ways: in person, through the organisation of four workshops (two of which took place in London, one in Birmingham and one in Northern Ireland), and remotely, through the development of the online space, launched early in the pilot year and accessible to all Q Lab participants (see Section 2.2.2).

18 Some participants joined the Lab in the early months of 2018, towards the end of the Lab life cycle.
In addition to this, the Q Lab team organised a number of focused webinars and emailed fortnightly updates to participants to ensure that people were kept up to date with the Q Lab progress. Lab team members also adopted targeted communication strategies with participants (emails, telephone calls) when they had a desire for individualised communication, offered valuable feedback, or had doubts or concerns regarding the project.

Figure 3.1 highlights the varying routes to engagement offered to participants of the Q Lab, and the degree to which these were utilised by the 31 respondents of the second survey. The vast majority of participants engaged through the fortnightly email updates, and usage of various other methods was also high. However, utilisation of the Q Lab online space was low in comparison.19

Figure 3.1. Participants routes to engagement

As confirmed by our interviews with Q Lab participants, this deliberately varied engagement approach was instrumental in involving individuals with different professional roles, time constraints and drivers to engagement, and confirmed the need for a customised engagement strategy. Some participants placed great value on the face-to-face workshops and felt that their engagement was entirely dependent on the possibility to attend such events. Others seemed more appreciative of the opportunity to connect with Q Lab remotely, especially in the light of the difficulties experienced in attending full-day workshops (e.g. inability to obtain funding or to secure time off work).

The second survey suggested that respondents classified as having more free time (i.e. with no more than 40 contracted weekly hours) were more likely to engage with Q Labs through face-to-face workshops than those deemed to have less free time (i.e. more than 40 contracted hours per week). Engagement through

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19 However, the evaluation team noted that activity on the online space increased after March 2018, after the survey was conducted, driven in part by posts and comments by Q Lab participants related to Q Exchange submissions.
the Q Lab online space, the Q Lab website and the websites of other relevant initiatives or organisations (e.g. Q or the Health Foundation) was much more common among participants with less free time.

Most individuals we interviewed suggested that the Q Lab team was highly successful in keeping people engaged throughout the whole Lab life cycle. Some added that the regular email updates and targeted communications made them feel as if they were ‘part of the Q Lab’s journey’, rather than just being kept informed.

There is no excuse for saying you didn’t know about something. [Q Lab] could not try harder to make sure that people are kept in the loop. Once you’re in the loop, you’re kept in the loop tremendously well, and I think that is a great strength, and it shows no signs of withering over time. (INT 015, Q Lab participant, distilling and sharing learning phase)

I think with Q Lab there’s this kind of shoulder to shoulder journey between the Lab and the participants, who’re kind of walking through the journey together, really. At no point do I feel like I’m not aware of the work that the Lab’s doing in the background before the next time. […] I feel very much aware of everything that’s being conducted and I think that’s really nice. (INT 020, Q Lab participant, distilling and sharing learning phase)

Others, however, reported that they experienced difficulties keeping in touch with the work of the Lab, and had expected more face-to-face meetings. One participant suggested that, in the future, the Lab should organise shorter, focused events (e.g. late afternoon gatherings) in addition to the full-day workshops, in order to allow participants who may struggle to attend full-day events to benefit from the face-to-face experience.

Experiences of the online space were varied (DOC 041, DOC 038, Learning Log 19.02.2018) and few participants contributed to the online space prior to March 2018. The Q Lab team reflected on how to modify the online space to make it easier for participants to contribute – including having scheduled chats around a topic, nominating people ‘responsible for keeping the conversation going’ and having a clearer agreement about what the space is for and how to use it (DOC 041).

It is clear that the Lab team have been learning and making progress quickly with respect to their engagement strategies; throughout the Lab life cycle, the number and diversity of people showing interest in the Q Lab has been constantly growing, exceeding the team’s expectations, and reaching a total number of around 200 individuals.

3.3.2. Participants were motivated by different reasons and faced different barriers to engagement

During the pilot year, the Q Lab team were mindful of the need to customise their engagement strategy based on participants’ preferences, as well as their ability to commit to work with Q Lab. They identified

20 As of April 2018, the Q Lab team had started to develop ‘A guide to the online group’ to provide greater clarity to participants on the aims and ethos of the online space, as well as suggestions and ‘challenges’ to encourage engagement.
a group of ‘highly engaged’ participants (i.e. individuals who appeared motivated to work closely with the Q Lab team) that were often included in ad hoc consultations and in the delivery of main Lab events (e.g. in the form of talks and presentations in the workshops). The Q Lab team also attempted to cluster participants based on their motivation for taking part in Q Lab, whether related to their interest in the selected topic or their interest in the Lab approach more broadly. This clustering exercise was extremely helpful to further characterise the participant group.

Our evaluation suggests that an interest in the topic may not be directly correlated with sustained engagement, as demonstrated by the fact that some ‘highly engaged’ participants were not experts in the field of peer support. The professional backgrounds of those identifying as ‘very engaged’ or ‘extremely engaged’ with the work of Q Lab in the second survey emphasises this point. Of those providing the relevant survey information, three have a background in corporate and administrative services, two in management and two as clinicians.

Our data further suggests that engagement may be strongly influenced by participants’ willingness to commit time and resources to the Lab: whilst some participants showed a high investment in the Q Lab improvement endeavour as a whole, others joined with more bounded and practical expectations (e.g. learning more about peer support, or maintaining a relationship with the Health Foundation); they knew from the start that they would only engage in the events/activities that looked applicable and relevant to their work.

I would like the Q Lab to know that if they have active members, they also have silent members like me, who [...] can’t attend events but I read up on it. And they’re actually helping me to enhance my knowledge of peer support [...] I wouldn’t want that to stop [just because I’m less visible] (INT 022, Q Lab participant, distilling and sharing learning phase)

Another theme that came across strongly in the interviews was that participants’ engagement was hindered by a lack of clarity about what was expected of them – i.e. how exactly they could contribute to shaping the Lab.

I remember leaving the Barbican workshop, and I was thinking this is great, I really want to be involved, what do I do next? (INT 021, Q Lab participant, distilling and sharing learning phase)

Maybe what they have to do is pin down people to do jobs. [...] I know people don’t always do what’s asked of them, but if you’re never asked in the first place, then you’re not going to do anything, are you? Actually, unless somebody says to me could I do x, y and z, then I probably am not going to do that, and I feel I’ve got reasonable expertise [...] But nobody’s come to me and actually physically asked me to do that, and of course, if they did, I would ... I’d say, yeah, of course, I’d be really pleased to. (INT 017, Q Lab participant, distilling and sharing learning phase)

The issue was also observed in the second survey. Of the 31 respondents, 12 stated that more clarity about what is expected of them would make it easier for them to participate in the Q Lab. Only the offering of funding to cover travel and subsistence to attend Q Lab events (which the Q Lab team offered, on an ad hoc basis, to patient leaders and other participants) was rated as a more important enabler of engagement.
Again, there is evidence that, through the pilot year, the Q Lab team has become aware of this issue and has tried to tackle it in a number of ways. For example, recognising that the success of many of the initiatives supported by the Lab would be dependent on users’ contributions and buy-in, the Lab team dedicated a session of the December 2017 workshop to explore delegates’ expected levels of commitment.

Each participant was given a piece of paper, called ‘personal commitment card’, and was asked to take the time to reflect on, and write down, what they will do, personally, in peer support. This could have been to do with putting in a bid for a project, investing some time each week to share learning on peer support via the online space, or simply spreading the Lab’s access survey. Participants were invited to make their commitment ‘realistic but ambitious’ and were then invited to discuss these with others at their table. (Observation of Q Lab workshop, December 2017)

3.3.3. Participants valued the relationships nurtured through the Q Lab

A relevant outcome of the engagement work carried out by the Q Lab was the creation of a physical and virtual platform for participants to meet and network.

We’ve talked a lot about [...] empowering people with skills and knowledge and connections and building their confidence and know how to tackle these kind of problems. So we’re being quite thoughtful about how we’re designing interactions with people to try and stimulate that. (INT 004, Q Lab team member, early research and discovery phase)

The Lab participants we interviewed acknowledged that engaging with Q Lab allowed them to connect with individuals they would have not met otherwise, and this was also observed in the second survey. As displayed in Figure 3.2, 22 of the 31 respondents formed at least one new relationship due to their participation in Q Labs, with seven forming at least three new relationships. This networking opportunity was highly valued: interviewees spoke enthusiastically about the new and relevant connections they made thanks to their engagement with the work of the Lab, and felt that they had been able to identify, and connect with, individuals with relevant expertise and experience in their area of work.
The fate of these connections was, however, variable. In some cases, the connections generated an opportunity for new partnerships and the sharing of knowledge and working practice.

*The networking was great from that initial London conference. [...] In the future, I’m planning a trip to [region name] to shadow some of the peer work they are doing, because I think [we] seem to be going head to head. We’ve been quite informed about peer work and are doing some quite interesting stuff. So, we thought it might be cool to do a bit of a [swap] and see the work we do. So, that networking’s been great.* (INT 020, Q Lab participant, early distilling and sharing learning phase)

*In the Birmingham workshop, I got together with two other people in the [region name], and we said we definitely must try and do something. [...] So with two people in [region name] we agreed we [...] will do something. And then there was a contact that I was given by one of the... one of the speakers, [...] I clocked that too... as people to visit, and talk to, so that I can perhaps use them as a case study locally for people to turn to.* (INT 016, Q Lab participant, early distilling and sharing learning phase)

In other cases, the connections made at the Q Lab workshops were regarded as highly valuable in the moment, but they did not result in any contact outside those events. Of the 22 survey respondents who formed new relationships, eight stated that the impact of such relationships was ‘meeting someone with shared experiences and hopes as myself’; nevertheless this aspect of community-building and validation was appreciated by participants and should not be discounted.

Participation in the face-to-face events seemed crucial to encourage participants to make contact with each other. Of the respondents to the second survey, those who attended Q Lab main events were much more likely to have formed three or more new relationships than those that did not attend any events, and were less likely to not have formed any new relationships. The professional delivery of the workshops, enjoyable space and locations, and general ‘hygiene conditions’ provided an excellent opportunity to network.
It’s partly a product of having some resources, so a meeting in a pleasant place, over a protracted period of time, just generally making people feel comfortable and looked after, instead of being crowded into a poorly lit room where there aren’t enough chairs and, you know. The comfort and hygiene factors are clearly thought through, in terms of the design of how to spend the time. [...] I valued that meeting some people who I wouldn’t otherwise have met, and that’s what happens when you bring people together. (INT 025, Q Lab participant, distilling and sharing learning phase)

However, in the last phases of the Q Lab life cycle, there has been evidence that the online space and Profile Cards may also provide participants with an opportunity to identify potential contacts outside face-to-face events.21 Importantly, participants recognised that initiating connections outside formal events required time and sustained engagement: there were indications that people may not feel comfortable contacting fellow Lab participants if they only met once. Thus, spontaneous networking outside Q Lab events seemed more likely to happen in the second half of a Lab life cycle.

It was that relationship building, and it did feel... I did feel more confident, and think to myself, actually, that was nice to meet up with such-and-such again, and he would be someone [...] actually I feel quite comfortable now contacting him. I think it’s something about relationship building and feeling confident and comfortable that you can contact someone and they’ll reciprocate and understand where you’re both coming from. (INT 016, Q Lab participant, early distilling and sharing learning phase)

The focused and time-bounded nature of Q Lab poses questions about the legacy of each Lab cycle’s participant group, specifically the extent to which the Q Lab team will continue to provide support to the participant group or whether this is expected to be self-sustaining in the future. In February 2018, the Q Lab team hosted a webinar (the ‘Future Community Webinar’), attended by six participants, to explore this issue (DOC 041). The topic was also discussed in the focus groups conducted in the March 2018 workshop (led by the evaluation team), with some participants stating that the work done by the Q Lab in its first nine months was mainly ‘preparatory’, and that actual change was more likely to happen from that moment onwards.

You know, [we’ve been working at this] for nine months, and I’m not sure that it’s actually … We’ve not actually done very much yet, in terms of changing the world yet. [...] I think that … it’s got … it’s promising. (FG 002, Q Lab participant, March 2018 workshop)

We’ve been reflecting an awful lot on what we do, and we’ve been having conversations in the areas that we work in, but now that we’ve got all this information, and we’ve got the report,

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21 The Q Lab team introduced Profile Cards as a way for participants to virtually share information about themselves with one another, including their name, professional background and level of interest in both peer support and the Q Lab approach.
3.4. How does the Q Lab fit within Q more widely, the Health Foundation and the broader health and care system?

In this section, we reflect on the ecosystem within which the Q Lab initiative arose. We describe the relationships, synergies and differences between the Q Lab initiative and the Q community and the role of the funders in shaping the Lab approach. Finally, we reflect on how the Q Lab may fit into the broader health and care system in future cycles.

3.4.1. The tight link between Q and Q Lab brings both benefits and potential areas of tension

As described in Section 2.2, the concept of Q Lab was initially introduced to and discussed by Q members in 2014. The Q Lab shares key values and principles with Q: collaboration, reciprocity and an attempt to inspire and support change and improvement by bringing multiple perspectives together. Sometimes referred to as ‘the sharp end of Q’ (INT 004, early research and discovery phase), the Q Lab is a way of applying the potential of Q to a specific topic/challenge, combining a focus on nurturing a community with an emphasis on generating actions and solutions.

\[\text{I have had some difficulty in identifying exactly what the Q community is doing [...] the Q Lab seems much more specific (and therefore more likely to have an impact).} \text{ (SUR 001, Q Lab participant, research and discovery phase)}\]

\[\text{[...] the Lab is [...] very important for Q because it provides a focus and a place for people to come together.} \text{ (INT 005, research and discovery phase)}\]

The tight link between Q and Q Lab meant that most of the Q Lab early participants were also Q members and became aware of it through Q. However, by the end of the first Lab cycle, a considerable proportion of the Q Lab participants were not Q members; these new participants were attracted to the Q Lab either by learning about it from existing participants or hearing about it through the Health Foundation or Q Lab communications. Interestingly, the Q Lab has become a gateway to Q, with some Q Lab participants applying to become Q members: the flow of individuals between the two initiatives seems to work in both directions.

The Q Lab team has consistently acknowledged the benefit of their Lab ‘emerging’ from Q, and recognise that having access to such a community adds strength and value to the topics addressed by the Q Lab.

\[\text{Part of [the Q Lab’s] uniqueness is its positioning [within] Q [...] the access and link to 1300 people [...] is clearly a unique position and that has shaped how [Q lab] has developed and what it is.} \text{ (INT 004, early research and discovery phase)}\]

However, there is also potential for tension. Becoming a Q member occurs through a selective process; becoming a Q Lab participant does not. The possibility of the positive culture of equality nurtured by the Q Lab team being eroded was thus mooted, though the Q Lab team consciously attempted to mitigate this in the later phases:
There’s a bit of a tension here because […] anybody could apply to go to Q Lab, which is great, but then some of us are members of Q, and some weren’t. So at the first workshop and then at this [July] workshop, there were times where the organisers would say, ‘Oh you know, so hands up if you’re a Q member’ and those of us would put our hands up and the others didn’t. I kind of felt that sense of a bit of an exclusive club type feeling. […] I do get a feeling that there’s starting to be almost like ‘cliqueiness’ developing (INT 009, early developing and testing phase)

I think there is a risk that Q Labs also become something like a club that you join, a badge of elitism. It’s really spooky for me when you go to meetings and almost everybody has got the Q badge on their lapel that people are wearing, and they all sort of puff up with pride and say, well I’m part of Q. And that worries me. You know, this is not an elitist endeavour, it shouldn’t be an elitist endeavour. It should be something that allows the total to be more than the sum of its parts in that the participants and members and those involved can, through their different talents and skills, come up with something very different. And I have seen in the most recent Q Lab very good examples of that. (INT 015, Q Lab participant, early distilling and sharing learning phase)

As the Q Lab participants continued to expand in number during the Lab life cycle, there was growing evidence that not all participants were able to articulate the differences and synergies between Q and Q Lab, to untangle the mission of the two projects, and to describe Q Lab’s positioning within the broader portfolio of initiatives of the Health Foundation.

The relationship between Q Lab and the Health Foundation, mother and daughter, father and son, I don’t know. I don’t really understand that relationship, nor do I feel I need to. (INT 025, Q Lab participant, distilling and sharing learning phase)

During the ‘marketplace’ exercise, where the Lab team presented opportunities for funding of projects on peer support and encouraged participants to come up with project ideas, it became evident that many participants were unable to distinguish between Q and Q Lab. They asked questions about what Q is and how it differed from Q Lab; some participants thought they were Q members by virtue of being Q Lab participants. (Observation of Q Lab workshop, March 2018)

3.4.2. The Q Lab has benefited more than financially from its funders: the Health Foundation and NHS Improvement

The support offered to the Q Lab by the Health Foundation and NHS Improvement had important implications for how the Lab developed throughout the pilot year. As described in Section 3.2.1, the financial support provided by the Health Foundation and NHS Improvement was a key resource for the Q Lab and shaped the development of the approach.

However, financial security was by no means the only form of support offered to the Q Lab by the Health Foundation. The importance of being linked to, and supported by, an organisation with a well-established reputation and brand was acknowledged by the Q Lab team and was recognised by participants. Notably, the Q Lab benefited from having some influential ‘sponsors’ within the Health Foundation, who took
action to ensure that the Q Lab connected with relevant stakeholders in the healthcare improvement ecosystem and to help the Q Lab raise its own profile.

*I think the benefits are it’s a brand that is well recognised and well respected so you can open doors in a way that you couldn’t if you weren’t affiliated with that brand.* (INT 004, Q Lab team member, early research and discovery phase)

In addition, the Health Foundation offered an invaluable repository of knowledge on healthcare services and improvement science, which the Q Lab leveraged, for example, during the research and discovery phase.

The Health Foundation – and Q more specifically – also offered the pilot Q Lab a ready-made community to leverage. Considering the importance of engagement to the Q Lab approach, this was likely to have had a crucial influence on the outcomes achieved by the pilot Q Lab, though its importance may diminish as the Q Lab approach becomes more established in its own right in future cycles.

*It comes with a ready community, which was always difficult with establishing social innovation labs, because you’ve got to go through a long process of drawing people together, so that’s a positive. [...] It comes with funding, which again is a great thing, so everyone was ready to start as a team, off they go.* (INT 006, developing and testing phase)

3.4.3. The Q Lab’s place within the broader health and care system is still unclear

Since the first Q Lab was a pilot, its place in the wider system is yet unclear. Evaluations of future cycles will be able to address this question more fully. What is already clear is that the Q Lab operates in a crowded improvement space but the particular place where Q Lab functions is not occupied. Early in the pilot Q Lab cycle, participants pointed to other (improvement) initiatives they deemed similar to the Q Lab, including Nesta, Nuffield and the King’s Fund (SUR 001). They also pointed to initiatives that involved networks, such as the Academic Health Science Networks (AHSNs) (SUR 001). Participants also flagged the need for the Q Lab to make its uniqueness and distinguishing features more visible (FG 001), and as Q Lab has evolved its distinctive features have indeed become more apparent. We offer two further suggestions for how the Q Lab could find its niche in the broader health and care system.

Firstly, the Q Lab could refine but broadly replicate the approach taken in the pilot year, as described in the programme theory proposed by the evaluation team (Section 2.4). The strength of the Q Lab, as demonstrated in the first cycle, has been in particular to contribute to a more holistic understanding and increased visibility of the topic (peer support), and to enable collaborations between individuals and groups that otherwise might have had limited opportunities to interact in a meaningful, effective way. Participating in the Q Lab has also increased individual participants’ capability and motivation to act in their own contexts. Taken together, the pilot Q Lab has been able to create momentum and energy around ideas that have the potential to impact the health and care system, culminating, for instance, in
the submission of entries related to peer support to the Q Exchange.\textsuperscript{22} The value of what the Q Lab has been able to achieve in its pilot year should not be underestimated, even if it is not (yet) possible to attribute changes to the broader system. This value is perhaps best described as establishing a provisional ‘proof of concept’ alongside a wealth of specific learning about the detailed steps required to deliver such a complex approach.

Secondly, if one of the ultimate aims of the Q Lab approach is to ‘leverage routes to spread’ (see the programme theory as articulated by the Q Lab team, Section 2.3), it may be that this is best achieved by working with a partner. We found that the Q Lab excelled in the mechanisms, principals and outcomes articulated by the evaluation team’s programme theory, but that system impact was unlikely to have been achieved in the pilot year. This sentiment was expressed both by participants and senior stakeholders:

\begin{quote}
It feels like […] we’re still having conversations that we were having in Covent Garden a year ago […] it feels like we’ve come to the end of the year and now’s the time we actually go out and do stuff […] now it’s time to go out and implement it and make a difference where we work. (FG 004, Q Lab participant, March 2018 workshop)

I think those goals were probably more reasonable to ask of the lab once it’s in its fully flourishing kind of state rather than in its first stage (INT 027, senior leader, distilling and sharing learning phase)
\end{quote}

It may be that the second Q Lab will demonstrate that partnership working enables the Q Lab to leverage the partner’s existing networks and credibility in the chosen topic area, and thus accelerate spread and impact. If so, going forward partnership working may offer the Q Lab the best option of being able to leverage routes to impact.

3.5. Does the Q Lab make a valuable contribution to achieving change alongside other approaches?

It is well known that improving quality in healthcare is difficult and Dixon-Woods et al. (2012) have identified 10 key challenges: convincing people that there is a problem that is relevant to them; convincing them that the solution chosen is the right one; getting data collection and monitoring systems right; excess ambitions and ‘projectness’; organisational cultures, capacities and contexts; tribalism and lack of staff engagement; leadership; incentivising participation and ‘hard edges’; securing sustainability; and risk of unintended consequences. This is not the place to review these diverse challenges but it is important to recognise that selecting an appropriate approach to supporting quality improvement should be informed by the nature of the likely challenge. It should be apparent that the Q Lab approach can offer contributions across these challenges; for example, it can secure emotional engagement to understanding

\textsuperscript{22} Besides submissions to the Q Exchange, the pilot year might yet yield other future potential solutions and impacts that would not have been captured during the evaluation period. During the pilot year, the Q Lab team began tracking outcomes, including new collaborations and specific improvements to practice in participants’ contexts (DOC 047).
the problem and seeking solutions, it can provide insights into how organisations really work and the
behaviours of service users and professionals, and it can support a kind of leadership that is oriented
towards relationship management and bridging organisations.

However, the Q Lab approach does not lend itself so obviously to securing spread and sustainability (at
least insofar as it has been developed in the pilot year). Whether Q Lab is a suitable approach to secure
leadership for the topic from stakeholders who have the necessary range of leadership skills and/or agency
in the system to deliver change, remains unclear. Indeed, Q Lab might suffer from what Dixon-Woods et
al. (2012) call ‘excess ambitions and “projectness”’, where enthusiasm may result in ambitions that cannot
be met with the resources available. The authors note: ‘Activities such as team- and relationship-building
are time-consuming, especially when they start from a low base, and it may be hard to sustain enthusiasm
and effort over long periods and maintain focus when interests and priorities move elsewhere’ (p. 880). It
is to the credit of both the Q Lab team and the Health Foundation leadership that this risk has been
sufficiently managed to ensure a further cycle to allow the process to ‘bed in’ more fully. However, it is
also worth emphasising that spread and impact may not be the right roles for a Q Lab – instead, its most
useful function may be that of generating possible solutions and insights that can then be piloted, tested
or researched on a broader scale by other actors.

The pilot year has provided the Q Lab team with an opportunity to formulate and refine their
programme theory, a model that includes the features, mechanisms and the anticipated impacts of the
approach and details the specific modalities through which Q Lab achieves impact in the selected topic
area. Since January 2018, the Q Lab team has rebranded their programme theory as an ‘impact model’
(see Section 2.3). Working with stakeholders including the evaluation team, the Q Lab team has
iteratively developed and revised the model with the aim of capturing both the mechanisms and activities
through which Lab works (‘what Lab does’, which we discussed in Section 3.1) and the expected
outcomes (‘what Lab achieves’, considered in this section), including short- and long-term outcomes. One
of the previous iterations of the impact model also articulated ‘the case for Q Lab’, i.e. the opportunities
brought about by the Q Lab approach that occupy a marginal position in the current improvement
landscape.

In the following sections, we summarise the views of the Q Lab team members and other stakeholders on
the impact and achievements of the Q Lab. We recognise that these are, to some extent, aspirations or
potential achievements, rather than proven outcomes, and we therefore also reflect on whether and how
they have been visible to participants and to us as evaluators, in what areas, and why.

3.5.1. Q Lab consolidates learning and knowledge

One of the expected impacts of the Q Lab initiative was to provide its participants, and the broader
healthcare system, with an improved understanding of the topic area, and to consolidate and capture this
learning in ways that make it highly visible and accessible to all. Indeed, since the evaluation started in
May 2017, the Q Lab team has invested a substantial amount of time and energy in reviewing literature
on the selected topic, and also gathering evidence of users’ experience, while examining the problem
components of peer support.
It is important to consider that this impact level focuses on learning and knowledge as ends in themselves, rather than the means to achieve change in working practice. This impact level is described in the Q Lab impact model as follows:

[Q Lab] deeply analyses topic to identify challenges and opportunities. [It] draws on existing data and evidence, and generates new insights from collective intelligence and lived experience, to develop a deep understanding of the topic. (Figure 2.3)

The Q Lab participants we interviewed spoke positively about the learning they achieved by working with the Lab. Irrespective of their previous expertise in the topic, most interviewees talked about how they gained a better understanding of the complexity of the peer support landscape, the multiple and diverse ways to deliver and commission peer support, and the challenges in accessing it.

I learnt a great deal and it really encouraged me to think from different perspectives about peer support. (INT 009, Q Lab participant, early developing and testing)

I think my expectation was to understand what type of peer support work was out there, who’s doing what, and just to have a bit more knowledge on what people want to do, what are the techniques that we could use. So, I think the Q Lab has actually fulfilled that. (INT 022, Q Lab participant, distilling and sharing learning phase)

I personally also learnt a lot about what the whole issue of peer support was about, because to be honest, I’d been attracted to [Q Lab] from a different place, in a way. I don’t really do that in my work. (INT 016, Q Lab participant, early distilling and sharing learning phase)

Consistent with this, in the second survey, 23 of the 31 respondents stated that the Q Lab has successfully ‘generated new knowledge about the challenges around and evidence for peer support’. Some 20 respondents reported that they have personally ‘gained new knowledge about the challenges around and evidence for peer support’, with a further 19 stating they ‘have learned about new ideas and best practice for peer support’.

Particularly relevant to the aim of achieving an improved understanding of the topic area was the work conducted by the Q Lab on examining the barriers and enablers of access to peer support (the access brief, see Section 2.2). To the Q Lab team’s knowledge, the nationwide survey on decision-making in peer support they designed and conducted in partnership with YouGov was, to date, the largest survey conducted in the UK on peer support. Targeted at three different groups of people (the health and care workforce, peer support workforce, and the public), the survey provided valuable insights on what matters to people when deciding to either access peer support or refer or recommend peer support to others.

Our hypothesis was that if we know more about what matters to people when they are referring to, recommending or considering accessing peer support, this may deepen our understanding of behaviours in peer support, improve the conversation between different groups of people and so improve access to and uptake of high quality peer support. (DOC 056)

Also included in the desired impact of consolidating learning on the topic was the work conducted to strengthen the evidence base for peer support. Having recognised the need for making information, insight and evidence on peer support more accessible and easy to use, the Q Lab worked with National Voices, Mind and Positively UK to support the development of a long-standing repository of evidence on
the impact of peer support – the Evidence Hub. As described in Section 2.2, going forward National Voices will be the main lead of this stream of work; the expected date for the launch of the peer support Evidence Hub is 2019. It is hoped that it will help inform and guide people and services who deliver or would like to deliver peer support (DOC 055). The Evidence Hub will build on the insights, developed by the Q Lab in the pilot year, into what is meant by evidence in the context of peer support, and will combine traditional forms of qualitative and quantitative evidence (such as health outcomes measures and economic evaluations) with ‘softer’ indicators such as those acquired through storytelling and participatory research (DOC 039).

The Evidence Hub is also an example of the impact achieved by Q Lab in terms of generating ideas with potential to improve:

> [Q Lab] identifies key challenges and areas of opportunity for action; generates and refines ideas with a wide range of people and organisations, selecting a small number for prototyping and testing; creates opportunities for people to test new approaches, providing some practical support to take work forward. (Figure 2.3)

This achievement and impact area may not be entirely visible to participants yet: since the Evidence Hub will only be launched next year, and it had not been announced when many of the interviews were conducted, very few of our interviewees were aware of it. However, one participant who was involved in the development work around the Hub hoped that it would provide not only a valuable repository of knowledge for stakeholders in peer support, but would also have a symbolic role to highlight the value and raise the profile of peer support in the healthcare system:

> I suppose, the challenge is, getting [peer support] accepted within the medical system [...] And there’re more people who understand the value and the contribution that people with lived experience can bring to the organisation, and peer support, you know, roles are starting to develop [...] I think the hub, once that gets up and running [...] will have a big impact because it’ll engage with those people that are finding it difficult to engage with [new approaches and understanding different ways of working, really. (INT 019, Q Lab participant, distilling and sharing learning phase)

### 3.5.2. Q Lab raises the profile of the topic area

One of the impacts that the Q Lab has achieved in its pilot year has been to prepare the ground for change by attracting attention and providing visibility to the topic area. Through the Q Lab’s outreach work, and the endorsement offered by the Q community and the Health Foundation, the Q Lab has been able to raise the profile of the topic of peer support and to ‘legitimise’ improvement investments in the area. As phrased in the Q Lab impact model:

> [Q Lab] provides a platform that focuses collective energy and resources on the topic, raising the profile and generating momentum. (Figure 2.3)

In the second survey, participants were directly asked what outcomes the Q Lab had achieved in relation to peer support, and how participating in the Q Lab had impacted them directly. Of the 31 respondents, 12 felt that the Q Labs have ‘increased social capital for those involved with peer support, i.e. raised its
profile’, with five stating that they have personally ‘increased social capital due to the increased profile of peer support’.

Moreover, various Q Lab participants agreed that, by placing peer support at the centre of their first challenge, Q Lab has been successful in sensitising service users and carers to potential solutions to challenges, as well as system leaders to the importance of peer support. A large proportion of our interviewees spoke about the impact of Q Lab in creating momentum and energy around the topic, and legitimising it in the eyes of policy-makers and high-level stakeholders.

But the value, the relevance of […] peer support is something that is now going to become much more part of a currency, and part of an orthodoxy […] I’ll go back to that analogy of the boat. [Q Lab] has built a seaworthy boat and there is a high chance that over the next five or ten years perhaps, that that is a cornerstone of a very significant change in resources available to people, particularly those with long-term conditions. So I think the tangible outcomes so far are all about ideas and their currency, relationships and their energy, and a much better informed cohort to take these things forward. (INT 015, Q Lab participant, early distilling and sharing learning phase)

I don’t know if others live and breathe peer support, but we want it to go forward, and we need the validity of it to go forward, and I think the Q Labs will help that. (FG 004, Q Lab participant, March 2018 workshop)

It is important to note that the Health Foundation have now selected an external partner – the mental health charity Mind – to work with Q Lab. This should reinforce the legitimacy of the second Q Lab, and further enhance its presence in the topic area.

I think having an external partner […] will add weight and give credibility […] I don’t think it [the Q Lab approach] lacked weight, but I think by having an external partner you are kind of anchoring the approach […] Some of the partners that we’ve been exploring with there are some very credible national partners there that I think just worth weight will help anchor this process and will help add to the credibility. (INT 032, senior leader, distilling and sharing learning phase)

### 3.5.3. Q Lab increases individual and collective capabilities and generates motivation for action

As well as enhancing knowledge on, and raising the profile of the topic area, Q Lab seeks to provide participants with capabilities and a greater sense of agency that, in turn, will drive individual and collective action. As stated in the Q Lab impact model:

> [Q Lab] supports people to take action. [It] provides a developmental opportunity for those involved, through stimulating and creative environments that nurture new skills and increase morale; supports collaborations and meaningful relationships to flourish by reducing silo working and enabling people to work across professional boundaries; galvanises collective energy around ideas that are well-placed to impact health and care. (Figure 2.3)
The potential of Q Lab to achieve this impact came across very strongly in the interviews we conducted. Participants mentioned how working with Q Lab had enabled and empowered them, for example by giving them skills and confidence to enact change and make an impact in their own context in the future.

I've gone away [from the Lab workshop] and I've got […] the twin approaches of trying to persuade the commissioners using data and stories, but then also just seeing what exists in this county, and seeing if that can be spun up into a better peer-support mechanism. So that's work that's going on. It's quite hard to do, for me, but it's something that I wouldn't have been able to do without Q Lab, I don't think. And I've got some more skills and confidence to do it. (FG 004, Q Lab participant, March 2018 workshop)

The positive and supportive atmosphere that characterised the Q Lab workshops was described as a key contributing factor to enhancing participants’ confidence and self-efficacy; workshop attendees felt empowered by meeting and conversing with like-minded people, who were equally invested in the cause of peer support. Some of them described the Lab events as an opportunity to ‘recharge the batteries’ and reflect on opportunities for improving their current work; this was perceived as particularly valuable in the context of a pressured and under-resourced NHS.

I think, working in the NHS, it can be quite lonely sometimes. You’re not always amongst like-minded people. And it’s been great to get into the [Q Lab workshops], really, where you can kind of think out loud and explore new ideas and get support […] So, all those connections and that time together helps. And recharges your batteries, apart from anything else. The system can grind you down a little bit […] It's good to get out of that environment a little bit and just get some ideas flowing and get some energy back. (INT 019, Q Lab participant, early distilling and sharing learning phase)

Also included in this route to impact was a specific point on developing and nurturing relationships between stakeholders who might not otherwise be provided with opportunities for joint working, exchanging knowledge and spreading good practice (see Section 3.3.3). These relationships were seen both as a resource in themselves (in the form of participants’ enhanced mutual support and social capital) and as a means for mobilising change in the healthcare system.

[Q Lab] convenes a diverse group of people with experience and expertise on a topic, including relevant organisations and Q members. (Figure 2.3)

We’ll raise the profile and the level of connectivity between people interested in the topic. We’ll create new connections that will lead to things happening that it is unlikely would have happened as fast without us, without this happening […] I expect people working in peer support to find peer supporters from other people working in peer support. (INT 005, Q Lab team member, early research and discovery phase)

To build a supportive network [where people] could learn from one another, and nudge the practices around peer support across the wider world you could say. I think that’s the overall purpose kind of to help people to learn more, and I said already to network with one another. (INT 022, Q Lab participant, distilling and sharing learning phase)
Of the 31 respondents to the second survey, 22 said that participating in the Q Lab had enabled them to form new relationships and 19 stated that participation had enabled them to strengthen existing relationships. Among those forming new relationships, 12 said these enable ‘the development of new initiatives or collaborations’ in the field of peer support and elsewhere. Furthermore, 11 respondents said such relationships enable ‘learning from one another’, such as ‘sharing working practices and approaches on peer support’. Likewise for those strengthening existing relationships, 13 said it enables ‘new initiatives or collaborations’ and 14 stated it leads to ‘learning from one another’.

The Future Community Webinar, hosted by the Q Lab team in February 2018, confirmed the value that the Q Lab ‘peer support’ community had for those who worked closely with the Q Lab. When asked what they would like the community to look like after the end of the first Lab life cycle, the six webinar attendees discussed that their preferred scenario would be one where the community morphs into a ‘special interest group’ as part of Q, with a small number of Lab participants volunteering as community leads, encouraging and monitoring the use of the online space, and people using the space to discuss issues and make connections (DOC 041).

### 3.5.4. Q Lab disseminates and spreads ideas locally and nationally

Finally, the Q Lab hoped to achieve impact by disseminating ideas that are ready to be tested and implemented, either locally by individual Lab participants or in the wider healthcare system by relevant organisations and stakeholders; this route to impact seems to be the one most directly concerned with creating a tangible ‘system-level’ change. As described in the Q Lab impact model:

> [Q Lab] develops outputs that have relevance across the health and care community, with longevity beyond the Lab process; leverages routes to spread through Lab participants and Q community, and contributes insights on spread and adoption. (Figure 2.3)

The Q Lab sought to achieve this impact in a number of ways, including the dissemination of the Lab essays between May and August 2018 (the online collection of essays capturing learning and insights from the Q Lab pilot project), the work on the Evidence Hub conducted in partnership with stakeholders in the topic area, and the ‘light-touch’ support offered to participants to start their own peer support improvement work. This latter stream of work, initially branded as support for ‘self-started projects’, aimed to encourage and empower participants to build their own improvement ideas and solutions in the field of peer support following participation in the Lab process. Launched in September 2017, the call for self-started projects initially saw little uptake from Q Lab participants. The team reflected that this might have been due to a number of reasons:

> Our offer wasn’t entirely clear; Lab participants lack time to deliver a project; or participants simply weren’t aware of it. (DOC 021)

The team therefore decided to modify their offer, and, from March 2018, encouraged Q Lab participants to take part in Q Exchange, an initiative included in Q that invites improvement experts across the UK to propose project ideas that have the potential to generate value for the health and care system. Projects will be shortlisted by a selection panel, with final decisions on funding made by a group of around 400 Q members. This transparent (albeit competitive) process seeks to encourage participants to share and help others develop their ideas. The increased activity seen on the Q Lab online space since March 2018 seems
to suggest that this initiative is raising interest amongst Q Lab participants. However, it is still too early to assess whether the support offered by Q Lab via Q Exchange will result in workplace change and system-level improvement.

Given the experimental nature of the pilot Lab and its time-bounded nature, this impact level (i.e. generating new ideas and interventions with potential to improve) was unsurprisingly the one that was least visible to the Q Lab participants we spoke with. Most interviewees acknowledged the Q Lab’s contribution to increased learning and enhanced social and intellectual capital, but found it harder to articulate the Lab’s contribution to change in their working practices or contexts, and the broader peer support landscape.

I wonder where the initiatives go [...] I would question about embedding, you know... Where is it going to be embedded, where will we see it within a health setting. Maybe I’m being too practical or pragmatic [...] But... where does this actually lead us to? (INT 023, Q Lab participant, distilling and sharing learning phase)

I think our conclusion is likely to be that, in its current form, the Lab, however well it’s being done internally is insufficiently powered to reach meaningfully and deeply into those kinds of levels. (INT 027, senior leader, distilling and sharing learning phase)

The challenges experienced by Q Lab in making an impact in the health and care system (e.g. by affecting how peer support is commissioned and delivered in a day-to-day basis) were, in our judgement, unsurprising and are related to both the short life cycle of the Lab and the Lab participants lacking the needed power and agency in their organisation to bring change forward. Consistent with this, of the 28 respondents to the second survey who disclosed the necessary information, only three were classified as being in a senior position in their organisation, none of whom identified themselves as ‘very engaged’ or ‘extremely engaged’ with the Q Lab.

If you don’t get the right people in the room or those people haven’t got the agency for change they would need, that’s not going to come to fruition. So that one is very much about who is engaging with us, who are we reaching… (INT 004, Q Lab team member, early research and discovery phase)

I’m sorry to say, but it’s mostly women [...] and it’s probably patients, carers, nurses, members of the multi-professional team, but maybe not male doctors. [...] I mean, the people I work with, medics, there’s some who absolutely get it, but the majority don’t get it. [...] [This is a problem with] Lab approach, and I suppose particularly peer support, because unless you have people, let’s say with influence who are supporting the peer-support approach, then we’re not going to get anywhere with this, really. (INT 017, Q Lab participant, distilling and sharing learning phase)

The challenge is now putting it into practice, because all of us are doing this on top of our day-jobs, in a way, and so I’ve had to struggle, I’ve struggled to see how I can implement it and convince people to take it on board, when it’s something that I’m dipping in and out of [...] How to translate it in the local kind of context, without a full-time person, dedicated
person being able to go and do presentations and explain how it works and, if you like, coach people. (INT 016, Q Lab participant, distilling and sharing learning phase)

Relatively, some interviewees highlighted that, in the pilot year, the Q Lab has struggled to get the ‘critical influencers’ on board from the onset. Yet, there was little agreement on who those critical influencers are. One participant pointed out that the Lab work on improving access to peer support (i.e. the access survey) was highly valuable, but that she/he was struck by the lack of GPs at the Q Lab events.

We didn’t see GPs attending the Q Lab meetings [...] So, you know, we’re all in this room, great, we’re all energised, we really want to push on peer support, and, you know, are we pushing on closed doors, and people behind closed doors don’t want to open them, you know. (INT 021, Q Lab participant, distilling and sharing learning phase)

Two participants also highlighted that the Q Lab did not seem to be able to attract policy-makers, and that this ‘notable absence’ may have made it particularly hard to affect the wider healthcare system.23 Policy-makers were also absent from the respondents to the second survey, with no one in a primary role of ‘decision-maker or civil servant’ providing a response.

So the storytelling [work stream], I think there’s some useful resources for us internally. [But] I don’t think that it’s had an impact on convincing the powers that be that they shouldn’t just be looking at, you know, numbers, and they should really get to know people [...] [Q Lab] hasn’t [...] convinced any kind of commissioners or policymakers that this is a good way to go when collecting data. (INT 021, Q Lab participant, distilling and sharing learning phase)

I think there’s a missed opportunity [...] in getting more government policy makers involved... If they could allow a quota where they sort of target some key policymakers, then I think that joins it up. [...] If the policymakers aren’t in the laboratory... then I think that’s a missing bit of a jigsaw. (INT 024, Q Lab participant, distilling and sharing learning phase)

Similarly, NHS Improvement (despite it being a funding partner) had limited visibility and was rarely mentioned by respondents (except in the case of one senior respondent who commented on its relative absence). This may also have contributed to the perception of a missed opportunity for embedding the work of Q Lab into the NHS. One participant commented:

It’s interesting that Q Lab was part-funded by NHS Improvement, and to be quite honest they weren’t actually at the last workshop, or we haven’t actually had them saying ‘Right, this is how we’re going to take it forward... You know, as part of the NHS we’re going to help this, you know, we want this to impact upon our work.’ (INT 021, Q Lab participant, distilling and sharing learning phase)

23 We note that this finding may be influenced by the timing of our data collection, and that these views may have changed by the end of the first Lab life cycle.
Overall, and despite broad enthusiasm for the Q Lab approach, there was a sense among participants that some relevant impact areas had not been achieved, and this was often associated with a recognition of the scale of the challenge that the Lab team had set to themselves in the pilot year.

"I think probably [my hopes] weren’t achieved and I’m not sure that this is necessarily the fault of the Health Foundation, I think sometimes it just feels impenetrable trying to raise this stuff against the NHS and Social Care who are quite entrenched in what they do. (INT 021, Q Lab participant, distilling and sharing learning phase)"

"It’s always difficult, isn’t it, to quantify benefit. I mean, anecdotally, of course, we can all say there are benefits to this approach, but this is something that we struggle with again and again. [...] the people [...] with the power [...] and by that, I do mean the clinicians, the medics[...] they’re the people still with the power in healthcare, and actually, they’re very under-represented at days like this, because [...] I imagine, and I don’t want to speak for them, but I imagine they see it as like a soft approach. [...] But the problem is that we don’t always convince people that that approach is right, so then [...] we’re not really able to quantify benefit, and that’s the thing which we’re always up against, because some people still like numbers; they’re coming from it from a scientific, positivist approach. (INT 017, Q Lab participant, early distilling and sharing learning phase)"

The evaluation team, in accordance with some of our interviewees, suggest that this disappointment may be easily tackled in future iterations of the Q Lab approach by further specifying the (bounded) purpose of the Q Lab and by identifying, clear measures of success.

"I think with all quality improvements, particularly when you’re looking at these really complex challenges [...], how will you know that this endeavour has in and of itself contributed to a meaningful change at the coalface, in a sense? [...] You’ve got to try and find a measurement against that aim. (INT 015, Q Lab participant, distilling and sharing learning phase)"

These recommendations will be discussed in greater detail in Chapter 4.
4. Reflections and recommendations

We have argued that the Q Lab approach is dynamic and relational (see Section 2.3). Being dynamic places a premium on the Q Lab team being able to learn and adapt following each stage of redesign, and to rethink the approach to incorporate learning from the pilot stage. Success, in this context, depends not only on having a credible model but also on being able to revisit this model in the light of experience, feedback and evidence. A feature of the approach is also to create a sense of urgency and excitement by time-limiting each topic and this creates an added need for nimbleness. Funding an embedded evaluation and inviting the evaluation team into many decision-making forums is just one part of this. We have been impressed not only by the Q Lab team’s willingness to continuously engage with the evaluation team but also with their wider commitment to reflection and learning, which is given substance in how meetings are run, the adoption of learning logs, how approaches have been changed in response to feedback, and the role of the senior management at the Health Foundation in creating a safe space for this. In a real and significant sense, the Q Lab modelled the kind of approach to learning and improvement that they sought to encourage in others.

The dynamic and relational feature of the Lab approach also means that relationship building is not just a convenient and more pleasant way to organise activities but is actually core to delivering the approach. Attending to participants’ diverse needs is an important backdrop to helping them talk authentically about their experiences. However, building relationships with those with the leverage to change the system proved more difficult.

Overall, there is much that is positive to report as well as lessons to apply in the next iteration of the Q Lab. In the following sections we briefly reflect on our findings as detailed in the previous chapters before going on to make recommendations.

24 The importance of integrating dynamic explanations is discussed in Kriznik et al. (2018).
4.1. Key reflections on the evaluation questions

Is the Q Lab approach likely to become an effective, valuable way of developing ideas or interventions to support positive change at multiple levels of the health and care system?

This is the overarching question for the evaluation. Our conclusion is that not all improvement challenges would benefit from this model. For example, a specific and well-understood problem affecting patient flow and requiring a discrete set of actors to work differently together towards agreed goals might not benefit from an approach dedicated to brokering new relationships to unpack a complex problem and test solutions. We know that ‘although QI is frequently advocated as a way of addressing the problems with healthcare, evidence of its effectiveness has remained very mixed’ (Dixon-Woods & Martin 2016, p. 191) and that, more generally, many attempted innovations in health and social care fail to deliver the anticipated benefits (Herzlinger 2006). The Q Lab approach is therefore not entering an improvement landscape of universal success and at least in part this may be because good improvement approaches have been applied in the wrong context. The Q Lab approach is probably best suited where: 1) past efforts have been hampered by too narrow or too hurried an understanding of the problem; 2) not all the perspectives needed to develop solutions have been involved; and 3) securing collaboration across organisational and professional boundaries is key to success. For these situations, the Q Lab is based on sound principles and has potential to develop further as a methodology for supporting improvement in health and care.

However, the approach needs to be clearer about its goals, scope and boundaries to reach full potential and should avoid overreaching. In fact, the latest iterations of the impact model show that the Q Lab team has been moving towards the conclusion that an attempt to have immediate impact on the health system is too ambitious, and also risks undermining the unique role that a Q Lab can play. But, even in its most recent form, the Q Lab impact model does not make explicit its potential to exploit a valuable opportunity to mature a solution (or set of solutions) to the point where they can either be evaluated in studies or introduced in pilots by actors/stakeholders other than the Q Lab team.

What are the distinguishing features of the Q Lab approach, and what are the mechanisms through which Labs work?

The Q Lab, drawing inspiration from social innovation labs, makes a distinctive offer to the UK improvement landscape. It brings an inclusive approach to topic selection, a multi-perspective and sustained exploration of the problem, creative stakeholder engagement within an effective and psychologically safe platform, and – in the Health Foundation – the branding of a trusted, independent and well-networked host. Its topic-specific and time-bounded nature creates focus and energy. Although each of these features can be found elsewhere, their combination is powerful. However, we recommend experimenting with reproducing a similar combination of characteristics but more narrowly scoped (in, for example, mini-Q Labs based around a single AHSN).

One key mechanism to highlight is the Q Lab’s ability to leverage and bring together evidence, including both formalised evidence and people’s lived experience. The existence of a group of individuals with lived
experience of peer support who also had the time and commitment to engage was critical. Not all problems for which a Q Lab might otherwise be an answer will have such a potential group. The knowledge thus co-produced should not be thought of as simply two bodies of knowledge sitting alongside each other. Rather, as Filipe et al. (2017) note:

One way of going about the co-production of health care more meaningfully is to look at it as a dynamic, experimental, and reflective process sustained by different forms of engagement, interactions, and social relations and that may generate, in turn, new forms of care other than health care (e.g., inclusive relationships, solidarity), values beyond economic value (e.g., equity, justice), and new insights and research practices that are relevant to different disciplines and practices (e.g., community participation, patient advocacy, collaborative research).

It will also be important not only to continue to ensure that the Q Lab draws upon sound evidence but also that it actively contributes to this body of evidence (in the pilot year, this took the form, for example, of publishing the results of the survey exploring decision-making in peer support).

What resources, stakeholders, conditions and infrastructure are required to deliver a Q Lab effectively?

The Q Lab team were an important asset, providing planning, communications, creative events and relationship-building skills. They made best use of these skills by effective team working and task sharing. The team’s skillset means that, in future Lab cycles, they will be able to draw on creative and flexible approaches to tailor their activities and specific aims to the particular stakeholders and topic as appropriate. Over time, the Q Lab team is likely to develop an approach that is both experimental and emergent but that nevertheless draws on learning and practice that have been tried, stabilised and even entrenched in previous cycles.

As a dynamic approach, Q Lab required and delivered a capacity to learn and adapt. This was especially important in the pilot year but will almost certainly be necessary in any future Labs (on the grounds that the approach is inherently one of exploring knowledge that cannot be known in advance). Evidence of the Q Lab team’s learning process (and reflections on how to take this into Lab 2) can be found throughout this report and, for example, in DOC 043. That document provides the notes from a team meeting that the Q Lab team held on 11 April 2018 to review the pilot Lab and its achievements. Of note, the Q Lab team seem to have taken on board feedback from the March focus groups and write that they will have a small shift in focus next year on ‘Developing our approach to skills development and making this an explicit offer and framework for Lab participants’ (DOC 043).

How does the Q Lab engage participants? How valuable have participants perceived their participation to be?

Convening a range of diverse stakeholders is one of the mechanisms through which the Q Lab accomplishes its work, and the Q Lab team worked hard to identify relevant stakeholders. Their deliberately varied engagement approach, including both face-to-face events and online platforms, was
instrumental to involving individuals with different professional roles, time constraints and drivers to engagement, and confirmed the need for a customised engagement strategy.

Focus groups and interviews, as well as observations of events, highlighted the enthusiasm of Q Lab participants; those who felt engaged in the process were able to contribute meaningful insights and shape the Lab in important ways. It is difficult to be certain how widely this feeling was shared because of the low response rates to our second survey, in which we asked specifically about participant engagement (so we can say little about the distinctive attributes of the engaged and very engaged, for example). The design of events involved careful and detailed planning and while a minority found these overly complicated the overall view of participants was that the workshops facilitated engagement.

**How does the Q Lab fit within Q more widely, the Health Foundation and the broader health and care system?**

The Q Lab provides a home for those Q members (and others) who feel passionately about the topic or about the Q Lab approach. However, most Q members are not active Q Lab participants and many active participants are not Q members. Through the Q Exchange initiative, Q also provides a place where Lab participants can go for further funding (providing they either are or can work with Q members). Although our evaluation highlighted some degree of confusion among participants about the relationship between Q Lab and Q, and the potential for tension between the initiatives, this was not especially damaging. Nevertheless, we believe that the relationship between Q Lab, Q and the Health Foundation should be made clearer not only to participants but also to wider stakeholders.

In its pilot year, the Q Lab benefited from the reputation and branding of the Health Foundation and, most obviously, from the Foundation’s financial backing and the expertise of its senior staff. For the Health Foundation, the Q Lab offers a distinctive addition to its suite of improvement methodologies. Being part of Q was relevant but not critical to success. Nevertheless, it is possible to conceive of a Q Lab that is not associated with Q and the Health Foundation. As an approach, the associations with Q and the Health Foundation have guided the Q Lab’s principles (i.e. being inclusive, creative, people-centred, topic-specific and time-bounded) and are likely to have aided the pilot Lab in implementing the mechanisms of its programme theory (i.e. leveraging both formal knowledge and lived experience, convening a diverse group of stakeholders, and providing an effective and psychologically safe platform) (see Figure 2.4). However, neither Q nor the Health Foundation is intrinsic to the Q Lab’s programme theory. The Q Lab approach is sufficiently discrete that it may be possible to replicate the approach in other parts of the health and care system, as long as it retains its distinguishing features and mechanisms. This could mean a geographically bounded entity which otherwise replicates the conditions found in Q Lab.

**Does the Q Lab make a valuable contribution to achieving change alongside other approaches?**

The awareness of the patchy impacts of previous improvement activities (Ling et al. 2010) is keen within the Health Foundation and beyond, and there is an appetite to understand where and how new
approaches might fit. The Q Lab approach provides a new technique in the suite of improvement activities available to the wider health and care system. We have described above some of the characteristics that describe the ‘home ground’ of improvement labs and the circumstances that would make it an attractive offer. However, this position needs to be consolidated over time with ongoing evaluations.

The Q Lab faces a particular challenge in when and how best to involve those with formal power and leverage in the system and when and how to align their work with the priorities of the system. If the first workshops had been driven by existing priorities, and had the events been dominated by those with formal power and status, there is a significant risk that the inclusivity of views and the creativity of how they were discussed would have been compromised. The question is therefore how and when to align the creative thinking and the system priorities to maximise the chances that improved services and outcomes will be achieved. In the life cycle of each topic this may vary.

One other important question to explore is how resource-intensive improvement labs need to be in order to be effective (and relatedly, whether ‘mini-Q Labs’, with more narrowly focused briefs, could also be effective). The ‘vital ingredients’ of the Q Lab approach also warrant further specification. On that front the Q Lab team had already, in January 2018, begun working on this issue in planning for fidelity to the theory of change in the next Q Lab topic (DOC 040).

4.2. Key areas for action and recommendations

This final section identifies recommendations for the next stage in the development of Q Lab. It should be noted that these are not recommendations for how best to deliver an improvement Lab for peer support but about how to take the approach forward. Of course, this is complicated by the fact that any future topic, and future partners, would require specific adaptations to the approach. Among other things, the choice of partner is likely to have an impact on the Q Lab’s engagement strategy. For example, will being associated with a specific organisation change the inclusive and participatory features of Q Lab? Will only some people be attracted to participate (i.e. will the partner and its brand act as a ‘filter’)? Or, conversely, will the partner be able to attract a broader group of people, potentially better suited to make a change in current landscape?

Aware of these questions, we make the following concise recommendations for consideration by the Health Foundation management in particular but also the Q Lab team, the new partner organisation and wider stakeholders.

4.2.1. Keep the core elements in the Q Lab approach…

Reflecting the broadly positive tone of this report, we recommend continuity in many aspects of Q Lab’s approach. The time-bound and topic-specific nature of the Q Lab is central to the approach. Having a specific and dedicated team to lead and coordinate activities is necessary given that the collaborations required for success are not self-organising. However, the size and composition of this team may vary according to the topic and the selected partner. Maintaining variable links with other networks and groups is desirable – although we suggest below that this should be more strategic and phased. The consciously emergent approach and the commitment to learning that has characterised the first year
should continue – modelling the curiosity and openness Q Lab seeks to inspire in others – but should become more systematic and focused (see below). The techniques needed to support inclusivity and psychologically safe spaces for engagement should continue to be used (although possibly with less complex and more accessible processes). Branding and communications have been done well and will be needed going forward, not simply to promote the Q Lab brand but as a necessary part of relationship building.

4.2.2. But consider changing some important aspects

Goals and realism
In retrospect, the expectation that Q Lab should deliver – within the life of the topic-specific cycle – even initial signs of health and care system change was distracting and not realistic. The aims as articulated in the Q Lab team’s most recent impact model (Figure 2.3) are more achievable. However, if the Q Lab approach is to last, further work will be needed to understand how the outcomes identified in the impact model do in the end lead to benefits for service users and the health and care system.

Topic selection process
The process of topic selection benefits from being inclusive and open to inputs from many parties. We have reported on the general satisfaction with the approach. However, there was less clarity about the ultimate responsibility for topic selection, once different views had been considered. In our view, this should lie with the Q Lab team and this arrangement should be apparent to participants from the outset. The selection of the topic should therefore not be based on democratic popularity but upon clearly articulated principles identified in advance. These principles include, but may not be limited to: 1) relevance to the needs and desires of service users; 2) urgency and novelty, and evidence that the problem identified lacks existing evidence-based solutions; 3) an emphasis on systemic and complex issues; and 4) a sufficiently bounded and focused scope for impact and change.

A dynamic and phased approach to relationship building
Further consideration should be given to how to engage different groups and stakeholders at different stages in the Q Lab process: the Q Lab team should carefully consider what an ideal balance of different groups of stakeholders may be, as well as whether different types of stakeholders can best contribute in different phases of the cycle. Bringing in more individuals and groups with authority and system leverage early on runs the risk of inhibiting user voices and undermining the very good work done in the pilot Q Lab to establish an inclusive and creative space for service users and carers. However, system changers need to be included in the process and be part of the conversation, especially in the later stages of the Q Lab cycle building towards change. A strategic approach to how and when to engage key potential partners should be agreed early on, with particular reference to royal colleges, third sector bodies, AHSNs, Q and the THIS Institute.25 Q Lab should recognise and solicit the benefits of the abrasion of conflicting perspectives and avoid seeking a comfortable consensus. In the next Q Lab, it will also be important to

25 For more on the THIS Institute, see: https://www.thisinstitute.cam.ac.uk/
define and articulate the contribution and role of the partner organisation with particular attention to the question of where and how to ensure the coming together of lived experience with system leverage.

**Communicating what success looks like**

Participants – even those who were otherwise very happy with their engagement – expressed concern that they were unclear what success would look like for the pilot year. This was understandable, given the emergent nature of the pilot, but would be less excusable going forward.

**Contributing to the evidence**

The long-term impact of Q Lab requires, among other things, the building of an evidence base for the approach being developed. Testing new ideas within Q Lab is not only about the acceptability of ideas that emerge but also about the hard evidence that they have the impacts claimed for them. Therefore engaging with researchers and sponsoring experiments that are separately evaluated within the work of the Lab would make an important contribution to achieving long-term change. Since we know that evidence on its own does not deliver change, embodying rigorous data collection within a wider change process has considerable appeal.

A second dimension of data collection concerns evidence about the effectiveness of the improvement Lab approach. The evaluation reported here makes an initial contribution, but further evidence of effectiveness (or not) will be needed to justify the considerable investment in the approach. We suggest that rather than evaluating the approach as a whole, it might be worth identifying specific aspects of the change process with high impact but also with high uncertainty. For example, much more is now known by the Q Lab team about the format for engaging participants in creative ways and while this is important it is less uncertain. However, understanding how participants take insights learned and use them in health and social care – and how they use them to engage others in discussion and change – is also important but less well known (how far does the ripple effect extend?).

**Building learning capacity through partnership working**

We commented favourably above on the Q Lab team’s commitment to learning and adaptation during the pilot year and recommend that this continues. However, in working with a partner organisation a new dimension will be introduced, reflecting the need for mutual learning between Q Lab and the partner organisation, and between both and wider organisations. The capacity of the partnership to perform well is likely to be observable in four dimensions: decision-making capacity; managerial capacity; networking and cooperation capacity; and system engagement and alignment (Haarich 2018). This requires, in addition to building on this evaluation, a more topic-specific evaluation of the partnership.

**Completing an early skills audit**

Moving into partnership working may require some re-balancing of the skills needed to deliver the work. It would be helpful early on in the process to conduct a skills audit and to identify gaps and duplication of skills in the partnership and to make changes to the Q Lab team accordingly.


Independent evaluation of the Q Improvement Lab


Annex A. Overview of data sources

This annex provides an overview of data sources for the evaluation. Table A.1 gives information on the observations conducted; Table A.2 the interviews conducted; Table A.3 the focus groups conducted; Table A.4 the surveys; and Table A.5 the documents reviewed.

Table A.1. Observations conducted

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<th>Location</th>
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</thead>
<tbody>
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<td>5 May 2017</td>
<td>Q Lab office, London</td>
</tr>
<tr>
<td>OBS 002</td>
<td>2 June 2017</td>
<td>Q Lab office, London</td>
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<td>OBS 003</td>
<td>8 June 2017</td>
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<td>22 June 2017</td>
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<td>OBS 005</td>
<td>13–14 July 2017</td>
<td>Barbican, London (workshop location)</td>
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<td>OBS 006</td>
<td>27 July 2017</td>
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<td>OBS 007</td>
<td>10 August 2017</td>
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<td>OBS 010</td>
<td>1 November 2017</td>
<td>Q Lab office, London</td>
</tr>
<tr>
<td>OBS 011</td>
<td>15 November 2017</td>
<td>Q Lab office, London</td>
</tr>
<tr>
<td>OBS 012</td>
<td>5 December 2017</td>
<td>Etc.venues Maple House, Birmingham (workshop location)</td>
</tr>
<tr>
<td>OBS 013</td>
<td>14 December 2017</td>
<td>Q Lab office, London</td>
</tr>
<tr>
<td>OBS 014</td>
<td>17 January 2018</td>
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</tr>
<tr>
<td>OBS 015</td>
<td>21 February 2018</td>
<td>Q Lab office, London</td>
</tr>
<tr>
<td>OBS 016</td>
<td>21 March 2018</td>
<td>BMA House, London (workshop location)</td>
</tr>
</tbody>
</table>

Source: RAND Europe
## Table A.2. Interviews conducted

<table>
<thead>
<tr>
<th>Interview reference</th>
<th>Phase</th>
<th>Interviewee(s) category</th>
</tr>
</thead>
<tbody>
<tr>
<td>INT 001</td>
<td>Research and discovery phase</td>
<td>Q Lab team member</td>
</tr>
<tr>
<td>INT 002</td>
<td>Research and discovery phase</td>
<td>Q Lab team member</td>
</tr>
<tr>
<td>INT 003</td>
<td>Research and discovery phase</td>
<td>Q Lab team member</td>
</tr>
<tr>
<td>INT 004</td>
<td>Research and discovery phase</td>
<td>Q Lab team member</td>
</tr>
<tr>
<td>INT 005</td>
<td>Research and discovery phase</td>
<td>Senior leader from Q, THF or NHSI</td>
</tr>
<tr>
<td>INT 006</td>
<td>Developing and testing phase</td>
<td>Q Lab team member</td>
</tr>
<tr>
<td>INT 007</td>
<td>Developing and testing phase</td>
<td>Q Lab team member</td>
</tr>
<tr>
<td>INT 008</td>
<td>Developing and testing phase</td>
<td>Q Lab participant</td>
</tr>
<tr>
<td>INT 009</td>
<td>Developing and testing phase</td>
<td>Q Lab participant</td>
</tr>
<tr>
<td>INT 010</td>
<td>Developing and testing phase</td>
<td>Senior leader from Q, THF or NHSI</td>
</tr>
<tr>
<td>INT 011</td>
<td>Developing and testing phase</td>
<td>Senior leader from Q, THF or NHSI</td>
</tr>
<tr>
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<td>Developing and testing phase</td>
<td>Q Lab participant</td>
</tr>
<tr>
<td>INT 013</td>
<td>Developing and testing phase</td>
<td>Two Q Lab team members</td>
</tr>
<tr>
<td>INT 014</td>
<td>Developing and testing phase</td>
<td>Q Lab team member</td>
</tr>
<tr>
<td>INT 015</td>
<td>Distilling and sharing learning phase</td>
<td>Q Lab participant</td>
</tr>
<tr>
<td>INT 016</td>
<td>Distilling and sharing learning phase</td>
<td>Q Lab participant</td>
</tr>
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<td>INT 017</td>
<td>Distilling and sharing learning phase</td>
<td>Q Lab participant</td>
</tr>
<tr>
<td>INT 018</td>
<td>Distilling and sharing learning phase</td>
<td>Q Lab participant</td>
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<tr>
<td>INT 019</td>
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<td>Q Lab participant</td>
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<td>INT 023</td>
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<td>Q Lab participant</td>
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<td>INT 027</td>
<td>Distilling and sharing learning phase</td>
<td>Senior leader from Q, THF or NHSI</td>
</tr>
<tr>
<td>INT 028</td>
<td>Distilling and sharing learning phase</td>
<td>Q Lab participant</td>
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<td>INT 029</td>
<td>Distilling and sharing learning phase</td>
<td>Q Lab participant</td>
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<td>INT 030</td>
<td>Distilling and sharing learning phase</td>
<td>Q Lab participant</td>
</tr>
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<td>INT 031</td>
<td>Distilling and sharing learning phase</td>
<td>Three Q Lab team members</td>
</tr>
<tr>
<td>INT 032</td>
<td>Distilling and sharing learning phase</td>
<td>Senior leader from Q, THF or NHSI</td>
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Table A.3. Focus groups conducted

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<th>Location</th>
</tr>
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<tbody>
<tr>
<td>FG 001</td>
<td>14 July 2017</td>
<td>Barbican, London</td>
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<tr>
<td>FG 002</td>
<td>21 March 2018</td>
<td>BMA House, London</td>
</tr>
<tr>
<td>FG 003</td>
<td>21 March 2018</td>
<td>BMA House, London</td>
</tr>
<tr>
<td>FG 004</td>
<td>21 March 2018</td>
<td>BMA House, London</td>
</tr>
<tr>
<td>FG 005</td>
<td>21 March 2018</td>
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Table A.4. Surveys conducted

<table>
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<th>Survey reference</th>
<th>Dates</th>
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<tr>
<td>SUR 001</td>
<td>July to August 2017</td>
<td>66 [132]</td>
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<tr>
<td>SUR 002</td>
<td>January to March 2018</td>
<td>31 [199]</td>
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Table A.5. Documents reviewed

<table>
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<tr>
<th>Document number</th>
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<th>Source</th>
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<tbody>
<tr>
<td>DOC 001</td>
<td>Labs design story</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 002</td>
<td>Option for choosing a topic area</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 003</td>
<td>Documenting the longlisting process</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 004</td>
<td>Lab workshop: synthesis and next steps</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 005</td>
<td>Q Lab email to Q Lab participants, August 2017</td>
<td>Email</td>
</tr>
<tr>
<td>DOC 006</td>
<td>Choosing lab topics</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 007</td>
<td>Outcome mapping draft 2</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 008</td>
<td>Brief - access to peer support FINAL</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 009</td>
<td>Brief - evidence of lived experience_FINAL</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 010</td>
<td>Brief – sharing what does and doesn’t work FINAL</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 011</td>
<td>Ranking the solutions</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 012</td>
<td>Unpacking the ideas</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 013</td>
<td>Access Survey – Overview</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 014</td>
<td>Developing and testing visual</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 015</td>
<td>Q Lab team learning logs for September 2017</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 016</td>
<td>Q Lab team learning logs for October 2017</td>
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</tr>
<tr>
<td>DOC 017</td>
<td>Q Lab team learning logs for November 2017</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 018</td>
<td>Q Lab team learning logs for December 2017</td>
<td>Huddle</td>
</tr>
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<td>DOC 019</td>
<td>Q Lab workshop slides – 5 December (AM)</td>
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</tr>
<tr>
<td>DOC 020</td>
<td>Q Lab routes to impact slides for discussion</td>
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</tr>
<tr>
<td>DOC 021</td>
<td>Lab community brief (Oct 2017)</td>
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</tr>
<tr>
<td>DOC 022</td>
<td>Birmingham workshop – Agenda and attendees list</td>
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<tr>
<td>DOC 023</td>
<td>Christina feedback on survey questions – 25 October 2017 EL</td>
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<td>DOC 024</td>
<td>Q Lab learning logs for January 2018</td>
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<td>DOC 025</td>
<td>Access survey comms plan</td>
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</tr>
<tr>
<td>DOC 026</td>
<td>Approach to disseminating the findings</td>
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</tr>
<tr>
<td>DOC 027</td>
<td>Discussing Lab 2</td>
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<tr>
<td>DOC 028</td>
<td>Distilling and sharing learning – comms plan</td>
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</tr>
<tr>
<td>DOC 029</td>
<td>Distilling and sharing learning phase</td>
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</tr>
<tr>
<td>DOC 030</td>
<td>Draft proposal – partner facing</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 031</td>
<td>Exercise 1 reviewing connections with Q</td>
<td>Photo taken during observation</td>
</tr>
<tr>
<td>DOC 032</td>
<td>Exercise 1 reviewing existing meetings</td>
<td>Photo taken during observation</td>
</tr>
<tr>
<td>DOC 033</td>
<td>Exercise on “What would success look like?”</td>
<td>Photo taken during observation</td>
</tr>
<tr>
<td>DOC 034</td>
<td>Peer Support Access Survey – Key Questions</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 035</td>
<td>Theory of change – 1</td>
<td>Photo taken during observation</td>
</tr>
<tr>
<td>DOC 036</td>
<td>Theory of change – 2</td>
<td>Photo taken during observation</td>
</tr>
<tr>
<td>DOC 037</td>
<td>1 – Labs monthly dashboard – DEC JAN 2018</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 038</td>
<td>Q Lab learning logs for February 2018</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 039</td>
<td>18022-Q-Labs-Booklet</td>
<td>Huddle</td>
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<tr>
<td>DOC 040</td>
<td>Design questions for Lab 2</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 041</td>
<td>Future Community Webinar</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 042</td>
<td>Lab 1 week by week</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 043</td>
<td>Lab 2 design questions – progress document</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 044</td>
<td>Notes from team meeting – learning on Lab process</td>
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<tr>
<td>DOC 045</td>
<td>Q Lab learning logs for March 2018</td>
<td>Huddle</td>
</tr>
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<td>DOC 046</td>
<td>Q Lab learning logs for April 2018</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 047</td>
<td>Impact Tracker as of December 2017</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 048</td>
<td>Summary – March workshop write-up</td>
<td>Email</td>
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<tr>
<td>DOC 049</td>
<td>Using stories to build the evidence base for peer support</td>
<td>The Health Foundation website</td>
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<tr>
<td>DOC 050</td>
<td>What we’ve learned about peer support – Insights from the Q Lab (working document April 2018)</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 051</td>
<td>Impact model – April 2018 iterations</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 052</td>
<td>Lab online space scoping paper (Nov 2017)</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 053</td>
<td>Impact model – for discussion on 22 Feb</td>
<td>Huddle</td>
</tr>
<tr>
<td>DOC 054</td>
<td>Essay 1 What is the Q Improvement Lab?</td>
<td>The Health Foundation website</td>
</tr>
<tr>
<td>DOC 055</td>
<td>Essay 2 Learning and insights on peer support</td>
<td>The Health Foundation website</td>
</tr>
<tr>
<td>DOC 056</td>
<td>Essay 3 How do people make decisions in peer support?</td>
<td>The Health Foundation website</td>
</tr>
</tbody>
</table>

Source: RAND Europe
Annex B. Interviewee selection approach

This annex sets out the interviewee sampling approach taken for the interviews in the second round of data collection.

Participants selected purposively

The Q Lab team has provided a list of 14 participants whom they consider to be highly engaged and who will therefore be able to provide detailed views on the Q Lab based on close involvement with the process. From that list we will purposively select and interview seven participants who represent a variety of backgrounds and have expertise in and experience of peer support.

Participants selected randomly based on survey responses

We will randomly select interviewees based on responses to two questions from the survey conducted in July–August 2017. We will ensure that for each possible response to those questions there are a certain minimum number of interviewees who selected that response. These questions, responses and minimum quotas are shown in the table below.

<table>
<thead>
<tr>
<th>Question</th>
<th>Possible responses</th>
<th>Minimum quota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking into account how much time you have available, how active would you like to be within the Q Lab over the coming year?</td>
<td>Contributing significantly to help shape the Q Lab (e.g. attending workshops, contributing to research, testing new ideas in your organisation)</td>
<td>If fewer than two of the highly engaged participants suggested by the Q Lab team selected this option on the survey, then more respondents will be selected to make the total at least two</td>
</tr>
<tr>
<td></td>
<td>Occasional contribution towards helping shape the Q Lab</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Occasional use of a small number of resources and activities</td>
<td>2</td>
</tr>
<tr>
<td>How does your relationship with each of the following people support the aims of the Q Lab? [One question per reported connection]</td>
<td>Learn from them</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Collaborate with them</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Inspired/encouraged by them</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Environment improved by them</td>
<td>1</td>
</tr>
</tbody>
</table>

The sampling will proceed as follows:

- Order all survey respondents uniformly at random.
- Working down the list of respondents one at a time, if the respondent gives a response that has not yet reached its minimum quota, select them to be interviewed.
This will give between four and ten interviewees, and most likely five or six.

Participants selected completely at random

To make sure that all Q Lab participants have a chance of being selected – even if the Q Lab team has not identified them as highly engaged or they have not responded to the survey – we will select some participants completely at random. These will be selected from the 118 people who have participated at least at a low level, and specifically if they have:

- Attended the 16 March workshop
- Participated in the 23 May webinar
- Participated in the 14 June webinar
- Attended the July workshop
- Attended the December workshop
- Participated in the 20 October webinar
- Created a Q Lab profile
- Joined the Q Lab online space.

The evaluators will randomly select enough interviewees to take the total number of interviewees to 18. If at least nine of the interviewees selected purposively and from the survey were survey respondents, then the randomly selected interviewees will be selected only from survey non-respondents; otherwise, they will be chosen so that there are nine survey respondents and nine survey non-respondents among the list of 18 interviewees.
This annex presents the interview and focus group topic guides. The interview topic guides include separate protocols for Q Lab team members, participants and other stakeholders.

C.1. Interview topic guide – Q Lab team

SAMPLE QUESTIONS FOR SEMI-STRUCTURED INTERVIEWS

1. Introductory questions
   - How long have you worked with the Lab?
   - What is your present role at the Lab?
   - What does a ‘normal’ working day look like for you?

2. Distinguishing features, mechanism and approach of Lab
   - If you had to describe what Lab is, in only one sentence…. 
   - What is your understanding of the mission of Lab? What values underpin this mission?
   - Can you tell me about the ‘Lab approach’ – how would you describe the culture around here? (explore consistency/congruence with mission, etc.)
   - How is learning produced?
   - How are decisions made at the Lab (deliberate/mandate approach, how are people consulted)? (Explore leadership – does it overlap with formal roles, or is it charismatic/spontaneous?)
   - What do you think are the benefits of the approach you described? And what the potential challenges? (e.g. Does it engage people, generate sense of ownership, contribute to achieve the Lab aims, incentivise participation, allow bridging boundaries, nurture relationships?)

3. Key actors, networks, relationships
   - Who do you interact more frequently with (face-to-face, mail, etc.)?
   - What are the external stakeholders of Lab (maybe, ask them to show stakeholders map and discuss based on that)?
   - What are the main ‘external influencers’ of Lab? What actors/organisations/forces shape the work of Lab?
   - How ‘valuable’ is Lab to its stakeholders, you think?
Do you think Lab’s external stakeholders have a good understanding of the work you do/the value you produce? (If this could improve, explore how.)

Has the Lab formed new communities/networks so far?

What are the barriers and facilitators to the formation of useful relationships by Q lab?

How does the Lab fit in the wider Q community, Health Foundation? (Explore gaps or duplication, how Lab fits alongside other initiatives?

What do you think the role of Lab will be in linking with the broader healthcare system?

What resources, conditions and infrastructure as identified are required to deliver a Lab effectively?

What are the resources, conditions, infrastructure, the tools that the Lab need in order to be successful? Material (appropriateness of space, working tools, infrastructure, money, etc.) and immaterial resources (time, power, relationships, etc.).

What resources are you happy with and what are currently lacking you think?

How does that impact on Lab work/ What do you think should happen to obtain these resources?

What is generated in Lab meeting that wasn’t there before (tangible outcomes and value perceived by participants)?

Explore: new knowledge/evidence, a forum for exchange ideas – make different perspective converge that would not meet otherwise, new practices/interventions to be tested/solutions to a known problem, new tools/methods to test interventions/solutions.

What are the outcomes you expect to achieve during the next months/year?

Conclusions (test for unexplored areas, anything to add).

C.2. Interview topic guide – Q Lab participants

Introductory questions

1. Role, organisation.

2. How did you learn about the Lab?

3. How long have you known the Lab for?

Distinguishing features, mechanism and approach of Lab

4. If you had to describe what Lab is, in only one sentence…..

5. What is your understanding of the mission of Lab? What values underpin this mission?

6. What do you think are the benefits of the approach you described? And what the potential challenges? (e.g. Does it engage people, generate sense of ownership, contribute to achieve the Lab aims, incentivise participation, allow bridging boundaries, nurture relationships?)

7. How does the Lab fit in the wider Q community, Health Foundation/NHSI? (Explore duplication, how Lab fits alongside other initiatives, what Lab adds and whether there is any ‘gap’ that Lab is filling.)
8. What do you think the role of Lab will be in linking with the broader healthcare system?

Involvement, relationships, and routes to engagement

9. Through what means/channels are you involved in the Lab’s work? (e.g. attending workshop, email, phone, online space, others.)
10. ‘Who’ is the Lab, in your experience? What are the main people you interact with?
11. When did you feel more involved in Q Lab work? (Give examples of what phase/event/activity.)
12. Has the Lab allowed you to meet people you did not know before?
13. Have you maintained contact with other Lab participants? (Explore ongoing relations, collaborations and through what channels.)
14. Do you feel that you had a role in widening the Lab participants group?
15. What are the barriers and facilitators to the formation of useful relationships with other Lab participants?
16. In your opinion, is there anything that the Lab team can do to improve involvement/engagement in their work?

Outcomes

17. What were your own hopes and expectations when you started working with the Lab? Were these achieved?
18. What tangible outcome has the Lab achieved, in your opinion [Explore first with no prompts, then explore 1) specific briefs 2) new knowledge/evidence 3) creating a forum for exchange ideas, 4) sharing new practices/interventions to be tested/solutions to a known problem (self-started projects), 5) new tools/methods to test interventions/solutions].
19. Did you feel that you had an active role in helping the Lab achieving these outcomes?

Conclusions

20. As you may know, the Q Lab team has obtained funding for a second Lab, which will focus on a new topic. Do you think the learning generated through the pilot year will help the next Lab to succeed?
21. Do you have any recommendation for the team (keep doing, stop doing)?

C.3. Interview topic guide – external stakeholders

Introductory questions

1. Role, organisation
2. What is your relationship to the Q Lab?

Main prompts/questions

3. What were your initial hopes and expectations related to the Q Lab?
4. What would you consider as a ‘success’ for the Q Lab?
5. How can the evaluation help to demonstrate that those results have been achieved/to what extent they have been achieved?
C.4. Focus group topic guides

**Focus group, Barbican workshop, July 2017**

**Prompts/questions:**

- What brought you here today?
- Workshop feedback.
- Feedback on Theory of Change.
- What’s your vision on what a successful Lab would look like? What does the Lab needs to do to get there?
- Who needs to support this/ who could help you to mobilise change?/ what is the role of policy?
- Who does the Q Lab need to bring in to build presence/endowment?
- What’s the value of the Lab?
- Elements that support/undercut the Lab’s effort to be a success.

**Focus groups, BMA House workshop, March 2018**

‘Stories of impact’ groups

**Aim:** Explore participants’ own experience of participating in the Q Lab and impacts they have seen. Encourage participants to share their reflections in the form of stories.

**Warm-up activity** (using prompt cards): If Q Lab was a means of transportation helping you to get to where you want to go, how would you describe it?

**Prompts/questions:**

- What were your own hopes and expectations when you started working with the Lab? Were these achieved? How?
- What tangible outcome has the Lab achieved, in your opinion? Can you point to any documentary evidence showing these outcomes?
- Did you participate in any specific brief?
- Did you feel that you had an active role in helping the Lab achieving these outcomes?

‘Impact model’ focus groups

**Aim:** Take an analytical approach to examine the activities and short-term impacts of Q Lab as described in the Impact model.

**Warm-up activity** (using prompt cards): Choose a postcard that for you represents the Q Lab.

**Structure:** Break into smaller groups of 3–4 participants to reflect on the achievements and activities using the following. Report back to plenary after each prompt.

**Prompts/questions:**

- In light of your understanding of quality improvement and your experience of the Q Lab to date, which parts of the impact model make more/less sense to you?
- Are any parts unclear?
- Is it complete?
Introduction

RAND Europe, in collaboration with the University of Cambridge, has been commissioned by the Health Foundation to carry out an independent evaluation of the Q Improvement Lab (‘Q Lab’) until the summer of 2018. As part of this evaluation process we are carrying out two rounds of surveys with Q Lab participants; one at the early stages of the evaluation (round 1, July 2017) and one at the end stage (round 2, March 2018). The current survey is the first of these two rounds. The evaluation team at RAND is independent from the Q Lab project team and the Health Foundation and data collected will be stored on RAND servers in the UK and in the US. While this survey is not anonymous, individually identifiable survey responses and linked data will not be shared outside RAND (and will not be shared with the Q Lab project team or Health Foundation), unless consent is explicitly given (and unless it regards the workshop data, see below). Summary findings will be shared and will be published as part of evaluation reports.

RAND adopts good industry practices regarding the protection of personal data as part of its obligations as a Data Controller under the Data Protection Act 1998 and takes appropriate technical and organisational measures to align these with ISO 27001:2013 to protect personal data. Respondents to this survey have the right to oppose, have access to, rectify or remove personal or sensitive personal data held by RAND.

This survey also contains questions relating to the Lab workshop that was held on 13 and 14 July (Section 1). These questions need only be answered by those who attended the workshop. The data collected from these questions will be shared with the Q Lab team and will be stored securely on the Health Foundation servers.

Please send any questions about the survey or the evaluation process to the Professor Tom Ling (Principal Investigator) by emailing tling@rand.org or phoning +44 (0)1223 353 329.

Thank you very much for taking part in this survey.
SECTION 1

Please note that data provided by you in this section will be shared with the Q Lab team.

Feedback Q Lab workshop

1. Did you attend the Q Lab workshop on 13-14 July 2017?

☐ Yes
☐ No

IF A1 = YES:

2. Overall, how would you rate the workshop?

☐ 1 (Very poor) (1)
☐ 2 (2)
☐ 3 (3)
☐ 4 (4)
☐ 5 (5)
☐ 6 (6)
☐ 7 (7)
☐ 8 (8)
☐ 9 (9)
☐ 10 (Excellent) (10)

Free text: If you’d like to share any comments on your rating, please do so here OPEN TEXT BOX
3. How helpful was the workshop for:

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<thead>
<tr>
<th></th>
<th>1 (Not at all helpful)</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 (Very helpful)</th>
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<tr>
<td>Increasing your understanding of</td>
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<td>the Q Lab? (1)</td>
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<td>Developing connections with people</td>
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<td>working on similar issues to you?</td>
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<td>Introducing you to new tools or</td>
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<td>approaches? (3)</td>
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<td>Generating new ideas for, or new</td>
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<td>perspectives around peer support</td>
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<td>(4)</td>
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4. Based on your experience of the workshop, what advice should we pass onto the team who are designing and delivering the Q Improvement Lab?

OPEN TEXT BOX

IF A1 = NO:

5. Did you follow the activities and discussions at the workshop via any of the following: [multiple choice]

☐ Twitter

☐ Live blog on the Q Website

☐ Other OPEN TEXT BOX

6. Do you have any reflections on anything you heard about the workshop?

OPEN TEXT BOX
SECTION 2

Please note that data provided by you in this section will not be shared with the Q Lab team unless you explicitly provide your consent at the end of the survey.

A. Your participation in the Q Lab

1. To date, have you been involved in the Q Lab in any form?
   □ Yes
   □ No

2. Under what circumstances would you want and be able to engage with the Q Lab?
   OPEN TEXT BOX

3. How did you become aware of the Q Lab?
   □ Via my Q membership
   □ Through someone I know in Q
   □ Via the Health Foundation website or newsletter
   □ I was approached by the Q Lab team to take part
   □ Social media
   □ Other – please specify OPEN TEXT BOX

4. What support do you have from your employer, or elsewhere if not employed, to participate in Q Lab events and activities?
   □ Protected time
   □ Study leave
   □ Annual leave
   □ Unpaid leave
   □ None
   □ Don’t know
   □ Other – please specify OPEN TEXT BOX

5. Taking into account how much time you have available, how much time would you like to spend on the Q Lab over the next year?
RAND Europe

☐ Less than 1 day
☐ 1–3 days
☐ 4–6 days
☐ 7–10 days
☐ More than 10 days

6. How active have you been within the Q Lab since April 2017??
☐ Contributing significantly to help shape the Q Lab (e.g. attending a workshop, contributing to research, etc.)
☐ Occasional contribution towards helping shape the Q Lab
☐ Occasional use of a small number of resources and activities
☐ Other – please specify OPEN TEXT BOX

7. Taking into account how much time you have available, how active would you like to be within the Q Lab over the coming year?
☐ Contributing significantly to help shape the Q Lab (e.g. attending workshops, contributing to research, testing new ideas in your organisation, etc.)
☐ Occasional contribution towards helping shape the Q Lab
☐ Occasional use of a small number of resources and activities
☐ Other – please specify OPEN TEXT BOX

8. If you wish to add any comments to your responses, please enter them here.
OPEN TEXT BOX

B. Mission of the Q Lab

9. Please rank the elements of the Q Lab’s mission below in order of importance to you.
☐ Forming new relationships and collaborations with organisations and/or individuals around a specific topic
☐ Developing people’s skills and abilities to tackle complex problems in health and care
☐ Developing a deep understanding of particular challenges through building evidence, generating ideas and testing solutions (for example around peer support)
☐ Other – please specify OPEN TEXT BOX
10. In your understanding, what values does the Lab display?

OPEN TEXT BOX

11. If you had to describe in one sentence what the Q Lab is, what would this be?

OPEN TEXT BOX

12. Has the Q Lab contributed to you forming new relationships/collaborations so far?

☐ Yes – please specify the relationship/collaboration: OPEN TEXT BOX
☐ No – and I do not expect this to happen over the coming year
☐ No – too early to say
☐ Don’t know

13. If yes, on a scale from 1 to 5 (where 1 is low quality and 5 high quality), how would you rate the quality of these connection developed so far?

☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ Too early to say

14. To what extent do you think that similar initiatives to the Lab exist in health and care? If so, what are they and what are the similarities and/or differences? (e.g. the Q community, the Health Foundation)

OPEN TEXT BOX

C. Future of the Q Lab

15. Do you expect the Q Lab to contribute to forming new relationships/collaborations over the next year?

☐ Yes
If you have any thoughts on the type of relationships/collaborations you expect to emerge, please add them here: OPEN TEXT BOX
☐ No
If you have any thoughts on why you do not think this will be the case, please add them here OPEN TEXT BOX
☐ Don’t know

16. What are your top three reasons for being part of the Q Lab? If you have fewer than three, then please leave the remaining boxes blank.

**First reason (drop-down menu)**
☐ Forming new relationships and collaborations with organisations and/ or individuals working on peer support
☐ Developing people’s skills to tackle complex problems in the health and care system
☐ Developing a deep understanding of a particular challenge through building evidence, generating ideas and testing solutions (for example around peer support)
☐ Being part of a new, innovative initiative
☐ Other – please specify OPEN TEXT BOX

**Second reason (drop-down menu)**
☐ Forming new relationships and collaborations with organisations and/or individuals working on peer support
☐ Developing people’s skills to tackle complex problems in the health and care system
☐ Developing a deep understanding of particular challenges through building evidence, generating ideas and testing solutions (for example around peer support)
☐ Being part of a new, innovative initiative
☐ Other – please specify OPEN TEXT BOX

**Third reason (drop-down menu)**
☐ Forming new relationships and collaborations with organisations and/or individuals working on peer support
☐ Developing people’s skills to tackle complex problems in the health and care system
☐ Developing a deep understanding of particular challenges through building evidence, generating ideas and testing solutions (for example around peer support)
☐ Being part of a new, innovative initiative
☐ Other – please specify OPEN TEXT BOX
17. Going forward, how will the Q Lab enable you to contribute to effective and sustainable improvements in health and care in the UK, if at all?

OPEN TEXT BOX

18. What would be a barrier to the Q Lab contributing to effective and sustainable improvements in health and care in the UK in terms of the internal working of Q Lab? Please give specific examples if possible.

OPEN TEXT BOX

19. What would be a barrier to the Q Lab contributing to effective and sustainable improvements in health and care in the UK in terms of the environment it operates in? Please give specific examples if possible.

OPEN TEXT BOX

20. If you could change one thing about the Q Lab, what would this be?

OPEN TEXT BOX

D. Social Network Analysis

21. On a scale of 0–10, how important is the network of Q Lab participants specifically (as opposed to your wider network) for each of the following? 0 means that this is not something the network will contribute towards; 10 means that this is the main function of the network.
   a. Spreading an understanding of the problems to be solved
   b. Bringing together knowledge needed to solve problems
   c. Bringing together skills needed to solve problems
   d. Spreading an understanding of solutions to problems
   e. Nurturing receptive conditions for solutions to scale up
   f. Supporting normalisation of solutions at scale

22. How do your connections with each of the following people support the aims of the Q Lab? Please leave blank if you do not have a connection with that person or if that connection does not support the aims of Q Lab. Please select all that apply. [Learn from; Collaborate with; Inspired/encouraged by; Environment improved by]
   a. Jane Doe
   b. [other names, removed in this interim report for confidentiality purposes]

E. About you
23. In which region or nation do you work?
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ England: East of England
☐ England: East Midlands
☐ England: London
☐ England: North East
☐ England: North West
☐ England: South East
☐ England: South West
☐ England: West Midlands
☐ England: Yorkshire and the Humber
☐ Prefer not to say

24. If you work in England, in which Academic Health Science Network (AHSN) area do you work?
☐ East Midlands
☐ Eastern
☐ Imperial College
☐ Greater Manchester
☐ Kent, Surrey & Sussex
☐ North East & North Cumbria
☐ North West Coast
☐ Oxford
☐ South London
☐ South West Peninsula
☐ UCL Partners
☐ Wessex
☐ West Midlands
☐ West of England
☐ Yorkshire & Humber
☐ Not applicable – I do not work in England
☐ Don’t know
☐ Prefer not to say

25. How many hours a week are you contracted to work?
☐ 0 to 5 hours
☐ 6 to 10 hours
☐ 11 to 20 hours
26. Approximately how much of your time in paid employment is currently spent in work directly related to improving health and care quality?
- None
- 1 to 5 hours a week
- 6 to 10 hours a week
- 11 to 20 hours a week
- 21 to 30 hours a week
- 31 to 40 hours a week
- More than 40 hours a week
- Not applicable – I am currently not in employment
- Prefer not to say
- Other – please specify

27. Approximately how much of your time that is not paid is currently spent in work directly related to improving health and care quality? This could include voluntary work, unpaid overtime or work in the evenings or weekends, for example.
- None
- 1 to 5 hours a week
- 6 to 10 hours a week
- 11 to 20 hours a week
- 21 to 30 hours a week
- 31 to 40 hours a week
- More than 40 hours a week
- Not applicable – currently not in employment
- Prefer not to say

28. Do you have face-to-face contact with patients/service users as part of your job or current role?
- Yes, frequently
- Yes, occasionally
- No
- Prefer not to say

29. What is your current primary role? If you have more than one role, please provide your operational group for our primary and secondary roles.
☐ Academic
☐ Administrator
☐ Board member
☐ Carer
☐ Commissioner
☐ Clinical (further specified into Clinical: Midwife, Clinical: Nurse, etc.)
☐ Data analyst
☐ Executive / director
☐ Manager
☐ Patient leader/Service user/Expert by experience
☐ Policy maker / Civil servant
☐ Quality Improvement professional
☐ Social care worker
☐ Volunteer
☐ Other (please specify):
☐ Not applicable – currently not in employment
☐ Prefer not to say

30. Which of these best describes your primary place of work?
☐ Academic Health Science Network
☐ Academic Institution/Education Provider
☐ Acute Care Provider
☐ Ambulance Service
☐ Care Home Provider
☐ Central Government
☐ Charity/Third sector/Voluntary/Non-profit organisation
☐ Civil Service
☐ Commissioning organisation
☐ Community Care Provider
☐ Independent patient representation organisation/association
☐ Integrated Care Provider
☐ Local Government
☐ Mental Health Provider
☐ National policy making/regulation organisation
☐ Pharmacy
☐ Primary Care Provider
☐ Private company / consultancy
☐ Professional Body
☐ Public health organisation
☐ Social care organisation
☐ Other – please specify OPEN TEXT BOX
☐ Not applicable – currently not in employment
☐ Prefer not to say

31. Which of these best describes your professional background? This may or may not relate to the operational group that you identified earlier.
☐ Academia / Research
☐ Clinical further specified into Clinical: Midwife, Clinical: Nurse, etc.)
☐ Commissioning
☐ Corporate and Administrative Services
☐ Improvement Science
☐ Information / data analysis
☐ Management
☐ Public Health
☐ Social care
☐ Policy
☐ Other – please specify OPEN TEXT BOX
☐ Prefer not to say

32. What is your gender?
☐ Female
☐ Male
☐ Other
☐ Prefer not to say

33. What is your ethnic group?
☐ White: English
☐ White: Welsh
☐ White: Scottish
☐ White: Northern Irish
☐ White: Irish
☐ White: Gypsy or Irish Traveller
☐ White: Other White Background
☐ Mixed / Multiple ethnic groups: White and Black Caribbean
☐ Mixed / Multiple ethnic groups: White and Black African
☐ Mixed / Multiple ethnic groups: White and Asian
☐ Mixed / Multiple ethnic groups: Any other mixed background
☐ Asian / Asian British: Indian
34. What is your annual (FTE) income, before taxes but after any regular out of hours or overtime payments?
  - Less than £10,000
  - £10,000 to £19,999
  - £20,000 to £29,999
  - £30,000 to £39,999
  - £40,000 to £49,999
  - £50,000 to £59,999
  - £60,000 to £69,999
  - £70,000 to £79,999
  - £80,000 to £89,999
  - £90,000 to £119,999
  - £120,000 to £149,000
  - £150,000 or more
  - Prefer not to say

35. If you wish to add any comments to your responses, please enter them here.
OPEN TEXT BOX

F. Final comments

36. If you have any further comments you wish to make, please enter them here.
OPEN TEXT BOX

G. Sharing data with the Q Lab project team

37. The Q Lab project team would like to obtain the raw data from this survey for purposes of improving the design and delivery of the Q Lab. Your responses to Section 2 of this survey
Independent evaluation of the Q Improvement Lab

will not be shared with the Q Lab project team, unless you give explicit consent. If you do not consent, we will not report these raw data to the Q Lab project team, and they will not know whether you withheld consent or did not respond to the survey.

Do you consent for us to share your responses to this survey with the Q Lab project team, for the purposes of improving the design and delivery of the Q Lab?
☐ Yes
☐ No

38. If yes, do you consent to the Q Lab project team contacting you in relation to your responses, to help improve your experience of the Q Lab?
☐ Yes
☐ No

39. If you have any comments you wish to make about data sharing, please enter them here. These will not be shared with the Q Lab project team under any circumstances.

OPEN TEXT BOX
Introduction

RAND Europe, in collaboration with the University of Cambridge, has been commissioned by the Health Foundation to carry out an independent evaluation of the Q Improvement Lab (‘Q Lab’) until the summer of 2018. As part of this evaluation process we are conducting a survey to explore the participants’ experiences and perspectives of the Q Lab. It should take no longer than 15–20 minutes to complete.

The evaluation team at RAND is independent from the Q Lab project team and the Health Foundation and data collected will be stored on RAND servers in the UK and in the US. While this survey is not anonymous, individually identifiable survey responses and linked data will not be shared outside RAND (and will not be shared with the Q Lab project team or the Health Foundation), unless consent is explicitly given. Summary findings will be shared and will be published as part of evaluation reports.

RAND adopts good industry practices regarding the protection of personal data as part of its obligations as a Data Controller under the Data Protection Act 1998 and takes appropriate technical and organisational measures to align these with ISO 27001:2013 to protect personal data. Respondents to this survey have the right to oppose, have access to, rectify or remove personal or sensitive personal data held by RAND.

Please send any questions about the survey or the evaluation process to Professor Tom Ling (Principal Investigator) by emailing QLabEvaluation@rand.org or phoning +44 (0)1223 353 329.

Thank you very much for taking part in this survey.

Section 1: Your participation in the Q Lab

The questions in this section ask about how you participate in and contribute to the Q Lab.

1. What were you hoping to achieve when you started working with the Q Lab? Tick all that apply.
   a. Learning more about peer support
   b. Raising the profile of peer support in the healthcare system
   c. Contributing to improve peer support, or identifying solutions to challenges faced in peer support
Independent evaluation of the Q Improvement Lab

d. Meeting other people with an interest and expertise in peer support
e. Being part of a community of people with interest and expertise in peer support
f. Acquiring knowledge, practices and tools that are directly applicable to my work
g. Participating in an innovative improvement initiative
h. Offering my knowledge and expertise to contribute to a worthwhile initiative
i. Learning more about the Q Lab approach
j. Networking with the Q community and the Health Foundation
k. Other, please specify

2. Overall, on a scale of 1 to 5, how engaged do you feel with the work that Q Lab is conducting?
   a. Not at all engaged
   b. Not so engaged
   c. Somewhat engaged
d. Very engaged
e. Extremely engaged

3. On a scale of 1 to 5, how engaged did you feel at each stage of the Q Lab life cycle?

<table>
<thead>
<tr>
<th>Stage</th>
<th>1 - Not at all engaged</th>
<th>2 - Not so engaged</th>
<th>3 - Somewhat engaged</th>
<th>4 - Very engaged</th>
<th>5 - Extremely engaged</th>
<th>Other, please specify</th>
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<tbody>
<tr>
<td>January to March 2017: The setting up of the Q Lab initiative (topic selection)</td>
<td>○</td>
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<td>April to August 2017: The research and discovery phase (identifying and exploring the key challenges and opportunities in peer support)</td>
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<td>September 2017 to January 2018: The developing and testing phase (designing tools and resources to improve access to, and evidence on, peer support)</td>
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<tr>
<td>February to April 2018: Distilling and sharing phase (collating and sharing what has been learnt on peer support)</td>
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4. **How (through which means/routes) do you participate in the Q Lab?** Tick all that apply.

   a. Attending the Q Lab main events, for example, the London (Barbican) workshop in July 2017 or the Birmingham workshop in December 2017
   b. Attending webinars organised by the Q Lab team
   c. Via phone/email contact with individual Q Lab team members
   d. Via reading the email updates sent by Q Lab
   e. Using the Q Lab online space or interacting with the Realtime Board
   f. Using social media, such as Twitter
   g. Visiting the Q Lab website
   h. Visiting the website of other initiatives or organisations (e.g. Q or the Health Foundation)
   i. Other (please specify)

5. **Which of the following statements best describe the way you have contributed to the work of the Q Lab?** Tick all that apply.

   a. I contributed significantly to help shape the Q Lab (e.g. advising, providing targeted feedback on events and other initiatives, co-designing research tools or other resources)
   b. I contributed by engaging with the initiatives run by the Q Lab (e.g. providing feedback during workshops, filling in profile cards)
   c. I contributed occasionally, when I had time (e.g. adding comments to the Realtime board or the online space)
   d. I am informed about the work that Q Lab is conducting but have not contributed directly
   e. I am not informed about the work that Q Lab is conducting
   f. Other, please specify

6. **Which of the following statements best describe the way you would like to contribute in the next Q Lab project?** Tick all that apply.

   a. I would like to contribute significantly to help shape the next Q Lab project (e.g. advising, providing targeted feedback on events and other initiatives, co-designing research tools or other resources)
   b. I would like to contribute by engaging with the initiatives run by the Q Lab (e.g. providing feedback during workshops, filling in profile cards)
   c. I would like to contribute occasionally, when I have time (e.g. adding comments to the Realtime board or the online space)
   d. I would like to be kept informed about the work that Q Lab is conducting, but not contribute directly
   e. I do not plan to be engaged in the next Q Lab project
   f. I do not know at this stage.
Independent evaluation of the Q Improvement Lab

Your participation in the Q Lab: barriers and enablers

7. What would make it easier for you to participate in the Q Lab? Tick all that apply.
   a. Being offered funding to cover travel and subsistence costs to attend Q Lab events
   b. More personalised communication
   c. More email updates
   d. Live-streaming events
   e. More opportunities to engage online e.g. webinars, surveys, collaborating on documents
   a. More clarity about what is expected from me
   b. Other, please specify

8. Did you experience any difficulties in participating in the work of the Q lab?
   a. Yes
   b. No

9. What made it difficult for you to participate in the work of the Q Lab? Tick all that apply.
   [ONLY IF Q8 = YES]
   a. I did not have time to attend events
   b. I did not have the funding to cover travel and subsistence costs to attend the events run by the Q Lab
   c. I do not have time and/or could not justify time away from work to work on peer support, outside of attending events
   d. Peer support is not my main area of work
   e. I did not receive enough updates on the work of Q Lab outside the main events
   f. I was not sure about how to contribute outside events and what was expected from me
   g. I was not sure how being involved in the Q Lab would benefit me and my work
   h. Other, please specify

Section 2: Relationships in the Q Lab

10. Has participating in the Q Lab enabled you to strengthen existing relationships that you had before participating in the Lab? Pick the option that best describes your situation.
   a. No
   b. Yes, I have strengthened 1 to 2 of my existing relationships
   c. Yes, I have strengthened 3 to 5 of my existing relationships
d. Yes, I have strengthened more than 5 of my existing relationships

11. Which of the following statements best describe any impact arising from the existing relationships you consolidated? Tick all that apply. [Ask only if response to Q10 was not ‘No’]
   a. The development of new initiatives or collaborations in the field of peer support
   b. The development of new initiatives or collaborations in a different field
   c. Learning from one another, e.g. sharing working practices and approaches on peer support
   d. Sharing practices and knowledge on different topics/themes
   e. Nothing concrete yet, but a collaboration may materialise in the future
   f. Enhancing my professional network
   g. Meeting someone with shared experiences and hopes as myself
   h. Other, please specify

12. Has participating in the Q Lab enabled you to form new relationships? Pick the option that best describes your situation.
   a. No
   b. Yes, I have formed 1 to 2 new relationships
   c. Yes, I have formed 3 to 5 new relationships
   d. Yes, I have formed more than 5 new relationships

13. Which of the following statements best describe any impact arising from the new relationships you formed? Tick all that apply. [Ask only if response to Q12 was not ‘No’]
   a. The development of new initiatives or collaborations in the field of peer support
   b. The development of new initiatives or collaborations in a different field
   c. Learning from one another, e.g. sharing working practices and approaches on peer support
   d. Sharing practices and knowledge on different topics/themes
   e. Nothing concrete yet, but a collaboration may materialise in the future
   f. Enhancing my professional network
   g. Meeting someone with shared experiences and hopes as myself
   h. Other, please specify

14. How are you maintaining relationships with other Lab participants? Tick all that apply.
   a. Attending Q Lab events
   b. By email
   c. By social media
   d. By using the Q Lab online group
Section 3: Achievements of the Q Lab

15. In your opinion, what outcomes have the Q Lab achieved in relation to peer support? Tick all that apply.
   a. Generated new knowledge about the challenges around and evidence for peer support
   b. Provided a forum for the exchange of ideas and best practice
   c. Developed a community of people with a shared vision for peer support
   d. Supported the development of collaborations
   e. Identified opportunity areas in peer support
   f. Helped develop new tools/methods to test interventions and solutions
   g. Increased social capital for those involved with peer support, i.e. raised its profile
   h. Other; please specify [OPEN TEXT]

16. Which of the following statements describe how participating in the Q Lab has impacted you? Tick all that apply.
   a. I have gained new knowledge about the challenges around and evidence for peer support
   b. I have learned about new ideas and best practice for peer support
   c. I have used what I have learned about peer support (challenges, evidence for, new ideas and best practices) in my day-to-day work
   d. I am part of a stronger community of people with a shared vision for peer support
   e. I have capitalised on opportunity areas in peer support
   f. I have developed new skills around the tools/methods the Q Lab has used
   g. I have increased social capital due to the increased profile of peer support
   h. Other; please specify [OPEN TEXT]

Section 4: About you

17. In which region or nation do you work?
   ☐ Scotland
   ☐ Wales
   ☐ Northern Ireland
   ☐ England: East of England
18. If you work in England, in which Academic Health Science Network (AHSN) area do you work?
☐ Not applicable – I do not work in England
☐ East Midlands
☐ Eastern
☐ Imperial College
☐ Greater Manchester
☐ Kent, Surrey & Sussex
☐ North East & North Cumbria
☐ North West Coast
☐ Oxford
☐ South London
☐ South West Peninsula
☐ UCL Partners
☐ Wessex
☐ West Midlands
☐ West of England
☐ Yorkshire & Humber
☐ Don’t know
☐ Prefer not to say

19. How many hours a week are you contracted to work?
☐ 0 to 5 hours
☐ 6 to 10 hours
☐ 11 to 20 hours
☐ 21 to 30 hours
☐ 31 to 40 hours
☐ More than 40 hours
20. Approximately how much of your time in paid employment is currently spent in work directly related to improving health and care quality?

☐ None
☐ 1 to 5 hours a week
☐ 6 to 10 hours a week
☐ 11 to 20 hours a week
☐ 21 to 30 hours a week
☐ 31 to 40 hours a week
☐ More than 40 hours a week
☐ Not applicable – currently not in employment
☐ Prefer not to say

21. Approximately how much of your time that is not paid is currently spent in work directly related to improving health and care quality? This could include voluntary work, unpaid overtime or work in the evenings or weekends, for example.

☐ None
☐ 1 to 5 hours a week
☐ 6 to 10 hours a week
☐ 11 to 20 hours a week
☐ 21 to 30 hours a week
☐ 31 to 40 hours a week
☐ More than 40 hours a week
☐ Not applicable – currently not in employment
☐ Prefer not to say

22. Do you have face-to-face contact with patients/service users as part of your job or current role?

☐ Yes, frequently
☐ Yes, occasionally
☐ No
☐ Prefer not to say
23. What is your current primary role?

☐ Academic
☐ Administrator
☐ Board member
☐ Carer
☐ Commissioner
☐ Clinical
☐ Data analyst
☐ Executive / director
☐ Manager
☐ Patient leader/Service user/Expert by experience
☐ Policy maker / Civil servant
☐ Quality Improvement professional
☐ Social care worker
☐ Volunteer
☐ Other (please specify):
☐ Not applicable – currently not in employment
☐ Prefer not to say

24. Which of these best describes your primary place of work? [Ask only if response to Q23 was not ‘Not applicable – currently not in employment’]

☐ Academic Health Science Network
☐ Academic Institution/Education Provider
☐ Acute Care Provider
☐ Ambulance Service
☐ Care Home Provider
☐ Central Government
☐ Charity/Third sector/Voluntary/Non-profit organisation
☐ Civil Service
☐ Commissioning organisation
☐ Community Care Provider
☐ Independent patient representation organisation/association
☐ Integrated Care Provider
☐ Local Government
☐ Mental Health Provider
☐ National policy making/regulation organisation
☐ Pharmacy
☐ Primary Care Provider
25. Which of these best describes your professional background?
☐ Academia / Research
☐ Clinical
☐ Commissioning
☐ Corporate and Administrative Services
☐ Improvement Science
☐ Information / data analysis
☐ Management
☐ Public Health
☐ Social care
☐ Policy
☐ Other – please specify OPEN TEXT BOX
☐ Prefer not to say

26. What is your gender?
☐ Female
☐ Male
☐ Other
☐ Prefer not to say

27. What is your ethnic group?
☐ White: English
☐ White: Welsh
☐ White: Scottish
☐ White: Northern Irish
☐ White: Irish
☐ White: Gypsy or Irish Traveller
☐ White: Other White Background
☐ Mixed / Multiple ethnic groups: White and Black Caribbean
☐ Mixed / Multiple ethnic groups: White and Black African
☐ Mixed / Multiple ethnic groups: White and Asian
☐ Mixed / Multiple ethnic groups: Any other mixed background
☐ Asian / Asian British: Indian
☐ Asian / Asian British: Pakistani
☐ Asian / Asian British: Bangladeshi
☐ Asian / Asian British: Chinese
☐ Asian / Asian British: Any other Asian background
☐ Black / African / Caribbean / Black British: African
☐ Black / African / Caribbean / Black British: Caribbean
☐ Black / African / Caribbean / Black British: Any other Black / African / Caribbean
☐ Other ethnic group: Arab
☐ Other ethnic group: Any other ethnic group
☐ Prefer not to say

28. What is your annual (FTE) income, before taxes but after any regular out of hours or overtime payments?
☐ Less than £10,000
☐ £10,000 to £19,999
☐ £20,000 to £29,999
☐ £30,000 to £39,999
☐ £40,000 to £49,999
☐ £50,000 to £59,999
☐ £60,000 to £69,999
☐ £70,000 to £79,999
☐ £80,000 to £89,999
☐ £90,000 to £119,999
☐ £120,000 to £149,000
☐ £150,000 or more
☐ Prefer not to say

Final comments

29. If you have any further comments you wish to make, please enter them here.

[OPEN TEXT BOX]