What does good governance look like for Q?

Part 5
Final report on
the Commons Stewardship Group pilot

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30 November 2018

Summary

This is the final report on the pilot of the Q regional governance project. It is the fifth report in a series on the design and testing of a governance model for the Q community. Part 4 described the structure and process elements of the pilot. This report focuses on the outcomes of the three Commons Stewardship Groups (CSGs) during 2017-18 and provides recommendations for the future governance of the Q community.

The CSGs have successfully demonstrated Q's values, provided local leadership for Q and worked closely with their AHSNs to provide local activities for Q members and others with an interest in quality improvement. The pilot provides support for creating a local presence that expresses the values and principles of co-production, multi-disciplinary working, and the stewardship of common resources that underpin Q. The CSG model was perceived as having the potential to provide opportunities to bolster local improvement initiatives, placing QI further up the agenda with STPs, and growing Q membership locally.

Innovation is not about hiring an Einstein or creating a slogan.
Everybody is capable of it
and the first sign that it is happening is when people work together,
excited because they want to be there, focused on finding a solution to a challenge they all understand.

Tim Smit

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Acknowledgements

I am grateful to all those who took part in the CSG pilot, in particular the Convenors - Hein Le Roux, Helen Smith and Karen Morrell, and CSG Members from the **West of England**, Anna Burhouse, Jodi Brown, Kathryn Hall, Kay Haughton, Mark Juniper, Lesley Jordan, Anne Reader, Andrew Seaton Julian Simcox, Seema Srivastava, the **South West of England**, Jono Broad, Emma Greenslade, Matt Hill, Simon Knowles, Paul McCardle, and **North East North Cumbria**, Andreia Cavaco, Janet Folland, Sue Gallagher, Nik Jackson, Gill Long, Ruth O'Dowd, Annette Richardson, Anna Stabler as well as members of the three AHSN teams and the Cumbria Learning and Improvement Collaborative (CLIC) team, in particular, Sophie Bland, Lou Porter, Millie O'Keefe, and Dave Evans, Jo Redgrave, Lisa Robinson, Tony Roberts, Helen Ridley, Julia Newton, and the Q team, in particular Stacey Lalley, Brefne Jowers, Dimple Keen, Penny Pereira, Matthew Mezey and Johanna Cronin.

Introduction

A pilot project was established to test Q's Commons Stewardship model in three regions, North East North Cumbria (NENC), the West of England (W) and the South West of England (SW) (See Appendix 1).

Q members from the three regions met in October 2016 for an introductory workshop at The Health Foundation. They were introduced to the model and invited to discuss its applications, drawbacks and advantages. A detailed 'Governance Guidance' document was subsequently co-produced with input from the Q Team and Q members from the three regions who took part in the introductory workshop (see Table 1).

Table 1 Contents of the Governance Guidance Document

Overview of the Commons Stewardship Model
Purpose of the guidance
Q compact
Principles and responsibilities of the Commons Stewardship Groups
The role of the Convenor
The role of the Commons Stewardship Group members
Guidance on reward and recognition for Q members
Dealing with conflicts of interest
Managing complaints
Mediation
Ostrom's eight principles applied to the Q Community

The recruitment process for the Convenors and the CSG members began in early 2017 (for details see Report 4). Following recruitment, each CSG began formulating ways of working together. The Convenors met with the Q team several times and the Q team held a WebEx discussion in July 2018 involving the three Convenors and CSG members. A final webex meeting between the Q team and Convenors was held in November 2018.

The three pilot sites had freedom to devise and develop the model in ways that suited their local context. All worked closely with their AHSNs. The CSGs met for a minimum of four meetings. The SW and West of England have completed their pilot phase. The NENC CSG started later in the year and will not complete their twelve month cycle until March 2019. They are planning to co-host a Q event with the NENC AHSN in May 2019.

This report gives a narrative account of the three CSGs, highlighting the ways in which their vision, values, events and impact have evolved.

West of England Commons Stewardship Group

Membership and meetings

The West of England CSG met four times during the pilot. Attendance at meetings averaged 80%. Terms of reference were agreed at the first meeting (see Appendix 2). Eleven members were appointed from across the West of England (see Table 2). Key components of the CSG membership were that it required individuals of influence and experience from across the health and care sector, commissioners, providers and patients. A WhatsApp group was established as a means of exchange on logistics of meetings as well as personal thoughts and experiences relevant to the work of the CSG. It was used regularly by CSG members throughout the pilot.

Table 2 West of England CSG Members

Member	Location
GP (Convenor)	Gloucestershire
Consultant and Quality Lead	Avon
Consultant & Associate Medical Director	Avon
Director of Service Transformation	Avon
Director of Safety	Gloucestershire
Patient representative	North Somerset
Director of Service Improvement	Gloucestershire
Head of Patient Safety	Avon
Consultant & Patient Safety Lead	Avon
NHSE Quality and Safety Improvement Manager	South Central
Director of Quality Development	Gloucestershire/Northumbria

Vision and values
From the first meeting there was a shared sense of excitement, optimism, and an expectation that the CSG could create opportunities to 'do things differently' utilizing and building on Q and wider QI networks and initiatives, and 'venturing into the unknown'. The CSG was also described as providing 'rocket fuel' for the day-to-day work.

The vision agreed by the CSG was *"to co-create and nurture a culture of continual improvement for all within our local care systems.'*

It was important that the statement captured principles of inclusion and patient-centredness, and emphasized 'continual' rather than 'continuous' quality improvement. As one CSG member wrote;
Don Berwick… usually prefers the phrase Continu-al Improvement rather than Continu-ous Improvement – this is because the word Continu-al implies the methodical application of science, and science lies at the heart of what he describes as a "Learning Organisation" - [what Berwick recommends the NHS to be]."Continuous" as change with no breaks or jumps. Improving continuously therefore may be theoretically possible, say in a mechanical or automated system, but it cannot be in one that involves human beings".

The CSGs were not perceived as 'funding committees' or even 'events committees' but a vehicle through which Q members could be nurtured locally, encouraged to cross organisational boundaries in order to share and learn, driven by curiosity and collaboration and not by competition. This was captured during one meeting in the phrase '*none of us are as smart as all of us*' a sense of belonging to a community of quality improvers committed to one another, carrying shared values into their working lives, a vehicle for Q, a platform for communicating that Q members are '*in it for the system, and not for ourselves.'*

The specific objectives articulated by the CSG reflected these observations;

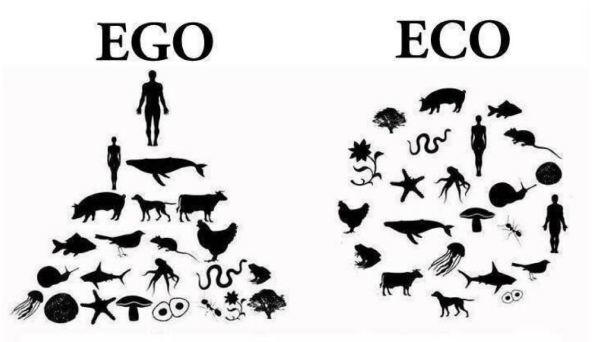
1. To grow the Q community and its influence in the West of England

2. To extend the reach of Q to professionals and patients who do not see themselves as QI experts but are doing quality improvement work, to equip them, mobilise them and build their confidence
3. To create conversations within and across the STPs about QI, helping to change their focus from cost savings to quality, and tackle 'wicked problems' such as reducing hospital admissions, improving out of hospital care for patients.

Themes

Ego versus Eco

One of the recurring themes during the four meetings was reference to Banksy's construct of 'ego versus 'eco.' 'Ego' is predominantly about hierarchies and top down directives and 'eco' about developing shared decision-making, seeing each participant as an equal contributor. Members acknowledged that both were needed but the balance between the two was frequently lost in health and care organisations, often with a negative impact on working relationships. Q was an opportunity to find a balance, recognise the value of each individual within the system, rather than to make assumptions based on profession, role or job title. This was seen as a vital element of Q's inclusiveness, mobilising people through organisations to become involved in QI activities and to take ownership of improvement activities.



(Attributed to Banksy)

System wide influence

The CSG discussed its potential to influence system-wide leadership styles, foster more mutual respect, and foreground the use of 'soft power' strategies and coaching styles. A related area of influence was in shifting cultural norms, for example promoting the use of measurement for improvement with Statistical Process Charts instead of rag ratings, emphasizing positive initiatives to counter the dominant focus on negatives particularly during inspections, and thinking about ways to address the dosing challenge locally.
"if you have enough critical mass of QI trained people in the organisation to make change so that people on the ground have more knowledge of QI than the Chief Executive."

The other important focus was finding ways of exerting direct influence on senior leaders in the STPs, CCGs and the wider health and care system to view QI as a solution to some of the 'wicked' problems and to appreciate the importance of proactive, population based work, for example, in areas like the management of frailty. Part of getting the right care for patients would involve influencing at all levels of organisations, for example influencing Finance Directors to see that QI solutions are also good for Trust finances. There was a desire to;

- Embrace Banksy's 'eco' and 'ego' constructs to be successful influencers in the system, even if CSG members felt they were personally more attracted to one than the other.

- Influence the divide between hospitals and primary and social care, illustrating the QI work that is going on in hospitals can also impact on primary care as well as the other way around. Bringing people together would be a vital part of this vision for change.
- "Tell the story" of QI, even where there are no benchmarks, numbers or clear attribution and where establishing baseline data is not yet possible.

"Traditional QI methodologies on their own are not enough to sustain change at a system level, to allow social mobilization to take place, where lots of people at every level are involved in change"

Barriers to QI influence and impact at a strategic level were also identified;

- Organisations have separate operations, separate datasets, and separate reporting for QI and Programme Management
- There is often a lack of understanding of QI amongst managers, Board Executives and Non Executives
- If there is no support for QI from senior managers, then change is hard to implement
- There is a lack of information on the number of people in the organisation who are trained in QI.

The West CSG members continued to exchange thoughts and reflections through WhatsApp during the pilot. These exchanges ranged from suggestions for agenda items, organising the events, sharing papers and clips, making connections, and introducing the AHSN's new CSG administrator when she joined in August 2018.

Events

The CSG worked closely with AHSN colleagues on organizing and delivering two regional events for Q members in March and May 2018. In March, Sam Riley and Richard Wilson from NHSI led a workshop on "*Making Best Use of Data'* It was attended by 73 Q members and others with an interest in the topic. Participants included senior leaders, clinicians, programme leads, finance teams, and data analysts from across the region. The May event, *QBrings2*, which attracted 74 participants, focused on new Q members and for those interested in joining Q, aimed at showcasing local QI projects, providing presentations on flow, coaching, health integration teams, mental health collaboratives, sepsis, end of life care and a masterclass on personal impact. The CSG had a strong presence at both events, with the Convenor, Hein Le Roux providing an introduction to the day and CSG members working as facilitators during the practical sessions.

The feedback from both events was positive. Participants reported that their expectations had been met in terms of new learning and networking. CSG members who attended found it valuable too. As one CSG member described it;

'My reflection later that evening was about hearing [a CSG colleague] describe the experience of people feeling proud to invite colleagues into Q and the different type of conversations and encounters this [approach] allows to flourish. It's hard to measure this kind of outcome but this is the social movement we are trying to grow'.

Impact
Feedback from the CSG members and the team at the AHSN was predominantly positive. The CSG members had worked well together, found themselves aligned in terms of values and aspirations and enjoyed their meetings and WhatsApp exchanges. There was strong support and praise for the Convenor, for his collaborative leadership style and his commitment to the work.

Both Q events were well managed by the AHSN team, with support from the CSG Convenor and members. During the pilot, the West of England Q membership grew by 44%. In terms of the objective to exert system-wide influence, members felt that QI was gaining traction and presence across the region as a result of collaborative efforts. Engagement with the CCGs, STPs and other senior leaders had been well received and was beginning to have tangible impact in the form of new cross boundary projects. One example was the suicide prevention initiative, bringing together mental health, primary care and acute services across Bristol, North Somerset and South Gloucestershire (BNSSG). Different parts of the region were approaching this in different ways, but all CSG members said they were aware that Q and QI had a higher profile, whilst recognising that there was still some way to go. In terms of increasing connectivity, the survey to Q members distributed as part of the AHSN's annual review found that 100% of those who responded said they had 'met colleagues they would not otherwise have met.'

One member of the team at the AHSN expressed concerns about the time commitment involved in establishing the CSG. They estimated that the actual time commitment had been ten days per year rather than the estimated five days. Their other concern was that the time commitment for CSG members meant that the CSG would not be accessible to 'frontline staff' who would not be given the time to become involved in CSG meetings. This was linked to an observation of the appeal of QI more widely; "*if we want to attract healthcare assistants into QI activities, we shouldn't talk about QI, we should ask' 'How do we make your life better?"*

Next steps
One of the practical suggestions for the future was to help co-create, with the AHSN, a repository of QI projects (starting with those involving CSG members) so that Q people knew what was going on and what they might want to be involved with. Each project could be searchable by STP and region, medical condition, issue, date. This would allow Q members to see who was working in similar fields and facilitate contact and shared learning. It would also *"allow the CSG to gauge the nature and worth of each project, and get a feel for what aspects of the culture are changing – it will allow it to see what proportion of Q members are engaged…getting into the DNA of the culture to better understand what interventions would likely make the most difference".*

There was a feeling that CSG meetings would not continue in their current quarterly form but the Group will continue to keep in touch with each other and will continue to work closely with the AHSN. Gloucestershire's new QI system-wide Group was seen as part of the next steps for the CSG's work locally, and for growing Q more widely.

'Q is only going to flourish if we make it something people want to do. It's the informal spread of messages and connections, not meetings but joining people up, sharing ideas and projects freely. Espousing the values of Q – the legacy of the CSG needs to be in that space'.

South West of England CSG

Membership and meetings
The SW CSG met four times during the pilot. Attendance averaged 80-85%. The CSG was made up of six members all of whom lived and worked in Devon (see Table 3). All had expressed an interest in the Convenor role and had been appointed following this. Terms of Reference were agreed at the second meeting (see Appendix 2).

Table 3 South West of England CSG Members

Background	Location
Consultant & Medical Director (Convenor)	Devon
Patient representative	Devon
Head of Quality Development	Devon
Consultant & Regional Patient Safety Lead	Devon
Non Executive Director NHS Trust	Devon
Consultant & Assistant Medical Director for Safety and Quality	Devon

Vision and values
The CSG's terms of reference described the 'organising principles' of the Group (see Table 2 below) The CSG model was welcomed as a way of '*challenging the status quo'* on many levels, with a potential for '*breaking down barriers'* and '*thinking differently'*.

Table 2 SW CSG's Organising Principles

Transparency
Thoughtful Collectivism
Inclusivity, Diversity and Respect
Connected but Independent
Open Learning & Improvement
Mature Management of Conflict
Proportionate Accountability

From the outset there was enthusiasm for the visual descriptions associated with the Commons Stewardship model, and there were frequent references to the role of the CSG in '*nurturing, growing and 'spreading'* Q and QI across the region, connecting Q members in a '*shared common purpose'* to improve health and care. The imagery of the Commons, of a place where individuals work collaboratively rather than in competition, creating their own QI initiatives side by side, supported by the shared resources of the community, was welcomed. Realizing this would mean increasing the visibility of the CSG and of Q across the region, raising awareness and understanding of Q at Board and senior leader level across multiple organisations.

Q as 'The Commons'

Increasing visibility and connectivity

The SW CSG discussed 'what success would look like' for them and much of what they sought to achieve focused on visibility and connectivity. As one member described it, '*The work of the CSG will be to socialize the commons concept with people of influence*.' In order to achieve its purpose, the Q community would need to build an infrastructure locally, find ways to raise awareness and to increase the diversity within the Q community to include more commissioners, GPs, users and families. A focus on trans-boundary work was seen as critical to success. '*For so long its been 'us and them' in primary care, secondary care'.* This was seen as an opportunity to bring people together in a different way, with the potential for change. The CSG agreed from early on that it wanted to 'start small,' recognizing that there were already well established and successful QI initiatives across the South West, all of which were also contributing this objective. One way for the CSG to achieve this was to showcase existing QI projects such as the 'Excellence Every Day' work at Derriford Hospital, and use these as a vehicle for promoting QI. One of the key responsibilities of the CSG was to diffuse QI throughout the system, 'bringing QI into everybody's consciousness' in a similar way to Frimley Park in Surrey.

Specific outputs from the CSG included the creation of a 'concordat' for use with system leaders, and buddying schemes for Q members. The aim of the concordat was to invite system leaders to give staff leave from their own duties to support colleagues in neighbouring organisations with their quality improvement work. The concordat proposed that this arrangement would be reciprocal, in that any participating organisation could, in turn, seek expertise they might need for their own quality improvement work. The SW AHSN would undertake to keep an up-to-date register of Q members and their skills to allow this staff exchange to take place. In the spirit of 'starting small', the concordat was piloted first with the Organisational Development Group at the Devon STP. The CSG planned to extend this to other STPs and Clinical Senate meetings. With the advent of the Q Exchange, the concordat work took a different turn, as the concept was similar to the successful Timebank proposal from a team in the South West led by Richard Byng. The CSG is currently in discussion about practical ways of collaborating with the Timebank Project. The CSG welcomed the high proportion of Q Exchange projects submitted by colleagues in the South West – 13 out of 188 projects overall. Conversations had also begun to focus on how CSG members could the Q Exchange projects that had not been funded.

Another output was a buddying scheme for clinicians to help support those with less experience in QI, and local 'coffee and cake' meetings for Q members in a locality.

The successful Q Exchange 'Patients as Equal Partners' project led by CSG Patient Representative Jono Broad was welcomed as another vehicle for increasing visibility and connectivity. This project, led by users of services, aims to increase the diversity and expertise within the Q community and offer QI training and support to other users in the South West and beyond.

Events
There was one Q event held during the year. Unfortunately it was poorly attended due to adverse weather conditions and therefore did not create the opportunity for CSG members to engage with the Q community on its proposals for the concordat.

Impact
The CSG generated a number of initiatives, particularly on increasing visibility and connectivity and was proactive in engaging with senior leaders in the STPs, CCGs, and NHS Trusts as well as with the wider care sector on this. The concordat had been well received by senior leaders (with one exception) but its impact had yet to be felt. '*Embedding Q in everything we do will be the secret of success'* but this would require ongoing support and an infrastructure, which was only just beginning to establish itself across the region. One CSG member suggested that '*This work has the potential to reach into 'non-traditional' areas as well, such as nursing homes, hospices, people who are socially isolated. The work of the CSG will be to socialize the commons concept with people of influence*.' During the pilot, the number of new Q members across the South West increased by 35%.

There were a number of barriers to progress during the year. Firstly, the CSG had struggled with intermittent operational support, particularly during the relicensing period at the AHSN. As one member put it '*We have been managing the drought on the Commons….whilst at the same time building the tool shed'* The work going forward would require a clear purpose and support from the AHSN.

Secondly lack of time. There had '*never been a lack of will, but not enough time in the day to deliver*'. A number of other QI initiatives in the region, such as the NHS LEAN project had taken up time for some CSG members during the year, and there were challenges over where to use time and energy with when there was so much activity. However, there was now an opportunity to connect Q with this major project as well as other QI projects. There were also wider opportunities across the South West to provide quality improvement expertise to other ongoing work such as the 'Getting it Right First time' Initiative (GIRFT). Multiple contact points would be required to get this connectivity established, with support from the AHSN. The re-organisation of the AHSN would make this more likely to happen. The CSG wanted to contribute via a combination of small local meetings and one big meeting to '*fire people up'*. Making better use of social networks was seen as essential alongside Q events and activities.

Next steps
There was a sense that the CSG membership might need to change, having started as a small group based in Devon. There were still outstanding questions about the CSG's role in the region, described by one contributor as varying from a '*spotlight to a floodlight approach to QI.'* What was the CSG's 'unique selling point'? Was its purpose to provide light touch, local accountability, or to assist the AHSN in organizing events? It might be

that the CSG could become part of the SW collaborative. Whatever the future shape, it would require operational support from the AHSN going forward. Amongst the objectives under discussion were; linking with other QI initiatives across the South West, building up the profile of Q members regionally, supporting frontline staff and users of services to join Q through mentoring, buddying, training and support for QI projects, and continuing the work of influencing at senior levels within organisations to promote cross-boundary working and more open sharing of QI expertise.

North East North Cumbria CSG

Members and Meetings
The NENC CSG held it first meeting in April 2018 and has met twice since then with a further meeting planned for December 2018. Attendance averaged 80%. The CSG was made up of nine members, who were predominantly based in Cumbria (see Table 4). It included a patient representative. Terms of reference were agreed at the first meeting (see Appendix 3). One member resigned in October 2018 due to other work commitments.

Table 4 North East North Cumbria CSG Members

Background	Location
Head of Continuous Service Improvement (Convenor)	Cumbria
Nurse consultant	Newcastle
Consultant	Cumbria
Director of Nursing and Quality	Cumbria
Patient Representative	Cumbria
AHP Professional Lead	Cumbria
Head of Clinical Education and Practice Development	Cumbria
Programme Manager Rubis QI	Northumbria
Service Improvement Manager	Cumbria

Vision and values
At the first two meetings, there was discussion on the purpose of the CSG, articulated as helping to '*bringing new people into the Q community.'* An important goal was to attract not *just those who see themselves as QI experts*, but staff who are already engaged in QI work but have not had formal training or recognition in QI. The objective was to grow the community from different sources, grass roots clinical staff, as well as patients, and senior leaders.

CSG members agreed that if the work of the CSG was to add value, it had to engage with frontline clinicians at all levels, *looking back, looking forwards, looking outwards*, involving and co-producing with patients in meaningful ways. The CSG could become a catalyst for wider sharing and learning using multiple strategies, which would reach clinicians at every level rather than staying with the more senior leaders within organisations.

As one member observed;' *The commons stewardship model relates to me because it is all about relationships, people having autonomy, a bottom up ethos, irrespective of where people come from.'*

The members were focused on implementing activity as soon as was feasible, in order to demonstrate the value of the CSG, attract more people into Q and promote QI across the region.

Activities
The conversations moved quickly into identifying a specific improvement project that would be values based, inclusive, strategic, build improvement capability in the region, and make a difference to patients. The group discussed two possible frameworks/approaches – A Rapid Process Improvement Workshop and the Engaging for Improvement Scheme as a vehicle to support the delivery of the improvement. Engaging for Improvement as a six step structured approach to support engagement in improvement and develop capability. Both were thought to be good vehicles for delivering an improvement that could develop improvement capability and spread across the STPs. The CSG discussed a number of potential improvements topics that the CSG could support. These included supporting Care groups in North Cumbria, improvement projects on workforce recruitment, using NICE guidance around intermediate care and re-ablement for ICCs, and improvement work with vulnerable patients including those with Dementia.

This led to a discussion about variation across the system and the number of near misses/safety incidents. The CSG felt that leading an improvement project around the reduction of safety incidents and near misses would meet their objectives and could be delivered through an Engaging for Improvement Scheme. The improvement project would be called "*Why do we keep making the same mistakes*?" It would include exploring how to align the technical approach to safety with a compassionate approach to quality. The focus of the improvement project would be to engage as many staff as possible across the STPs in exploring this approach to safety and making recommendations for how the system as a whole could reduce safety incidents. This would focus on practical issues for staff and on what could be learnt and shared between them. The project was quick to obtain support from the AHSN and senior sponsorship from leaders in the north east and the north west of the region.

Over the following months, the CSG members were able to work with colleagues at the AHSN on developing the methodology and tools for the project. A survey was devised by the CSG members, and was distributed in mid November via the AHSN to 280 Q members. The survey asked for feedback on experiences of learning from serious incidents and whether Q members would welcome the development of regional tools and examples of sharing learning in this area.

The project aimed to gather case studies, examples of good practice, local and national guidance and evidence, and to draw these together and present them at the Q event in 2019. The AHSN will fund the event, which will also serve as an opportunity to welcome new Q members, and provide a platform for wider discussion on local QI projects. It would also help to identify priorities for the Patient Safety Executive, and the potential for further local activities.

Impact
The NENC CSG has taken an improvement project approach to its work, focusing on a specific topic with appeal and interest across the region. The aim is to use this as a catalyst for wider sharing and learning, effectively making the CSG its own PDSA. This practical and single focus approach reflected a desire to *help to galvanise people, pull people in locally. Communication from the Q centre, like the newsletter, however good it is, can't achieve that on its own.'*

Given the time frame for the CSG's improvement project, the impact of this approach cannot be assessed. Alongside this, CSG members have been proactive in promoting Q through local meetings and events. They created a local Q banner which is being displayed at local events and which help to attract interest amongst clinicians. During the pilot to date, Q membership in the region increased by 28%.

Next Steps
The CSG is planning further meetings in December 2018 and in 2019, to look at the data and bring together learning. They will work closely with their AHSN colleagues on the tools, and on the design and delivery of the Q Event in May 2019, when their improvement project will form the centerpiece on learning from serious incidents.

Observations of the CSGs

This section provides observations of the pilot across the three regions. It makes reference to the indicative responsibilities for the Commons Stewardship Groups outlined in the Governance Guidance document (see Appendix 5).

From the outset, a key objective of the CSG governance project has been to establish a vision and value base for Q locally, articulated through words and demonstrated through behaviours. From the conversations and practical outputs over the year, it would seem fair to conclude that this objective has been met. An early output of the project was to involve Q members in testing and refining the Q Compact, a statement of the expectations, behaviours and values that underpin the Q Community. All three CSGs were proactive in this space, exploring the vision and value base of their work and the work of the Q Community itself. CSG Members, to varying degrees, expressed a keen interest in this element of the model and were aware of their individual and collective responsibilities to provide leadership for Q at a local level.

Many of the conversations and activities during the pilot were concerned with system-wide influence and culture shift, to bring Q and QI to the attention of others and to actively seek to make connections across organisational and professional boundaries. This occurred through Q events, but also through CSG Members' day-to-day activities and conversations with colleagues which served to enhance the visibility and reputation of Q in the region. There was a focus on encouraging front line clinicians and other professional groups employed in the NHS (finance directors, data analysts) to become involved in Q and QI, through a wide range so called 'bottom up' as well as 'top down' initiatives. As one CSG member observed, "*Q is full of people who know how to deliver what the STPs are assigned to do. Q can give them the tools to achieve their goals*.'

In addition to the work within their regions, the three CSGs shared their insights, experiences and outputs during the pilot, either via their AHSN colleagues, via the Convenors and webex conversations. There was no sense of rivalry or competition between them. They acknowledged that there were differences in approach, but perceived the flexibility of the CSG model, and its ability to adapt, as a strength rather than a weakness. Each CSG placed great value on their Convenors, seeing them as crucial to the work.

The role description of the CSG changed or remained untested during the pilot in two ways. With the advent of the Q Exchange in 2018 which created a shared responsibility across the Q Community itself for funding QI projects, the CSGs were no longer required

to test their role in local oversight of Q's finance and resources. Second, the CSGs were constructed as a vehicle for managing conflict within the Q community, but this remained untested, as no conflicts or conduct issues within the Q Community were reported during this time.

The Governance Guidance document produced as part of the governance work was not used during CSG meetings, although it was acknowledged as a useful frame of reference for the Commons Stewardship model. Those who commented on the recruitment process for Members said that it could be simplified to make it less time consuming for those involved. In the future, Q members might be asked to vote on who they wanted as CSG members within a region, rather than rely on an appointment process. There was a sense that the Governance Guidance document could evolve further into a reference document for the Q Community over the longer term.

Enthusiasm and interest in the Commons Stewardship model and the values that underpinned it balanced against certain disadvantages. The key detractors were time and operational support. All CSG members, including the Convenors, gave their time without financial reward. All members had full work commitments elsewhere, including the three patient representatives. Allocating time to the work was therefore challenging. However, CSG members viewed the objectives of the CSG as '*aligned to the day job'* of promoting QI locally and encouraging colleagues to join Q.

The degree of operational support varied between the three regions, and over the life of the pilot. The West of England CSG had the most consistent support from the AHSN. Much of their work on operationalising the CSG model assisted the other two sites in the way they established support. The South West AHSN went through a period of re-structure that meant that Q and Q activities were not given the priority that had been evident at the start of the pilot. This was resolved part way through the year as new structures and new resources were embedded. The NENC also went through a period of change (described in the fourth report in this series), which meant that the operational support for Q and for the CSG varied over time. Once the NENC Convenor was appointed, support came from Cumbria Learning and Improvement Centre (CLIC), as well as the AHSN. This allowed the CSG to meet and plan their Improvement Project in a short space of time and to obtain support for its implementation.

All three CSGs used the AHSN as the primary vehicle for e-communications and updates on activities, through newsletters and emails. The frequency of newsletters varied between the three regions, with the West of England AHSN giving the CSG's work most prominence in all their communications.

There were a number of references to the impact of geography on the CSGs. Those covering large regions in the North and South West had greater challenges arranging meetings, and membership of both CSGs had greater representation from one particular county or area over another. Although there was no conscious bias in the recruitment process, the size of a region may have an influence on connectivity and visibility of CSGs over the longer term.

One of the metrics that the three CSGs used to measure success was the number of new Q members joining in their region. It would not be accurate to attribute the growth directly to the presence or activities of the CSGs They may have contributed to this. It is noteworthy that all three regions had increases above the national average increase of 20%. The West of England CSG, who were able to work consistently with their AHSN

throughout the pilot, saw the largest increase. Table 3 give the numbers and percentage growth during the pilot.

Table 3 Number of new Q members joined during the CSG Pilot year

Q members	Founding cohort	Total (pre CSG pilot)	Total (post CSG pilot)	% increase
North East and North Cumbria	9	130	166	28%
South West of England	9	118	159	35%
West of England	11	110	158	44%

The CSGs were involved to varying degrees in the design and delivery of Q events during the year. The West of England CSG supported the AHSN in two hosting major Q events, both of which were part of their strategy to influence and grow Q locally and both of which were well attended and well received. The South West CSG were equally keen to bring events into their approach, but adverse weather and changes in administrative support meant that these were less successful. In North East North Cumbria, the CSG took longer to become established. A major Q event is planned for next year, in which the improvement project work led by the CSG members will form a centerpiece.

The approximate overall cost was £10,000 per year per region.

Summary and recommendations

The original brief for this work was to address the question; What does good governance look like for Q? This was first posed 2016 when Q was a fledgling community of 231 members drawn together by a shared commitment to QI in health care. Two years on, it is a growing community of over 2,700 members, an ever-expanding network of individuals and organisations across the UK. Q has established the Q Lab, which has recently launched its second project in partnership with MIND. It has developed an innovative, community based funding approach through Q Exchange, and created continually expanding options for the Q Community to share learning and to gain new skills and experience.

What the CSG pilot has demonstrated is that there is a strong commitment to a values based approach, which reflects Q's principles of co-production, inclusiveness, stewardship, and patient and person centredness. Some of the original purpose behind creating a governance structure has changed, and, with the introduction of the Q Exchange, there is no longer a need for local oversight of finances and resources in the way originally envisaged. There have been no instances where the CSGs have been tested in their ability to manage challenges to Q's compact amongst Q members. However, the core purpose, which has been to place values at the forefront of all initiatives, to work across boundaries and professional groups, to influence from the top and from the frontline has provided both a spotlight and a floodlight for quality improvement activity in the three regions.

The pilot has also successfully demonstrated a shared leadership model, or 'primus inter pares' approach, which has come to be associated with the Q Community. Don Berwick, in

his IHI keynote speech in December 2017 made use of the term ‘convener’ when describing the non-hierarchical nature of leadership that is reflected in Q’s Commons model;

"Every story has a trusted convener who uses fame or position or power or gravitas, not as leverage for control, but as wellsprings of confidence and mutuality among those who don’t have fame or position or power…they teach purpose, they teach generosity, they make spaces safe for the failures that open doors."

The importance of demonstrating this leadership style to the wider system was one of the themes that emerged during discussions at all the CSGs, along with its role in shifting cultural norms and addressing ‘wicked’ problems in collaborative ways.

For those regions where there are AHSNs or other organisations with a strong culture and commitment to these ways of working and high levels of commitment to embedding quality improvement across systems, the creation of CSGs may not be essential. However, for regions where this does not yet exist, creating and funding CSGs could provide a critical catalyst for this member led, local presence for Q. The role and contribution of a local values-based presence for Q in the long term should not be under-estimated. It has the potential to become a powerful mechanism for problem solving across organisational and professional boundaries, creating a ‘shared common purpose’. This is the bedrock of sustainable quality improvement initiatives, wherever they occur.

Options for the future of the Commons Stewardship Group model

1. Continue to support the three CSGs and invite other AHSNs to establish their own CSGs with financial support from Q.

2. Retain the three Convenor roles, and recruit Convenors in the other regions.

3. Use the learning from the CSG pilot and disseminate key lessons about the importance of sustaining Q as a values-based initiative founded on co-production, inclusiveness, stewardship, and patient and person centredness. Publish a thought piece on the Commons Stewardship model for the Q Community, and invite the Convenors and CSG Members to present on their experience at a future national Q event, or through a WebEx for the community.

Appendices

Appendix 1 The Regional CSG Pilot

A Governance Model for Q Summary Paper

This paper describes a governance and regional organising model for Q, drawing on literature, interviews with external stakeholders and discussions with the Q team. A detailed report on the options considered is available upon request.[1]

The Q Initiative emerged as a bold response to the Berwick Report [2], itself a compelling exhortation to embed learning into the health system.

Through Q, the Health Foundation and NHS Improvement are building capacity and capability for improvement in ways that have not been tested before in any system in any part of the world.

The RAND evaluation that has run alongside Q has made some clear recommendations for Q going forward, praising Q and the culture and characteristics it has nurtured from the start [3]. These include; the importance of harnessing diversity through 'a shared core of values supporting a wide variety of activities', maintaining inclusivity, lack of hierarchies, creative ways of working, a commitment to the inclusion of under represented groups, self awareness, and the desire to listen and respond to all views however challenging or contradictory. (p62).

All of these characteristics and ambitions require a governance and organising model that is visionary, values based and inclusive, as well as robust and accountable. This paper therefore proposes the concept of a 'Q Commons', in which stewardship, shared decision making and a desire for the common good become encrypted in the structures and create a platform that allows Q to continue to flourish.

1. Introduction

1.1. Q is a growing community of people skilled in improvement, working cross the UK. Q is also resources, activities and fledgling infrastructure, connecting, supporting, mobilising and developing people and improvement projects. Its long-term aim is to create, at national scale, capacities for improvement,[4] to increase the dosage and use of quality improvement expertise in the health and care sector, [5] and foster a learning environment to improve health and care.[6]

1.2 Q is committed to co-design, innovation, agility and a predominantly non-hierarchical approach to all its endeavors.[3] It shares many of its values with quality improvement initiatives and social movements around the globe, but is unique in design and composition. Q's design statement outlines a theory of change that is inclusive, ambitious and recognises the broader context and organizational structures in which Q activities sit.[7]

1.3 Literature on the components of 'good' governance suggests that accountability, transparency, inclusivity, and effectiveness are key.[8] 'Good' governance for Q must involve establishing structures and processes that are capable of overseeing a high quality multi-provider programme of activities in a way that furthers its long-term aims and underpinning values.

2. What does a Q governance model need to take account of?

2.1 One of the distinctive features of the Q community is its approach to new ways of working across traditional boundaries.[3] Q has the potential to offer something qualitatively different through its activities, building cross-boundary capacity and capability within the system, creating opportunities to test and develop new ideas for improving health and care.

2.2 One of the other important features of the Q initiative has been its lack of hierarchy and its commitment to involving patients, carers and diverse professions from within and beyond the health and care sector in design processes.[3]

2.3 Q has a strong commitment to flexible, iterative learning, minimising bureaucratic processes, maximizing learning between members and promoting a sense of shared ownership across the community. Any governance model will need to facilitate two-way relationships between national and regional activities, as well as strong relationships with other improvement organisations and ensure these are well managed as the Q community grows in size and complexity.

2.4 In summary, the new governance model will need to nurture these cross-boundary, non-heirarchical, creative relationships which allow Q to contribute to improvement at all levels of the health and care economy. Investing in cultivating effective structures and patterns of behavior for the stewardship of Q-specific resources and activities has the potential to create connections and ways of working that help the Q community contribute to its aspirations. The 'governance' structures are not just

a technical enabler for delivery, but will be a significant backdrop to the member experience and reputation of Q. What we put in place should bring wider benefits in terms of establishing a platform for collaboration between different parts of the mainstream health and care system, creating a strong interface with existing organisations and groups that play a significant role in the delivery of QI across the UK.

3. A new model of governance for Q

3.1 This specific project has identified a wide variety of governance models used across health and care, education, voluntary sector organisations and private enterprise, drawing on examples from around the world [1]. These range from formal bureaucracies, to informal collectives defined by lack of formal structures, sometimes known as adhocracies (see Appendix 1 for a summary). The model proposed for Q draws on different elements of these.

The 'Commons' model

3.2 The governance model proposed for Q is one that is values based and inclusive, as well as robust and accountable. It is based on the notion of stewardship of services or assets, offered for 'the common good'. This model was referred to by Berwick in 2009 [9] and more recently by Ham and Alderwick [10] as having the potential to envision a different and more dynamic way of working in healthcare. It also has strong links to Donabedian's assertion that the ethical dimension of quality improvement work is essential to its success[11].

3.3 Communities in many parts of the world have traditionally had communal land, described as 'the commons,' where people graze their livestock. In 1968, Garrett Hardin wrote a paper using the grazing commons as a metaphor for the problem of over-population arguing that many of the world's resources – food, water, energy, were being squandered because human beings were unable to self-organise in the interests of the collective good. He called this 'the Tragedy of the Commons.[12]

3.4 Around the same time, the economist Elinor Ostrom[13,] was working on an alternative theory, which demonstrated - in very practical ways, that people could co-produce, guided by design principles which promoted local, collective, non-hierarchical decision-making. She worked with communities around the world on projects ranging from town planning, to policing, water supplies, and fishing. All of these used 8 design principles (see Appendix 2) for *'Governing the Commons'* and always involved bringing multi-professional groups together in 'workshops," converging around a common problem they all wanted to solve. Ostrom worked on the premise that complex, multi-level solutions were required for complex, multi-level problems, and the best way to achieve those was through co-production. Through active, committed consensual stewardship and cooperation, 'the common resource' in whatever context, had the potential to become more productive for a greater number of people.

3.5 For Berwick, adopting this 'commons' approach relates directly to achieving better health, better care at lower cost. Berwick [9] describes a healthcare facility in Cedar Springs, based on this model, which not only delivers better outcomes and has reduced professional rivalry, but costs 27% less than the average per capita cost across the US. In a similar vein, Ham and Alderwick refer to Ostrom's model when they suggest that NHS organisations need to move away from a 'fortress mentality' and replace this with a collaborative, place-based approach to delivering care. This will require a new kind of leadership in which stewardship of the 'common pool of resources' in health and care becomes a driver for change.

3.6 In her keynote speech at Q's third design event in 2015, Mary Dixon-Woods [14] argued that community-based approaches have huge potential for large scale learning in quality improvement. She suggested that ideally, quality improvement work has to happen locally, nationally and internationally to achieve the desired outcomes. This needs the commitment of policymakers but it also needs strong and effective networks that become the delivery mechanism for change, working *with* people rather than *on* them. In this context, Dixon-Woods referred to Elinor Ostrom's design principles, suggesting that these might provide a steer for the Q Initiative going forward, and a way of ensuring collective decision-making was at the heart of Q.

3.7 Building on these reflections, this paper proposes that by using the language and spirit of 'the Commons,' Q would be communicating a clear message about the non-hierarchical, diverse nature of the Q community, embedding the values of co-production, shared decision- making and stewardship within its national and

regional structures as well as with existing QI infrastructures. This would also draw on the strengths of a distributed and shared governance and organising model, in which Q member input into decision making operates on multiple levels, and connections and interactions between members in different parts of the UK is maximized.

3.8 The collective scarce resource or 'commons' in the context of Q would be (a) any resources made available specifically for Q activities and at least as importantly (b) the expertise and energy that Q members choose to bring to Q. We know that time and space are scarce and precious to Q members: their decision to voluntarily make time and commit to Q will be critical to its vitality. For members to do this, they will need to feel like collective spaces and time is well used and not inappropriately dominated by one group or agenda.

3.9 The model would allow members freedom to work together and to make decisions locally, and to self organize within regional structures. It would hold individuals to account in ways that are proportionate to the task in hand, and provide an underpinning logic and framework for groups who choose to work together on projects. An analogy used by one stakeholder was of people on a modern-day common, where there may be less grazing, but multiple users. Some people take responsibility for managing and improving the space and agreeing and ensuring the rules of the common are met (such as not cutting down trees or digging up the grass). However the vibrancy of the space depends on people bringing their picnics, ball games, more organized sports or activities and occasional fairs.

What might the Commons model look like for Q?

3.10 The commons principles would be something that would apply across Q, with all members having a chance to influence how the 'common space' of Q is run (see Appendix 3). For most people, this might mean occasional input into decisions and active involvement in specific aspects of running Q (such as helping lead specific activities, recruitment processes or lab projects). We would then seek to identify a small group of people in each area that are willing to take a more active stewardship and leadership role for Q, forming a **Q Commons Stewardship Group** (provisional working title) for that region or UK country. Representatives of those who take responsibility at a regional level in this way would be the members of a central Q commons stewardship group.

3.11 The **Central Q Commons Stewardship Group** would become in effect a unitary board with between 14-16 members. There would be Q executive and non-executive members, all appointed, and chaired by an appointed Convenor. It would have a representative from the English regions and from Scotland, Wales and Northern Ireland's Commons Stewardship Groups. It would have some responsibilities for financial, strategic and performance oversight for Q. We would invest in a selection process and some development for the convenors and members of each commons group. Once established, these Q commons

stewardship groups would self-organize and evolve to reflect the local context and infrastructures in line with some general principles that would be agreed collectively for Q. These principles would align with Ostrom's principles and might include:

- Transparency: meetings held in public with minutes shared online
- Thoughtful collectivism: creating opportunities for members to help make decisions and deliver aspects of Q, in ways that are likely to feel satisfying for members and ensure high quality outcomes.
- Inclusivity and respect for diversity: encouraging involvement of different groups
- Connected but independent: making the most of connections with existing groups and institutions, but avoiding capture by any one agenda or organization.
- Open learning and improvement: creating ways to reflect openly on what's going well and not so well as a way of helping continually improve
- Mature management of conflict: seeing disagreement as an inevitable and often creative part of a cross-boundary passionate community and finding productive ways to use or resolve such conflicts
- Proportionate accountability and recognition for contributions: finding ways to enable delivery of Q activities and leadership that predominately works on a voluntary basis, but recognises when more formal delivery contracts will be needed.

4. Conclusions

4.1 The Commons governance model combines elements of centralised structures, such as clear lines of accountability, whilst drawing on the creative elements of less formal structures, such as freedom to self organize in ways which foster local stewardship for the common good. It is visionary, values-based and inclusive. Its regional structures would work with existing infrastructures where appropriate. Finally, and importantly, the model has the support of the Q team.

4.2 Q members from the regions are invited to consider piloting the commons model described above, with support from the Q team. We would be looking for up to three regions to act as pilot sites and to work with us to test the model, and look at ways in which it enhances existing work through Q as well as other established QI organisations and structures.

(For references see full version)

Appendix 2 West of England CSG Terms of Reference

1. Background

The Q initiative has invited the West of England Academic Health Science Network (AHSN) to be one of three areas in the UK to **pilot** a Q Governance and Leadership Model of a lead Convenor and a 'Commons Stewardship Group' (CSG).
The pilot is for a period of 12 months, with the Convenor role officially commencing on 7 September 2017. Therefore, these Terms of Reference relate to the pilot period only, including the support provided by the West of England AHSN.
The aim of the model being piloted is to provide an approach to distributed leadership and decision making that is consistent with the overall goals and values of Q. The proposed model is designed to [be]:

- Values-based and inclusive;
- Robust and accountable;
- Facilitate two-way relationships between national and local activities, as well as strong relationships with existing improvement organisations and networks;
- Ensure relationships are well managed as the Q Community grows in size and complexity.

The model will need to support cross-boundary, non-hierarchical creative relationships, which allow Q to contribute to improvement at all levels of the health and care economy. Investing in cultivating effective structures and patterns of behaviour for the stewardship of Q-specific resources and activities has the potential to create connections and ways of working that help the Q community achieve its aspirations.

The governance structures are therefore not just a technical enabler for delivery, but will become a significant backdrop to fostering strong relationships, as well as enhancing the member experience and reputation of Q. What is put in place should bring wider benefits in terms of establishing a platform for collaboration between different parts of the mainstream health and care system, creating a strong interface with existing organisations and groups that play a significant role in the delivery of quality improvement across the UK, as well as nurturing the Q community itself.

2. Purpose

The purpose of the Commons Stewardship Group is:

Each of the CSGs in the English regions and Scotland, Northern Ireland and Wales will provide local stewardship of Q members and activities, facilitating learning and development and knowledge exchange within and between local groups. Each of these (potentially 18) groups might have around seven members, depending on the context. Some members might have a specified remit or role such as a patient or service user representative, or as the formal link person to the organisation that is a system-level partner or regional partner for Q in that area. The CSG would build alliances with other QI organisations (AHSNs, collaboratives, and other QI initiatives) where these exist. They will also provide a direct, two-way link to the UK-wide Common Stewardship Group.

The **UK-wide Commons Stewardship Group** will be developed this year to provide leadership at a UK level, working closely with the Q project team. It will be multidisciplinary and will be chaired by an appointed convenor who is also a Q member. It

will have representation from each of the CSGs in the English regions and from Scotland, Wales and Northern Ireland's CSGs. Finally, it will have some delegated responsibilities for financial and performance oversight for Q, administered through grant arrangements to be agreed with the Health Foundation/NHS Improvement.

3. Roles & Responsibilities

1 3.1 Commons Stewardship Group:

These responsibilities aim to reflect Ostrom's principles for governing the commons:

- Establish the values of the Commons Stewardship Model.
- Work with others to develop and monitor the delivery strategy for Q at a local level, including how it connects with other QI initiatives and organisations. This should help Q evolve over time as an important platform for cross-system collaboration and development.
- Monitor and support the Q recruitment processes to attract and develop a pipeline of applicants for Q. Share good practice in the recruitment of new members.
- Contribute to the strategic growth of the Q community and its activities at a local level.
- Secure resources and make decisions about the allocation of Q-specific funding, involving members as appropriate.
- Develop and oversee/support the 'common spaces' of Q: agreeing ground rules with members, ways of monitoring the health of the community locally, and where appropriate, manage the sanctions for departures from the values of the commons.
- Monitor the work to encourage and support the core of active members who play particular roles in leading Q locally, ensuring they are appropriately recognised for their contribution. This will include the Q connectors[1].
- Oversee design, delivery, evaluation and improvement of Q-specific events and activities, helping to resolve issues locally wherever possible through active stewardship of people and resources. Ensure that learning about what works and what does not is reflected on and shared, including by contributing to Q-community wide mechanisms for capturing learning.
- Promote engagement in Q Lab projects[2] and other activities and the outputs of these.

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[1] Q Connectors are members who will play a key role in sharing knowledge and interfacing across geographical and other boundaries (add hyperlink)

[2] Q Lab projects will provide Q members and others with the space to work together on high priority challenges https://q.health.org.uk/q-improvement-lab/

- Protect and enhance the reputation of Q, promoting it to stakeholders, ensuring they understand and respect the basis on which Q works.

- Provide financial oversight as required by the Q project team and any others making a financial contribution to Q activities.

- Oversee processes for resolving disputes within the Q community.

2 3.2 Q Convenor:

Each CSG will have a convenor, with the following indicative responsibilities:

- Uphold and promote the vision of Q, its values of creativity, co-production, shared decision making and stewardship and reflect the community's commitment to person centredness and multidisciplinary collaboration.

- Convene and chair meetings of the CSG and work closely with the Q project team on the agenda, meeting notes, and engagement and dissemination.

- Provide support to the CSG members as required.

- Ensure there are opportunities for training and development of the other commons convenors and group members, and participate in review of the group members' contribution and time commitment as required.

- Liaise with the Q Project team and to Q Connectors as required.

- Act as an ambassador for Q, representing the interests of the community.

- Develop and maintain constructive, collaborative relationships with Q members and external stakeholders and organisations with a shared interest in continuous and sustainable improvement in health and care.

- Represent their group on the UK-wide CSG.

- Commit up to 10 days a year on CSG activities in the first 12 months, initially.

3 3.3 CSG Members:

Members of the Commons Stewardship Group (CSG) will:

- Uphold and promote the vision of Q, its values of creativity, co-production, shared decision making and stewardship and reflect the community's commitment to person centredness and multidisciplinary collaboration.

- Develop and maintain constructive collaborative relationships with Q members and other local stakeholders and organisations with a shared interest in continuous and sustainable improvement in health and care.

- Demonstrate strong influencing skills in the support and promotion of local improvement initiatives, potentially championing a specific cross-STP improvement project.

- Co-create, along with other CSG members, the Q Community masterclasses, to meet the needs of local community members, encouraging cross-organisation collaboration.

- Demonstrate leadership at local Q events and be a local contact point for improvers to gain direction, motivation and coaching.

- Attend and positively contribute to CSG meetings, bringing expertise to the discussions and actively participating in promoting Q.

- Commit to four two-hour CSG meetings (preferably face-to-face) throughout the 12-month pilot, with an option to review contribution and time commitment after each meeting.

- Demonstrate enthusiasm, determination and commitment to enhancing the positive reputation of Q and have strong influencing skills.

- Positively promote the CSG and Q initiative to others who may be interested in joining the Q Community[3].

4. Membership

Although it is recognised that THF *Q Governance Guidance* suggests a membership of seven, in the West of England, we are initially aiming for membership which will consist of (at least) **three Qs from each STP** in the region with the intention that providers (primary, acute, mental health), patients / carers and commissioners are all represented, totalling **nine**.

Membership to the CSG is on a voluntary basis.

[3] There are currently 123 Qs in the West of England and we would aim to increase that by 100% (i.e. double the existing cohort) by 31 March 2019.

Appendix 3 South West of England CSG Terms of Reference

Name of Group	South West Regional Q Commons Stewardship Group
Purpose and Aims of the Group and why is was created	The Regional Commons Stewardship Groups (CSG's) have been created by the Health Foundation as part of the governance model for Q with the aim of providing distributed leadership and decision making consistent with the overall goals and values of Q. This Governance model aims to: • allows Q members the freedom to work together and to make decisions locally, to self-organise within local structures. • Support cross boundary and non-hierarchical creative relationships which allow Q to contribute to improvement at all levels • Become a significant backdrop to fostering strong relationships and enhancing the reputation of Q, both within the Q Community and wider across the health and care system. Each Regional CSG is expected to - provide local stewardship of Q members and activities, - facilitate learning, development and knowledge exchange within and between local groups - build alliances with other relevant organisations within their local system The Regional CSG's will connect with a UK- Wide Commons Steering Group providing leadership for Q at a UK Level.
Organising Principles for the CSG Might Include:	- Transparency - Thoughtful Collectivism - Inclusivity, Diversity and Respect - Connected but Independent - Open Learning & Improvement - Mature Management of Conflict - Proportionate Accountability
Scope In/Out of scope for the SW Q CSG	To focus on supporting the Q Community to grow and flourish in the South West by engaging with provider organisations, CEO's, Clinical Cabinets and other networks. Create a concordat allowing Q members to support each other to drive forward ever challenging change through the system, exchanging support from each other's strengths.

	See Also Indicative Responsibilities of the Regional Commons Stewardship Group 1-10 (below)
Membership of the Group Length of membership - if appropriate	A Q Convenor (initially appointed for a 12 month fixed term basis from Sept 2017 - also a link/member to the UK wide Steering Group and Health Foundation) Up to 7 Members - recruited from Q members. To include at least one member with a specific patient or service user perspective Main role of the Convenor and Members is to promote the vision of Q together with the principles of creativity, co-production, collaboration, shared decision making and stewardship and to develop and maintain strong and constructive relationships with stakeholders, Q members and potential future Q members.
Meeting Arrangements How many per year Topics/Format Chair/other roles	Up to 4 face to face/half day meetings per year for the CSG members convened by the Convenor. These meetings will have a public/transparent dimension, with minutes/actions shared online/electronically. Q Convenor to Chair the meetings, supported by project administration support from the SW AHSN team for meeting room arrangements, agendas, minutes, action points etc. Other discussions/meetings may take place on a virtual basis and occasional basis The Convenor may attend meetings and updates with the Health Foundation/Other convenors – either virtually or face to face as required.
Ways of working / Working methods – sharing information in the group and wider	CSG members are expected to undertake actions and work to meet the aims of the group. This will include (and are not limited to) - Face to face meetings - Virtual online space - Mobile discussion group
Reporting/Accountability Reporting structure for this group Format/Frequency	The Convenor will hold the following important relationships - With the Health Foundation and the UK Steering Group - With Convenors in other Regions - With the CSG Members and the wider Q Community - With the SW AHSN The Health Foundation and SW AHSN may require reports and updates from time to time.

Resources and Budget	To be allocated by the Health Foundation and SW AHSN for 2018
Deliverables/Output	Success criteria for 2018: CSG members recruited and CSG meetings taking place Visibility of Q CSG across the Q Community and beyond Increase in regional Q membership through engagement with the new central recruitment process from Summer 2018 Increase in Q activities across the region Increased awareness and understanding of Q across Board level/Senior Leaders in the stakeholder organisations
Review date for ToR	To be reviewed as part of the pilot review by end of 2018 The Convenor, the Health Foundation and SW AHSN to be part of this review process.

Appendix 4 North East North Cumbria CSG Terms of Reference

Background

The Q initiative has invited the North East and North Cumbria Academic Health Science Network (AHSN) to be one of three areas in the UK to **pilot** a Q Governance and Leadership Model of a lead Convenor and a 'Commons Stewardship Group' (CSG).
The pilot is for a period of 12 months, with the Convenor role officially commencing on 1st January 2018. Therefore, these Terms of Reference relate to the pilot period only, including the support provided by the North East and North Cumbria AHSN.
The aim of the model being piloted is to provide an approach to distributed leadership and decision making that is consistent with the overall goals and values of Q. The proposed model is designed to [be]:

- Values-based and inclusive;
- Robust and accountable;
- Facilitate two-way relationships between national and local activities, as well as strong relationships with existing improvement organisations and networks;
- Ensure relationships are well managed as the Q Community grows in size and complexity.

The model will need to support cross-boundary, non-hierarchical creative relationships, which allow Q to contribute to improvement at all levels of the health and care economy. Investing in cultivating effective structures and patterns of behaviour for the stewardship of Q-specific resources and activities has the potential to create connections and ways of working that help the Q community achieve its aspirations.

The governance structures are therefore not just a technical enabler for delivery, but will become a significant backdrop to fostering strong relationships, as well as enhancing the member experience and reputation of Q. What is put in place should bring wider benefits in terms of establishing a platform for collaboration between different parts of the mainstream health and care system, creating a strong interface with existing organisations and groups that play a significant role in the delivery of quality improvement across the UK, as well as nurturing the Q community itself

Purpose

The purpose of the Commons Stewardship Group is:

Each of the CSGs in the English regions and Scotland, Northern Ireland and Wales will provide local stewardship of Q members and activities, facilitating learning and development and knowledge exchange within and between local groups. Each of these (potentially 18) groups might have around seven members, depending on the context. Some members might have a specified remit or role such as a patient or service user representative, or as the formal link person to the organisation that is a system-level partner or regional partner for Q in that area. The CSG would build alliances with other QI organisations (AHSNs, collaboratives, and other QI initiatives) where these exist. They will also provide a direct, two-way link to the UK-wide Common Stewardship Group.

The **UK-wide Commons Stewardship Group** will be developed this year to provide leadership at a UK level, working closely with the Q project team. It will be multidisciplinary and will be chaired by an appointed convenor who is also a Q member. It will have representation from each of the CSGs in the English regions and from Scotland, Wales and Northern Ireland's CSGs. Finally, it will have some delegated responsibilities for financial and performance oversight for Q, administered through grant arrangements to be agreed with the Health Foundation/NHS Improvement.

Roles & Responsibilities

Commons Stewardship Group:

These responsibilities aim to reflect Ostrom's principles for governing the commons:

- Establish the values of the Commons Stewardship Model.
- Work with others to develop and monitor the delivery strategy for Q at a local level, including how it connects with other QI initiatives and organisations. This should help Q evolve over time as an important platform for cross-system collaboration and development.
- Monitor and support the Q recruitment processes to attract and develop a pipeline of applicants for Q. Share good practice in the recruitment of new members.
- Contribute to the strategic growth of the Q community and its activities at a local level.
- Secure resources and make decisions about the allocation of Q-specific funding, involving members as appropriate.
- Develop and oversee/support the 'common spaces' of Q: agreeing ground rules with members, ways of monitoring the health of the community locally, and where appropriate, manage the sanctions for departures from the values of the commons.
- Monitor the work to encourage and support the core of active members who play particular roles in leading Q locally, ensuring they are appropriately recognised for

their contribution. This will include the Q connectors[4].

- Oversee design, delivery, evaluation and improvement of Q-specific events and activities, helping to resolve issues locally wherever possible through active stewardship of people and resources. Ensure that learning about what works and what does not is reflected on and shared, including by contributing to Q-community wide mechanisms for capturing learning.

- Promote engagement in Q Lab projects[5] and other activities and the outputs of these.

- Protect and enhance the reputation of Q, promoting it to stakeholders, ensuring they understand and respect the basis on which Q works.

- Provide financial oversight as required by the Q project team and any others making a financial contribution to Q activities.

- Oversee processes for resolving disputes within the Q community.

Q Convenor:

Each CSG will have a convenor, with the following indicative responsibilities:

- Uphold and promote the vision of Q, its values of creativity, co-production, shared decision making and stewardship and reflect the community's commitment to person centredness and multidisciplinary collaboration.

- Convene and chair meetings of the CSG and work closely with the Q project team on the agenda, meeting notes, and engagement and dissemination.

- Provide support to the CSG members as required.

- Ensure there are opportunities for training and development of the other commons convenors and group members, and participate in review of the group members' contribution and time commitment as required.

- Liaise with the Q Project team and to Q Connectors as required.

- Act as an ambassador for Q, representing the interests of the community.

- Develop and maintain constructive, collaborative relationships with Q members and external stakeholders and organisations with a shared interest in continuous and sustainable improvement in health and care.

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[4] Q Connectors are members who will play a key role in sharing knowledge and interfacing across geographical and other boundaries (add hyperlink)

[5] Q Lab projects will provide Q members and others with the space to work together on high priority challenges https://q.health.org.uk/q-improvement-lab/

- Represent their group on the UK-wide CSG.
- Commit up to 10 days a year on CSG activities in the first 12 months, initially.

CSG Members:

Members of the Commons Stewardship Group (CSG) will:

- Uphold and promote the vision of Q, its values of creativity, co-production, shared decision making and stewardship and reflect the community's commitment to person centredness and multidisciplinary collaboration.
- Develop and maintain constructive collaborative relationships with Q members and other local stakeholders and organisations with a shared interest in continuous and sustainable improvement in health and care.
- Demonstrate strong influencing skills in the support and promotion of local improvement initiatives, potentially championing a specific cross-STP improvement project.
- Co-create, along with other CSG members, the Q Community masterclasses, to meet the needs of local community members, encouraging cross-organisation collaboration.
- Demonstrate leadership at local Q events and be a local contact point for improvers to gain direction, motivation and coaching.
- Attend and positively contribute to CSG meetings, bringing expertise to the discussions and actively participating in promoting Q.
- Commit to four two-hour CSG meetings (preferably face-to-face) throughout the 12-month pilot, with an option to review contribution and time commitment after each meeting.
- Demonstrate enthusiasm, determination and commitment to enhancing the positive reputation of Q and have strong influencing skills.
- Positively promote the CSG and Q initiative to others who may be interested in joining the Q Community[6].

Membership

Although it is recognised that THF *Q Governance Guidance* suggests a membership of seven, in the West of England, we are initially aiming for membership which will consist of **Q members from each of our geographical areas** with the intention that providers

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[6] There are currently 140 Qs in the North East and North Cumbria AHSN and we aim to increase this significantly by December 2018.

(primary, acute, mental health), patients / carers and commissioners are all represented, totalling **nine**.

Membership to the CSG is on a voluntary basis.

Administration

- The CSG will be chaired by the Q Convenor.
- It is the responsibility of the Convenor to ensure everyone has an equal opportunity to access and contribute to the discussion. It is the responsibility of members to support the Convenor in this role.
- The North East and North Cumbria CSG will meet on a quarterly basis during the 12-month pilot and will be a maximum of two hours in length. The meetings will be conducted using a PDSA cycle approach, so that we can test, evaluate and make changes to improve them throughout the course of the pilot.
- Administrative support will be provided during the 12-month pilot, by the North East and North Cumbria AHSN Academy Co-ordinator which includes:
    - Booking venues across our geographical areas throughout the year;
    - Distributing the agenda and any associated papers (note, the agenda should be shaped by the Convenor and the CSG members);
    - Writing the minutes and circulating within two weeks of the meeting.
- In line with the THF *Q Governance Guidance*, meetings will be held in public with minutes shared online for transparency.
- Travel and subsistence payments will be made in line with Health Foundation guidelines:
    - Where Q members are employed and their employers fund the costs of professional development activities, travel and subsistence costs may be met by the employer.
    - Where Q members are self-employed and have no access to travel and subsistence costs, they may apply to Q for these costs when undertaking governance work.
    - Q will provide travel and subsistence costs for patients and carers and additionally a personal assistant where this is required. In this context, a carer is defined as someone who is designated as such by a Q member and who is not in paid employment in the public sector.

- In line with Ostrom's principles of governing the commons, in the unlikely event that any conflict arises between members, it will be resolved within the CSG, using advice and guidance from The Health Foundation where required. There is no external responsibility to members' employing organisations or the North East and North Cumbria AHSN.

Appendix 5 Indicative responsibilities of the CSGs

Commons Stewardship Group
Indicative responsibilities

1. Establish the values of the commons stewardship model
2. Work with others to develop the delivery strategy for Q at a local level, including how it connects with the wider HF strategy for improvement and with other QI initiatives and organisations. This should help Q evolve over time as an important platform for cross-system collaboration and development.
3. Monitor and support Q recruitment processes and develop a pipeline of applicants for Q and share good practice in the recruitment of new members.
4. Secure resources and make decisions about the allocation of Q-specific funding, involving members as appropriate.
5. Develop and oversee the 'common spaces' of Q nationally, agreeing ground rules with members, the ways of monitoring the health of the community locally where appropriate manage the sanctions for departures from the values of the commons.
6. Monitor the work to encourage and support the core of active members who play particular roles in leading Q locally, ensuring they are appropriately recognized for their contribution.
7. Oversee design, delivery, evaluation and improvement of Q specific events and activities.
8. Promote engagement in Q lab projects and the outputs of these projects.
9. Protect and enhance the reputation of Q nationally, promoting it stakeholders, ensuring they understand and respect the basis on which Q works.
10. Develop processes for resolving disputes within the Q community