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Strengthening the contribution of improvers to UK health and care?

An evaluation of the Q Initiative 2016–2020

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Preface

Q is an initiative run by the Health Foundation, with additional funding from NHS England and Improvement. Q has the aim of connecting people across the UK interested in, experienced in and committed to improving health and care. In 2016, RAND Europe was commissioned by the Health Foundation to conduct an independent evaluation of the second phase of the Q initiative. This builds on an evaluation conducted by RAND Europe on the first co-design phase of Q (Garrod et al., 2016). The second phase of the evaluation took place from 2016 to 2020. A report of the interim findings of the second phase evaluation was published in 2018 (Ling et al., 2018). The present report was written in January 2020 and thus the data and findings are related to the context of Q at that time. Where appropriate, however, the report reflects on the whole journey of Q to date, including the co-design phase.

This evaluation of the Q initiative is likely to be of interest to policymakers, improvement practitioners and researchers interested in how to improve health and care in the UK. Q is also of international importance and is a significant example of an effort to achieve change at scale in a complex system. It is therefore likely to be of interest to researchers and practitioners with a wider interest in understanding how best to build a capacity to learn and improve and create effective communities/networks.

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Executive summary

What is Q?

Q is an initiative that, from April 2020, is led by the Health Foundation and supported by partners across the UK and Ireland, to connect people with improvement expertise from across UK health and care. It aims to 'foster continuous and sustainable improvement in health and care' through connecting members across the UK (The Health Foundation, n.d.-a). This greater level of connectedness can then encourage the sharing of knowledge and experiences while learning how to overcome challenges faced by improvers in the healthcare system.

Q has four key areas of focus: connecting, supporting, developing and collaborating. 'Connecting' refers to members being able to create and strengthen new relationships within the Q community and beyond. 'Supporting' involves Q members offering support to each other in their improvement work. 'Developing' relates to Q members learning more about improvement work and engaging other members in this learning. Finally, 'collaborating' relates to Q members being able to organise to establish, develop and spread improvement work. It is anticipated that by developing the infrastructure to create a national network and community of improvers and supporting this group to undertake improvement work, Q will contribute to a sustainable environment of improvement across the health and care system in the UK.

Q is unusual as an organisation committed to supporting improvement in that it is co-owned and was co-designed by its members. The demographics of Q members have widened over time, from a small but broad group of Quality Improvement leaders at its inception to over 3,500 members from a wider range of backgrounds including the front line of healthcare, improvement leads, patient representatives and policymakers. Q is also designed to support other improvement initiatives in the healthcare system.

Q offers members a variety of resources and activities, many of which have been introduced since the co-design year was completed and this evaluation began in 2016. An outline of these opportunities can be found in Box 1 below. While we outline the different activities and resources below, we are aware that Q is more than a suite of offers. It aims to create a platform for improvement across the UK through bringing members together in new and creative ways, creating opportunities for learning new skills, experiencing new ways of working and supporting change in areas of shared interest. In practice, many members value being able to 'dip in and out' of the different offers at a time and intensity that suits them.

Q has indicative commitments for funding until 2030, and the intention is to grow the membership of Q to some 10,000.

What do Q members do?

The number and type of resources and activities offered through Q have expanded over the years and includes both virtual and face-to-face opportunities for engagement. These are largely viewed in a positive light by members, who report that they find them useful in their improvement work. However, it is important to note that members value not only the activities and resources on offer but also the relationships and mutual learning that underpins the design of Q. In addition to engaging with each other in less formal settings, members can expect to engage with at least some of the following organised activities:

Box 1: Resources and activities offered through Q[1]

Member Directory:
An online directory of all Q members which can be filtered by area of interest and location. Members can message Q members through this website.

Randomised Coffee Trials (RCTs):
RCTs offer Q members the opportunity to be randomly paired with another Q member to discuss (in person or remotely) ongoing projects or other areas of interest.

Events:
Q events can be on a national, regional or local level for all Q members or for those with specific interests. Annual national events are held that are open to all Q members and take place in various locations across the UK. Events are also held at a local and regional level, organised by Q members and often focusing on a particular topic and/or have a keynote speaker who is a recognised individual working in improvement.

Q Visits:
These are visits to healthcare and non-healthcare organisations to provide Q members with insights into quality improvement and learning approaches that are being used elsewhere. Themes have included co-design, Lean methodology[2] and Improving Joy in Work. Q visits have taken various forms to date, including immersive visits, study days, open days and workshops, and have included visits to organisations such as GlaxoSmithKline, Prostate Cancer UK, the Sheffield Flow Coaching Academy (FCA) and Jaguar (The Health Foundation, 2019g).

1 This reflects the activities and resources available as of January 2020. The date when each activity was launched can be found in Figure 2.

2 Lean methodology was originally created in the manufacturing industry in the 1950s to introduce mechanisms to reduce waste. The approach has since developed over time and has been applied to other sectors, including healthcare, as a way of optimising efficiency while reducing waste. More information can be found here: https://leankit.com/learn/lean/lean-methodology/

Q Communications:
There is a range of communications activities to share news and other relevant information to members from the Q team at the Health Foundation. For example, monthly Q-municate newsletters distributed to members via email to provide updates on Q, such as upcoming events, and share information on the improvement work members have been involved with. Q also has a strong presence on Twitter, in which 16,000 people follow the Q account.

Webinars:
Q members can attend and organise their own webinars on quality improvement online. The talks so far have included such topics as quality improvement for beginners, human factors, communities of practice and service user involvement in improvement (The Health Foundation, 2019i).

Journals and learning resources:
Q provides members with access to several online resources and academic journals, including the opportunity to publish members' work. Members have access to the *BMJ Quality & Safety* journal and can publish in *BMJ Open Quality* journals. Resources to support Q members in understanding key improvement tools and concepts are also provided, such as the Institute for Healthcare Improvement (IHI) Open School (The Health Foundation, 2019b).

Creative Approaches to Problem Solving toolkit:
This toolkit provides Q members with 25 methods of creative and collaborative problem solving (The Health Foundation, 2019a).

Liberating Structures:
Q offers members' workshops and a Special Interest Group (SIG) on Liberating Structures, a set of over 30 techniques for facilitating meetings, events and conversations (The Health Foundation, 2019c).

A Quality Improvement[3] Connect WebEx series:
Set up in 2014 in Glasgow, these WebEx series allow global improvement leaders to speak about their area of expertise within QI. Q provides access to these webinars, rather than directly funding the sessions. So far, this has involved over 1,000 organisations and 88 universities from 62 countries. The QI Connect podcast provides Q members with the last five QI Connect sessions in the series. These podcasts are also available to non-Q members (The Health Foundation, 2019h).

3 Quality Improvement (capitalised) refers to a set of quality improvement approaches and methods which, by convention, are capitalised by practitioners. As Q includes both Quality Improvement and other improvement work that may not necessarily quality as official Quality Improvement, we use these terms interchangeably throughout this report.

Online groups/Special Interest Groups (SIGs):
These are online groups with a dedicated message forum for members to connect and share resources on a specific topic. SIGs are also able to organise their own webinars and events. As of January 2020, there are 47 active SIGs, including groups focusing on particular health delivery areas (e.g. Urgent and Emergency Care; Women's Health), methods and tools (e.g. Big Data; Evaluation) and well-being at work (e.g. Staff Wellbeing and Quality Health Care, Improving Joy in Work) (The Health Foundation, 2019d), as well as 28 other online groups, such as those for Q Lab and regional groups.

Connecting Q locally:
This is a funding programme open to Q SIGs/online groups and partner organisations to support Q members to build networks across the improvement landscape. In 2019/20, members could apply for £5,000–£20,000 to undertake a project in one of the following areas: facilitating local network development, holding events or site visits to support the development of new connections, or activities to convene Q members around a particular topic.

Q Exchange:
This is a funding programme that launched in 2018 and has since run a second round in 2019. It offers those improvement projects which are selected by a vote of members of the community up to £30,000 in funding. Applicants develop their ideas with the help of the Q community through a collaborative online process. The 2019 funding round was focused on two themes: building improvement capability across boundaries and understanding alternatives to traditional outpatient appointments (The Health Foundation, 2019f).

Q Lab:
The Q Lab works with Q members and others to make progress on specific important and complex challenges that have proved difficult to overcome. The Lab undertakes a fast-paced research and discovery phase, pooling the best available evidence about an issue and drawing on the 'hive mind' of Q to draw out practical lessons from patients and practitioners. Drawing on these insights, it works with frontline teams to develop and test improvement ideas in practice, sharing learning about promising interventions and insights.

Impacts on members' professional lives

Q members reported being able to expand their networks, connecting to individuals they felt they would not have been able to meet without Q. These new connections span multiple boundaries, including professional, organisational and geographical (particularly for those in remote, rural locations). Members generally report positively on their experiences of engaging with Q with some regarding it as transformative.

The connections made through Q were used in several ways, including both in supporting ongoing improvement activities as well as helping with identifying and creating new improvement projects. We tracked many of these changes through our social network analysis (SNA) in the co-design phase of Q and this demonstrated significant growth in both bridging (to individuals at some distance) and bonding (with more proximal individuals). For methodological and practical reasons, it was not possible to replicate the SNA in later years, but our interview data and focus groups show that continuing growth of bridging and bonding was highly appreciated by members. In particular, Q Exchange was highlighted as a collaborative approach to bidding for funding, which has led to the creation of new connections and new projects that would not otherwise have been possible. For those engaging with Q Lab, while the process was often thought of as a positive opportunity to engage with a range of experts (including experts by experience), some participants were unsure about the impacts realised.

Members report that Q has supported them to develop in several ways. It has contributed to acquiring and sharing knowledge through training and exposure to new approaches (Liberating Structures is a particular training session frequently mentioned by members as being useful) and online resources. In addition, Q Exchange and other connections made through Q were seen as ways of learning what was happening in other areas of the country and to learn from elsewhere. Q also supports the personal development of members, with participants reporting feeling greater confidence when undertaking improvement work. However, there were differing opinions as to whether Q offers the same support for service users, with some feeling that Q meaningfully and actively engaged service users and others feeling this is not the case.

While further progress should be made in this respect, we recognise how challenging it can be to create effective engagement mechanisms for very different groups of service users and identify Q Lab as having especially creative responses to this challenge.

The Q community is often described by its members as being a visible, warm, open and a safe space to express ideas and develop new knowledge. For many Q members, this has contributed significantly to their self-confidence as improvers. In places, and not yet at scale, this is making an important contribution to improving the context of improvement in the UK health and care system.

Impact on the health and care system

Q has contributed to raising the profile of QI at an organisational, regional and national level. Many specific examples of improvement to the health and care system were identified, but these are yet to cohere into a change across the system and at scale. A barrier to achieving change at scale is that Q has faced challenges in engaging organisational and system leaders who might then draw upon and galvanise the resources Q makes available. Many leaders outside of Q were not aware that Q is available to them as a resource and were not aware of who the Q members are in their organisation. There were also concerns that Q is not as visibly aligned with the key priorities of the NHS as it should be, leading to it being viewed by some as 'outside' the system. For these reasons, we regard Q as an underutilised asset and believe that leaders at the organisational, regional and national level could collaborate more effectively with Q as an organisation with mutual benefits for the community of improvers as well as the health and care system as a whole. We are aware that this

view is shared by the Q leadership team, as is reflected in current plans for Q.

The design and governance of Q

The co-design phase of Q was key to ensuring Q was designed around the needs of the members. Q is still seen as a community co-owned by the members and the Q team and stakeholders. Partnerships, such as with NHS England and Improvement, Academic Health Science Networks (AHSNs) and country partners, have been vital in creating Q and supporting the rapid growth and evolution of Q to where it is today. Continuing to foster these relationships, as well as creating new partnerships, will be important for the Q team going forward. Relationships with stakeholders have been open and mutually supportive.

The Q team at the Health Foundation has grown considerably since Q was first established and as the membership of Q has expanded. It will be important to consider how the existing Q team manages roles and responsibilities as the Q membership continues to expand if the Q team does not (or even if it does). The ability to grow the Q infrastructure in a way commensurate with Q's growth in scale and ambition in the coming decade will be critical to its success.

There are several efforts in place to create regional structures and approaches such as the Commons Model, Q Convenors and Q Connectors. This highlights the need for an effective infrastructure for engagement and mobilisation that can operate between the levels of the individual members and the UK-wide Q team. There are mixed opinions as to the extent to which these efforts have been successful. In our view, they reflect careful thought but have not yet created stable structures at this level in England (although this situation is different in Northern Ireland, Scotland and Wales as each of which has its own approach to this challenge).

In summary

Q has:

- Engaged a cadre of thousands of improvers who have brought energy, a willingness to learn and mutual support to a community working across the UK health and care system inspiring new behaviours.
- Created a set of activities and resources that create a capacity to support improvement work that contributes to patient and health care improvements both directly (through projects that would not otherwise have taken place) and indirectly (through raising the profile of improvement and the self-confidence of improvers). The activities outlined in the box above offer a range of routes into engaging with Q and members highly rate the freedom of choice this offers. Members pick and choose among these options, rarely pursuing more than three in any depth.
- Built a design, reputation and approach that can credibly support the claims to increase the scale and ambition of Q in the coming decade. Demand, as measured by new members, remains buoyant with the feasible aim of achieving some 10,000 members by 2030.
- Convinced leading international commentators on improving quality in healthcare (interviewed for this evaluation) to remain supportive of Q and its progress, and at the same time persuaded stakeholders, including NHS England and Improvement, to continue to support the initiative.

Q has not (yet):

- Put in place an organisational infrastructure (i.e. the systems and supports that make possible, among other things, Q activities, membership support and information

about events and resources) that will support the ambitions of Q in the coming decade.

- Connected the energy it has created to establishing a sustained basis for improving health and care at scale and across the UK health and care system.
- Persuaded system leaders in delivering health and social care to regard Q as a crucial resource when considering how to improve services and achieve better outcomes for service users.

Looking forward

The wider context of Q is that quality improvement activities do not regularly improve quality (Dixon-Woods & Martin, 2016) and certainly not at scale. In our view, techniques for delivering and measuring improvement are critical but they succeed only if they can change the way improvement work is done, if people have the confidence, space, skills and resources to put into practice the improvement tools. We are clear that Q has introduced members to new ideas and approaches, established new relationships and built confidence; the cultural capital needed to command attention, collaborate and identify solutions is not automatically generated by the routine working of the health and care systems and might even be undermined by it.

In our view, Q provides this missing element in improvement. 'Quality Improvement', and 'improvement' in general, involves simultaneously gaining confidence in the mastery of improvement techniques while navigating organisational change (for example, bringing the language of Lean management or Plan, Do, Study, Act (PDSA) into a clinical setting) and mobilising the relationships needed to be resilient and sustain change.

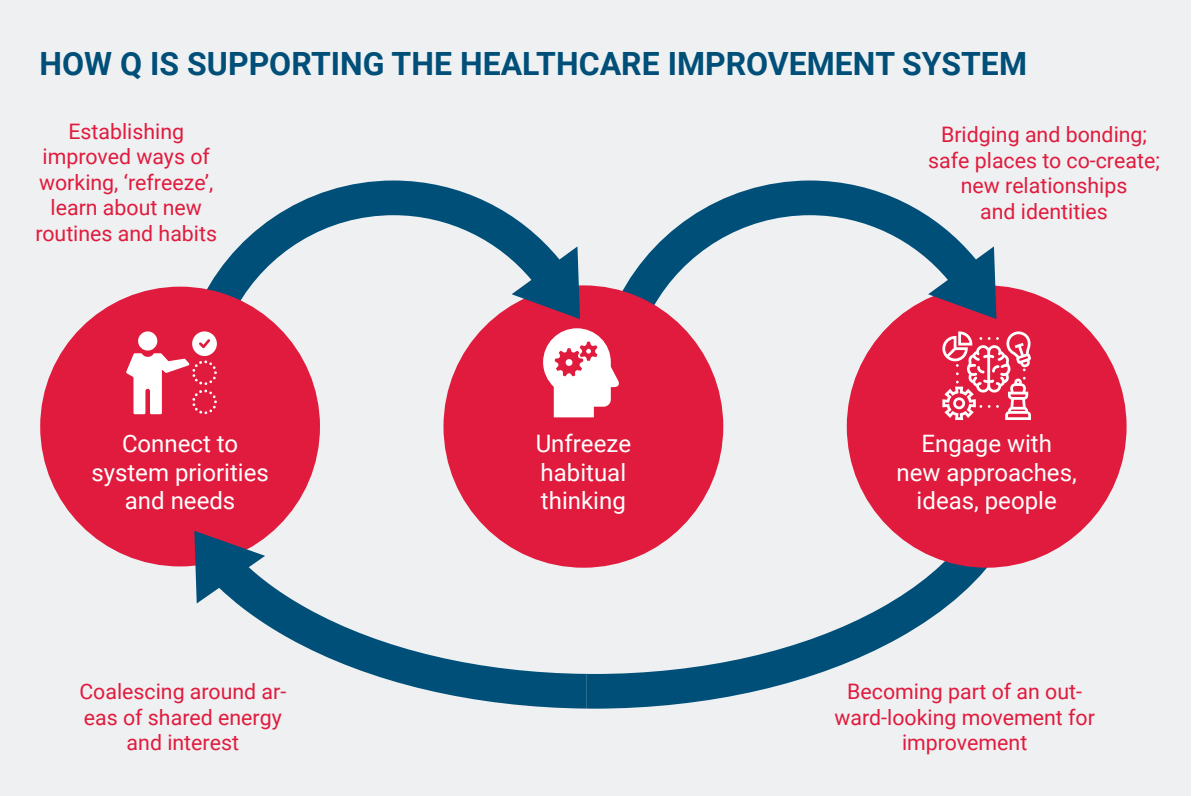
What might be needed to deliver this vision in the coming years?

We have completed our evaluation of Q up to the beginning of 2020 and, as far as the data allowed, addressed the evaluation questions. However, we also reflect here in the potential of Q to deliver in the coming years and the barriers it may face. The purpose and approach of Q remains as broadly described in the theory of change but operationalising this will necessarily evolve as the scale and ambition of Q and its members develop. This will simultaneously provide an opportunity to revisit the theory of change in light of this evolution.

Unlocking increased energy for improvement; unfreezing habits and inspiring new behaviour

When people in the health and care system 'do' improvement, they are doing a very particular kind of work. They are taking time out of their routine tasks and focusing on how to do these better. Specifically, they are drawing upon a distinct set of techniques, concepts, ways of working and bodies of evidence to think in new ways about the problems they face in their organisational setting and how these might be addressed. It involves drawing upon ideas that have their origins outside of health care and then socialising these ideas so they can make sense in a health and social care setting. This requires an elaborate set of skills and knowledge, and an ability to navigate the particular power relationships and organisational structures that form health and social care systems. However, in addition to the formal knowledge of techniques of improvement and measurement that are fundamental to the process of improvement, they also involve tacit, informal and often unconscious processes. These are part of what Bourdieu describes as the 'habitus' of the social world (Bourdieu, 1977). Although not originally focused on health and care settings,

Figure 1: The contribution of Q to supporting at scale improvement in health and social care systems



this describes the ingrained dispositions of people working there. It is evident from this evaluation how improvers perceive the world and their role within it. Their ability to affect change reflects their position in society more generally but also their place in a health and care system. Habitus might be thought of as the way that improvers perceive the social world around them and react to it. It might be thought of as 'the way we do things around here', but it is also 'the way we change things around here'. It precedes and shapes how improvers engage with improvement tools. As a result, it should be unsurprising that without relational and emotional support available in the workplace place setting improvers often fail to achieve lasting change. What we have learned is that it is at least possible to create a set of relationships and resources that will help improvers become more confident in their skills and their understanding of improvement and to be inspired to act differently. This is a process that involves unfreezing habitual thinking, engaging with new ideas, and eventually creating new routines around an improved system. We have found that Q contributes to supporting improvers to think differently, acquire new skills, and bridge and bond to others as part of an outward-looking movement for improvement. We have also found that connecting this to system priorities and needs, and coalescing new behaviours around these, is still developing. As this becomes established, we anticipate that new improvements will become stabilised in new routines and habits. We describe this in Figure 1.

Q is a radical approach to balancing the two legs of improvement; on the one side, the formal technical tools and measurements and on the other side the informal, tacit and unconscious dispositions. By connecting individuals and groups in new ways, both bridging and bonding, to introduce new ideas and as part of an outward-looking 'movement for improvement' (Waring and Crompton, 2017), Q links these two dimensions in practical ways. Ideally, this movement helps participants work together in new ways that allow sustainable improvement at scale across the whole system. In our view, this only becomes possible when the movement aligns its goals with the priorities of the wider system. This is an approach to 'doing' improvement that is focused on changing the work that improvers do by mobilising connections and stimulating learning. Through Q Labs and Q Exchange, for example, Q members show not only engagement with new groups and individuals but also report new behaviours. Habitual dispositions can be unfrozen and new possibilities entertained by improvers with the self-confidence to believe that they can deliver practical change. Individuals, working as peers with other improvers, can support a sense of agency in others and groups can forge a new sense of purpose around particular improvement projects. This is not trivial and it has wider implications for understanding how change happens in complex organisations.

Agency is therefore central to understanding what Q has achieved. Agency reflects both the capacities and resources individuals have and their perceptions of their own capacities and resources. Agency can be enhanced both by developing new skills and resources and by increased self-confidence in using them. Being part of a movement or group such as Q can both increase confidence (and this is consistently seen in member surveys) and make new tools and techniques available (through access to web-based material, site visits, workshops at national events and so forth). Accomplishing greater agency is challenging and requires psychological and emotional support.

In summary, we recommend:

	Priorities to change	To consider	To continue
 **Governance, design and management of Q**	Q Connectors role – little evidence of impact and uncertainty around the role Q Convenors role – little evidence of impact and some uncertainty around the role AHSNs – played an important role in Q in England. In some English regions, members view AHSNs as crucial; in others, there can be an active regional dimension with much less AHSN involvement. Creating an effective approach that respects regional differences but ensures support across the UK is critically important	NHS England and Improvement could play a more visible role in Q governance, bringing added legitimacy without being perceived as exerting excessive control Commons model – pilot Commons model does not seem to have worked, yet a governance model for regional Q is needed as it grows The Q team should review its use of the theory of change and its role in communicating the design of Q to its members to continue its use as a management tool, but end its use as a communication tool for members	The Health Foundation should reflect upon the success of the Q team's leadership and ways of working and ensure their approach remains fit for purpose in light of the challenges facing Q as it grows in scale and (most likely) complexity
 **Q community and infrastructure**	Q offers members a good infrastructure for recruitment and engagement, but this will need to be reviewed, initially by the Q team but in close collaboration with regional partners and members, in the light of continuing increases in scale, the need for regional involvement in recruitment and discussions about how rigorous the recruitment process should be Members appreciate a variety of routes to engagement. However, as the scale and reach of Q grows, the evaluation lead of the Q team should consider conducting a discrete choice experiment to more precisely understand how members trade off the benefits they perceive from different activities (i.e. going beyond understanding that they like every free good that is offered)	Q has always thrived on the basis of the time and effort put in by members and this effort has always been unevenly distributed. Q team and members should consider whether they want to give the more active contributors to Q some form of recognition Learning materials are well regarded but some members report they are difficult to navigate and should be improved The Q communication strategy was not a focus of this evaluation but could be included in future evaluations of Q	Q Exchange and site visits are highly regarded and should be continued (with possible incremental improvements) by Q leadership Members continue to show loyalty and trust to Q and the existing branding and communications that support this should be continued

	Priorities to change	To consider	To continue
 **Support for members to undertake improvement work**	Q members feel connected, enabled and empowered by Q, and continuing this is fundamentally important for future success. However, Q members should also challenge each other to ensure that what may be relevant and important to them is also important to other stakeholders in the health and care system		Continue offering members flexible packages to support a broad suite of skills and knowledge including technical, leadership, persuasion, collaborating and learning Q activities continue to be well regarded by participants and should continue to provide a platform for mobilising and supporting a significant cohort of improvers
 **Contribution to improvement in health and care across the UK**	Q members should seek greater visibility at senior levels of Trusts, other health and care organisations, and the NHS. NHS England and Improvement, the Health Foundation and the Q team should actively support and facilitate this	Q team should consider, with members, how recruitment criteria might be adapted to include members with special skills in influencing decision makers	Q should continue to be a resource that independently sets its own improvement agenda
 **Cross-cutting recommendations/ tensions to manage**	Q should: 1. Both build networks and relationships, on the one hand and engage with those in positions of professional and organisational power on the other; being both movements for mobilising members and a resource for the wider health and care system. 2. Continue to identify novel approaches and innovative ways of working, but at the same time provide support for long-term learning based upon routinised working; both at the cutting edge and the core of the health and care system. 3. Both strengthen links among people and groups who already know each other and create opportunities for new groups to be formed; both bridging and bonding. 4. Combine and mobilise both the experiential knowledge of service users and improvers and the formal evidence from research; both tacit and technical. 5. Be both top-down (responding to what system leaders want) and bottom-up (drawing upon the experience and insight of those delivering services); responding to signals from both above and below.		


Exit

Table of contents

Figures

Tables

Boxes

Abbreviations

AHSN	Academic Health Science Network
AMR	Antimicrobial resistance
BAME	Black, Asian and Minority Ethnic
BMJ	British Medical Journal
CCG	Clinical Commissioning Group
EAG	Evaluation Advisory Group
FCA	Flow Coaching Academy
GP	General Medical Practitioner
HIS	Healthcare Improvement Scotland
HSC	Health and Social Care
HSCQI	Health and Social Care Quality Improvement
ICS	Integrated care systems
IHI	Institute for Healthcare Improvement
ISQua	International Society for Quality in Health Care
IQT	Improving Quality Together
NHS	National Health Service
PDSA	Plan, Do, Study, Act
QI	Quality Improvement
QuIPPs	Quality Improvement Partner Panels
SIG	Special Interest Group
SNA	Social network analysis
STP	Sustainability and transformation partnership
THIS Institute	The Healthcare Improvement Studies Institute
UK	United Kingdom
US	United States

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We would also like to thank our internal reviewers, Jenny George and Jon Sussex, and the anonymous external reviewers, who provided valuable comments on an early draft of this report.

We are grateful to the many Q members and wider stakeholders who gave us their time to provide invaluable and thoughtful reflections for this evaluation. We also appreciate the open and frank relationship fostered by the Q project team, particularly the Evaluation and Insight Managers and Evaluation Advisory Group (EAG) over the last five years. Q as an initiative seeks to nurture a spirit of openness, and this spirit has continued to be apparent in our engagement with stakeholder organisations and individuals involved in supporting Q.

The report was designed by Jess Plumridge.


Hall Two

1 Q in context

This chapter provides an overview of what the Q initiative is, including its aims and how it sets out to meet these. It will also describe how Q has changed and evolved since it was first established in 2014, and how Q fits within the wider improvement landscape across the UK (which we return to in Chapter 4). It also provides an overview of the evaluation approach and the strengths and limitations associated with the approach.

1.1. What is Q?

Q is an initiative which, as of April 2020, is led by The Health Foundation and supported by partners across the UK and Ireland, to connect people with improvement expertise from across UK health and care. It aims to 'foster continuous and sustainable improvement in health and care' through connecting members across the UK (The Health Foundation, n.d.-a). This greater level of connectedness can then encourage the sharing of knowledge and experiences while learning how to overcome challenges faced by improvers in the healthcare system.

Q has four key areas of focus: connecting, supporting, developing and collaborating. 'Connecting' refers to members being able to create and strengthen new relationships within the Q community and beyond. 'Supporting' involves Q members offering support to each other in their improvement work. 'Developing' relates to Q members learning more about improvement work and engaging other members in this learning. Finally, 'collaborating' relates to Q members being able to organise to establish, develop and spread improvement work. How these key areas of focus are linked to the Q infrastructure is outlined in the theory of change discussed in Section 1.1.5. It is anticipated that by developing the infrastructure to create a national network and community of improvers and supporting this group to undertake improvement work, Q will contribute to a sustainable environment of improvement across the health and care system.

Q is unusual as an organisation committed to supporting improvement in that it is co-owned and was co-designed by its members. The demographics of Q members have widened over time, from a small group of Quality Improvement leaders at its inception to over 3,500 members from a range of backgrounds including the front line of healthcare, improvement leads, patient representatives and policymakers. Q is also designed to support wider improvement work that is ongoing in the healthcare system.

Q offers members a variety of resources and activities, many of which were not designed when Q was first established but which have since been introduced. An outline of these offers can be found in Box 2 below. While we outline the different opportunities below, we

are aware that Q is more than a suite of offers. It aims to create a platform for improvement across the UK through bringing members together in new and creative ways, creating opportunities for learning new skills and experiencing new ways of working. In practice, as we note in Chapter 2, many members value Q in its offer of being able to 'dip in and out' of the different resources at a time and intensity that suits them, rather than treating it as an 'all or nothing' offer.

Box 2: Resources and activities offered through Q[4]

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Q members can attend and organise their own webinars on quality improvement online. The talks so far have included such topics as quality improvement for beginners, human factors, communities of practice and service user involvement in improvement (The Health Foundation, 2019i).

Journals and learning resources:
Q provides members with access to several online resources and academic journals, including the opportunity to publish members' work. Members have access to the *BMJ Quality & Safety* journal and can publish in *BMJ Open Quality* journals. Resources to support Q members in understanding key improvement tools and concepts are also provided, such as the Institute for Healthcare Improvement (IHI) Open School (The Health Foundation, 2019b).

Creative Approaches to Problem Solving toolkit:
This toolkit provides Q members with 25 methods of creative and collaborative problem solving (The Health Foundation, 2019a).

Liberating Structures:
Q offers members' workshops and a Special Interest Group (SIG) on Liberating Structures, a set of over 30 techniques for facilitating meetings, events and conversations (The Health Foundation, 2019c).

A Quality Improvement[6] Connect WebEx series:
Set up in 2014 in Glasgow, these WebEx series allow global improvement leaders to speak about their area of expertise within QI. Q provides access to these webinars, rather than directly funding the sessions. So far, this has involved over 1,000 organisations and 88 universities from 62 countries. The QI Connect podcast provides Q members with the last five QI Connect sessions in the series. These podcasts are also available to non-Q members (The Health Foundation, 2019h).

6 Quality Improvement (capitalised) refers to a set of quality improvement approaches and methods which, by convention, are capitalised by practitioners. As Q includes both Quality Improvement and other improvement work that may not necessarily quality as official Quality Improvement, we use these terms interchangeably throughout this report.

Online groups/Special Interest Groups (SIGs):
These are online groups with a dedicated message forum for members to connect and share resources on a specific topic. SIGs are also able to organise their own webinars and events. As of January 2020, there are 47 active SIGs, including groups focusing on particular health delivery areas (e.g. Urgent and Emergency Care; Women's Health), methods and tools (e.g. Big Data; Evaluation) and well-being at work (e.g. Staff Wellbeing and Quality Health Care, Improving Joy in Work) (The Health Foundation, 2019d), as well as 28 other online groups, such as those for Q Lab and regional groups.

Connecting Q locally:
This is a funding programme open to Q SIGs/online groups and partner organisations to support Q members to build networks across the improvement landscape. In 2019/20, members could apply for £5,000–£20,000 to undertake a project in one of the following areas: facilitating local network development, holding events or site visits to support the development of new connections, or activities to convene Q members around a particular topic.

Q Exchange:
This is a funding programme that launched in 2018 and has since run a second round in 2019. It offers those improvement projects which are selected by a vote of members of the community up to £30,000 in funding. Applicants develop their ideas with the help of the Q community through a collaborative online process. The 2019 funding round was focused on two themes: building improvement capability across boundaries and understanding alternatives to traditional outpatient appointments (The Health Foundation, 2019f).

Q Lab:
The Q Lab works with Q members and others to make progress on specific important and complex challenges that have proved difficult to overcome. The Lab undertakes a fast-paced research and discovery phase, pooling the best available evidence about an issue and drawing on the 'hive mind' of Q to draw out practical lessons from patients and practitioners. Drawing on these insights, it works with frontline teams to develop and test improvement ideas in practice, sharing learning about promising interventions and insights.

1.1.1. The origin and evolution of Q

Q was set up in response to two main factors. The first and more immediate influence was the release of two reports highlighting failings in the NHS and the need for improvement to be conducted at scale and a faster pace in an environment of financial pressures. The first of these two reports was the Francis Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, which highlighted failings in the Trust from 2005 to 2009 (Francis, 2013). The Francis Report made over 300 recommendations for improvement, such as the need to identify who has improvement

expertise within the healthcare system. The second report was the Berwick Review, released in 2013 in response to the Francis Report. The Berwick Review focused on several issues, including those relating to patient safety and human factors.[7] The review recommended the creation of a system devoted to learning and improvement within the NHS to rapidly support the 'bottom-up' capacity of the healthcare system and connect the pockets of improvement happening across the UK (Berwick, 2013).

The second factor driving the creation of Q was growing anxiety about a variety of improvement programmes and initiatives ongoing in the 2000s and early 2010s, including some offered by the Health Foundation, in which the evidence of success was limited (e.g. Ling et al., 2010). These improvement activities faced some challenges that contributed to the difficulties in demonstrating success, including being too short term, disregarding the local context and a lack of learning from others working in similar areas.

In the spring of 2014, the Health Foundation, following an invitation and support from NHS England, agreed to design and lead what was provisionally known as the 5,000 Safety Fellows initiative in response to these two main driving factors and in recognition of the Health Foundation's ability to implement such a programme on a UK-wide scale. Initial scoping involved several Quality Improvement (QI) leaders and other key experts. In March 2015, the 5,000 Safety Fellows initiative was rebranded as Q reflecting a sense that improving safety and improving quality were closely linked.

The following month, April 2015, saw the recruitment of the founding cohort of 231 Q members through nominations from 48 organisations, who co-designed Q along with other leaders of improvement and wider stakeholders (over 500 people in total). This group has continued to support the design and development of Q since they were first recruited. A second co-design phase was initiated, in which design events were held in Birmingham (July 2015), Glasgow (September 2015) and London (November 2015). Q's theory of change was modified after this second co-design phase and a report was released in November 2015 outlining the proposed model for Q (The Health Foundation and NHS England, 2015). As well as evaluating Q from 2016 to 2020, RAND Europe has also evaluated this co-design phase, which was published in spring 2016 (Garrod et al., 2016).

Recruitment for Q was opened more widely in the summer of 2016 into what is referred to here as the Phase 2 cohort. This group was made up of individuals from selected organisations and graduates of specific healthcare improvement courses. The recruitment opened further to a wider group in 2017, with four recruitment phases held throughout the year implemented by Academic Health and Science Networks (AHSNs). Phase 3, wave 1 was recruited in March 2017, wave 2 in May 2017, wave 3 in July 2017 and wave 4 in November 2017. Following these waves of recruitment in 2017, recruitment is now open on a rolling basis, run centrally from the Health Foundation rather than AHSNs, allowing individuals interested in improvement to apply to join Q at any point in time. As of January 2020, Q has 3,580 members. The application is undertaken online and requires prospective members to reflect on their experience and knowledge relating to improvement and the reasons for wanting to join Q. Applicants need

7 'Human factors' refer to factors such as teamworking, workspace and organisational culture that shape the way the technical and medical knowledge is used in providing care.

to demonstrate how they have influenced and been involved in improvement efforts in the health and care sector that span more than one team. Applicants also need to be able to reflect on approaches to change and outline why they want to join Q. The questions are designed so they can be answered by both healthcare professionals and service users, as well as those working at the local, regional and national level, not just those on the front line of improvement projects (Pereira & Creary, 2018). Prospective members can be unsuccessful in their application; however, the success rate is 91 per cent (since the rolling recruitment started).

Support to Q is provided by country partners in the other UK nations. In Scotland, this support is provided by Healthcare Improvement Scotland (HIS) and NHS Education for Scotland; in Wales, support is provided by Improvement Cymru (the national improvement service for NHS Wales); and in Northern Ireland by the Health and Social Care Safety Forum (HSC Safety Forum), part of the HSC Public Health Agency.

As outlined previously in Box 2, there are many activities and resources available to Q members, many of which did not exist when Q was first established. The governance structure of Q has also changed over time since the co-design phase in 2015. For example, during the phased recruitment, AHSNs (for England) and country partners (elsewhere) were tasked with recruiting members and a small number of Q members have taken on the Q Connector and Q Convenor roles. The voluntary Q Connector role aims to connect Q members within a local area, as well as more widely across boundaries, and to act as a local point of contact for Q. Each AHSN (for England) and country partner (for Wales, Northern Ireland and Scotland) has a small number of Q Connectors, with 57 members signing up to be Q Connectors as of December 2019. Three individuals, one each in the South West of England, the West of England and North East North Cumbria, have taken on the modestly reimbursed role of a Q Convenor. The aim of this role is not only to connect Q members locally, but also to shape and evolve Q at the local level and to work with the Health Foundation, NHS England and Improvement and other country partners to retain a cohesive community at the national level. The Convenor role was established in 2017 as a pilot and is still ongoing into 2020.

Q Lab and Q Exchange are two of the largest activities offered through Q in terms of financial investment. As discussed in Box 2, Q Lab has developed over time since it was first established in 2017. Q Lab has a separate, dedicated team within the Health Foundation. It is, however, closely linked to Q and follows the same ethos of being co-produced with members and other relevant stakeholders. The first Q Lab, titled Peer Support Available to All, ran from April 2017 to May 2018 and involved over 200 participants. It aimed to explore what would be needed for peer support to be more available to those with long-term health and well-being needs. The second Q Lab focused on mental health problems and persistent back and neck pain was run in partnership with the mental health charity Mind. This Q Lab project ran from September 2018 to October 2019 and aimed to explore how care can be improved for those living with mental health conditions and neck/back pain. The Health Foundation commissioned RAND Europe and the University of Cambridge to evaluate the first Q Lab; the evaluation started in May 2017. This report was published in September 2018 (Liberati et al., 2018). The second evaluation of Q Lab is at the time of writing being run by

the Innovation Unit.[8] In the rest of the present report, we address Q Lab only in terms of its relation to Q. The RAND Europe/University of Cambridge evaluation report and the Innovation Unit evaluation report deal with Q Lab more specifically and in full.

Q Exchange has also developed over time, having run a pilot in 2018 and the second funding round in 2019. This is one of the largest opportunities offered to, and through, Q members in terms of its scope and financial investment. It is a programme with funding provided by the Health Foundation and NHS England and Improvement. The funding in 2018 for the programme was £450,000, rising to £600,000 for the 2019 funding round. The format of Q Exchange is somewhat different from traditional funding streams. Ideas are submitted to the Q website[9] (project teams can consist of Q members and non-members, but must be led by a Q member), which allows the Q community to provide feedback to the ideas and suggest areas for strengthening the initial project plans. Project teams then have an opportunity to refine their ideas into a formal proposal, submitted to the shortlisting panel. In 2019, this panel consisted primarily of Q member assessors (37 members)[10] who decided which projects are taken forward to the community vote. These shortlisted projects were then voted on by the Q community, with each Q member having six votes to cast in 2019, three for each topic theme.[11] The 20 projects (increasing from 15 in 2018) with the most votes then receive up to £30,000 of funding. The first Q Exchange round in 2018 was open to any project relating to improvement, with the Q team expressing particular interest in projects relating to peer support to complement the first Q Lab. In 2019, projects were required to be submitted to one of two themes; either understanding alternatives to traditional outpatient appointments or building improvement capability and insights across boundaries. As part of the work described in the rest of the present report, we include experiences, reflections and impacts of Q Exchange. These will be drawn on throughout the report and a detailed overview of Q Exchange can be found in Annex K.

Figure 2 provides an overview of key events in the development of Q and this evaluation.

1.1.2. Future of Q

It was announced in late 2019 that Q has indicative funding commitments until 2030 from the Health Foundation and partners across the UK and Ireland. This funding will be used for several activities from 2020 to 2030, outlined below (The Health Foundation, 2019e).

The aim is to increase the membership number to at least 10,000 and target specific groups working on healthcare improvement, with particular focus on patient groups and the public, those working in social care, those developing new technologies and those leading local system change. In addition, the Q team at the Health Foundation will work further on engaging Q members by developing member insight and feedback loops. Furthermore, it

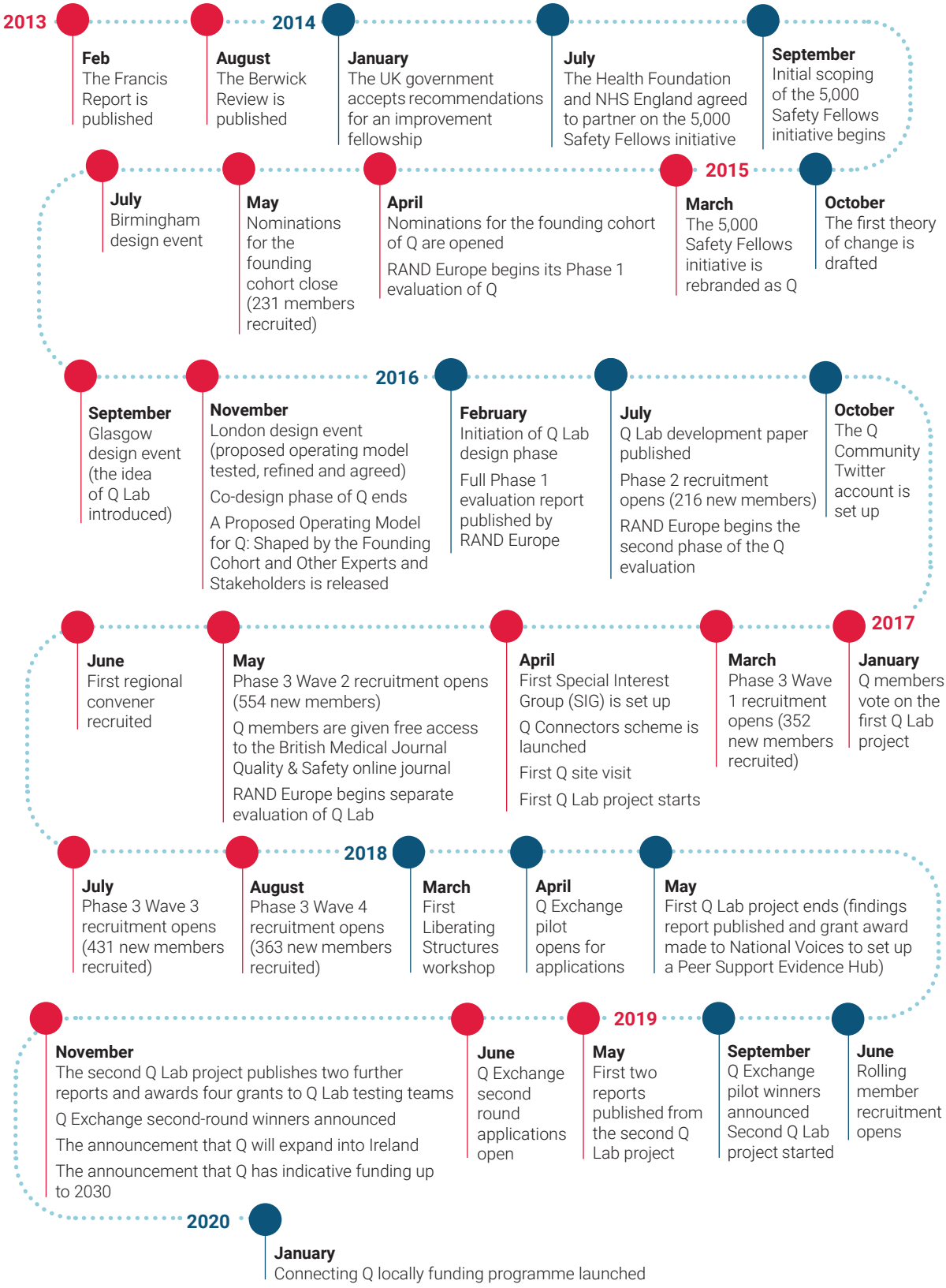
8 For more information about the Innovation Unit, see https://www.innovationunit.org/

9 In 2018, Q Exchange ideas were submitted to the Health Foundation AIMS online application system. This was changed in 2019 to allow Q members to submit their Q Exchange idea to the Q website to allow all members (and those outside of Q) to view the idea.

10 In 2018, the assessors were primarily made up of individuals from the Health Foundation and NHS England and Improvement, with a small number of Q members involved. In 2019, the majority of assessors were Q members.

11 In 2018, members had five votes each as projects were not submitted into topic themes. As two themes were introduced in 2019, members were given three votes for each theme.

Figure 2: Timeline of Q development



was announced in late 2019 that Q will be expanding into Ireland in 2020 (The Health Foundation, 2019e).

Between 2020 and 2030, the Q team at the Health Foundation will also continue to work on developing Q as a knowledge sharing and collaborative platform by formalising relationships with organisations across the four UK nations and Ireland. They will also focus efforts on introducing more digital methods of engaging with Q to share experiences and learning. With patients in particular, there will be a drive for Q to be a leader in co-production and partnership (The Health Foundation, 2019e).

The Q team at the Health Foundation will also continue to work on improving the skills and capabilities of members. This will be achieved through better understanding and demonstrating how to effectively lead change in a collaborative manner, as well as providing professional development opportunities, to benefit both the Q community but also wider improvement efforts (The Health Foundation, 2019e).

Finally, across 2020–2030, Q will build collective insights for making changes collaboratively, with the aim of delivering 200 change projects through Q Exchange, Q Lab and other approaches to be developed after 2025. In addition, there are plans to expand Q Lab, such as a Q Lab for Wales. The plan for Future Q also includes developing a new membership offer to allow those in improvement system leadership roles to learn both from others in similar positions, as well as members on the front line of health and care (The Health Foundation, 2019e).

These changes will be implemented in four main ways. The first involves expanding the Q team at the Health Foundation and changing the structure to encourage collaboration across different parts of the team. A more flexible funding arrangement has also been put in place for 2020–2030 that involves grant funding from the Health Foundation and country partner funding to support Q in each of the four nations, as well as project-specific partnerships between the Health Foundation and charities, government or other organisations. In addition, from 2020 to 2023 Q will explore becoming more autonomous from the Health Foundation to ensure it has the flexibility and tailored governance it needs to identify and take advantage of new opportunities. Finally, the continued investment will be directed towards evaluation and learning internally within the Q team, with additional external evaluation support for strategic reviews in 2025 and 2030 (The Health Foundation, 2019e).

1.1.3. Locating Q in the wider literature on healthcare improvement

In 2015 at the time the Q initiative was being co-designed, the wider evidence was ambivalent. On the one hand, Quality Improvement in healthcare was becoming more widely understood and accessible (The Health Foundation, 2013) and there was a growing recognition of the benefits it could bring (Mazzocato et al., 2010). The NHS was about to establish a five-year partnership with Virginia Mason Institute to support the NHS in developing a Lean culture of continuous improvement (NHS Improvement, 2016a). The US Institute for Healthcare Improvement and the UK Health Foundation were training and supporting ever more improvement fellows. Yet, on the other hand, in 2014 Braithwaite could note that 'For all the talk about quality healthcare, systems performance has frozen in time' (Braithwaite, 2014) and Mary Dixon-Woods and colleagues showed that results were marginal (Dixon-Woods et al., 2012) and could answer her own question 'Does quality improvement improve quality?' with the conclusion that its success was, at best, mixed

(Dixon-Woods & Martin, 2016). Braithwaite (op cit.) asserted:

> *For all the talk about quality healthcare, systems performance has frozen in time. Only 50–60% of care has been delivered in line with level 1 evidence or consensus based guidelines for at least a decade and a half; around a third of medicine is waste, with no measurable effects or justification for the considerable expenditure; and the rate of adverse events across healthcare has remained at about one in 10 patients for 25 years.* (Braithwaite, 2014).

Various reasons for this were suggested at the time: leadership needed to be better engaged (Kaplan et al., 2014), more engagement from below was required (Ham, 2014) and more time was needed for staff to engage in improvement work (Alderwick et al., 2017). It was, furthermore, suggested that Royal Societies and professional bodies could play an important role in engaging clinicians in quality improvement (Ling et al., 2010). More generally, the NHS (in common with other healthcare systems) was just so complex that it was difficult to change (Benning et al., 2011).

The literature suggests that it was not only the performance of health and care systems that had frozen but also quality improvement. The established way of 'doing' improvement would need to change. The Q initiative was, in a sense, a response to this analytical impasse and it drew upon what Waring and Crompton called the 'collaborative turn' in healthcare policy (Waring & Crompton, 2017). This involved a conscious coming together (or 'hybridity') of clinical leaders and managers to mediate these professional and managerial interests in a stable and effective way. In other words, it pushes towards the (undoubtedly very difficult) objective of both 'bottom-up' quality improvement and 'grassroots' change (Bate et al., 2004) while at the same time responding to system priorities as articulated through health and care management.

This, however, required not merely engaging professionals with quality improvement (Ling et al., 2010) but also changing their identity and role to include more system leadership. At the same time, it required management to engage with understanding how best to support clinical outcomes. Understanding how these habitual states of management and clinicians – professional and managerial dispositions – might change is a concern of much sociology of healthcare. One approach to understanding this is to draw upon the work of Bourdieu, whose original work was more concerned with the educational setting (Bourdieu & Passeron, 1977) but which has been applied to healthcare (see, for example, Collyer et al., 2015; Luke, 2003). Although used to analyse very different questions, we have found it helpful to apply the approach to understand what happens to improvers when they try to improve their own practice and, in turn, improve the services they deliver. A key concept is 'habitus' 'which can be defined as systems of dispositions that enable individuals to act, think and navigate the social world' (Olsson et al., 2019). The literature on habitus introduces us to the processes and circumstances under which choices are made; it allows us to explore what is happening when clinicians, managers and system leaders choose to 'do' improvement. In the context of this evaluation, applying this lens allows us to better understand that improvement is not only about tools and techniques but also about self-efficacy and dispositions, that change is always both top-down and bottom-up, and that it is about both the cultures and structures of the health and care system working together (or not) to support real change in the way that care is delivered through individuals with their sets of professional and managerial dispositions.

The evidence from the time when Q was being co-created is that quality improvement was

facing something of an impasse and that (although this was not fully acknowledged at the time) hybridity and changing the habitus provided intuitive, tacit underpinnings for what was to become a significant reorientation of improvement work in healthcare in the UK. This was to be neither simply top-down nor bottom-up and was intended to change the context of people working in the health and care system. To achieve this would require a collective effort to manage change requiring funding, organisational skills, cultural levers and personal commitment: a 'movement for improvement' (Waring & Crompton, 2017). In the following chapters, we will track the success of this 'movement for improvement' before returning in the final chapter to the question of whether or not a new habitus has emerged within which choices around engaging in quality improvement have been changed.

1.1.4. Q in the UK health and care landscape

Q's mission is an ambitious one: to support a shift in culture within the health and care system to one of learning, sharing and improvement. Other initiatives across the world have attempted similar culture changes, such as the Scottish Patient Safety Programme and IHI's 100,000 Lives initiative. At the time that Q was being established, the state of quality improvement was well-summarised by Dixon-Woods and Martin (2016, p.1) as:

> *Fidelity in the application of QI methods is often variable. QI work is often pursued through time-limited, small-scale projects, led by professionals who may lack the expertise, power or resources to instigate the changes required. There is insufficient attention to rigorous evaluation of improvement and to sharing the lessons of successes and failures. Too many QI interventions are seen as 'magic bullets' that will produce improvement in any situation, regardless of context. Too much improvement work is undertaken in isolation at a local level, failing to pool resources and develop collective solutions, and introducing new hazards in the process.* (Dixon-Woods et al., 2012)

For some Q members, the ability for Q to engage system leaders and catalyse organisational change was key to demonstrating its value and impact:

> The main challenges, as I see them at the moment, are retaining a focus on quality improvement as a viable way of meeting some of the challenges that my organisation faces. That would be number one because there is different value sets, different methodologies, and different approaches that are competing, I guess; against quality improvement as the way to kind of make improvement happen. So, it would be an ongoing kind of battle to make sure that quality improvement, in the way that I conceive it, is recognised as a useful, valuable approach to addressing the organisation's major challenges. [Phase 1 INT6, November 2016][12]

However, it is also important to note that Q was set up neither to replace existing approaches nor to add one more initiative to the fairly crowded improvement landscape. Rather, it was intended to work alongside and support these other initiatives, networks and programmes. Q is also distinct from most other improvement initiatives in that it is a membership community, not a training course or other type of implemented programme (The

12 An outline of how we reference the data collected throughout this evaluation can be found in Table 2 in Section 1.2.2. This quote was previously published in the interim evaluation report (Ling et al., 2018).

Health Foundation, n.d.-b). Q aimed to support these other improvement activities in several ways (The Health Foundation, n.d.-b):

- Support the sharing and understanding of what improvement work is being undertaken across the UK, by whom and where.
- Connect improvers across the UK and support existing networks by providing resources and platforms to develop relationships and share learning.
- Simplify the ability to collaborate on work with others with similar interests.
- Influence the improvement environment within organisations and the national landscape.

1.1.5. Theory of change

A theory of change is a structured way to approach the articulation and visualisation of how a particular intervention or programme is expected to lead to impacts and changes in practice.[13] A theory of change aims to communicate a clear, coherent narrative and description of the purpose of a programme or initiative, what it consists of (without being swamped by too much detail on the logistics of the programme plan), the inputs into the programme and how these are expected to lead to the desired outcomes and impacts. It can also provide a visualisation of how the different components of the programme interrelate and contribute to the desired outcomes. Designing a theory of change is also an opportunity to reflect on and challenge the assumptions as to how a programme may lead to impact and the possible enablers and barriers that may arise throughout these processes. It may be primarily a tool to support the strategic thinking of leaders or a communication tool to engage and inform stakeholders, or both. In the case of Q, the theory of change was intended to do both and particularly support strategic thinking through co-design. The theory of change is, therefore, an important statement of what Q is intended to do (and therefore of great interest to an evaluation), but its formation and subsequent development provides a map of the project team's thinking about Q.

The theory of change for Q aimed to summarise visually what Q is made up of, what it is trying to achieve and how it plans on achieving this. The theory of change for Q was used to support the initial co-design of Q and supported thinking about subsequent developments. Two theories of changes have been designed for Q. The first was developed during the co-design phase of Q during the first year of the initiative. A second iteration resulted from a stocktake process meeting between the evaluation team and the Q team in late 2017 and early 2018 and further engagement with Q members in early 2018 to refresh some aspects of the theory of change. The updated version of the theory of change can be found in Figure 3.

The use of the theory of change demonstrates how the Q team thought about causal pathways to guide both the strategy for Q as a whole and to design specific Q activities. It is also used externally to engage key stakeholders in communicating what Q is and how it provides value. The four key areas of focus (connecting, supporting, developing and collaborating) and the aims of achieving greater impact from improvement and contributing to sustainable improvement on a

13 For more information on theories of change, there are many sources of practical advice including (as of 15 April 2020): http://www.theoryofchange.org/what-is-theory-of-change/ and https://media.nesta.org.uk/documents/theory_of_change_guidance_for_applicants_.pdf.
For a reflection on why and how theory contributes to improvement, see Davidoff et al. (2015). For understanding the application of theories of changes in delivering and evaluating complex interventions, see De Silva et al. (2014)

national scale help frame Q as an initiative and have informed the evaluation to some extent.

As shown in Figure 3, the theory of change details how it is anticipated that Q will achieve a sustained improvement in health and care across the UK. The assumed route to impact is through creating an infrastructure and brand to support the creation of a platform through which Q members can both undertake improvement work and share their ideas and experiences efficiently within the community through the activities offered through Q. The theory of change outlines how this support from Q is expected to lead to more and better improvement work conducted by members, eventually delivering benefits for patients and healthcare organisations. Over time, it is expected that this will have positive feedback loops (The Health Foundation, 2019e).

1.2. Our evaluation of Q

1.2.1. Context and aims of this evaluation

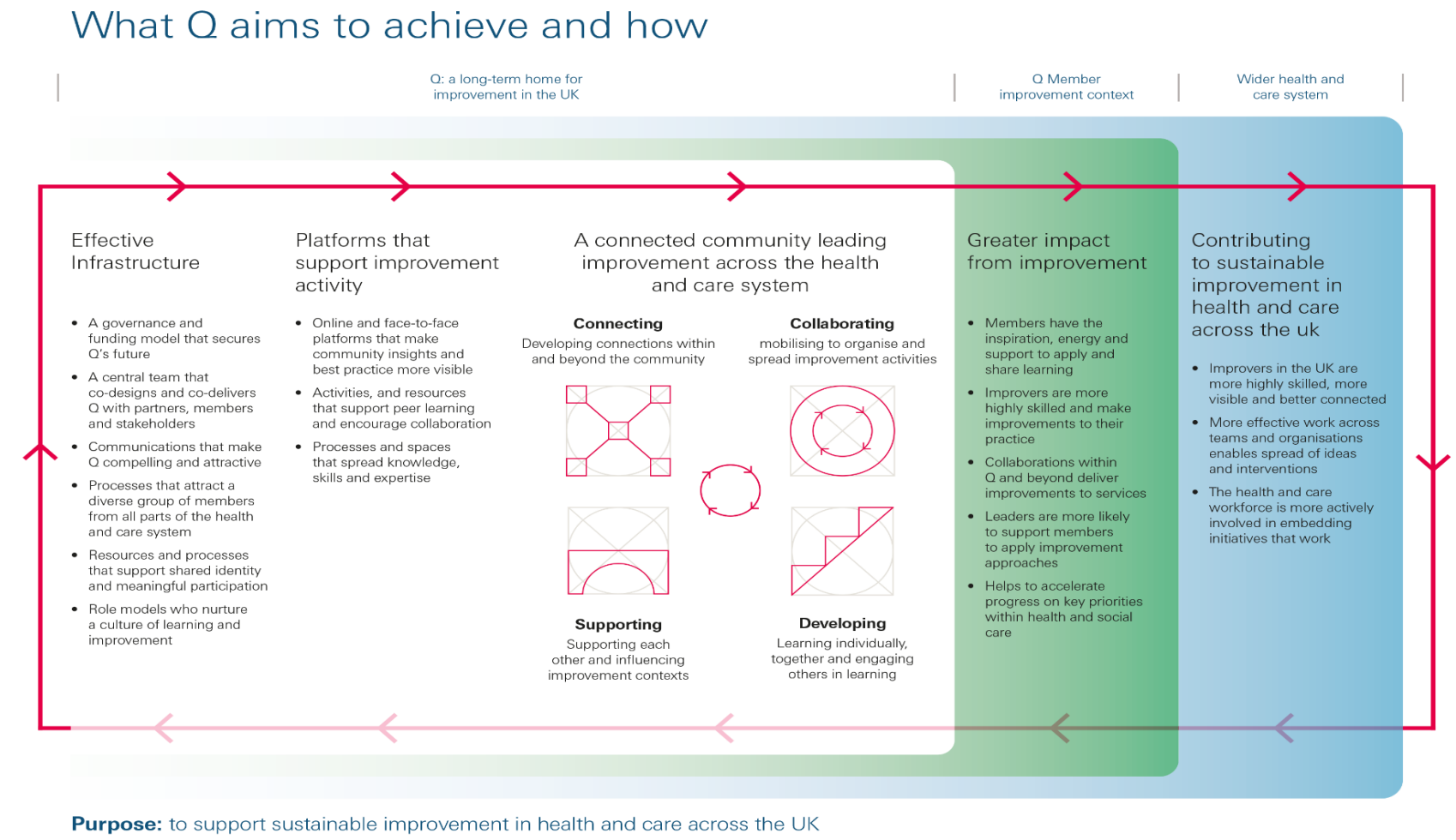
This report provides details of the evaluation conducted from 2016 to 2020. It uses data collected across this period, building on the interim report published in 2018 (Ling et al., 2018), and it also takes a summative approach to identify where and how Q has impacted members (and beyond) and what this means for the future of Q. As mentioned previously, in addition to this evaluation of Q running from 2016 to 2020, RAND Europe was also commissioned by the Health Foundation to evaluate the early co-design phase of Q (spring 2015 to January 2016), specifically focused on evaluating the co-design aspect of Q and providing continual feedback to the Q team throughout this process (Garrod et al., 2016).

RAND Europe was later commissioned by the Health Foundation to conduct an embedded evaluation of Q from 2016 to 2020. The first two years of this evaluation were primarily formative in approach, focusing on how Q was being designed and established, and feeding these data back to the Q team to further inform Q's design while maintaining independence and ensuring rigour in the findings. The principles for conducting an independent and embedded evaluation are presented in Table 1 and were previously presented in the evaluation of the co-design phase of Q (Garrod et al., 2016).

Table 1: Principles of our embedded and independent evaluation (adapted from Garrod et al., 2016)

Embedded	Independent
RAND Europe was embedded in the Q project team	RAND Europe maintained a critical distance from the Q project team
RAND Europe provided evaluation results in real time to allow the Q project team to learn and adapt as Q evolves	RAND Europe was not responsible for designing Q in any way
RAND Europe attended Q project team meetings in the early stages of the evaluation to collect data as well as to share ongoing findings from the evaluation	RAND Europe was not part of the Q project team and any recommendations for change were based on evidence

Figure 3: The Q theory of change



The interim report, published in early 2018, focused on these formative findings (Ling et al., 2018). The latter half of the evaluation took a more summative approach to explore how Q resources and activities are used, the impact of Q on members and the impact more widely of Q on health and care organisations. The present report covers the findings of both the formative and summative evaluation phases and does not require the interim report to have been read.

Throughout the evaluation, there were two main aims:

1. To provide evidence and analysis to support strategic decision making and inform the ongoing design and management of Q (the focus of the formative phase of the evaluation).
2. To assess the impact that Q has, primarily on members, but also on their organisations more widely; and to understand how this contributes to improvement in health and care quality across the UK (the focus of the later, summative phase of the evaluation).

To reach these aims, five key evaluation questions, and related sub-questions, were developed in consultation with the Health Foundation. These five questions are:

1. How effective is the ongoing governance, design and management of Q (see Chapter 5)? How has Q Lab progressed during the period of this evaluation (see Chapters 2 and 3)?
2. How well does the Q community and infrastructure meet the needs of members (see Chapter 2)?
3. To what degree is Q providing support, enabling connections and the development of expertise, and mobilising members to lead and undertake improvement more efficiently and effectively (see Chapter 2 and 3)?
4. What impact has Q had on the wider health and care system across the UK (see Chapter 4)?
5. Is Q achieving or contributing to sustainable improvement in health and care across the UK and, if so, how (see Chapters 4 and 6)?

The full list of evaluation sub-questions is presented in Annex A. It should be noted here that a small number of research questions are not directly answered in this report. This is primarily because the scope of the evaluation changed since these research questions were set. The sub-questions not covered in this report and the reasons are:

- How has Q Lab progressed from March 2016 to February 2017? – Q Lab was the focus of a separate evaluation by RAND, published in 2018, and an additional evaluation was undertaken by the Innovation Unit, due to publish in 2020. Therefore, it was decided that this report would not extensively cover Q Lab.
- What are the unintended consequences of Q for members – both positive and negative? – The positive consequences of Q are discussed in-depth; however, when members were asked about negative consequences, members could not identify any.
- What are the activities, resources, systems and spaces offered through the Q infrastructure? What are the costs associated with these (and if they cannot be identified, why not)? How do the different components of Q vary by quality, relevance, timeliness and cost? – While we cover most aspects of these questions, we do not evaluate the cost of Q or its cost-effectiveness as this was deemed to be out of scope for this evaluation after these questions had been set.

1.2.2. Approach

The evaluation took a mixed-method approach, using both qualitative and quantitative approaches to ensure the collection of robust, reliable findings. The methods selected balanced the need to provide useful and real-time findings to the evaluation team to inform the ongoing design and evolution of Q with gathering the data needed to inform the later, summative evaluation to explore the experience and impacts of Q. The approach to data collection, such as the type of interviewee and data collection materials, was adapted throughout the evaluation in light of new resources and activities offered through Q, emerging themes and the shift from a formative to a summative focus in the evaluation. The evaluation aimed to understand the consequences of Q for its members and health and care organisations, and the impacts of this on the health and care system, as evidenced through the experiences of Q members and documented through Q processes.

To address our research questions, the evaluation adopted the following methods:

- A review of key strategic documents provided by the Q team at the Health Foundation.
- A review of key healthcare improvement literature.
- Observations at Q events and Q team meetings.
- Semi-structured interviews (n=99) and focus group discussions (n=26) with a range of stakeholders, including Q members (covering general Q and those focusing on certain activities, including Q Lab and Q Exchange), the Q team, QI experts, key governance stakeholders, unsuccessful applicants, Q Lab volunteer group, steering group members, college of assessors, regional AHSNs, regional convenors, non-members and other key Q stakeholders.
- 4 deep dives of Scotland, Wales, Northern Ireland and the South West of England (involving 29 interviews).
- 13 general Q case studies (involving 14 interviews).
- 4 Q Exchange case studies (involving 10 interviews).
- 3 rounds of citizen ethnography[14] with Q members.
- 13 surveys of both members and unsuccessful applicants.
- Social network analysis (SNA) of connections reported by incoming Q members.

Annex B provides a detailed overview of the methods used throughout the evaluation and the strengths and potential limitations of these.

Box 3 below provides details on the number of interviews and focus groups conducted throughout the evaluation and Table 2 provides information on the number of survey respondents.

14 Citizen ethnography involves Q members providing ethnographic observations by observing, making sense of and taking notes at Q events, and relaying their experiences of Q in their day-to-day role. It should be noted here that the ethnography data is not drawn on to the same extent as the other forms of data collection due to the small number of Q members involved in this methodology.

Box 3: Number of interviews and focus groups

Number of interviews and focus groups[15]

- Q members (interviews, n=45, focus groups, n=12)
- Q project team members (interviews, n= 14, focus groups, n=4)
- External QI experts (interviews, n=8)
- A member of the governance group (interviews, n=2)
- An unsuccessful applicant (interview, n=1)
- Non-members (focus groups, n=2)
- Q Lab volunteer group (interviews, n=3)
- Q Lab participants (interviews, n=3)
- Steering group members (interviews, n=2)
- College of Assessors (interviews, n=2)
- Regional AHSNs (focus groups, n=3)
- Q member case studies (interviews, n=14)
- Regional convenors (interviews, n=2)
- Q Exchange bidders (interviews, n=13,[16] focus groups, n=3)
- Q Exchange case studies (interviews, n=10)
- Deep dives (interviews, n=29, focus groups, n=2)
- Key Q stakeholders (interviews, n=6)
- **Total number of interviews: 154. Total number of focus groups: 26**

Table 2: Number of Q member survey respondents

Survey	Date	Response rate
Application survey	Aug 16	59% (135/227[17])
Annual survey	March 17	39% (175/447[18])
New member survey	March 17	87% (307/352)
Unsuccessful applicant survey	March 17	27% (17/62)
New member survey	June 17	82% (455/554)
Unsuccessful applicant survey	June 17	43% (27/62)
New member survey	Sept 17	75% (327/436)
Unsuccessful applicant survey	Sept 17	52% (12/23)
New member survey	Dec 17	72% (261/363)
Unsuccessful applicant survey	Dec 17	18% (2/11)
Annual survey	Dec 18	37% (1015/2731)
Annual survey	Nov 19	24% (791/3362)

15 Focus group numbers refer to the number of focus groups undertaken, not the number of participants.

16 Two of these interviews were conducted with two individuals on each occasion.

17 216 members and 11 unsuccessful applicants.

18 231 founding cohort members and 216 Phase 2 members.

It should be noted here that a degree of confidentiality has been ensured to all data presented in this report, so individuals are not identifiable from their responses. This is particularly relevant for the general Q case studies where we provide a brief amount of information related to the interviewee, e.g. type of job role, to provide context to the case study but do not provide specific detail of their job roles or organisational affiliation. All case studies (both general and Q Exchange case studies) were sent back to the interviewees to confirm they were happy with the level of anonymity. Further detail on data protection and anonymity can be found in Annex B.

Reporting

Due to the formative nature of the first phase of the evaluation, findings were shared with the Q team at the Health Foundation at regular intervals and members of the evaluation team attended Q team meetings regularly, both to observe the meeting but also as an opportunity to share findings on an ongoing basis. The early, formative findings are provided in the public 2018 interim report (Ling et al., 2018). This final report builds on this report (as well as the evaluation of the co-design phase of Q conducted by RAND Europe, which was published in 2016 (Garrod et al., 2016)) and offers an additional summative view of Q.

The findings from across the many data collection approaches were analysed individually. In addition, some of these are written up in detail in self-contained annexes:

- Scotland deep dive (Annex C)
- South West of England deep dive (Annex D)
- Northern Ireland deep dive (Annex E)
- Wales deep dive (Annex F)
- Citizen ethnography diaries (Annex G)
- 2019 survey results (Annex H)
- 2018 survey results (Annex I)
- 2016–2017 survey results (Annex J)
- Q Exchange (Annex K).[19]

The resulting draft analysis reports were reviewed for completeness and balance by the Q team and two independent RAND Quality Assurance reviewers.

In addition to analysing the results of each data collection method individually, the evaluation team also synthesised the results into one narrative for the main body of this final report, with some common themes identified that will be discussed throughout and in the conclusions section. This bringing together of the narrative and identification of themes is achieved through an iterative process in which the evaluation team reviews emerging findings. An internal workshop was held by the evaluation team in December 2019 to support the identification of these key themes and conclusions.

In addition, the evaluation team has been supported by an independent Evaluation Advisory Group (EAG),[20] comprised of experts in healthcare research and evaluation. The EAG met with the evaluation team twice a year to provide additional inputs to the evaluation and data collection methods, and to act as 'critical friends' in informing the development of the evaluation.

19 It is important to note that a large part of the evaluation resource was directed to exploring the experiences and impacts of Q Exchange across 2018 and 2019. Therefore, more data was collected on this initiative compared to other resources offered through Q. Data concerning Q Exchange is drawn on throughout this report.

20 The members of the EAG are: Professor David Hunter (Newcastle University), Professor Alison Bullock (Cardiff University), Andrew Harrison (Learning Studio), Professor Becky Malby (London South Bank University), Helen Bevan (NHS Horizons), Professor Justin Waring (University of Birmingham), Mary Ryan (National Collaborating Centre for Mental Health), Professor Martin Marshall (University College London), Usha Boolaky (The Health Foundation) and Karen Fetcher (NHS Improvement).

Table 3: Coding used to reference data collection methods

Type of data collection	Code used in the report
General member interviews (2018 onwards)	Phase X INTX
Q team interviews (2018 onwards)	Q Team X
Stakeholder interviews (2018 onwards)	Stakeholder INTX
External improvement experts (2018 onwards)	QI INTX
Q Lab interviews (2018 onwards)	Q Lab INTX
Site visit interviews (2018 onwards)	Site visit INTX
Case study interviews (2018 onwards)	CSX[21]
South West deep dive interviews	South West DD
Northern Ireland deep dive interviews	Northern Ireland DD
Wales deep dive interviews	Wales DD
Scotland deep dive interviews	Scotland DD
Q Exchange interviews and focus groups	Q Exchange
2019 survey results	2019 survey
2018 survey results	2018 survey
Citizen ethnography diaries	Citizen ethnography 2019
Data collected pre-2018 and presented in the 2018 interim report	Ling et al., 2018.

Throughout the report, we have referenced data from these various data collections methods using codes as shown in Table 3. It should be noted that these codes are not used in the annexes, rather the annexes should be taken as individual reports where the codes used are relevant to the data collection method used for that annex.

1.2.3. Strengths and limitations of the methods

There are several strengths to this evaluation. Firstly, a mixed-methods approach was taken. Much of the collected data is qualitative, which allows for in-depth and nuanced evidence to be collected on individual reflections and experiences of Q. This is then supported by quantitative data from the large number of surveys conducted over time, which provides further insight into the themes identified from the qualitative data collection. The surveys also allow us to determine whether the data collected from the smaller number of participants of the qualitative data collection applies to the wider Q community. The large number of individuals we engaged with adds to this, allowing us to collect data from a range of Q members, as well as the Q team at the Health Foundation and other key stakeholders not directly involved in Q, such as QI experts, providing us with a rounded view of Q from a range of perspectives. The longitudinal nature of the data collection over five years allows us

21 A list of case studies and their assigned numbers is in Annex B.

to track the progress and development of Q over this time. In particular, conducting annual surveys has enabled us to track responses from the same members over time to see how their views of Q change, if at all. A further strength of this approach lies with the cross-analysis of data collected through the various methodological approaches, which is how the data is presented in this report. Again, this provides us with a rounded view of Q from multiple perspectives, points in time and methods of data collection.

As Q members are distributed across the UK, sometimes quite sparsely, the local Q communities and local networks play a significant role in shaping how Q establishes itself in different regions. While it is difficult to identify this regional variation at a very local and detailed level, the four deep dives provide an overview of how Q varies between regions and what causes these differences. We also aimed to engage members from across the UK in the interviews, focus groups and surveys to ensure we gather data from as many regions as possible.

As with all forms of research, it is important to be aware of the possible limitations of the data collection methods and analysis used in this evaluation. Here, we identify four key limitations which are discussed in more detail, in Annex B.

Firstly, with qualitative data collection, there can be certain biases. For example, social desirability bias in which participants may be reluctant to share negative views, focusing instead on positive aspects only. On reflection, we sense that participants were not significantly influenced by such biases as many were open in expressing more negative views and experiences, particularly in the surveys. In addition, the evaluation team also observed some members' lack of engagement when attempting to recruit them to participate in the research, which may have led to some biases in the data collected. To recruit Q members to participate in interviews, the evaluation team contacted a random selection of Q members. The majority of this randomly selected group of Q members did not respond to requests to interview, and others replied commenting that they did not want to participate in an interview because they had not engaged with Q (either recently or since joining Q) or that they would not have much to say because they did not often engage with the Q community. We recognise that based on the methods that the evaluation used, there is likely to be a selection bias in that the members of Q who agreed to engage with the evaluation team are likely to be more engaged than the average Q member.

Secondly, as data collection has taken place over several years, some of the views shared with us may since have changed and some aspects of Q have changed since we gathered data on them. For example, several changes were introduced for the second Q Exchange funding round compared to the pilot, meaning many perspectives on the application phase of Q Exchange and suggestions for what should be improved were no longer applicable by the time of reporting. This has been considered in the analysis where appropriate, and the month and year of the data collection is reported throughout this report for clarity. While it would have been possible to engage with the same Q members over time to understand how views may be changing over time, it was felt by the research team that this would restrict the breadth of insight gained. Instead, the evaluation team decided to focus on gathering the views of a larger number of members, particularly given the smaller number of interviews compared to the total number of Q members. However, as the interviews with members took place over multiple years and with members who joined Q in different recruitment phases, this enabled the evaluation team to explore the changes

in perceptions over time to some extent. In addition, interviews were conducted with some members of the Q team at the Health Foundation multiple times over the evaluation period to understand how the strategy and priorities for Q changed over time.

Thirdly, as shown in Table 2, survey response rates dropped over time and are often particularly low for the annual surveys. The new member surveys, conducted in March, June, September and December 2017 have relatively high response rates (72–85 per cent) compared to the annual surveys conducted in March 2017, December 2018 and November 2019 (24–39 per cent). The unsuccessful applicant surveys frequently saw higher response rates than the annual surveys. This may demonstrate some disengagement discussed above in relation to participant recruitment for interviews and focus groups. These response rates indicate that newer members of Q are more likely to engage with the evaluation, which is also suggested when exploring the response rate within groups of the annual surveys. In 2018, 57 per cent of members who had joined Q in the past three months responded, compared to 32 per cent and 33 per cent of members who joined Q less than one year ago (but more than three months) and more than one year ago respectively. Similar results were seen in 2019, in which 36 per cent of members who had been a member of Q for less than one year responded to the annual survey, compared to 23 per cent of members who had been members for longer than one year. This drop in response rates means the survey results should be interpreted with this in mind. However, the demographic composition of the respondents to the surveys was similar to the rest of the Q community and so we believe responses are largely similar to the rest of the Q membership and still provide valuable insight into the experiences and thoughts of Q members at the point in time that the survey was delivered.

Finally, while this is an independent evaluation, it is an embedded one and the evaluation team has been working closely with the Q team throughout the process, which brings a risk of bias. To mitigate this, the evaluation team has been monitoring the relationship with the Q team and are active in balancing the need for a strong and open relationship with the Q team while maintaining the independence needed to conduct a rigorous non-biased evaluation. The input of the EAG, two RAND Europe Quality Assurance reviewers, the Q team and two independent external reviewers have acted as an additional check in this regard.

1.3. Structure of this report

This report is structured as follows. Chapters 2 to 5 discuss the main research findings, analysed and presented thematically. Chapter 2 covers the Q member experience, from recruitment to use of resources and activities. Chapter 3 discusses the impact of Q on members' professional lives and Chapter 4 the impact of Q on organisations and the healthcare system. Chapter 5 covers the design, management and governance of Q. Chapter 6 summarises the findings into conclusions and proposes recommendations for the Q team to consider going forward. The annexes to the report provide additional detail about the methods and the findings from each data collection method.

2 Members' experience of Q

This chapter will discuss members' experience of Q, including their experiences through the recruitment process and how they engage with and value Q resources and activities. This chapter will also consider Q's strategy in engaging members, the level of engagement that has been observed through this evaluation and the barriers and enablers that members face in engaging with Q. A summary of the key points from this chapter is provided in the box below.

- While the membership has diversified over time and has grown to become more open to most individuals with an interest in quality improvement, there remain some underrepresented groups in the Q community. This includes relatively few members from roles such as primary care, social care, service users, those working in mental health and younger individuals. The Q membership could benefit from more members outside of the healthcare sector joining, as well as more members in currently underrepresented groups.
- Service user members of Q have reported that they have not been actively or meaningfully engaged in Q, although Q Lab was identified as an example of where service users have been appropriately engaged. Further work is needed in this area to engage this group of members.
- There are differing opinions as to whether Q's recruitment process should be more selective or whether Q should be open to all to prevent it from being seen as an 'elite group'. Both views have been expressed in similar numbers and which view is correct depends on what Q is trying to achieve. This may be a focus of Q moving forward to more clearly identify the target audience of Q.
- Although Q is internally described as a platform for quality improvement, from the members' perspective it is accessed through a series of resources, activities and events. These Q offerings are largely viewed as high-quality resources, with members finding them useful in their improvement work. However, some resources are used less than others, such as particular SIGs with low levels of activity and RCTs, largely due to a lack of engagement from the community. These resources may need to be rethought to make them more useful to a larger number of Q members and to increase engagement with these resources.
- Active engagement with Q varies across the membership, with most members reporting occasional use of resources but comparatively few reporting active involvement in creating and leading activities. The main barrier that Q members face in engaging with Q is time, but factors such as organisational support for engagement with Q are also important.
- While Q's approach to allowing members to 'dip in and out' of engagement with Q may attract some members, it may also contribute to lower levels of involvement from members that are not actively engaged. The lack of active engagement from fellow Q members was identified by many members as a factor that makes Q less useful and that prevents them from engaging more in Q. The central Q team will need to consider the desired balance of engagement among membership going forward.

2.1. Recruitment and membership

The recruitment approach for Q has changed over time, as outlined in Chapter 1. As such, members that reflected on their thoughts and experiences of the application process, particularly in the early stages of the evaluation, may have different reflections than members joining at other stages of recruitment due to differing strategies that Q has used to recruit, screen and induct members. This section will provide an overview of the recruitment process and the demographics of the Q membership (and where members think Q should expand its membership), and provide an overview of the SNA outlined in the interim evaluation report (Ling et al., 2018).

2.1.1. Experience of the recruitment process for applicants and members

The initial formative stage of the evaluation focused particularly on members' views of the recruitment process and experiences of applying to Q. While this was discussed by some members in the latter, summative stage of the evaluation, the evaluation team did not explore this aspect directly and so much of this section draws on analysis from the 2018 interim report (Ling et al., 2018). The details and timelines for the different recruitment phases can be found in Chapter 1.

Broadly, the Q recruitment process has been described as straightforward and well-managed by Q members (Ling et al., 2018). However, some members feel that the application process is overly time-intensive, laborious and difficult for service users to complete (Ling et al., 2018, Phase 2 INT10, Q Exchange). Applicants report that the application process itself encourages members to reflect on their quality improvement work in a way that is beneficial to both applicants and Q (Ling et al., 2018). In an early evaluation survey of Q members and unsuccessful Q applicants in 2017, both Phase 2 and Phase 3 members found the application process to be straightforward and reported that the burden of the application process was justifiable in terms of what they expected to be required to become a Q member, which some participants in Q Exchange also agreed with (Ling et al., 2018, Q Exchange).

> *I think that being part of a selection process means that you value membership more highly when successful. It requires a more active rather than passive engagement with the opportunity. I have joined a lot of on-line information sharing platforms and then never looked at them again…. Q seems like a different approach and that appealed to me.* [New member survey, Phase 3 Wave 1, March 2017]

Unsuccessful applicants were less likely to report that the application process was straightforward and are more likely to report that the burden of application is too high in terms of justifying the effort it takes to apply (Ling et al., 2018). Unsuccessful applicants were not always left with a clear understanding of why they were not successful in their application to become part of Q, although some did understand this and most were willing to apply again to Q in the future (Ling et al., 2018, Phase 3 INT14).

2.1.2. Membership of Q

Since its inception in 2015, Q has grown from a small organisation of fewer than 250 members, and who have been hand-selected by organisations in the health and social care sector, to a larger community of 3,580 members who have self-selected to apply to join Q. The current professional background and organisational demographics of Q membership as of January 2020 (for members recruited across all Q phases) are provided in

Table 4 and Table 5.[22] These tables represent information that has been self-reported to the central Q team by Q members. As such, some members may have misreported their primary role and organisation type, especially in cases where there are no clear-cut boundaries between categories.

Table 4: Q membership by current primary role

Primary role	Number of members	% of members
Non-clinical	2,518	70.3
Clinical	1,062	29.7

Table 5: Q membership by organisation type

Organisation type	Number of members	% of members
Acute care provider	1,396	39.0
Other	275	7.7
Academic institution or education provider	197	5.5
Mental health provider	192	5.4
Academic Health Science Network (AHSN)	185	5.2
Commissioning organisation	181	5.1
Integrated care provider	180	5.0
Charity, third sector, volunteer or non-profit	164	4.6
Primary care provider	145	4.1
Public health organisation	136	3.8
Community care provider	126	3.5
Private company or consultancy	105	2.9
National policymaking or regulation organisation	91	2.5
Ambulance service	65	1.8
Central government	53	1.5
Local government	22	0.6
Social care organisation	19	0.5
Professional body	17	0.5
Independent patient representative	15	0.4
Civil service	6	0.2
Pharmacy	4	0.1
Care home provider	2	0.1

22 In each table, the numbers may not add up to 3,580 (the total number of Q members) or 100 per cent because of rounding and fields that have been left blank in the membership database provided to the evaluation team by the Health Foundation.

Table 6: Q membership by region

Region	Number of members	% of members
England – London (North, East and Essex)	307	8.6
England – London (South)	153	4.3
England – London (West)	126	3.5
ANY LONDON	586	16.4
England – East Midlands	180	5.0
England – East of England	122	3.4
England – Greater Manchester	101	2.8
England – Kent Surrey Sussex	188	5.3
England – National	5	0.1
England – North East and North Cumbria	243	6.8
England – North West Coast	183	5.1
England – Oxford	107	3.0
England – South West	207	5.8
England – Wessex	206	5.8
England – West	216	6.0
England – West Midlands	195	5.4
England – Yorkshire and Humber	283	7.9
ANY ENGLAND	2822	78.9
Northern Ireland	201	5.6
Scotland	306	8.5
Wales	244	6.8
International	4	0.1

Q has attracted members from across the UK and a small number of members internationally. Although members come from across the UK, Q is heavily weighted toward England, with over three-quarters of Q members from England. Table 6 above provides details of how Q members are distributed across regions in England, across the UK and internationally.

Diversity of membership

Over time, Q membership has not only grown but has also become more diverse. In part, this was due to a conscious effort by the Q team to widen the audience for Q based in part on the recommendation from the evaluation of the first phase of Q that the Q team should have a clearer target group(s) for who should become members, which may have contributed to the recruitment of more carers and patient representatives (Garrod et al., 2016; Ling et al., 2018). However, this increased diversity may also be due to the changes in recruitment styles over the year, from a hand-picked selection of improvers in the founding cohort in 2016 to rolling recruitment open to all for

Phase 4 in 2018. Q has since expanded its demographics, with a wider range of seniority levels, professional backgrounds and sectors represented within the membership of Q.

Acute care providers have been the most frequent employer of Q members since the founding cohort and other cohorts of members are also prominent among Q membership. More than 70 per cent of Q members are in non-clinical roles, and at least 5 per cent of Q members work for academic institutions or education providers, mental health providers, Academic Health Science Networks (AHSNs), commissioning organisations and integrated care providers.

Some interviewees reported that Q now has the appropriate mix of people necessary to create change in the health and social care sector. Interviewees reflected that this mix has to do with the level of authority that is needed to make decisions around improvement and the range of backgrounds and expertise that is needed to get a broad perspective of opinions (Phase 3 INT5, Phase 3 INT6, Phase 3 INT7, Phase 4 INT2, stakeholder INT2). Some geographical areas may potentially be more diverse than others. Interviewees suggested that the government of Scotland, for example, is pushing the health and social care sector to look beyond its own boundaries to help improve quality (Phase1 INT12). However, while Scottish Q members may be more diverse in other ways, the proportion of Q members that work for acute care providers is similar in the Scottish Q cohort (38 per cent) as for the general population of Q members (39 per cent).

> *Scotland Q members are more diverse (social care, police officer etc.) – likely because the Scottish government wants to take improvement methods from healthcare and apply them to other areas like education, fishing and prisons.* [Phase 1 INT12, March 2018]

Although the overall diversity of Q has increased as the community has grown, there are still sections of the health and social care system that are underrepresented within the community. These areas are described in the sections below, although these are mostly based on members' opinions around representation because the target audience for Q membership has deliberately not been narrowly defined.

The number of patient and carer representatives who have been recruited through each stage has fluctuated over time. Patient and carer representatives made up 4 per cent of members recruited in Phase 1, 14 per cent of members recruited in Phase 2, 2 per cent of members recruited across all waves of Phase 3 and none of the members recruited in Phase 4 (as of January 2020 and based on self-reported data by members). In total, patient and carer representatives now make up only 0.4 per cent of the total membership of Q, which some have mentioned is lower than is appropriate (Phase 2 INT10, Phase 3 INT12).

Additionally, we have heard that sectors outside of healthcare are underrepresented in Q. For example, of the 2,147 members recruited from Phases 1–3, only 11 (less than 0.5 per cent) reported that their primary job is in social care. As of the time of writing, there are still just 0.5 per cent of Q members that are employed by social care organisations. Many Q members feel that Q should become more diverse in terms of having people from different professional backgrounds and sectors (Phase 1 INT5, Q Team INT10), particularly in social care (Phase 2 INT9, Phase 3 INT10, Q Team INT10), mental health care (Phase 2 INT9), primary care (Q Exchange, Stakeholder INT3 Wales DD), allied health professions (Phase 4 INT2) and the voluntary sector (CS8). In addition, others feel it would be helpful to have more people working in healthcare who are frontline staff (stakeholder INT5, Wales DD), in

operational roles (stakeholder INT4) and across hierarchies, including those in senior and junior positions (stakeholder INT3, stakeholder INT5, Phase 1 INT13, Phase 3 INT17, CS4, Q Team INT9).

> *Q needs more young people to help them develop and take forward their ideas and should reach out to people in more junior positions in the hierarchy. It should capture new ideas and give everyone the opportunity to contribute.* [Phase 1 INT13, March 2018]

> *There are a few frontline people on Q, but many are senior people in Q. I think there has to be a mixture. You have got to have buy-in and the executive buy-in, but you also have got to come up with a way of developing grassroots and enable those on the frontline to be able to do it but also have the time and resources to be able to do it.* [Stakeholder INT5, November 2019]

Certain demographics have been reported to be underrepresented in Q (Phase 1 INT5), for example, those from Black, Asian and Minority Ethnic (BAME) backgrounds (Phase 1 INT16) as well as people from certain regions of the UK (stakeholder INT3, stakeholder INT5). The demographic composition of Q members in terms of race and ethnicity has not been analysed in this evaluation, although it is an important aspect of diversity for the central Q team to consider.

Members in particularly isolated and rural areas of the UK feel that this inhibits their ability to engage with the Q community, for example, because it can be difficult to travel to events (Northern Ireland DD, Wales DD). Some Q members in Northern Ireland thought that membership should also be extended to Ireland, as they reported that having connections between these two areas would be useful in improving quality (Northern Ireland DD). Since these interviews were conducted, it has been announced that Q will be extended into Ireland during 2020.

Although all Q members have some kind of interest in quality improvement in health and social care, their professional backgrounds, areas of work and specific expertise vary significantly. Due to this, some members have reported that they struggle to find other Q members who are interested in the same areas (Q Exchange INT7, Q Lab INT2, Case Study INT8, Stakeholder INT4, Phase 3 INT13) and that this hinders the engagement they have with Q and the value that they derive from the Q network. Due to this difficulty, some members have mentioned that increasing the membership of Q beyond healthcare may further hinder the ability to find areas of common interest (QI INT1, Phase 1 INT7, Phase 1 INT5, Phase 2 INT9, Phase 3 INT10, Phase 3 INT13). However, the weight of the evidence suggests that most members prefer expanding Q membership, rather than limiting it.

> *There is an opportunity for Q to grow the membership and they need to make sure that there is a broad range of member's experience, like in children's health work, it is important to involve a wider range of people such as social workers. It will be important to recruit this wider range of backgrounds to ensure the opportunity to work together on a range of important health (and wider) projects.* [Phase 3 INT10, April 2018]

2.1.3. Q as an elite community versus as a community for all

As Q has grown from a small community of members with expertise in improvement and a strong sense of co-production to a larger organisation made up of members with diverse interests and expertise, there have been tensions associated with the optimal level of selectivity in a member organisation such as Q (Ling et al., 2018). Members have

diverse opinions as to the desired selectivity of Q, which will continue to play a role in how Q develops as it works towards its ambition of expanding its membership.

Some members feel that Q is overly elitist and can be seen by those outside it as an 'exclusive club' (Phase 1 INT14, Phase 1 INT15, Phase 2 INT10, Phase 3 INT9, Q Exchange, Ling et al., 2018). Members that voiced this criticism expressed that Q has focused too much on members with higher profiles and greater status within the healthcare sector and has not engaged enough with the frontline staff and other workers that are also able to affect change. While some members feel Q is now less exclusive since opening its membership to a wider group, others consider that there is already too much focus on pockets within Q membership with higher levels of expertise or seniority and that this focus hinders their ability to engage with Q and create change in the health and social care system (Site Visit INT3, Phase 1 INT13, Phase 3 INT7, CS4).

> *The Q community is very much a club rather than a network – it shouldn't be such an exclusive club, but making a network is a real challenge.* [Phase1 INT14, March 2018]

> *I wasn't sure what Q was actually going to be and the branding nearly put me off joining – the fact that it is just called Q makes it sound pretentious and wasn't clear what it actually was, so I felt people were just joining to be part of the exclusive club.* [Phase 3 INT9, April 2018]

Conversely, there are also a lower number of members that expressed that Q has not become too elitist and that it continues to have a democratising environment that puts members on a level playing field (Phase 1 INT10, CS5, Q Team INT9, Ling et al., 2018). This is discussed in further detail in Chapter 3. There are also some views that Q has opened up its membership too much and should instead be more selective in accepting members with less expertise (Q Team INT9, Ling et al., 2018). According to some members, being more selective about who is accepted into Q would help Q be better placed to maintain professionalism with quality improvement and enforce a sense of quality improvement activities requiring specific expertise and skills (QI INT1, Ling et al., 2018). However, the weight of evidence suggests that Q is at greater risk of becoming too elitist rather than too democratic according to members. In an interview with a Q team member, it was mentioned that as Q grows, it should not become overly focused on numbers and should instead be concerned about the quality of engagement and connections that Q produces (Q Team INT13), which Q may also consider moving forwards.

> *Potential for the effectiveness of Q to be watered down. Without wishing to sound elitist there probably needs to be a degree of improvement expertise and experience required to become a member and, perhaps, to give others incentive to aim higher?* [2017 survey respondent]

Some members discussed whether elitism has affected Q Exchange in particular, with some applicants feeling there is a level playing field for all applicants whereas others feel it is a 'popularity contest' skewed towards well-known members of Q with higher status in the field (Q Exchange, 2019 survey). This is discussed in further detail in Section 2.2.2. On the other hand, Q Lab has been identified as potentially an example of where Q has leaned more towards a flat hierarchy, with senior members of the NHS and service users being able to express their views equally without a focus on professional roles and experience. The correct level of inclusion will need to be considered as Q moves forward, and

Table 7: Differences in measures of connectivity before and after the Q design events, reproduced from data collected for the evaluation of the co-design phase (Garrod et al., 2016)

	Before	After
Average number of connections reported	4.7	14.9
Proportion of respondents reporting no connections	16%	2%
Proportion of respondents reporting at most three connections	51%	7%
Proportion of respondents reporting at least ten connections	13%	70%

specific areas within Q may be able to inform considerations around this balance.

2.1.4. Social network analysis

In the 2018 interim evaluation report, we presented the analysis and results of social network analysis (SNA) and we will briefly summarise the results from that again here (Ling et al., 2018). The SNA contributes to answering the evaluation question: How well does Q enable the development of meaningful connections? While it is difficult to understand whether the connections reported here are meaningful, it does demonstrate that Q contributed to the creation of connections across recruitment phases and geography.

In addition to the results of the SNA below, an analysis of the change in connections reported by members of the founding cohort was conducted during the evaluation of the co-design phase of Q (Garrod et al. 2016), which may be of interest as well in terms of understanding the *change* in connections as a result of Q, which we briefly summarise here. From this evaluation of the co-design phase, out of the 231 Q founding cohort members, there were 206 SNA respondents in the first survey and 162 in the second. Table 7 presents the data from this evaluation.

For more information on how Q has supported connections and collaborations between members, see Section 3.1.

Member surveys were used to collect data on the relationships between Q members.[23, 24] For members that joined in Phase 1 and 2, the annual survey from March 2017 was used, while for members that joined in Phase 3, their entry survey was used. As such, for members in Phase 3 data was collected before attending any Q events. It is highly likely that a different picture would be seen if the same question were asked later in the evaluation and care

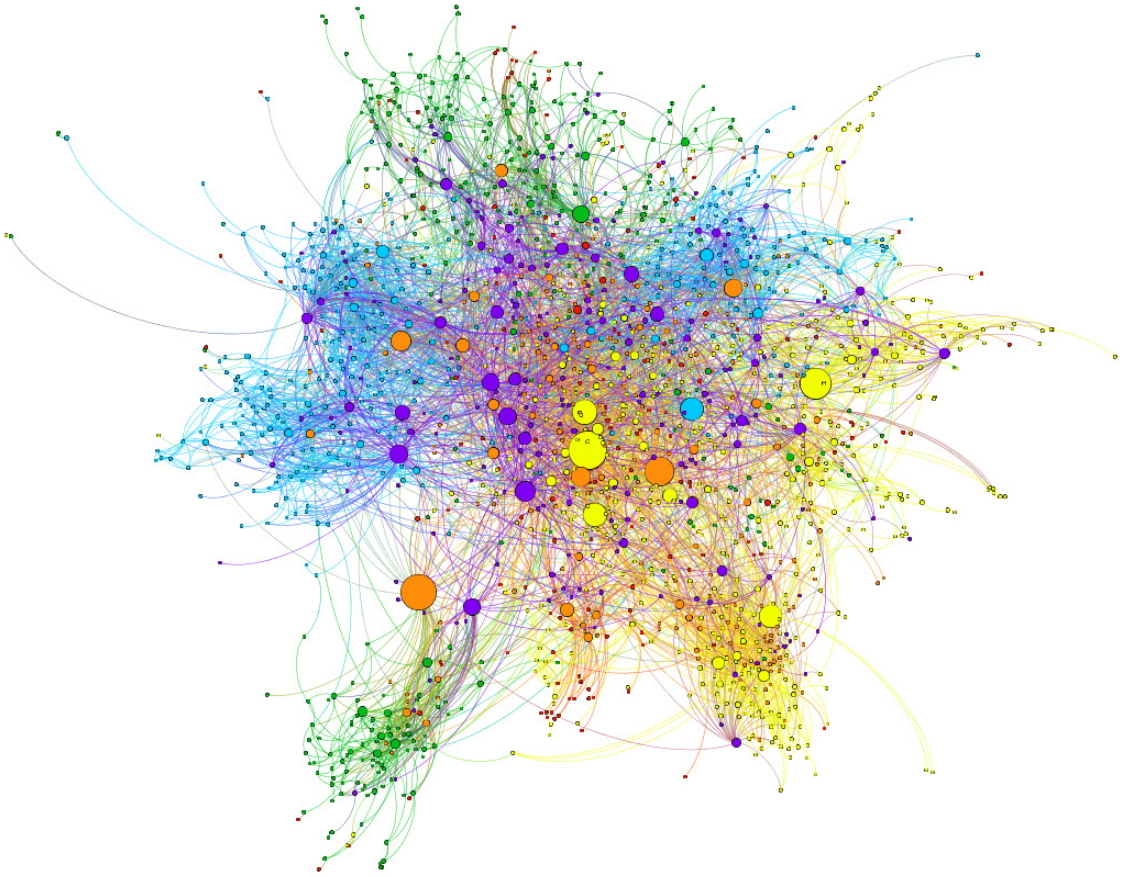
23 Survey question: *Please list people within Q (including those who have just joined) with whom you have a connection you consider to be beneficial or potentially beneficial to your improvement work or development as a leader of improvement. They might be someone: you see as a useful source of information, advice, resources or personal support; or you actively collaborate with or could imagine working with in future.* A 'connection' was defined as one member naming another in response to this question, regardless of whether this was reciprocated. This means that new members surveyed upon entry to Q were able to report connections to existing members from earlier recruitment cohorts and to members who did not respond to the survey.

24 Although the SNA conducted with the 2018 survey data provides some interesting insights, it was discontinued in later stages of the evaluation due to several concerns. Firstly, the way participants responded to the survey question may have varied, with some providing a long list of individuals they have met and others only providing the names of those they are well connected with. Additionally, while attempting to ask about Q connections in the Phase 2 application survey, we found that many respondents found the question burdensome and skipped it. In some cases, respondents' web browsers crashed due to the question, which made the data from that survey unusable.

should be taken when interpreting these results in light of the length of time that has elapsed since conducting this analysis. This analysis demonstrates the relative connectedness of different populations within the Q community, by location and recruitment phase, and is meant as a 'snapshot' of the connectedness of Q members as of January 2018, rather than a current picture of all member connections.

Figure 4 presents the connectedness of Q members by phase in which they joined. Nodes represent Q members and lines have been drawn between them if one of them reported in a survey that they had a connection to one another. Node colours indicate which Q recruitment phase they are from and the size of nodes represents the member's 'betweenness centrality' (a measure of how

Figure 4: Network map created by SNA[25]



Key: Purple: Phase 1; **Orange**: Phase 2; **Blue:** Phase 3 Wave 1; **Yellow**: Phase 3 Wave 2; **Green:** Phase 3 Wave 3; **Red:** Phase 3 Wave 4. Members with no connections and 'components' unconnected to the main graph (e.g. isolated pairs of nodes) are excluded.

25 Each node represents one Q member and is connected to another node by a line if one member reported that they were connected to the other. The colours indicate the recruitment phases (see the key under the figure for information) and the size of the node represents the betweenness centrality used as a proxy for influence (bigger nodes suggest greater betweenness centrality). In order to make the graph readable, minimum node size was set at 3 and maximum node size at 40.

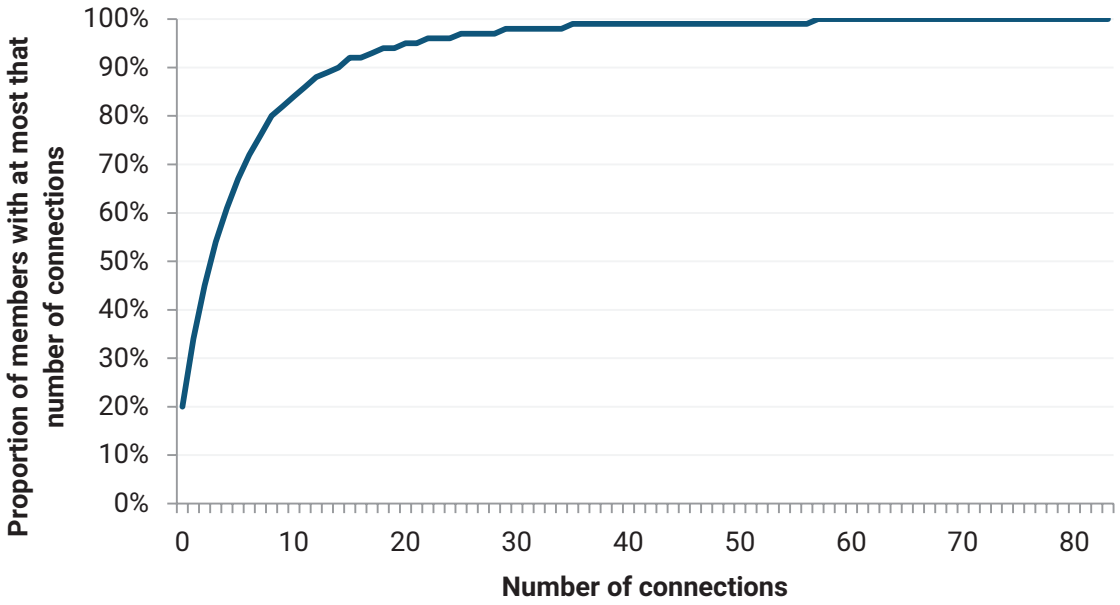
often a node is on the shortest path between two other nodes, thus used as a proxy for influence, with bigger nodes indicating greater betweenness centrality) (Ling et al., 2018), i.e. a larger node represents a greater number of connections. This figure outlines how most members have multiple connections with other members. There are a small number of individuals with a large number of connections (represented by the larger nodes) and a small number of individuals with very few connections (represented by the small nodes at the periphery of the figure). When looking at connections across phases, members from across Q phases tend to have connections with members that joined in other phases, although there is a trend for members within the same phase to report more connections with one another, which is represented by clusters of colours in the image below. However, for Q members that joined in Phase 1, they tend to report connections from across Q phases without a preference for fellow founding members of Q, which is demonstrated by the dispersal rather than clustering of purple nodes. In several areas, there seem to be clusters of Q members that are connected with one another but not with other members of Q, for example, as shown through the green portion at the top of the bottom of the figure representing two relatively distinct clusters of members that joined during Phase 3 Wave 3.

It can be noted that this analysis reflects the type of people the different recruitment phases of Q were open to and may also reflect the influence of Q welcome events on forming connections. As recruitment to Q is now on a rolling basis, rather than in recruitment waves with welcome events, the same level of connectedness between phases may not be seen.

In the member surveys, out of a total 2,150 Q members as of January 2018, 1,730 reported at least one connection or were reported to be connected by another member. Members who joined Q in Phase 2 and Phase 3 Wave 2 were reported to be the most highly connected in terms of betweenness centrality (see above for a description of metric), with a few key individuals from Phase 1 and Phase 3 Wave 1 also having high levels of betweenness centrality. In particular, the number of members reporting connections across the Phase 3 waves has notable variation. Members who joined Q in Phase 1 (9.9 average connections), Phase 2 (8.5 average connections) and Phase 3 waves 1 (7.9 average connections) show higher numbers of connections than those who joined during Phase 3 wave 4 (1.3 average connections) and Phase 3 Wave 3 (3.9 average connections). As discussed in the interim report, there are a few possibilities for this variation in connectedness within Phase 3. It may be a consequence of the widening of demographics discussed in Section 2.1.2 if that means that individuals are joining Q with a smaller existing network as they are not in full-time improvement roles. In addition, it may be due to the limited amount of time that those that joined in the later stages of Phase 3 had to make connections since joining.

The largest number of reported connections for a Q member independent of the Health Foundation was 73. Of all the Q members as of January 2018, 420 (19.5 per cent) reported not having any connections and over half of respondents (54 per cent) had more than three connections. Almost all members (90 per cent) had at most 14 connections, which reflects the number of connections for the vast majority of Q members as of January 2018. A small number of respondents (1 per cent) had 41 or more connections. Figure 5 shows the distribution of the number of reported connections from members.

Figure 5: Distribution of the number of connections for members[26]



The mean and median number of connections across geographical locations and recruitment phases was also calculated (Table 8). However, it should be noted that as Phase 1 and 2 members had been members of Q for a longer time than Phase 3 members, they had more of an opportunity to make new connections. As Table 8 shows, members in the North and South of England and Scotland have a higher than average number of connections than other regions.

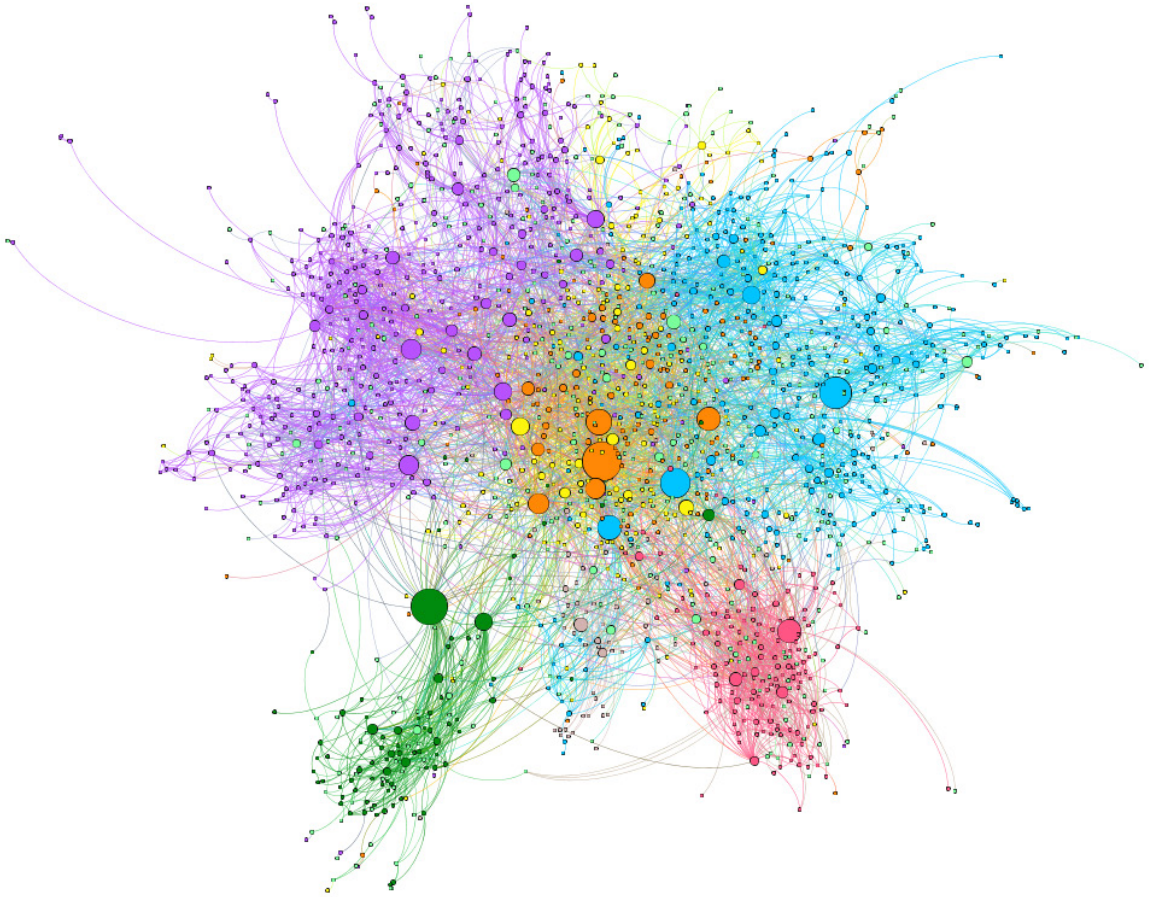
Figure 6 shows the network analysis broken down by geographical region. As demonstrated in the figure below, Q members within the South (purple), North (blue), Wales (dark green) and Scotland (pink) tend to form connections with one another, as represented by the clustered representation of these colours in the network map. In Wales in particular, this cluster's connection with other areas of Q membership may be disproportionately reliant on several key members, as represented

Table 8: Average number of connections for members

Grouping	Mean number of connections	Median number of connections
London	6	2
South	7.7	5
North	7.8	5
Midlands and East	4.9	3
Wales	6.3	3
Scotland	9.3	6
Northern Ireland	3.6	2
Phase 1	9.9	6
Phase 2	8.5	5
Phase 3 Wave 1	7.9	6
Phase 3 Wave 2	6.1	3
Phase 3 Wave 3	3.9	2
Phase 3 Wave 4	1.3	0
Total	**5.8**	**3**

26 The maximum number of connections is greater than 73 as reported above because this graph includes members of the Health Foundation team that were highly connected.

Figure 6: Network map of Q coloured by region



Key: **Purple:** South; **Blue:** North; **Orange**: London; **Yellow**: Midlands and East; Mauve: Northern Ireland; **Dark Green:** Wales; **Pink:** Scotland; **Light Green:** no answer provided. Members with no connections and 'components' unconnected to the main graph (e.g. isolated pairs of nodes) are excluded.

by the large dark green circle more closely placed toward the middle of the network map. On the other hand, members from London (orange) and the Midlands and East (Yellow) tend to be more centrally located within the Q network, connecting with one another more and with other areas of Q membership. This is represented on the network map below by the placement of orange and yellow nodes at the centre of the map dispersed with other colours rather than isolated from other colours.

2.2. Activities and resources

Although Q is internally referred to as a platform for quality improvement by the central Q team, from the members' perspective it is accessed through a series of events, activities and resources that members can engage with. Q was often referred to in these terms by members that were engaged through this evaluation. As such, this section reviews how Q members experience activities and

resources through Q, treating each element of Q separately. However, we also recognise that there are also elements of member experience that support the idea of Q as a platform, such as the networking and collaborative aspects of Q described throughout this report.

Q has a range of offers available to members, as discussed in Box 2 in Chapter 1. These activities and resources include both virtual resources, such as websites, access to online journals, forums and webinars, and more tangible resources, such as national events, site visits and funding. The number of resources has expanded considerably since Q was first established. These resources are typically free to access, although there is some cost associated with attending events and site visits in terms of travel and expenses for some members or their organisations.

Although members can access any of these resources, there is no minimum level of engagement that is expected from members and some members may not have engaged with any of them. On the whole, the resources that Q provides are valued by the Q community, and many members appreciate the ability to 'dip in and out' of Q resources as and when they have time and capacity to do so (Ling et al., 2018, Phase 1 INT17, Phase 4 INT2, stakeholder INT4, Q Exchange).

> *I think you need something that's more flexible that people can come in and out of and be more organic…. I think it's really important that people have the ability to be able to dip in and out of it.* [Phase 1 INT3, August 2016]

In the following sub-sections, each activity and resource that Q offers are reviewed in terms of how much members have engaged with it and members' views on the value of each resource.[27] Additionally, suggestions from members on how the resource or activity may be improved are provided. Of course, the Q network is a resource to Q members in itself and the creation of connections and networks is facilitated through a number of these activities and resources. This is drawn out throughout this section, and the cumulative impact of generating these connections and accessing these activities are discussed throughout Chapter 3.

2.2.1. National and regional events

Q regional and national events have been a staple activity offered since Q was established. Q holds national events every year that are open to all Q members. Regionally, Q members also hold events for local Q members on various topics.

Most members reported positive views of Q national events and regional events (Phase 2 INT10, Phase 3 INT8, Phase 3 INT15, Phase 3 INT17, Q Exchange, Scotland DD, South West DD, Wales DD, Northern Ireland DD, Ling et al., 2018), with many commenting on the unique opportunity to connect with others face to face who are working in quality improvement (Phase 3 INT6, Phase 3 INT15, Q Team INT9, Northern Ireland DD, Q Exchange), particularly during free time at the event. Events facilitated serendipitous connections with people in quality improvement who normally would not have the chance to meet or work closely together, both for people working inside of a particular region who may travel to a national event together and for people working in different regions (Ling et al., 2018). The ability to network is often viewed as the most beneficial aspect of attending events (Ling et al., 2018). For the overall quality of the national and regional events, members reported that

27 For more information on what each activity and resource consists of, please refer to Chapter 1.

these regional and national events were well organised and that they encouraged a sense of engagement, energy and enthusiasm during and after the event (Phase 2 INT10, Q Exchange case study INT2). Additionally, members benefited from having remote access to events through resources made available online without having to attend the event in person, such as the live stream of the 2019 national member event (Site Visit INT2, Scotland DD).

When respondents to the 2019 survey who had been involved with Q for at least a year were asked about which resources were more useful, while response rates were limited somewhat, the results showed that more than half of respondents reported that attending a national event (54 per cent) or attending a local event (64 per cent) was useful to some extent. However, in the 2019 survey, there is also a large proportion of respondents who were members of Q for over a year that reported having never engaged with either national or local events; 45 per cent reported that they had never attended a national event, and 34 per cent had reported that they had never attended a local event. Similar results were seen in the 2018 survey in which 40 per cent of respondents reported attending local or regional events less than every six months. Only 4 per cent reported attending these events every 2–3 months (although this may be because regional events are not likely held on such a regular basis in some parts of the country).

The interim evaluation report discussed the reasons why Q members might not attend events, particularly the annual national event. This is primarily due to other work commitments or being on annual leave. In general, members did not report that being unable to attend events was due to a lack of employer support or because they lacked interest in the content of the event (Ling et al., 2018). However, a small number of respondents reported having to use annual leave to attend events (Phase 3 INT7, Ling et al., 2018), and interviews conducted later in the evaluation suggest that obtaining funding and time off to travel to events is becoming more of a challenge for members (Scotland DD, Wales DD, Northern Ireland DD). Interviewees for the Wales deep dive mentioned the difficulty for members located in North Wales to attend any Q event at the time when the deep dive was conducted due to the Health Board bringing in special measures, meaning a travel ban was in place for members working in the Health Board (Wales DD). In addition, last-minute time commitments and/or high workloads are also frequently mentioned by interviewees as reasons for being unable to attend the national events (Phase 3 INT8, Phase 3 INT9).

> *I have absolutely no support from work at all. So, I've come down, I've taken annual leave this week so as I can come down.* [Liverpool member FGD2, November 2017]

Members also commented on what Q can do better in terms of improving national and regional events. In particular, many members reported in the 2019 annual survey and in interviews that Q events could be made more accessible (Phase1 INT14, 2019 survey), including by providing funding to attend the events, having more events per year (Q Lab INT1) and by having more events outside of London and the south of England (Phase 1 INT13, Phase 1 INT16, Phase 3 INT6, Phase 3 INT12, CS11). Having more accessible events was especially important for Q members in more isolated areas such as in Scotland, Wales and Northern Ireland, where it was suggested that more local events and having more digital access to events could help make the events more beneficial for Q members in these areas (Scotland DD, Wales DD, Northern Ireland DD). In Northern Ireland in particular, it was noted that the lack of welcome events during

rolling recruitment made it difficult to connect with people even within Northern Ireland, particularly if members live and work outside of populous cities (Northern Ireland DD).

Along with increasing access to events for Q members, members reported that having more local events, with involvement from local improvement organisations and trusts, would help increase the potential impact of Q at a local level (stakeholder INT4, Northern Ireland DD, South West DD) and would help stimulate Q activity between larger national events. Local events could also help with time constraints, as attending an event that focuses on topics of local concern may help people prioritise these events over more generic national networking events (Phase 3 INT9).

Some interviewees and survey respondents commented on improvements that Q could make in terms of providing more tangible resources and outcomes through events, reflecting that although connections made through events are useful, this is not enough to justify the expense of the event or the costs to individuals travelling to national events (Phase 3 INT9, Ling et al., 2018). Similarly, some members also felt that although the people who attend national events have a common interest in quality improvement, the specific areas that these attendees work in are too broad to be able to find people that are interested in the same area and to form useful connections (site visit INT3, Q Lab INT2). Some members suggested that having more specific thematic events or events that are tailored to specific expertise levels (Phase 3 INT11, Phase 3 INT15, Ling et al., 2018) would be useful so that people within Q working in the same area or at similar levels would be able to find each other, and so that members attending these events could derive a more tangible benefit from them.

On the whole, most members valued Q events and thought highly of the events in terms of event quality and the utility of connections that are made through face-to-face interaction. Perceived weaknesses of the events had to do with the accessibility of events, particularly in certain parts of the UK with fewer events occurring and in terms of the cost of travelling to attend. On balance, it seems that most Q members would encourage increasing the number of local and regional events, which tend to be more accessible and focused on local issues, while also maintaining the quality of national events.

2.2.2. Q Exchange

Q Exchange is a grant funding resource that provides a small amount (up to £30,000) of funding to member-initiated projects each year, with a voting process in which all members are invited to provide feedback on projects and vote for projects that should receive funding. Q Exchange has run two rounds of funding, one in 2018 and one in 2019, funding 35 projects over these two years. Annex K provides an in-depth exploration of the experiences of those submitting applications and those providing support to Q Exchange. The main points are summarised in the following paragraphs.

Reflections on the application process and reasons for applying to Q Exchange

Many members commented positively on the new, untested ideas that can be funded through Q Exchange, which may not happen with traditional funding streams, and the ability of Q Exchange to provide funding to projects that fall outside the 'usual suspects' that are typically funded to conduct projects in quality improvement (Q Exchange, 2019 survey). We note that RAND Europe's work shows that more conventional approaches to funding bring known risks (Guthrie, 2019):

- Decisions may be subject to conservatism
- Poor power to predict research outcomes

- Inconsistency, with variation across reviewers
- Possible bias based on gender, age or cognitive approach, and risk of cronyism
- Burdensome and time-consuming.

In particular, members often referred to the difficulty accessing other, traditional forms of funding for their project as one of the main reasons for applying to Q Exchange (Q Exchange).

> *I think it supports those with good ideas that haven't been able to access funding in the conventional way, to try and get their idea/innovation up and running as a test to see if it works or not.* [2019 survey respondent]

Participants frequently commented on the uniqueness of Q Exchange in terms of the collaborative application and voting process and the ability to comment on projects or receive feedback on projects that have been proposed (Q Exchange, 2019 survey, 2018 survey, stakeholder INT2, Q Lab INT2). In addition to funding novel ideas, the collaborative nature of the application process is described as a primary reason for applying to Q Exchange, with some interviewees emphasising that the feedback collected from Q Exchange was, in fact, more valuable than the funding (Q Exchange, 2019 survey).

The feedback from the Q community is valued by bidding teams for several reasons. The fact that a range of members provide feedback, offering several different perspectives on how to improve projects, including offering challenge and critique, is thought to be valuable (Q Exchange). In addition, those working in more isolated areas (either geographically or topically) feel that collaboration on projects is usually difficult for them and Q Exchange helps to overcome that barrier (Q Exchange).

The feedback provided to members that submit Q Exchange bids during the application process for Q Exchange led to refinements and changes to many bidding projects, such as changes to the focus of the project or changes in the language used to describe the project (Q Exchange). It is also felt that this collaborative process offers the opportunity to create new connections outside of usual networks, some of which have been carried through to supporting the implementation of the project (Q Exchange).

> *I just wanted to say, about the voting, what I found was extraordinary, was the amount of collaboration that we had when we published the idea and it was collaboration between other project members who also had ideas. It helped our project develop and refine it.* [Q Exchange FGD1, September 2018]

When asked about their experiences of applying to Q Exchange, many participants consider it to be straightforward and simple to navigate in comparison to more traditional funding opportunities (Q Exchange, 2019 survey, Phase 4 INT3, Phase1 INT17). Although members generally felt that Q Exchange applications were time-intensive, they reported that the extended feedback process and the use of online comments provide an opportunity to reflect and refine the project idea (Q Exchange, 2018 survey, Phase 4 INT3, Phase1 INT17).

> *We sometimes apply for novel idea start-up funding, but they are often quite complex and take a lot of time and effort and collaboration. That's why the Q Exchange was a bit easier, it was a lot less onerous and still lets you test ideas.* [Phase 1 INT17, November 2019].

Although the collaborative nature of Q Exchange is frequently seen as one of the main benefits of applying to it, some applicants

that were interviewed believed that, due to a large number of comments on their project webpages, it is difficult to find the time to acknowledge and respond to each of these (Q Exchange). Similarly, for the wider membership engaging in the bidding projects, some members reported that finding the time to read and engage with each of the shortlisted project's webpages to decide which to vote for is difficult (Q Exchange). In addition, a small number of applicants to Q Exchange were unsure of the aim of the feedback and reported only engaging with the online feedback out of obligation rather than it leading to any changes to the project. This is particularly felt by teams submitting ideas for projects that are already set up, rather than those starting new projects (Q Exchange). A small number of respondents to the 2019 survey reported that the application process is too onerous for teams, particularly due to the long feedback process, although this was a minority view.

> *Didn't win so whilst process was interesting, it was a lot of time and effort (not just) writing it but engaging with comments, which I'm not sure was the best use of my time as a jobbing clinician.* [2019 Survey respondent].

> *We got loads of comments which were helpful, and we engaged with all of them. But, hand on heart, did it change what we were planning very much? Not that much. I think the design idea initially was that there would be quite a long period of active engagement and changing and refining…have people really refined things that much? Not dismissing that those conversations were helpful and that it created new connections, but I would have preferred if the process had been quicker rather than pretending that we're all going to change our design massively.* [Q Exchange FGD2, September 2018]

Whether some team's non-engagement with online feedback is acceptable is a question that the Q team will need to consider, depending on the goals of Q Exchange. If Q Exchange is primarily meant to build better projects through feedback and collaboration, the Q team may wish to encourage deeper engagement with online feedback throughout the Q Exchange process.

Q Exchange also faces similar questions as Q in general in terms of the appropriate balance of selectivity versus the risk of becoming overly elitist by focusing on well-connected and experienced Q members. Some applicants to Q Exchange reported that the application process is democratic, transparent and creates a level playing field for all members (Q Exchange, 2019 survey). This is important to applicants who value that all teams (including those with typically underrepresented groups), not just those with senior, well-known project leaders, have an equal chance of receiving funding (Q Exchange, 2019 survey). Other participants feel that Q Exchange is more of a 'popularity contest' and particularly benefits project teams with large existing networks who are more known to members (Q Exchange, 2019 survey, 2018 survey). This was particularly expressed by applicants to the 2018 Q Exchange round, in which voting for projects was only possible for those attending the event, which was felt to leave project teams with smaller networks, or those from further away from the event location, at a disadvantage. The voting approach was changed for the 2019 funding round, allowing members to vote remotely over a three-week period, which is felt to be a fairer and more democratic approach (Q Exchange).

> *I found the funding process time consuming and I had little chance of being selected as I am from a [redacted – organisation] with no other Q members to support my application, I felt that the big trusts who have lots of Q members were*

> *going to get the votes and therefore the funding yet to learn the bidding process first hand but feel it was not a 'fair' process for the novice.* [2018 survey respondent]

Overall, members expressed positive views about the application and voting aspects of Q Exchange. This approach to formatting was thought to be unique in that it is collaborative and allows proposals to be improved based on feedback from the community. It was also felt that Q Exchange supports funding of novel and untested project ideas. The application process was largely seen as straightforward. However, there were a small number of members that felt, while the feedback on project ideas was useful, that there were too many comments to meaningfully engage with on the project webpages or that the feedback did not lead to any changes to the project ideas. In addition, a small number felt that the voting process was not equal, favouring those with larger existing networks. Some aspects of Q Exchange may be adapted to ensure that more members find the voting and feedback process as fair and productive in terms of supporting good quality improvement projects, while also ensuring that ideas are improved through the unique democratic feedback process of Q Exchange. Some members had mixed views as to the quality of the Q Exchange application and voting, with many members reflecting positively on the feedback mechanisms and voting format, although with a small number finding these problematic.

2.2.3. Q Lab

As mentioned previously, a separate evaluation of the first Q Lab has been conducted and published by RAND Europe and the University of Cambridge (Liberati et al., 2018). In the following paragraphs, we focus on reflections on the process of Q Lab (primarily from data presented in the interim report) (Ling et al., 2018), as well as the reflections and experiences of those involved in the first Q Lab as described in three interviews conducted in late 2019. Since the data for the evaluation was collected, there has also been an additional Q Lab (run in partnership with the charity Mind) on which we have limited information as this is a focus of a different evaluation run by the Innovation Unit. Reflections on the impact of Q Lab are covered in Chapters 3 and 4.

Q Lab was launched in early 2017 and is funded by both the Health Foundation and NHS Improvement. The Q Lab aims to tackle complex, 'wicked' problems faced by the health system, focusing on one of these problems at a time to identify potential solutions and ways forward to overcome the challenge. Two Q Lab projects have been run at the time of writing. The first Lab focused on peer support, which is the primary focus of this section, and the second (running from September 2018 to October 2019 in partnership with the charity Mind) is focused on persistent back and neck pain and mental health. Along with the topical focus on peer support, the first Q Lab also aimed to explore the approach that would be taken in subsequent Q Labs and ensure that it is appropriate and effective in identifying solutions to wicked problems in the healthcare sector. As such, the approach towards the second Q Lab has been refined, although this has not been a focus of this evaluation.

Even though only a small proportion of Q members participated in Q Lab, it represents an important and distinctive contribution to Q as a whole. The approach that Q Lab has taken towards working together to rapidly develop solutions to 'wicked' problems in a creative and open environment is viewed in a positive light by those that have participated. In the 2019 survey, while only 23 per cent of respondents who had been in Q for at least a year had engaged with Q Lab at all, 34 per cent of those that had used Q Labs reported that it was very useful and 52 per cent reported that

it was somewhat useful. Only 13 per cent of those that had used Q Labs reported that it was not a useful activity. As described in Ling et al. (2018), comments regarding the aspects that members value most about Q Lab cover: the collaborative aspect; the creative and fast-paced nature; acknowledging the value of lived experience; and the format of the Lab in terms of bringing people together from diverse backgrounds together in the same space.

Q Lab, while focusing on one specific problem at a time, engages a wide range of individuals, including those from outside Q, which is felt by participants to encourage the sharing of an appropriately wide range of expertise. This includes engagement of service users, individuals from across the UK, non-Q members, healthcare professionals and improvement experts (Ling et al., 2018, Q Lab INT1). Participants also reported positive views around the opportunity to make connections with other people interested in a certain area (Q Lab INT1), particularly in areas of work that can be lonely or isolating such as peer support (Q Lab INT2). In terms of the work conducted during Q Lab, the model of working on one subject of interest and 'bottoming it out' in a group of people with a common interest in the same topic was particularly appealing to some participants in Q Lab (Q Lab INT1, Q Lab INT3).

> *The majority of it was the ability to come together and share experiences with likeminded people and get something out of it that others could then use. The fact that we were able to have a lot of time invested in just 1 subject, and really bottoming out the issues and the problems, with a good balance of professionals and service users in the room, that had real value.* [Q Lab INT1, August 2019]

Participants noted how Q Lab is a creative, innovative, emergent and fast-paced approach to discussing and solving problems (Ling et al., 2018, Q Lab INT2), and reflected positively on the overall approach of Q Lab. Participants in the first Q Lab tended to comment positively on the way it was organised and managed (e.g. in terms of support from the Q team; the structure, frequency and length of meetings; the positive feeling of meetings) (Q Lab INT1, Q Lab INT2). In particular, Q Labs functioned well in terms of ensuring that hierarchies within the health and social care sector were not reproduced within the Q Lab (Phase 2 INT10).

> *The aim was really clear, and we tackled different aspects in different sessions. I think that was the right way to go about it, chunking it up like that. The atmosphere in the room was really positive and that's generated by the people leading it and keeping everyone upbeat all the time which is not easy to do in that environment. All of the members you met had the same attitude and smile which I found really positive.* [Q Lab INT1, August 2019]

Members of the Q Lab team, a dedicated team established in 2016 within the Q team and expanded in 2017, reported the heavy use of design thinking techniques for the Q Lab sessions. They also reported ensuring outputs are written in an easily accessible, appealing way, including the use of graphics and other visual aids (Ling et al., 2018). These techniques used by the Q Lab team may have contributed to the positive view that Q Lab participants had in terms of the overall approach of Q Lab in creating an open and innovative environment to think about issues in health and social care.

Participants felt the views of patient and carer representatives who participated in Q Labs were respected and incorporated into how Q Lab functioned (Ling et al., 2018, Phase 2INT10, Q Lab INT1, Q Lab INT3), which is not necessarily the same view expressed by patient and carer representatives in the wider Q membership as discussed in Section 2.1.2 above. It was noted that there is an active effort by the Q Lab team to gather both

'codified' knowledge on the Q Lab subject and tacit knowledge from service users in the form of lived experience (Ling et al., 2018). Q may be able to learn from the positive experience of patient and carer representatives that have participated in Q Lab in terms of replicating this through the wider Q initiative.

While this section covers participants' and members' view of the *experience of* participating in Q Lab, which tended to be positive, there are also divergent views on the *impact of* Q Lab, which tended to be negative or ambivalent. For more information on the impact of Q Lab, please see Chapter 3.

2.2.4. Site visits

Site visits allow Q members to visit other organisations to learn different approaches to improvement. At the time of writing (January 2020), 26 site visits have taken place across a variety of organisations in the UK since the first in April 2017. Visits in 2019 included to FutureGov,[28] Live Well Greenwich,[29] the Flow Coaching Academy (FCA)[30] and Healthcare Improvement Scotland (HIS),[31] among several others. The evaluation team collected reflections on site visits through the 2018 and 2019 annual surveys, and also focused on three specific site visits that took place in 2019. These were to the Jaguar factory (in July 2019), FCA (in September 2019) and HIS (in September 2019). Unless specified otherwise, the data outlined in this section of the report reflect the experiences of these three visits.

There is a strong view that Q site visits are useful, both in terms of what is learnt through them and in terms of the connections that Q members have made as a result (site visit INT1, site visit INT3, 2019 survey, 2018 survey, FCA survey, Jaguar survey, HIS survey, Northern Ireland DD).

> *I kept some contacts from the day and chatted with them afterwards…. I've kept in touch with people from the evaluation event, and I run ideas past these people. It's useful to have this close-knit network. I've also made note of people I met at the Healthcare Improvement Scotland visit, so when a collaborative comes up that they can plug into, I'll send them an email.* [Site visit INT2, November 2019]

For example, out of those 2019 survey participants who had taken part in a site visit, only 0.4 per cent reported the visit as not being useful. In particular, the opportunity to get an intensive view of quality improvement was viewed positively by those that had participated in site visits (site visit INT3, Phase 2 INT11), particularly in terms of not becoming too narrowly focused on methodologies that are used within the health and social care sector (site visit INT1, site visit INT3) and in understanding how other localities work to take learning back to participants' regions (site visit INT1, Flow Coaching survey, Jaguar survey). Participants tended to view site visits as high-quality opportunities to learn about quality improvements from within and outside of the

28 FutureGov creates innovative public services through digital transformation. For further information, see: https://www.wearefuturegov.com/about

29 Live Well Greenwich is led by Royal Greenwich Public Health and Wellbeing and works with local partners, services and communities to address challenges in physical and mental health. For further information, see: https://livewellgreenwich.org.uk/contact/

30 The Flow Coaching Academy programme aims to improve patient flow by empowering healthcare delivery staff and sharing this knowledge across the UK. For further information, see: https://www.health.org.uk/funding-and-partnerships/programmes/flow-coaching-academy

31 Healthcare Improvement Scotland leads on programmes to improve the quality of health and social care in Scotland. For further information, see: http://www.healthcareimprovementscotland.org/about_us.aspx

health and social care sector. Those engaged in this evaluation commented that site visits were well organised and that having small groups and one-to-one interactions were particularly effective in encouraging networking and shared learning (site visit INT1, site visit INT2, site visit INT3, Flow Coaching survey).

A small number of respondents expressed some negative views about the site visits. For example, some felt that the travel involved can be challenging, due to distance and/or cost (2018 survey, Flow Coaching survey). In addition, a very small number expressed the view that the content of the day was not relevant to them (2018 survey).

Unlike other activities and resources, participants described some clear recommendations for how site visits could be improved going forward. Some interviewees commented that they would like to have more of such opportunities. Some interviewees also thought that site visits could be more customised to particular skill levels or areas of expertise, with information available before the event on the topics that would be discussed (Site visit INT1, Site visit INT3, Jaguar visit survey). Participants commented that this would help members with more expertise to avoid site visits targeted towards quality improvement beginners and would help them avoid visits focused on topics in which they were already knowledgeable (site visit INT1, site visit INT2, site visit INT3). Similarly, participants commented that more pre-reading could potentially help participants get more learning out of the day (site visit INT3). Additionally, some participants commented that having more encouragement from site visit organisers to exchange contact details would help facilitate more connections to be made at site visits (site visit INT1, Flow Coaching visit), although one interviewee commented that there is also a risk that the networking process would become overly formalised (site visit INT1).

> *Being explicit about what will be covered on the day would probably help so that people can know what to expect and have realistic expectations…it would have been beneficial to know exactly what I was going into.* [Site visit INT1, November 2019]

2.2.5. Website resources and Q communications

There are many learning resources available to Q members (and non-members) on the Q website, as well as frequent communication from the Q team to Q members, such as the monthly Q-municate newsletter sent to all members.

When respondents to the 2019 survey who had been involved with Q for at least a year were asked about which resources were most useful, engaging with Q communications and using online learning resources and publications that were made available through Q were rated among the most useful resources. The majority (80 per cent) of respondents reported that Q communications (e.g. Q-municate newsletter, Q website and blogs) were very useful or somewhat useful, with only 14 per cent of respondents reporting not having engaged with Q communications (making Q communications the resource that is reported as most used by respondents of the 2019 survey). In addition, 68 per cent of respondents to the 2019 survey (who had been members of Q for more than one year) reported that using online resources (e.g. masterclasses, webinars, open school through

the Institute for Healthcare Improvement)[32] is very useful or somewhat useful. Similar results were seen in the 2018 survey, in which online learning resources were mentioned as the most useful resource by participants. Participants in the citizen ethnography exercise also reported that online resources and communications from the Q team were among the top ways that they engaged with Q.

Members who were interviewed for the evaluation also commented on the usefulness of the Q website and other online resources that Q provides, with many reporting that information on quality improvement methodologies has been a useful resource when conducting improvement work day to day (Phase 2 INT9, Phase 3 INT7, Phase 3 INT14, Q Team INT10, Wales DD). For example, members have commented on the usefulness of talks (which have since been discontinued) and webinars that are made available online (Phase 3 INT5, Phase 3 INT8), and have reported that they often use Q as a signpost for people interested in learning more about quality improvement (Phase 3 INT14).

> *The resources on quality improvement methodologies that are on the website are a good resource, especially when you're stuck. It gives you something to go to. All of the methodologies listed on the website are explained in a simplistic way, like the Q cards on the website, so it's been used a lot in my organisation.* [Phase 2, INT9, October 2019]

Members also mentioned several ways to improve online resources. For example, although virtual access to meetings can save costs and connect people from different regions, they may not be as effective as in-person meetings given the 'clunkiness' of online meetings and the benefits of face-to-face interaction (Phase3 INT6). Additionally, some participants mentioned that the Q website could be updated to be made easier to navigate and identify members to connect with (Q Team INT10, 2019 survey, Wales DD, Scotland DD).

> *I'm also probably a bit of a dinosaur and I prefer face to face. I can do the IT and over the phone, but if I'm wanting to really understand something and get to the bottom of how something actually worked. You can do it over Skype, but it's not as accurate and it is harder.* [Stakeholder INT5, November 2019]

Communications from Q, including emails from the Q team, were viewed by members in a variety of sometimes conflicting ways. Some interviewees found it useful to get emails on upcoming resources and events (site visit INT1, Q Team INT10) and reported that social media, in particular, is one of the primary ways that members stay engaged with Q, especially the Q Community Twitter account (site visit INT3, Q Team INT10), with 58 per cent of the respondents to the 2019 annual survey indicating that they find engaging with the Q Community Twitter to be a useful activity. However, there were also views that the communication strategy of Q could improve in some areas (Ling et al., 2018). For example, two interviewees mentioned that they were unaware of upcoming events and that they thought these could be better communicated in emails from the central Q team (Phase2 INT9), and that the communications from the central Q team relied too heavily on jargon, resulting in deleted emails (Phase2 INT10). A small number of members responding to the 2019

32 Open School is run through the Institute for Healthcare Improvement and offers online courses from around the world on improving health and care. For further information, see: http://www.ihi.org/education/ihiopenschool/overview/Pages/default.aspx

survey mentioned in free text responses that they had received no information since joining Q; however, it is unclear if they faced technical difficulty that caused this problem.

While not directly an online resource, being able to publish in open access journals for free as a Q member further is valued by members as a way of supporting the ability to share improvement work and what has been successful. It is felt that open access publishing and accessing other opportunities such as training would not be possible for many organisations without Q due to the costs involved (Q Exchange, 2019 survey, Northern Ireland DD).

2.2.6. SIGs and online forums

Members have been forming groups based on common interests and activities since the launch of Q in 2015, although SIGs did not receive their own designated online space until April 2017. At the time of writing (January 2020) there were 47 SIGs, as well as 28 other online groups covering a range of different areas of health and care improvement.[33] While there are a large number of online groups available, we discuss here how engagement with these appears to be fairly limited.

When respondents to the 2019 survey who had been a member of Q for at least a year were asked about which resources were useful, participating in SIGs and online groups ranked relatively low, with fewer than half (37 per cent) of respondents reporting that this resource was useful. Seven per cent of respondents reported that SIGs and online groups are not a useful resource (having engaged in SIGs in some way), which was the highest proportion of respondents that reported a resource as not useful in the 2019 survey. In addition, over half of respondents (56 per cent) reported that they had not engaged with this resource, making it the least used virtual resource that Q provides.

Through member interviews, it became clearer as to why this online resource is not widely used or widely valued by the Q community. Although members commented on the potential of SIGs in terms of forming a community of like-minded individuals to share learning and receive feedback on ideas (Phase 3 INT10, Q Exchange, South West DD), it was also reported that there is a lack of engagement among other Q members with SIGs and online forums which limits their utility (2018 survey, Phase 1 INT17, Q Exchange, stakeholder INT1, stakeholder INT2, Q Exchange, 2019 citizen ethnography). Some SIGs did not have activity for long periods, and despite the large number of SIGs in Q, members reported that many of them were 'dead' (Phase 1 INT17, Q Exchange, stakeholder INT2). This inactivity in SIGs and online forums also came through as a strong theme in the 2019 citizen ethnography exercise. Several participants reported having posted documents and requests for feedback in online forums without a response from other members, which was frustrating for those who had taken the time to post. In response to this, some participants suggested reducing the number of SIGs in the hope that there might then be more activity in each one. Similarly, a stakeholder suggested that having closer management of SIGs from the Q central team could help to address some of the inconsistencies between SIGs (stakeholder INT1).

> *I had hoped that the SIG's would have been more active. These have great potential, but I detect a reluctance to get involved. In my opinion you need to post a few examples of questions that you might*

33 Other online groups are organised around a variety of areas, including regional groups and groups organised around Q Exchange.

expect on the Q community SIG forums; adopt an 'all learn, all share…. There are no wrong questions. [2018 survey respondent]

I think there are a lot of SIGs, but I don't think all of them function very well. I think we get enthusiastic, and then understand that it has to be set up and run. Some groups work well but I think most of them probably don't have any connections. [Phase 1 INT17, November 2019]

There is some evidence that some SIGs may be more consistently active than they appear based on online activity. For example, one participant in the citizen ethnography exercise mentioned that even though their regional SIG appears inactive online, there are offline activities that the SIG is doing with support from Q. Additionally, the Reimaging Health and Social Care SIG, a group open to Q members nationally but run by members in the South West of England, seems to have succeeded in terms of encouraging deeper engagement from members. Those who are a part of that SIG are expected to actively contribute and those based in the South West of England meet monthly face to face with both Q members and non-Q members (South West DD). However, this does not seem to be the case for thematic SIGs, such as the two created for the 2019 Q Exchange funding round, focused on the two themes' funding areas.[34] Feedback from the moderators of these two SIGs indicates that there was a lack of engagement with these groups from the start of the process, which potentially contributed to teams designing similar projects not connecting and sharing knowledge as much as they could have done and less opportunity for applicants to make connections to useful individuals (Q Exchange).

Overall, it appears that some SIGs are viewed as high-quality resources and platforms for those that participate in them, but that this is patchy across the SIGs that exist within Q. The success of SIGs depends on the engagement of those that run them and the engagement of members that participate in them. The central Q team may be able to support this engagement to rectify the patchiness of SIG quality across Q, including by potentially cutting back on the number of SIGs to encourage more engagement.

2.2.7. Randomised Coffee Trials

Members who had participated in Randomised Coffee Trials (RCTs) have mixed views on this resource. On the one hand, members valued the opportunity to meet people in Q who they otherwise would not have connected with. RCTs facilitate this by matching Q members randomly with other members (Phase 1 INT14, Q Lab INT1, Ling et al., 2018).

I just think [the RCTs are] a brilliant idea because so much of life is serendipity…. I think that being offered that, even if it's literally a five-line email that says I'm interested a little bit, get in touch, it's helpful. It's more knowledge than you would have had to start with, so it adds value. [Phase 3 INT1, October 2017]

When I have them, they are successful, it is great and knowing what is going on more widely. I have pulled out some nice connections through them and some people you stay in contact with. [Q Lab INT1 August 2019]

However, interviewees reported that often the matches that are made through RCTs do not result in a meeting or communication between

34 The funding areas were focused on were: building improvement capability across boundaries and understanding alternatives to traditional outpatient appointments

the matches and that there is sometimes a lack of follow-up contact and actions even when RCTs do succeed in bringing people together (Phase 1 INT7, Phase 1 INT14, Phase 3 INT10, Q Lab INT1, CS11, 2018 survey, Wales DD). Additionally, due to the amount of time it takes to set up RCTs, some find that it is not worth the effort (Phase 1 INT17, 2018 survey).

> *We do the RCT's and for me, that fails 3 times out of 4. You just don't get a response from the other person. When they do happen, they are really good, but it is disappointing when you email someone twice in a month and you don't get a response.* [Q Lab INT1, August 2019]

> *With a lot of the coffee trials, people are enthusiastic at the beginning but most of them didn't happen. I can't remember when I last did one. When they first started, I did about 3–4 of them but I've pretty much opted out now. It takes a lot to organise. To set up a coffee trial by phone, you have to check diaries, confirm availability and then the other person isn't available, so it becomes a bit of a pain. And then when the conversation starts, it might not be in an area you are interested in or get anything from. It's a bit haphazard. If you're really tight for time, it isn't always a great use of time.* [Phase 1 INT17 November 2019]

These challenges may be exacerbated by the small number of Q members taking part in RCTs. In the 2018 annual survey, for those that had been members of Q for more than one year, the majority of respondents (63 per cent) reported never using RCTs, and 15 per cent used RCTs less than once every six months. In addition, 8 per cent of respondents simply did not know about RCTs, indicating that there were at least 71 per cent of respondents who had never used RCTs. Based on the low engagement in RCTs and the frustration around RCTs for members that expressed their opinions through this evaluation, RCTs are a resource that may need to be reconfigured significantly to be valuable to the wider Q membership.

2.3. Engagement by members in the community

This section will cover the Q team engagement strategy, as well as the level of engagement of Q members over time, with an exploration of supporting and inhibiting factors for members engaging with Q.

2.3.1. Q's engagement strategy

As mentioned previously, Q's implicit strategy to engage members is based on allowing each member to be as involved as they would like to be with Q, without requiring a minimum level of engagement from any Q member. This ability to 'dip in and out' of Q helps members to engage with Q even when they have little time available, but it also may limit the amount of engagement from Q members because they are not obligated to contribute to virtual discussions or attend any national or regional events to maintain their membership. This engagement strategy of non-obligation is supplemented by regular communication from the central Q team, which reminds members of upcoming events such as national meetings or site visits, articles, online resources and other Q resources of interest.

> *I like the way it's still on its own journey of developing…. I like the way that Q is not thrust upon you. It very much feels member-led.* [Phase4 INT2, September 2019]

Early in this evaluation, we found that there was some confusion and lack of clarity as to what Q is among members and for those external to Q, which in particular was thought to be due to communication from the Q team to members not being as effective as it could

be (Ling et al., 2018). However, engagement with members since the early stages of the evaluation suggests that this is not the case anymore, with members having a much clearer idea of what Q is, what it means to them and how and why they engage with Q.

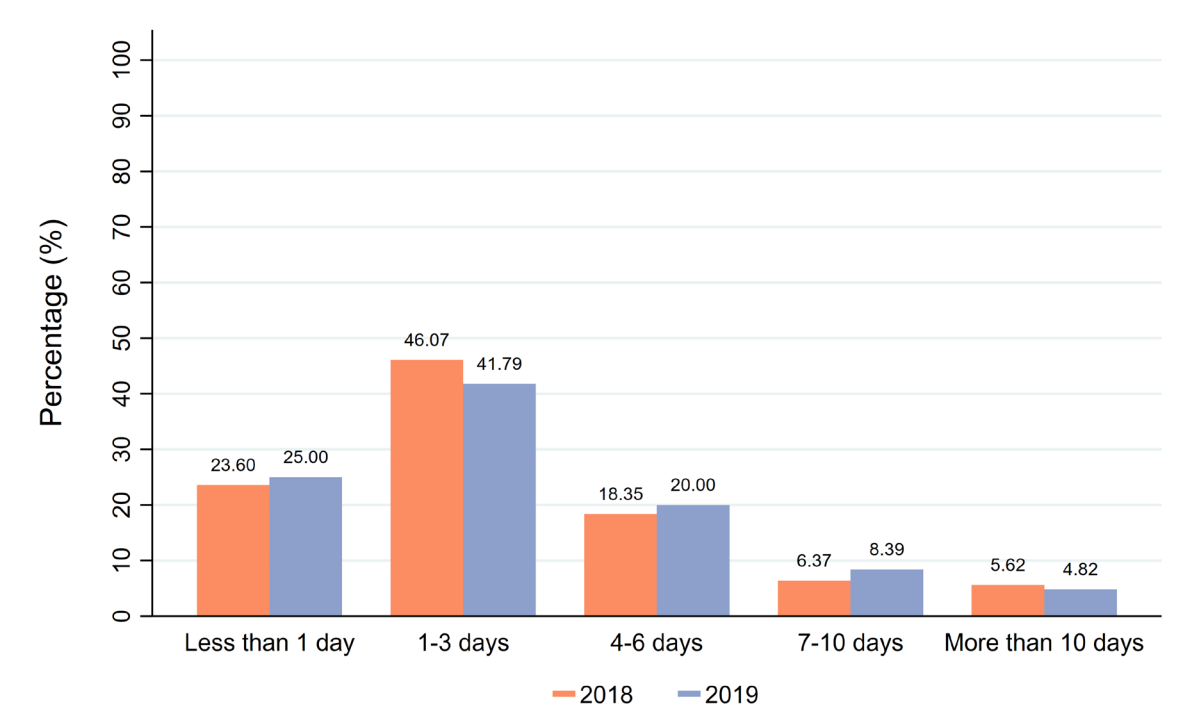
By 2018, the Q team was piloting a commons model that encouraged everyone to contribute to the Q community based on the mutual benefit that is derived from any member's contributions toward the community. The thinking behind this was informed by the work of Elinor Ostrom, which showed how individuals with mutual interests might work together to protect their shared assets and resources – the 'commons'. This was a response to a recognised need to provide some regional and local structures so that, as Q continued to grow, relationships could form naturally to help members pursue their mutual interests in improvement. This model proved to be more difficult to establish than the Q team anticipated (Q Lab INT1, QI INT1, South West DD), perhaps due in part to increased demands in the health and social care workforce that prevent people from dedicating time to activities that are outside their 'day jobs' (South West DD). Efforts to help support the Commons model, such as the Q Commons Stewardship Group in the South West of England, also came up against challenges of mobilising groups of very busy people and it was difficult to gain momentum. Thus, although the Q team has creatively explored new models of how Q can stimulate engagement 'from below' while working on a large scale, the commons model (always designed as a pilot) has not worked as anticipated (South West DD). Further detail on the commons model is discussed in Section 5.4.

The issues associated with Q's commons model feeds into a wider question of the most effective mechanisms for sustaining the initial enthusiasm and excitement around Q over a longer period, and in particular as it grows further in the coming years. Some interviewees have commented that the initial feeling of enthusiasm, particularly that among the founding cohort of Q, has not been sustained as the network has grown (Phase 1 INT16, Phase 3 INT14, Stakeholder INT1). Engagement strategies going forward will need to consider the sustainability of relying on members to co-produce Q and maintain the Q network, versus the need to provide top-down resources and direction to keep the Q initiative moving forward (Q Team INT13, Q Team INT11). Additionally, the Q team will need to consider how to engage members that are more diverse than the membership of the founding cohort as Q continues to grow (Q Team INT10), how to deal with fluctuating engagement over time (Q Team INT11) and how to encourage engagement in pockets of the UK where Q participation is not as active (Stakeholder INT5).

2.3.2. Level of engagement of Q members

In the 2019 annual survey, respondents were asked to indicate how much time they spend engaging with Q and how much they expect to engage with Q in the future (Figure 7). From these, 42 per cent of the respondents who had been members of Q for more than a year had spent 1–3 days over the past 12 months on Q, while 25 per cent spent less than a day on Q in the past 12 months, and 20 per cent spent 4–6 days on Q. Only a small proportion of longer-term Q members spent 7–10 days (8 per cent) or more than 10 days (5 per cent) on Q over the past 12 months. This amount of engagement was similar to that reported by Q members in the 2018 survey, which asked members about their engagement from 2017 to 2018.

Figure 7: Amount of time respondents spent engaging with Q in the past year for members that had been in Q for at least a year from the 2018 and 2019 annual surveys[35]

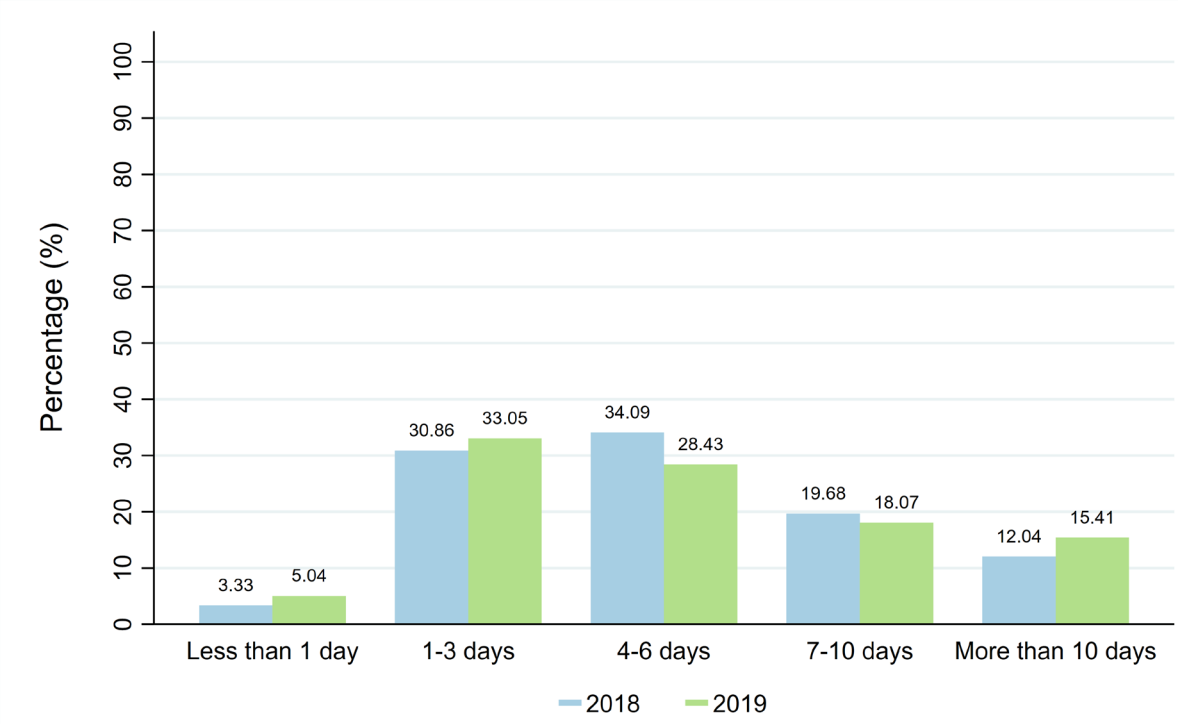


2018: Number of total observations: 534
2018: Number of observations from left to right: 126, 246, 98, 34, 30
2019: Number of total observations: 560
2019: Number of observations from left to right: 140, 234, 112, 47, 27

The 2019 survey also asked respondents about the time they want to spend engaging with Q in the next year (Figure 8). For both older members and newer members of Q, only 5 per cent of respondents reported that they wanted to spend less than a day on Q in the coming year, with most respondents wanting to spend either 1–3 days (33 per cent) or 4–6 days (26 per cent). Eighteen per cent of respondents reported wanting to spend 7–10 days on Q in the coming year, and 15 per cent reported wanting to spend more than 10 days on Q. While the response rate for the 2019 survey was only 24 per cent, this still indicates that on average members want to spend more time in the future on Q than they are currently spending, although this may not necessarily translate into increased engagement in the coming year.

35 Question text: *How much time have you spent engaging with Q over the last year? (e.g. participating in local events or other activities, visiting the website, attending a centrally run visit/event, participating in the Q Lab, writing a blog, participating in a webinar or twitter chat etc.).* This question was not asked to Group B respondents as they had joined Q within the last 12 months.

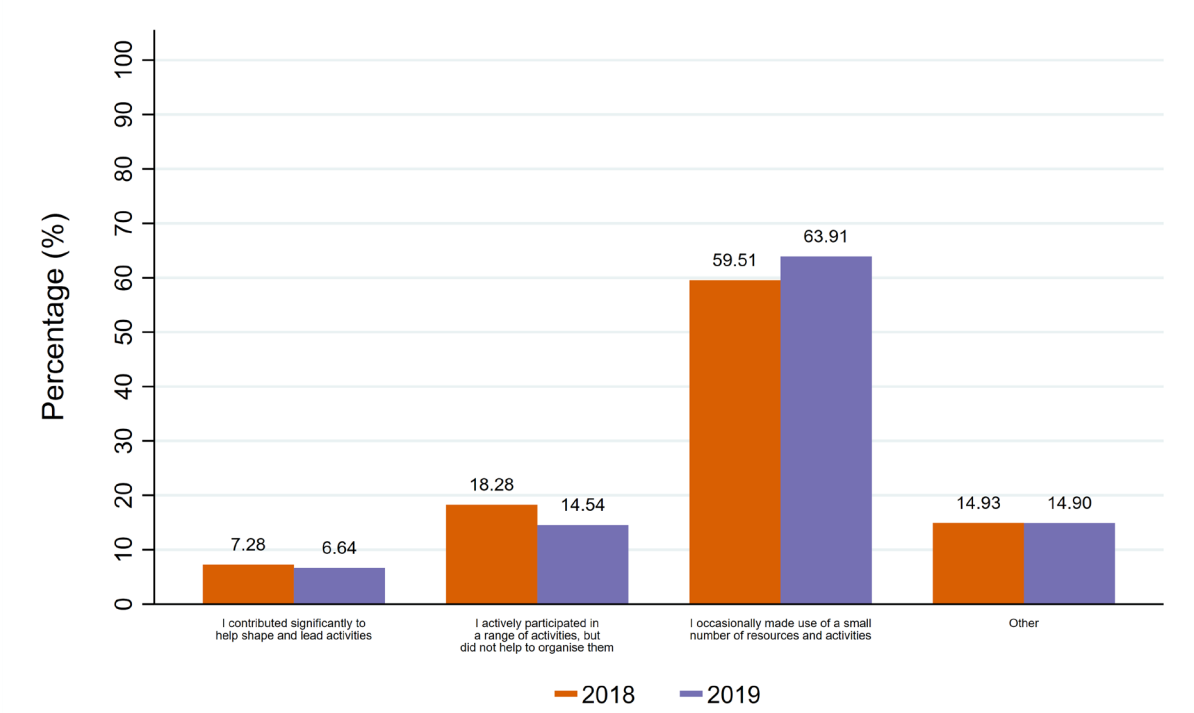
Figure 8: Time respondents want to spend over the next year (all Q members) from the 2018 and 2019 annual surveys



2018: Number of total observations: 930
2018: Number of observations from left to right: 31, 287, 317, 183, 112
2019: Number of total observations: 714
2019: Number of observations from left to right: 36, 236, 203, 129, 110

In addition to the amount of time spent on Q, the 2018 and 2019 Q member surveys asked members who had been a part of Q for more than one year the type of engagement they have had with Q (Figure 9). In 2018, the majority of members (60 per cent) reported occasionally making use of a small number of resources, with 18 per cent actively participating in activities and 7 per cent contributing to developing activities. In 2019, the number of respondents reporting occasional use of resources increased to 64 per cent, while the number reporting actively participating in activities dropped to 15 per cent. The percentage reporting contributing to developing activities remained the same at 7 per cent. This may indicate that, as the membership of Q grows, members are engaging more passively in Q, rather than contributing as actively to the community.

Figure 9: How active respondents who were members of Q for more than one year reported being in the last year from the 2018 and 2019 annual surveys



2018: Number of total observations: 536
2018: Number of observations from left to right: 39, 98, 319, 80
2019: Number of total observations: 557
2019: Number of observations from left to right: 37, 81, 356, 83

As mentioned previously, participants also reported that they had observed low levels of engagement by other Q members. Some interviewees reflected that although there are many Q members, many of them may have minimal engagement with Q (Phase1 INT14, Phase 3 INT9, citizen ethnography 2019, Ling et al., 2018). Through the citizen ethnography exercise, it was also brought up that some Q members may 'lurk' on online forums and other virtual resources and may be engaging with Q and benefiting from membership in their role, even if they do not 'visibly' contribute to the community. There were mixed views on whether this is necessarily negative, as those members are still engaging with Q even if their engagement is not visible to others. Indeed, there are various models, or ladders, of engagement[36] and all of these recognise that it is appropriate to facilitate and support different levels of activity, ranging from members observing through to playing a leadership role. However, some respondents felt uncomfortable with low levels of engagement when members might not share thoughts or resources with the wider Q community, but still expect to benefit from it personally. This tension between members, with some

36 See, for example, Rosenblatt's pyramid of engagement: https://www.the-vital-edge.com/engagement-pyramid/

expressing concerns at the lack of participation from others, is one that has existed since Q opened recruitment beyond the initial founding cohort (Ling et al., 2018). In part, this may come from uncertainties around the amount of time members are expected to spend on Q, with some appreciating the ability to have flexibility in the time commitments, but others preferring to be told how much time should be dedicated to Q (Northern Ireland DD, Ling et al., 2018). Overall, the benefits of offering variable levels of engagement are considerable but as Q grows it would help to clarify again what the expectations are for new members in particular. Free-riders pose a risk to the cultivation of the commons.

> *There is a risk that there can be a high membership number, but these people aren't necessarily involved.* [Phase 1 INT14, March 2018]

The perceived low level of engagement by some Q members does not necessarily reflect an active disengagement with Q, as members across the surveys and interviews continually express wanting to spend more time on Q and to participate more actively in activities than they currently are (Ling et al., 2018, 2018 survey, 2019 survey).

2.3.3. Barriers and facilitators to members engaging with Q

There are several reported barriers and facilitators for Q member's engagement with Q activities and resources. Some are external to Q, such as time allowed for participation and organisational support, and some come from within Q, which are outlined in the following section.

Barriers and facilitators outside Q

Insufficient time was unsurprisingly the most significant barrier that members face in engaging with Q (Phase 2 INT9, Phase 3 INT5, Phase 3 INT7, Phase 3 INT8, Phase 3 INT9, Phase 3 INT11, Phase 3 INT12, Phase 3 INT15, Stakeholder INT4, Stakeholder INT5, CS11, Q Lab INT2, Northern Ireland DD, Wales DD, Ling et al., 2018), as well as a reason why Q is not embedded into everyday working (Q Team INT10). Many members commented that they became less involved with Q when their professional roles changed to a role less focused on quality improvement (Phase 3 INT8, Phase 3 INT14, Q Lab INT2, site visitINT1, Stakeholder INT5), indicating that Q is sometimes taken on as an extension of members' day jobs in quality improvement rather than as an embedded part of working in the health and social care sector.

> *I failed to make time work as a senior leader to engage with the community. I do work when I can, but really struggle to find time [for Q].* [Phase 3 INT11, April 2018]

> *[I have] seen list of events but cannot attend them due to time constraints. I don't have time to spend on things which don't affect the local area.* [Phase3 INT9, April 2018]

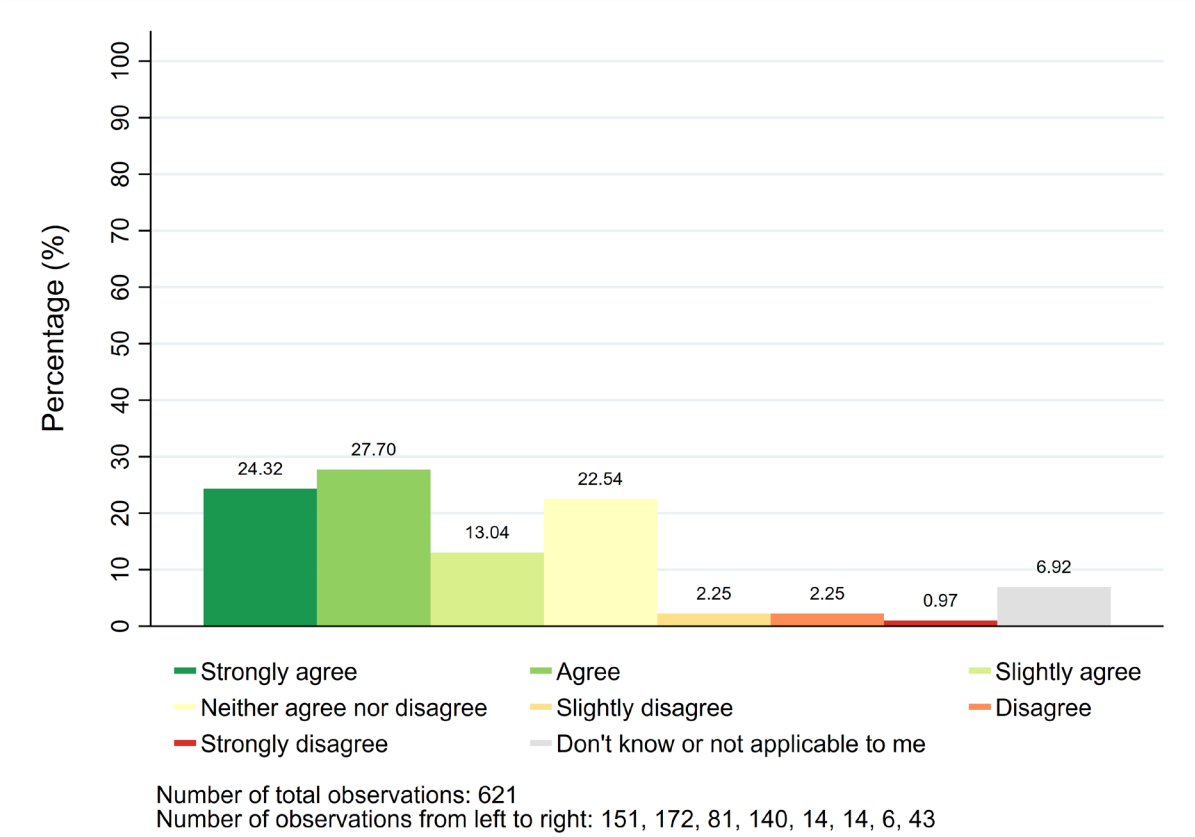
Insufficient resources was also identified as a major barrier, as some members could not afford to go to events outside of their immediate region (Stakeholder INT4, Phase 1 INT13, Phase 1 INT16, Phase 3 INT6, CS11, Wales DD, Scotland DD, Ling et al., 2018). This was particularly difficult for patient and carer representatives (Phase 1 INT5).

> *[Q] may also need to shake things up and to find new ways of working together. It is good at creating relationships from across the whole UK but there are problems with travel and overnight stays so contributing remotely is important.* [Phase1 INT13, March 2018]

Organisational support for engaging with Q and management of the organisation recognising the value of Q were identified

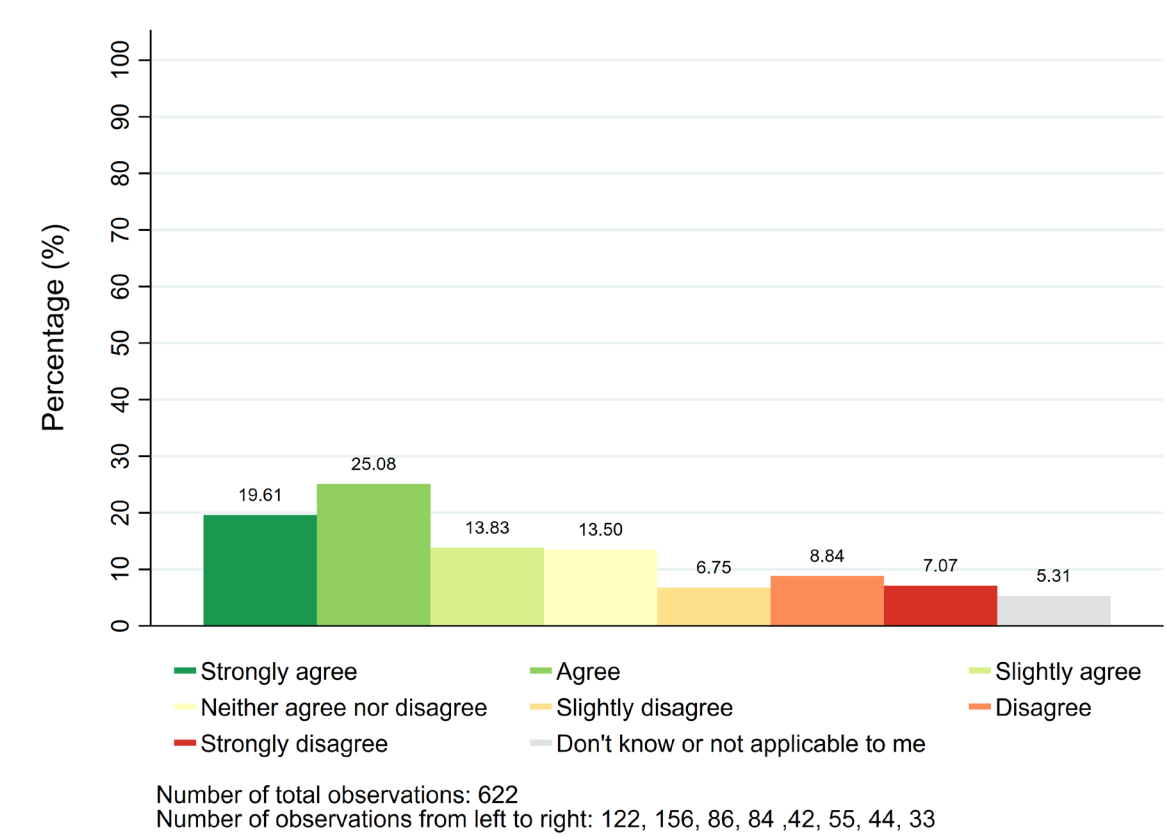
as a major facilitator of engaging with Q (Phase2 INT9, Phase 4 INT2, Phase 4 INT3, site visit INT2, Ling et al., 2018). In the 2019 survey, nearly two-thirds of members reported that their organisation was positive about their involvement in Q, with only 5 per cent disagreeing (Figure 10). However, when it came to organisations providing support for members, while 59 per cent reported that their organisation provides practical support, such as travel costs and protected time, almost one quarter (23 per cent) said that their employer did not provide this type of support (Figure 11).

Figure 10: Agreement with whether members' organisations are positive about their involvement in Q[37]



37 Question text: *My organisation is positive about my involvement in Q.*

Figure 11: Agreement with whether member's organisations provide practical support for their involvement with Q[38]



A small number of interviewees reported that their organisation allowed them to take time off from work to attend national events, that they can use Q as professional development time (Phase 3 INT14, Scotland DD, Wales DD), and that they are paid for their time while participating in Q (Phase 3 INT12). There are also cases in which members of Q within an organisation meet to share learning with their wider teams after Q events, which also encourages participation in Q at an organisational level (site visit INT3). However, many members reported that their organisations did not support their involvement with Q, which limited the extent to which they could engage, or reported having to make a business case to management to demonstrate the value in being away from work for a day (Phase 3 INT5, Phase 3 INT7, Phase 3 INT13, Northern Ireland DD, Ling et al., 2018). For example, members participating in a focus group held at a national Q event reported having to take annual leave to attend the event or having to fund their travel themselves (Ling et al., 2018), which was also reported by one interviewee in the later stages of the evaluation (Phase 3 INT7).

38 Question text: *My organisation provides the practical support I need (e.g. travel expenses, protected time) to participate effectively in Q.*

> *To go to all day events, I would have to take it as annual leave at the moment, it is not part of my job, so I could not take it out of my working hours. This may change in the future, if they see it as something they could allocate time to.* [Phase3 INT7, February 2018]

Some interviewees commented that because of the lack of tangible outcomes outside of networking benefits from Q events, it is difficult to justify the investment of time and resources that it requires to engage with Q and to get management on board with taking time off (Phase 2 INT10, Phase 3 INT13, Ling et al., 2018). These interviewees mentioned that if Q had more tangible outcomes (for example, working around a specific project, rather than just general information or networking opportunities), members would be able to engage more.

> *There has to be a senior cohort environment where senior figures feel as though they're contributing at a level appropriate to them, rather than going to the events which are very broad and have hundreds of attendees.* [Phase3 INT11, April 2018]

Barriers and facilitators within Q

There were also some facilitators and barriers to engagement that were identified by Q members as something that the Q team could potentially address more directly, as compared to the overarching facilitators and barriers described above over which the central Q team has less control.

Interviewees commented that it is sometimes difficult to engage with Q because although all members have a common interest in quality improvement, members come from a wide variety of backgrounds and work in different areas within health and social care (Phase 3 INT11, Phase 3 INT13, Q Exchange, Q Lab INT2, site visit INT3). These interviewees commented that if there were more opportunities to engage with Q members who have a closer interest in their particular areas of work, then they would derive more benefit from Q and may engage with the Q network more. Additionally, citizen ethnography participants mentioned that it may be difficult to engage with Q because of the 'sameness' of activities provided through Q. These members reflected that if there were more diverse opportunities available through Q (e.g. events for people at different skill levels, more site visits outside of the health and social care sector), it would be easier to engage with Q.

Conversely, some members reported that the ability to engage with Q when they had the time and to not engage with Q when they did not have time enabled them to remain engaged with Q despite other professional and personal commitments (Phase 1 INT17, Phase 4 INT2, Stakeholder INT14, Q Exchange). As mentioned previously, this both enables more members to engage with Q and also potentially limits the engagement of some members because there is no minimum requirement to remain a Q member. Members of the central Q team have commented that there is a need to define what success looks like in terms of passive engagement with Q versus active participation in Q (Q Team INT13, Ling et al., 2018). In other words, what would be a desirable amount of engagement from members to maintain the co-produced ethos of Q? Based on this evaluation, evidence suggests that it may be more desirable to encourage a higher level of engagement among existing members of Q to increase the value of Q to the membership, while also working to grow membership (both in numbers and diversity of members). This should include clarifying what the expectations are for new members joining Q. It may also require going further than this by setting a minimum level of activity (to avoid the 'free-rider' problem) but also recognise the benefits

of supporting a 'ladder' of engagement such that members will inevitably have different capacities and time to engage.

Patient and carer representatives have also commented on barriers and facilitators to their engagement in Q. Some service user members feel that the Health Foundation and Q respect service users and make them feel that they have equal footing in the network, which has been identified as a facilitator that allows more patient and carer representatives to get involved in Q (Phase3 INT12, 2019 survey). However, there were also many service user members that were engaged through this evaluation who commented that service users do not have the same voice within Q as professionals in the network, which restricts their participation in terms of finding the right place to contribute (Phase 1 INT5, Phase 1 INT16, Phase 2 INT10, 2019 survey). Some patient and carer representatives also lack clarity around the financial reimbursement available for service users attending activities; some interviewees feel that not all service users know that they are entitled to reimbursement (Phase 1 INT5, Phase 2 INT10). Service user respondents to the 2019 survey provided some examples of how Q can better engage this group, such as creating strategies to better engage a wider range of service users in an accessible way and better supporting service users to work with frontline health professionals.

> *When you look at Q participants, Q does profess to value patient voice and experience, but the numbers don't reflect that, and the events don't reflect that. The recruitment process isn't supportive of patient involvement. Patient's expenses aren't paid – not valuing their attendance as much as others. This is an area where Q can really show they are different. Q can show they are 'doing with', rather than 'doing for' but they have not grasped this opportunity yet.* [Phase 1 INT5, April 2018]

3 Impact on how members approach improvement

This chapter discusses the impact Q has on member's professional lives. It is structured by the four mechanisms to impact outlined in the Q theory of change: connecting, collaborating, developing and supporting. A summary of the key points from this chapter is below.

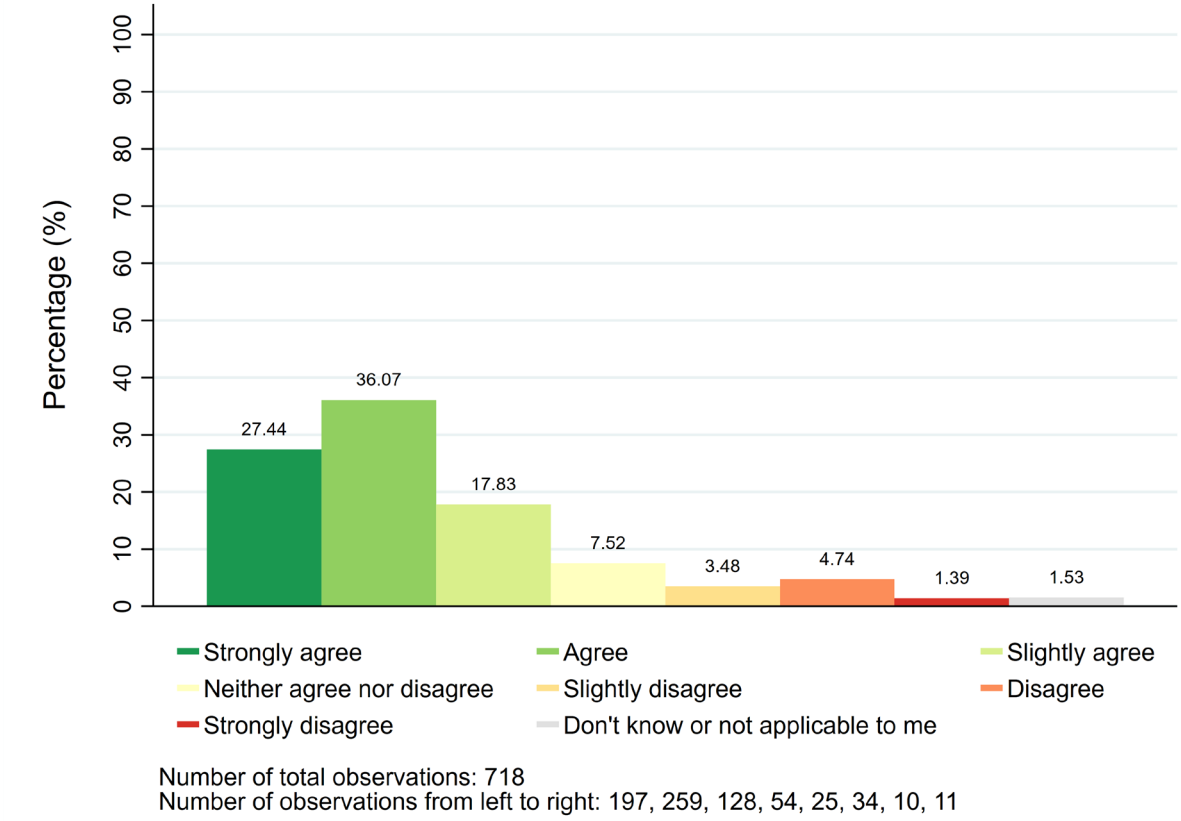
- Q members reported being able to expand their networks, connecting to individuals they felt they would not have been able to meet without Q. These new connections span multiple boundaries, including professional, organisational and geographical (particularly for those in remote, rural locations). The connections made through Q were used for several activities, such as support with ongoing improvement work, as well as to help with the creation of new improvement projects. In particular, Q Exchange was highlighted as a collaborative approach to bidding for funding, which has led to the creation of new connections to implement the Q Exchange projects.
- For Q Lab, while the process was often thought of as positive, with the ability to engage with a range of expertise, some participants were unsure as to the impact it had tackling the problems it set out to find solutions for.
- Q has contributed to the development and sharing of knowledge and learning by offering learning and development opportunities (Liberating Structures is a particular session frequently mentioned by members as being useful) and online resources. In addition, Q Exchange and connections made through Q were seen as ways of learning about priorities in other areas of the country and to learn from other members' work.
- Q supports the personal development of members, with participants reporting feeling greater confidence and empowerment in being able to undertake improvement work.
- Cross-analysis from the 2019 survey results suggests that roughly one-third of respondents who spent less than one day on Q perceive Q to offer a less of a benefit than those spending more than one day per year on Q. This was identified when members were asked about the personal benefit of Q, the benefit to the health and care system in the UK, members ability to undertake improvement activities and the development of skills and knowledge. Similarly, respondents reporting only occasionally use of resources were less likely to agree that Q positively impacted their own skills and knowledge, the strength and size of theirs and their colleagues' networks, visibility of improvement within organisations and nationally, and the quality of care within organisations and nationally.
- There were differing opinions as to whether Q offers the same support for service users as other members, with some feeling that Q meaningfully and actively engaged this group of members and others feeling this is not the case and more work needs to be done to engage service users.
- Q supports its members to conduct improvement work by creating a platform for improvement and increasing the visibility of improvement work at an organisational level. The Q community is often described as being warm, open and a safe space to express ideas that contribute to the creation of this platform for improvement.

Overall, participants generally expressed that Q has positively benefited them and their work.

> *It's been a really positive experience…. The national team have done an amazing job. It has enabled the space to be made and for us to think outside the box, not just from a QI perspective but massive transferable skills.* [Stakeholder INT5, November 2019]

This is particularly evident in each of the annual Q surveys in which members were asked whether they felt Q positively benefited them. In the 2018 annual survey, 63 per cent of members reported agreement to some extent that they benefited from being a part of Q. However, the agreement with this statement rose when asked in the 2019 survey: 81 per cent of respondents agreed to some extent that they benefited from joining Q (Figure 12). The reasoning behind these changes in perceived benefit from 2017 to 2018 and then again from 2018 to 2019 is unclear from these surveys. For the 2019 survey responses, we compared the perception that Q positively benefits members with the time members spent on Q. This breakdown is shown in more detail in Annex H. However, this analysis indicates that almost one third (31 per cent) of respondents who spend less than one day per year on Q disagreed to some extent that Q positively benefits them, which is higher than members who reported spending more than one day on Q (which ranged from 0 per cent to 8 per cent).

Figure 12: Perceived personal benefit from Q from the 2019 survey[39]



39 Question text: *I am confident I personally benefit from being part of Q (Group A) and I am confident I will personally benefit from being part of Q* (Group B).

3.1. Connecting: Q members are expanding their networks across multiple types of boundaries

One of the main reason's participants reported wanting to join Q is the ability to make new connections and expand networks. This is often highlighted by participants as being one of the main benefits of being a Q member, particularly that many of these new connections would not have been possible without Q (Scotland DD, South West DD, Wales DD, Northern Ireland DD, Phase1 INT18, Phase 2 INT19, Phase 3 INT6, Phase 3 INT7, Phase 3 INT8, Phase 4 INT4, stakeholder INT2, stakeholder INT3, stakeholder INT4, stakeholder INT5, site visit INT1, site visit INT2, site visit INT3, QI INT1, QI INT2, QI INT3, 2019 citizen ethnography, 2019 survey, 2018 survey, Sheffield Site Visit survey, Jaguar site visit survey, HIS site visit survey, Q Exchange, Garrod et al., 2016, Ling et al., 2018). Participants often referred to the ability to tap into a community of like-minded, enthusiastic and varied individuals with similar interests and values, allowing a range of perspectives to be accessed (Phase 1 INT14, Phase 1 INT17, Phase 2 INT10, Phase 3 INT1, Phase 3 INT6, Phase 3 INT7, Phase 3 INT8, Phase 3 INT14, Phase 3 INT15, Phase 4 INT2, Phase 4 INT3, CS8 site visit INT2, site visit INT3, stakeholder INT2, Stakeholder INT3, Stakeholder INT5, Q Exchange, Ling et al., 2018).

> *I've had one or two people that I still work closely with that I don't think I would have come into contact with without Q. The way it actually does structure contacts in a way that you potentially meet someone that you wouldn't normally meet but you do have common ground. I think that was the greatest change.* [Phase 1 INT11, July 2017]

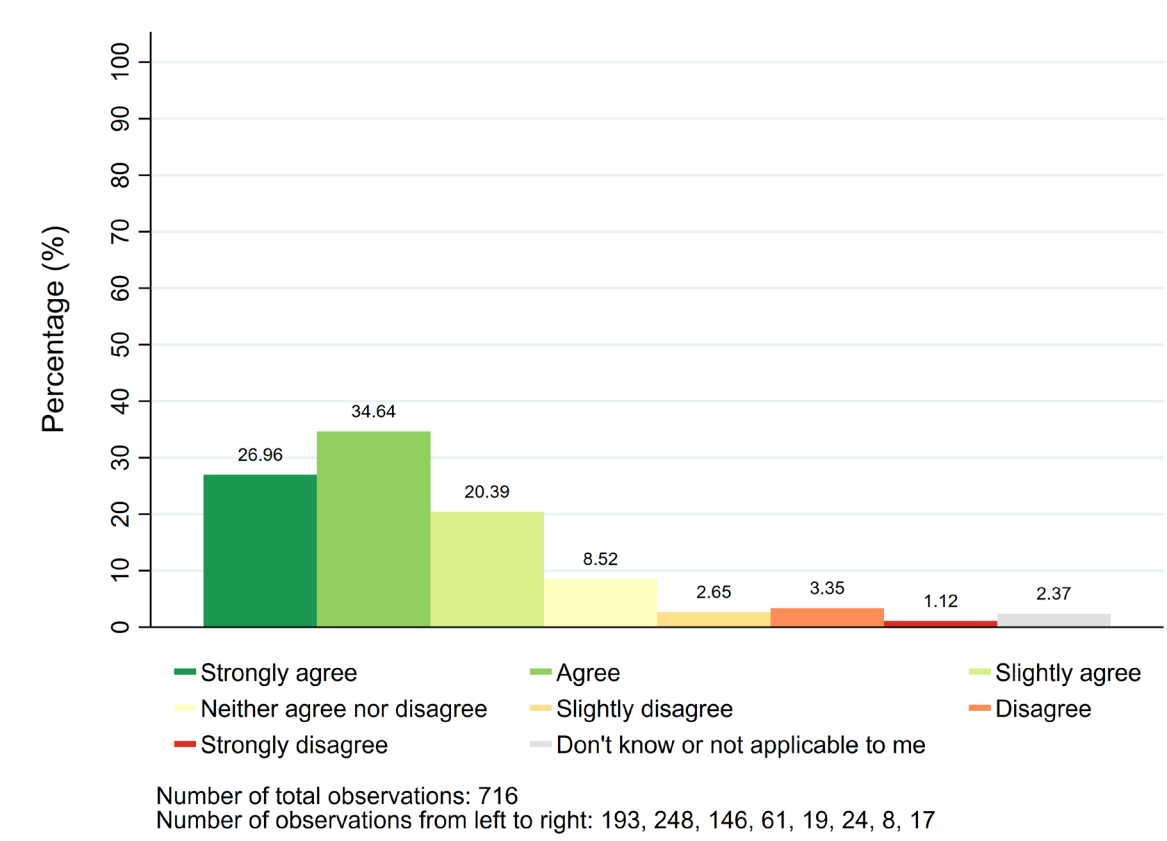
> *I think it's giving people the opportunity to be involved and to network with other colleagues here who are like-minded and in similar job roles, so I think it is a very welcome addition to what we are currently doing.* [Northern Ireland deep dive INT3, June 2019]

The ability to create new connections because of being a Q member came across particularly strongly in the 2018 and 2019 annual Q member surveys. In 2018, 64 per cent of participating members agreed that Q helps to make the connections needed for improvement work, which increased to 82 per cent in 2019 (Figure 13). This suggests that Q members may have felt one of the main values of Q is supporting the creation of new connections and that the ability to do so is increasing over time. When respondents to the 2019 survey who had been involved with Q for at least a year were asked about which resources were more useful, meeting and contacting other members of Q was rated among the most useful resources, with 72 per cent of respondents reported that other members of Q were a very useful or somewhat useful resource. Similarly, members participating in the 2019 survey were asked if they felt Q has helped to increase the size and strength of their professional network and the network within their region. 64 per cent of members that had been a part of Q for more than a year agreed that their professional network has increased in size and/or strength, and 59 per cent agreed with this statement for the network within their region.

Cross-analysis of the 2019 survey responses to engagement with Q resources and perceived impact on members' own and their colleagues' networks was conducted. This suggested that 36 per cent of members who only occasionally use Q resources and activities are not confident that Q benefits the strength and size of their network, compared to 9 per cent of members who actively participate in Q activities and 11 per cent of members who contribute to shape and lead activities. Similarly, 36 per cent of

members occasionally using Q resources did not feel confident that the strength and size of improvers networks in their regions benefited from Q, compared to 20 per cent for members actively participating in Q and 9 per cent of members who contribute to shaping Q activities. In addition, analysis was conducted to explore whether the use of Q to make connections led to differences in the ability to expand personal networks. This showed that 77 per cent of respondents who had used Q to connect to other members agreed that Q has supported the strengthening/widening of their professional network, compared to 39 per cent of respondents who had not used Q for this purpose.

Figure 13: Members ability to make new connections to undertake quality improvement work from the 2019 survey[40]



40 Question text: *As a result of my membership of Q, I can make the connections I need to undertake quality improvement work.*

Q members had connected with others through a variety of activities such as national events, local events, online or through Q Exchange. For example, some participants of the 2019 annual survey, who had supported bidding Q Exchange teams, reported making new connections and interacting with new groups of people through this process.

> *[Q Exchange] made me think about different aspects of the project and interact with a different network of people.* [2019 survey respondent]

While these new connections may not be followed up on immediately, some participants, particularly those who took part in site visits, felt that they know who to contact for a particular project or problem in the future and would be comfortable following up with individuals later down the line (site visit INT2, site visit INT3, Ling et al., 2018).

> *I think in our region we have two people who are founding members that are going to move region, but you still have those personal relationships. I've found that useful even though we don't have an immediate output, but it's good to know that you have those contacts in the region.* [Liverpool member FGD1, November 2017][41]

The ability of Q to help catalyse the development of new connections is also highlighted in one of our case studies, outlined in Box 4 below.

Box 4: Using the Q badge to spark new conversations

An interviewee from a national health charity, who joined Q in 2019, discussed how the visibility of her Q badge sparked new conversations about improvement during the process of hiring new staff.

In late 2019, this interviewee was hiring for a new, 12-month position at the national health charity to work on scaling improvement and innovation. Due to the short-term nature of the role, the organisation needed to hire someone who could 'hit the ground running' as soon as they joined. In addition, the role required an individual who understood quality improvement, including the evidence base behind improvement.

While interviewing candidates for a new position in her organisation, the Q member had their Q badge visible on their lanyard. One candidate noticed the badge, which sparked a discussion during the job interview about the improvement work undertaken by Q and the Health Foundation more generally. The Q member described this as 'one of those moments where you realise you are on the same page as someone' and as 'an interesting moment of someone spotting a symbol and it leading to a common understanding'.

The interview candidate was subsequently hired by the health charity, and the Q member who helped hire the candidate felt the individual was working better than expected. The new hire has been able to quickly learn about the innovation that needs to be scaled up and is also creating new relationships within the health system.

It was felt that having the Q badge visible was a shortcut in being able to find common ground and led the Q member interviewing candidates for the open position to feel as though the candidate would easily understand the requirements of the role and gave her confidence that the candidate 'speaks the same language' of improvement.

41 This quote was previously published in the interim evaluation report (Ling et al., 2018).

3.1.1. The connections made through Q span geographical, organisational and professional boundaries

Many participants discussed how the development of new connections through Q spans multiple boundaries including geographical, organisational, sectoral and hierarchical. The ability to make new connections across these boundaries encourages the widening of members' networks to ones that were more diverse in terms of both experience and location (Scotland DD, South West DD, Wales DD, Northern Ireland DD, site visit INT2, stakeholder INT3, 2019 survey, Phase 1 INT8, Phase 3 INT6, Ling et al., 2018).

> *Q Exchange opens [the] opportunity for cross disciplines [and] cross boundaries conversation and its [the] first and important step to system thinking, building relationships for long-term good.* [2019 survey respondent]

> *I think it's [Q] got a really important and possibly essential role because it brings together people from all the disciplines and across the whole patient journey…a lot of the improvement work that I see is done in silos either within particular geographical areas or particular disciplines or interest groups.* [Phase 2 INT8, August 2017][42]

Many participants, but in particular those from Scotland, Wales and Northern Ireland, discussed the benefit of Q enabling members to make connections to other parts of the UK, which would be difficult without Q (Scotland DD, South West DD, Wales DD, Northern Ireland DD, 2019 survey, stakeholder INT3, Phase 3 INT6). This was thought to be particularly important to those living in more remote, isolated parts of the UK (Scotland DD, Wales DD).

> *The ability Q brings to network nationally and internationally is very important and very valuable…. Q is a connection to the national improvement agenda…I think that is something that has never been done before.* [Northern Ireland deep dive, INT7, July 2019]

> *There are bits from time to time that you need to maybe focus on and they'll be somebody who has got a lot of expertise in that and who you can tap into. I think that's particularly for us who are feeling geographically isolated…. Just even having the opening, just having that intellectual bank is reassuring, I think.* [Scotland deep dive FGD1, September 2017]

For example, in Wales, interviewees discussed how being able to connect with members across the UK overcomes the challenge of Wales having, outside a concentration of members in the southern coastal area, fewer and more spread out members compared to other regions (Wales DD).

Other participants, particularly for the deep dives, discussed the importance of Q in developing connections to other organisations, such as other healthcare provider organisations (including across primary, secondary and acute care) or national bodies, as well as to organisations in other sectors, such as charities and private companies (South West DD, Northern Ireland DD, Phase 2 INT9, site visit INT2, 2019 survey). For one interviewee, building new connections outside their organisation was seen to be particularly beneficial when moving between job roles, as members were able to create external 'support systems' (site visit INT2).

> *Q membership has enabled me to demonstrate wider linkages to QI networks*

42 This quote was previously published in the interim evaluation report (Ling et al., 2018).

> *and resources. It has also enabled a charitable care provider to be linked to NHS resources and expertise which has been good. It has enabled an outward looking organisation to develop.* [2019 survey participant]

Others expressed the value in being able to make new connections within their organisation with local Q members (2019 survey, stakeholder INT3, Ling et al., 2018).

> *I've got to know colleagues in the same organisation, which I wouldn't otherwise have had the opportunity to do.* [2019 survey participant]

Although a small number of members felt that Q is elitist, it was felt by others that Q enabled connections to be made across hierarchies as all Q members are seen as equal by each other, and the safe space created by the community (see section 3.4.3 for more detail) encourages the sharing of ideas and experiences (South West DD, Phase 1 INT18, site visit INT2). This allowed Q members to feel comfortable in connecting with those in more senior positions.

> *I've kept in touch with people from the [site visit] event, and I run ideas past these people. It's useful to have this close-knit network…so when a collaborative comes up that they can plug into I'll send them an email. I think it's useful to be able to connect to people in that way, and it's important to give people the space to connect regardless of their role or seniority.* [Site visit INT2, November 2019]

3.1.2. Members can face some challenges in making new connections with Q members

Although the Q network of members was consistently identified as one of the top resources that Q has to offer, there were also some concerns as to whether this benefit was enough to justify the resources spent on Q. In interviews, a small number of members commented that the networking opportunities alone were not enough to justify the expense of travelling to Q events or the expense associated with the Health Foundation delivering the Q initiative (Phase 3 INT13, Stakeholder INT1, Stakeholder INT4). As one interviewee mentioned, if Q is trying to be a 'LinkedIn for QI' then it is working well, but if Q is trying to accomplish something more in terms of creating positive change in the health and social care sector, it still has 'a long way to go' (Phase 3 INT13). However, as we discuss later in this chapter, many members have taken these connections one step further to collaborate on exciting improvement projects and to set up new initiatives (Section 3.2.), some of which are novel and have not been tried before in the health and care sector.

There were also challenges that members face in terms of low engagement from the Q community (see Section 2.3 for more information on engagement levels of Q members). In the citizen ethnography exercise, a few participants expressed frustration at the lack of engagement of their fellow Q members, commenting that this limited their desire to participate in the Q community virtually due to not getting responses from other members (particularly in SIGs). However, other participants and members who were interviewed for the evaluation commented that this is not necessarily a negative thing, as the ability to be involved with Q without the obligation of regularly engaging was also a factor that attracted many members to Q (Phase 1 INT17, Phase 3 INT6, Phase 4 INT2 Stakeholder INT4, Q Exchange). In response to this tension, some have suggested that there may be a 'critical mass' of people who may need to be actively involved in Q (or actively involved at a regional level) to maintain the Q network, even though there will always be a percentage of members who do not engage

or who occasionally engage in Q without contributing further to the community (Phase 3 INT7, Phase 3 INT8, CS11, Stakeholder INT2). The extent to which this critical mass is reached may vary between regions; for example, it was identified by interviewees for our deep dives that areas such as Devon and North Wales may not have a critical mass of people in quality improvement networks to make a difference, but areas such as Somerset and Scotland may be closer to reaching this critical mass of members (South West DD, Wales DD). To help boost the percentage of Q members that actively participate rather than passively accessing Q resources, one member suggested that more recognition for members of Q that are more engaged than others would be helpful (Phase 2 INT9).

3.2. Collaborating: Members collaborate with their new Q connections on improvement projects

The previous section demonstrated that Q enabled members to make new connections and develop relationships with those outside their usual networks. This section focuses on how members *used* these connections for improvement projects. This will cover how connections were used to support existing improvement work, as well as to start new improvement projects. It will also cover the collaborative and feedback focus of the Q Exchange and how this contributed to creating project teams and ideas.

Many participants discussed how the connections they have made through Q have supported ongoing improvement work within their organisation (Wales DD, South West DD, Northern Ireland DD, Phase 4 INT2, CS 2, 2018 survey). For example, an interviewee for the South West deep dive discussed how, through Q, they have connected with an individual based in Plymouth who can provide support for their Learning for Excellence work ongoing in the South West). Another example from a deep dive for Northern Ireland highlighted how Q has supported the development of new connections among policymakers, which enabled effective conversations to be held that fed into the development of Northern Ireland's Quality 2020 strategy. Similarly, an interviewee from Wales highlighted how the connections made through Q by those working on the medicines safety programme has influenced thinking and the direction of the programme (Wales DD).

> *I wouldn't say it actually has tangibly delivered anything for Quality 2020, but it has enabled the networking opportunities where we put the right people in the right room at the right time to have those discussions which then informs what happens as part of the strategy.* [Northern Ireland deep dive, INT5, July 2019]

Box 5 below highlights another example from a case study showing how a Q Connector used the connections made through Q to support existing improvement work. Receiving support for ongoing work is particularly valuable for one interviewee, who described meeting someone who can provide support as making their job '10 times easier' (Phase 4 INT2).

Box 5: Q Connector powered improvement[43]

A Q Connector, who joined Q as a Phase 2 member, has described how Q helped her organisation, Bath and North East Somerset Clinical Commissioning Group (CCG), to implement QI techniques into an existing improvement programme in primary care settings in the area by enabling them to connect to a more experienced Q member.

Improving the management of hypertension in people with diabetes was one of the CCG improvement programmes in 2017–18, and process mapping techniques were used within all General Medical Practitioner (GP) practices to identify improvement opportunities. This was a new approach for both the CCG and the primary care teams and it was helpful to connect with a more experienced Q member in a nearby health economy who wanted to learn more about the management of diabetes in primary care organisations. He joined the process mapping training event as a facilitator and simultaneously learnt a lot more about primary care management of diabetes. This provided a benefit to the interviewee in terms of improving the workshop, but also provided a benefit to the individual from the South West hospital through access to multiple GPs involved in diabetes management.

This benefit to the interviewee could not have occurred without Q and she would not have known these individuals or thought of contacting them. The wide range of backgrounds and skills of Q members, all speaking a similar language and willing to collaborate outside of their organisation, are important aspects of Q according to the interviewee.

The same Q Connector also works for NHS England and Improvement in the patient safety team as one of three national project leads for healthcare-acquired infections and antimicrobial resistance (AMR) in England; the work programme of which includes identification and mapping existing AMR networks to support the implementation of the NHS ambition to reduce inappropriate antibiotic prescribing by 50 per cent by 2020/21. Understanding these networks can be expected to improve communication between national, regional and local organisations, allow rapid shared learning about what antimicrobial stewardship systems work well and support implementation of the national AMR strategy.

Tapping into the collective expertise of Q Connectors was made available within a Q network leadership master class in 2017. Q Connectors were encouraged to bring network-related challenges to the workshop for discussion. The interviewee shared the AMR network mapping task with the workshop, and the discussion and learning were invaluable, particularly as the expertise within the workshop was so varied. Some of the reflections included that opportunities exist to improve the effectiveness of AMR networks. Q Connectors also identified opportunities to use the Network for Health website to support AMR networks and identified links to the Q community Special Interest Groups, one of which is in the process of adapting to include AMR-related activity.

Lastly, the interviewee shared her experience of connecting with a Q member in Scotland through Q, among other collaborators, to capture the global Twitter activity relating to AMR within World Antibiotic Awareness Week in November 2017. Connecting within Twitter is another approach to learning and sharing, and the interviewee reports that it was fun to work together to capture and map the AMR-related activity without having ever collectively met together previously. The interviewee stated that connecting with people who you don't know is so much easier within the Q community, through use of the community networks, to those sharing a common passion for improvement and patient safety.

43 This case study was previously published in the interim evaluation report (Ling et al., 2018).

3.2.1. Collaborating with connections made through Q to start new improvement projects

In addition to Q supporting existing improvement activities, members frequently referred to how Q also provides some of the support members need to set up new improvement work through the creation of new connections, particularly connections with those in other healthcare provider organisations (Wales DD, South West DD, phase 2 INT9, CS1, CS4, CS10, CS13, stakeholder INT5, 2019 survey, 2018 survey, Ling et al., 2018).

> *Q opens up the opportunity to find individuals who have the relevant experience to collaborate with and make a change.* [Phase 3 INT6, February 2018]

An example highlighted by interviewees for the South West deep dive is of the Reimagining Health and Social Care SIG, mentioned by multiple interviewees for this deep dive. Although this is SIG is available to Q members across the UK, it is particularly active in the South West of England, where face-to-face meetings are held every month for both Q members and non-members. This SIG was described as 'vital' in progressing ideas for improvement in health and social care and creating the connections and conversations needed to do so, and some of these were starting to come to fruition. It was thought that without Q and the establishment of the SIG, the group could not have made as much progress as it has (South West DD). In addition, an interviewee for the Wales deep dive highlighted how connections made through Q enabled them to share information with the Welsh government on the need for a health service investigation branch to be created. The decision has since been made to create this branch, which one interviewee for our deep dive in Wales felt was partially as a result of the connections and information shared by Q members (Wales DD).

Box 6 to Box 10 provide case study examples of how connections made through Q have been used to support new improvement activities.

Box 6: Introducing duty of candour to doctors[44]

A Q member working for the General Medical Council has described how Q has contributed to setting up a duty of candour teaching programme for doctors by learning from another Q member the interviewee met at a Q event.

This interviewee is a founding member of Q and initially met another Q member interested in the duty of candour and quality improvement at a Q networking event, who introduced her to the Health Innovation Network in her region. The interviewee was not aware of these Health Innovation Networks before becoming a Q member and so may not have been able to meet this specific network of people without it. The networking part of Q was referred to as being a big part of her job and an aspect of the initiative that has worked very well.

Together, both individuals identified that different hospitals each had their own duty of candour programme, but that many were struggling with implementing them. In conjunction with the network, the Q member designed an hour-long programme and training resources and secured funding to disseminate this across health organisations. This programme consists of one-hour sessions across six months and aims to improve doctors' knowledge of the duty of candour. It is hoped that this programme will empower doctors and allow them to apply what they have learned into practice. So far, over 200 staff members have been trained in one South London trust and 95 per cent of doctors who participated said they would use the resources in their workplace (General Medical Council, 2018). After the initial success of the programme, Q supported the duty of candour programme further by refining the pitch the programme developers were making for a Q event.

Q also provided funding for some of the teaching resources created for the programme and helped in the design of these through a partnership with design consultancy Cynergy. The interviewee thought Q was very supportive during this time and that they could not have developed the programme without this support.

Box 7: Setting up online clinical supervision opportunities for general practice nurses

A Phase 3 Q member who works in quality assurance for general practice outlined how, through their Q Exchange project webpage, they were put into contact with an individual from NHS England to set up an online clinical supervision opportunity for practice nurses working in primary care.

The interviewee discussed the challenge in offering clinical supervision specifically to practice nurses, as supervision is often held outside of the practice and so is difficult for this group to attend.

In 2018, the interviewee submitted a Q Exchange bid intending to create an app to offer online clinical supervision for practice nurses to make it easier for this group to access these supervision opportunities. The bid was not successful, but through the Q Exchange project webpage the interviewee was contacted by an individual at NHS England who was running a pilot of a similar project. This project was testing whether clinical supervision could be offered to nurses via Skype, which makes it easier for nurses to attend during the working day. Therefore, before finding out that the Q Exchange bid had been unsuccessful, the interviewee decided to join up with NHS England's pilot.

The pilot has so far consisted of hosting six group Skype sessions, once a month, across the local CCG which has involved several GP practices. The interviewee is also considering the use of WhatsApp to offer clinical supervision, as many practice nurses are part of WhatsApp groups.

44 This case study was previously published in the interim evaluation report (Ling et al., 2018).

Box 8: Using Q to develop a national ambulance network

A transformation manager from an ambulance service, who joined Q as a Phase 2 member, described how being a member of Q enabled them to develop an ambulance network SIG. This network supports the training and development of staff within the ambulance services across the UK.

This interviewee described how delivering ambulance services can be challenging due to both the highly pressured nature of the work and the dispersed workforce. As a member of Q, this interviewee recognised the value of a community network that could support staff working across the ambulance services. Using Q as a foundation, the interviewee set up an ambulance services SIG, which has since expanded into a network made up of approximately 40 members from across the UK.

After the interviewee first set up the SIG, they put together a bid for the 2018 Q Exchange round. Although this bid was unsuccessful, it meant the interviewee had a well-thought-out idea of what they wanted to do with the network and how it could be expanded. After finding out the bid was not successful, a member of the Q team at the Health Foundation approached the interviewee as they were interested in the idea and provided a small amount of money to the interviewee and their team (£5,000).

With this small amount of funding (and the mantle handed to another Q member because the interviewee was on maternity leave), he and the growing team organised a one-day conference in Edinburgh, Scotland, for those involved in the network to attend. This event was facilitated by NHS Horizons, a small team within the improvement directorate of NHS England and Improvement, who continue to provide support to the ambulance network today.

In addition, another ambulance Q member re-submitted the idea as part of the 2019 Q exchange funding round and was successful in receiving the funding. This provides the first opportunity of its kind for the network members to visit each other, hold conferences and training events, and creates opportunities for further collaboration across staff working both inside and outside the ambulance services. Going forward, the interviewee describes ambitions to use the ambulance network to create a social movement of Ambulance Improvers that may include shared projects and shared training programmes, which can ultimately enable the community to exchange knowledge and grow together across the UK.

Finally, this interviewee highlights how important the Q network has been in supporting and facilitating the growth of the ambulance network. This includes aspects such as the unique branding of Q and the funding that is provided for events and training. In addition, the structure of the Q network, which cuts across traditional organisation structures, offers a unique way in which to promote innovation and improvement within the health services, particularly for ambulance services that often find these processes challenging due to the nature of the work.

Box 9: Using social media to engage Q members with expertise in key performance indicators

A Q member described how they sought to find Q members with experience in key performance indicators (KPIs) through the Q Twitter account. The interviewee found this to be highly important to them developing KPIs for the children's nursing team at their Trust.

They were previously considering using the NHS Safety Thermometer but found that this did not suit all their needs. Hence, they were keen to identify other safety indicators.

After putting out a call to the Q network through Twitter, numerous Q members got in touch with helpful suggestions on developing KPIs. The interviewee described one individual in particular who was very helpful and offered numerous suggestions on KPIs that had been used in their Trust.

The interviewee described how being a Q member enabled them to reach out to people who could bring different types of expertise to the table, something which was invaluable for them moving forward with their indicator development. The interviewee hopes that in time their approach will eventually expand to other Trusts.

Box 10: Offering data masterclasses to local Q members

A member from Northern Ireland's Improvement body, who joined Q as a Phase 2 member, described how their organisation offers a data masterclass to the local Q members. This is possible as the interviewee's organisation is the country partner of Q and has access to the mailing list of all local members.

This interviewee is aware of the challenges faced by those working on healthcare improvement projects in collecting the right data, storing it, and having the appropriate skills to effectively analyse relevant data and present the analysis in a meaningful and engaging format. As a result of identifying this need, the interviewee contacted an organisation based in Northern Ireland to deliver data masterclass sessions.

The data masterclass sessions are offered to all Q members, free of charge, within the local Q community. Through being a country partner of Q, the interviewee has access to an emailing list for all Q members in the area and this is used to disseminate information about the masterclass. Information about the masterclass is also shared by the interviewee using social media, as well as by word of mouth. The Q team at the Health Foundation also shares information on the masterclass via social media and provides other support by attending some of the training sessions, which the interviewee reported 'meant a lot to us and means that they know what we are doing'.

The masterclasses are attended by a mix of staff members, from senior chief executives to back office staff, clinicians and data officers. There have been tangible impacts as a result of staff attending the masterclass. For example, one staff member who attended the training held a 'mini-version' of the masterclass in their organisation that reached around 100 people. In addition, when the interviewee attended one of the masterclasses, they met another Q member, who is a psychologist, and discussed some of the challenges they faced in managing change when working on quality improvements. Because of this, the interviewee invited the psychologist to speak at a regional event in Northern Ireland for senior leaders, which subsequently led to the psychologist speaking at an event held by an attendee of this regional event.

The interviewee discussed the possibility of expanding the masterclasses to cover more in-depth and complex aspects of data collection, analysis and presentation. There are also hopes of setting up regular data surgeries in which staff members can drop in with any challenges they are facing with their data analysis.

Finally, the interviewee discussed how they hope that the data masterclasses would encourage staff members to apply for Q, as the masterclass is not frequently offered to non-members.

3.2.2. Collaborating to bid for Q Exchange funding is valued and is a way of creating new connections outside of existing networks

Q Exchange also provides an opportunity to collaborate across Q membership. Q Exchange has been explored in more detail in Section 2.2.2 above. The following paragraphs focus specifically on the collaborative aspects of Q Exchange rather than on the wider processes.

Most participants we spoke to about Q Exchange felt that Q Exchange was a more collaborative approach than traditional funding streams and that the process was more supportive than competitive (2018 survey, 2019 survey, Q Exchange, Q team INT10).

This demonstrated the perceived value of collaborating both to create bidding project teams and to get feedback on the initial project to refine ideas and plans. This view that Q Exchange is collaborative was also reflected in sub-analysis of the 2019 survey in which 79 per cent of members who had submitted a bid to Q Exchange felt that Q helps to strengthen their professional network, compared to 64 per cent of respondents who had not submitted a bid.

> *I think the emphasis on input from the Community, the opportunity to access the wide range of expertise available in the Q Community, is really helpful. It really supports that ethos of all being in it together so that, while everyone is in competition with each other for that funding, it still feels supportive.* [2019 survey respondent]

While most bidding teams for the 2018 Q Exchange round were made up of colleagues already working together, a small number of teams were created by reaching out to Q members with similar interests and/or job roles, or who may have been working on a similar project already (Q Exchange). Some of these connections were made through Q activities, such as Q Labs. This was reported to provide a range of perspectives for the team and is felt to be a good opportunity to collaborate with contacts made through Q that have not been followed up previously (Q Exchange).

When discussing the application stage of Q Exchange, many participants highlighted the value they saw in the opportunity to collect feedback on the project idea from the wider, diverse Q community (2018 survey, 2019 survey, Q Exchange). Some participants of the 2019 annual survey felt that the support from other Q members during the application phase of Q Exchange is the most valuable part of the process (2019 survey). The feedback process was thought to support the refinement and improvement of project ideas, as well as acting as a critical friend. However, it appears that feedback primarily led to changes in plans for projects setting up new processes, rather than projects building on existing processes, which may not have required as much refinement (Q Exchange). The online collaboration during the application phase then led to support from the Q community during the implementation of some projects that received funding (Q Exchange).

> *What I found was extraordinary, was the amount of collaboration that we had when we published the idea and it was collaboration between other project members who also had ideas. It helped our project develop and refine it.* [Q Exchange]

Once individuals have obtained funding through Q Exchange, they still benefit from working in collaboration with other Q members. Some individuals who were involved in the funded Q Exchange projects also reported gaining knowledge because of connecting with others during the projects (Q Exchange). For example, a service user who has taken part in the Quality Improvement Partner Panels (QuIPPs) project (which formed a case study for this report, see Annex K) has connected with another service user during the project workshops who is hard of hearing and shared several ways to support this patient group in accessing events. As a result, the individual contacted the patient experience lead in their organisation to implement changes to better support the engagement of patients with hearing difficulties, such as purchasing equipment to support those who are hard of hearing to attend and engage with conferences (Q Exchange).

3.2.3. The idea and approach to collaboration in Q Lab has been successful, although impacts are yet to be realised

As the findings of the separate RAND evaluation specifically on Q Lab were published in 2018 (Liberati et al., 2018) and include a more

comprehensive overview of the impacts of Q Lab, we do not discuss the impacts in-depth in this report. However, we will briefly discuss points raised since the RAND Q Lab evaluation was published. More information about the first Q Lab project can be found in Section 2.2.3 above, which focuses on the experiences of the *process* of the first Q Lab project, with the following paragraphs focusing particularly on the *impacts* of the first Q Lab project.

As mentioned, two of the three Q Lab interviewees, when asked, felt the *process* of Q Lab is positive and has subsequently led to impacts (Q Lab INT1, Q Lab INT2). For example, a Q member involved in the first Q Lab reported feeling less isolated and better supported in their work on peer support after being able to connect with others working in this area through Q Lab (Q Lab INT2). Another Q Lab participant reported that their knowledge has improved through being involved in the process and reported that they have introduced changes in their working practice as a result, such as improvements to their leadership and presentation styles (Q Lab INT1). The same interviewee reported making new connections through Q Lab, many of which were in their local area. This includes patient leaders who the interviewee has been able to offer support and guidance to in terms of improving peer support, two of which went on to submit a proposal to Q Exchange (Q Lab INT1).

> *It has added to some knowledge base and I have taken some of the techniques that we used and added them to my way of doing things…. I thought it was valuable for me in an education sense to see different leadership and presentation styles…. It wasn't a eureka moment, it wasn't something new, it was knowing I could take that tool and tweak what I do here.* [Q Lab INT1, August 2019]

However, the findings from the evaluation show different views about what impact is possible, and to what extent impacts have been achieved. While many respondents felt that the idea behind Q Lab is important, and the collaborative approach to solving big problems is an effective one, there were mixed opinions among participants as to the extent to which the first Q Lab project has had an impact (South West DD, Q Lab INT1, Q Lab INT3, Phase 1 INT18). A small number of interviewees for the South West deep dive felt this may be due to the outcome and impacts of Q Lab largely relying on the passion of Q members locally, but time and resource constraints limit what these members were able to achieve outside of their day-to-day work (South West DD). A participant of the first Q Lab discussed the difficulties in following up the potential impacts that occur from conversations held during Q Lab workshops, which create challenges in assessing the value (Q Lab INT3). These experiences suggest that the outputs of Q Lab were not being communicated widely enough to individuals who would be able to use the findings of the first Lab project in their work. This suggests that Q Lab may need to change its approach to communication and dissemination, both to engage a wider audience and to ensure the most appropriate type of outputs are published to engage those who could benefit from learning about the work undertaken during the first Q Lab project.

> *I did think it [Q Lab] would be a coming together of likeminded people…. I would have expected 2–3 very clear models to come out of it that people could look at and tweak for [the] local region. I don't actually think this happened…. What I query, thinking about the value for money aspect, how many projects have taken hold of all of this research and properly instilled it?* [Q Lab INT1, August 2019]

One participant suggested how Q could maximise the impact of Q Lab projects

suggesting that having an accelerated Q Lab (i.e. less time between the different activities to support continual engagement from those involved) with clearer direction and follow up would result in more impact for the health and social care sector. For example, by engaging system leaders throughout the project so when the reports and other communications are published, the leaders are engaged and can see the value in making changes to practice (Q Lab INT3). This interviewee also suggested that having a regional focus with institutional involvement would also help achieve impact (Q Lab INT3). Another interviewee commented that more carefully selecting the topics and partners through consultation with wider stakeholders would also lead to more impact (Phase 3 INT12).

Along with ambivalence around the impacts of Q, there was also a sense of confusion from one interviewee about how Q Lab fits into the wider Q initiative (Q Lab INT2) and a lack of understanding about how to contribute to Q Lab, which prevented some Q members from engaging (Q Lab INT2). It should be noted here that these recommendations from interviewees are based on their experiences of the first Q Lab project. Some of these suggestions were taken on board by the Q Lab team at the Health Foundation for the second Q Lab project; however, as this project finished late 2019, it is not yet clear if these efforts have been successful.

3.3. Developing: The gaining and sharing of knowledge, skills and confidence

While members often report that the main reason for joining Q, and one of the main benefits in being a member, is the opportunity to create connections and expand professional networks, Q also offers resources and activities for learning and skill development. These offers, and their perceived usefulness, are outlined in Chapter 2; this section will provide an overview of how taking advantage of these directly helps members to learn and gain new skills, as well as indirectly by sharing knowledge within the community (and outside it). This section will also cover another type of personal development that member's report: increased confidence and empowerment related to their improvement capabilities.

3.3.1. Developing and sharing improvement knowledge, learning and skills

An interview with a member of the Q team at the Health Foundation highlighted how one of the main aims of Q is to make learning easier and to create a learning system[45] within the community (Q team INT3). The aim is for Q to overcome organisational barriers to allow learning to be shared more widely within and across organisations and thereby to support members to develop their skills and to create capacity for learning within the NHS (Q team INT3). This section will discuss how opportunities offered through Q contribute to this development and sharing of learning and skills in terms of training and learning resources offered through Q, and the connections made through Q and Q Exchange.

> *It has had an impact on my general work and QI work. I am hoping that Q will help me become an expert in QI! There is a lot of education and you learn a lot from being a part of Q, such as communication, resilience, sharing knowledge, developing networks, spread of information, spread of QI projects, how to measure things. It has opened up a fountain for me. It has helped me develop the skills I need to overcome barriers.* [Phase 3 INT7, February 2018]

In the 2018 and 2019 surveys, we explored the more general thoughts of members who had been a part of Q for more than one year on whether they felt they have developed their knowledge and skills for improvement personally and whether they felt they can share this knowledge. In 2019, 76 per cent of respondents agreed to some extent that Q has helped to develop their skills and knowledge (Figure 14), and the same percentage considered that Q enabled them to share their knowledge (Figure 15). This is an increase from the responses in 2018, in which 58 per cent felt that Q enabled them to develop knowledge and skills and 54 per cent that Q helped to share this knowledge.

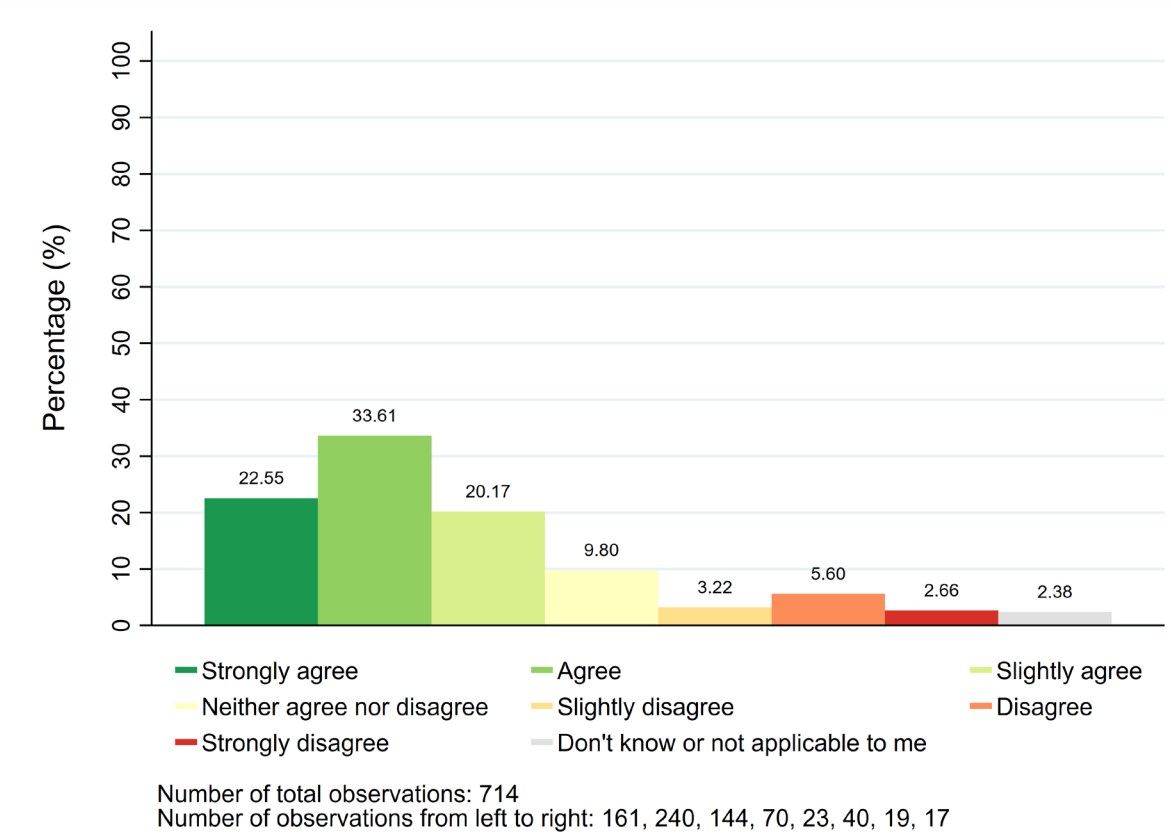
When these results from the 2019 survey were compared to the responses for the amount of time spent on Q, this analysis suggests that over one-third of respondents (34 per cent) who spent less than one day on Q per year disagreed to some extent that Q has helped them to develop their knowledge and/or skills for improving quality. This is higher than members who spend more than one day on Q (11 per cent for members spending 1–3 days, 5 per cent for those spending 4–6 days, 0 per cent for those spending 7–10 days and 7 per cent for those spending more than 10 days). Similarly, we compared the 2019 responses for the engagement with Q resources and perceived impact on the skills and knowledge of members colleagues. For, members reporting only occasional use of resources (rather than actively participating in and leading activities), 41 per cent of respondents reported being less confident that Q will benefit the skills and knowledge of those they work with (compared to 18 per cent of members who actively participate in activities and 21 per cent of members who help shape Q activities). The same trend was not as strong when members were asked about their skills and knowledge, in which 22 per cent of members who occasionally use Q activities did not feel confident that Q positively impacted their skills and knowledge, compared to 9 per cent of members who actively participate in Q and 17 per cent of members who lead Q activities.

45 A learning system in relation to Q is the bringing together of members (physically and virtually) and the offering of educational resources to create an environment that encourages and supports the sharing of learning between individuals.

The use of SIGs/online groups may be particularly beneficial in increasing members skills and knowledge around improvement. Out of those members reporting use of SIGs/online groups, 85 per cent feel that Q positively impacts their skills and knowledge. This drops to 70 per cent for respondents who have not used SIGs/online groups. Similarly, 82 per cent of respondents who reported using Q to connect with other members agreed that Q benefits their skills and knowledge, compared to 62 per cent of members who had not used Q to connect to others. However, it should be noted when interpreting these results that only a small number of respondents reported not having used Q to connect with other members.

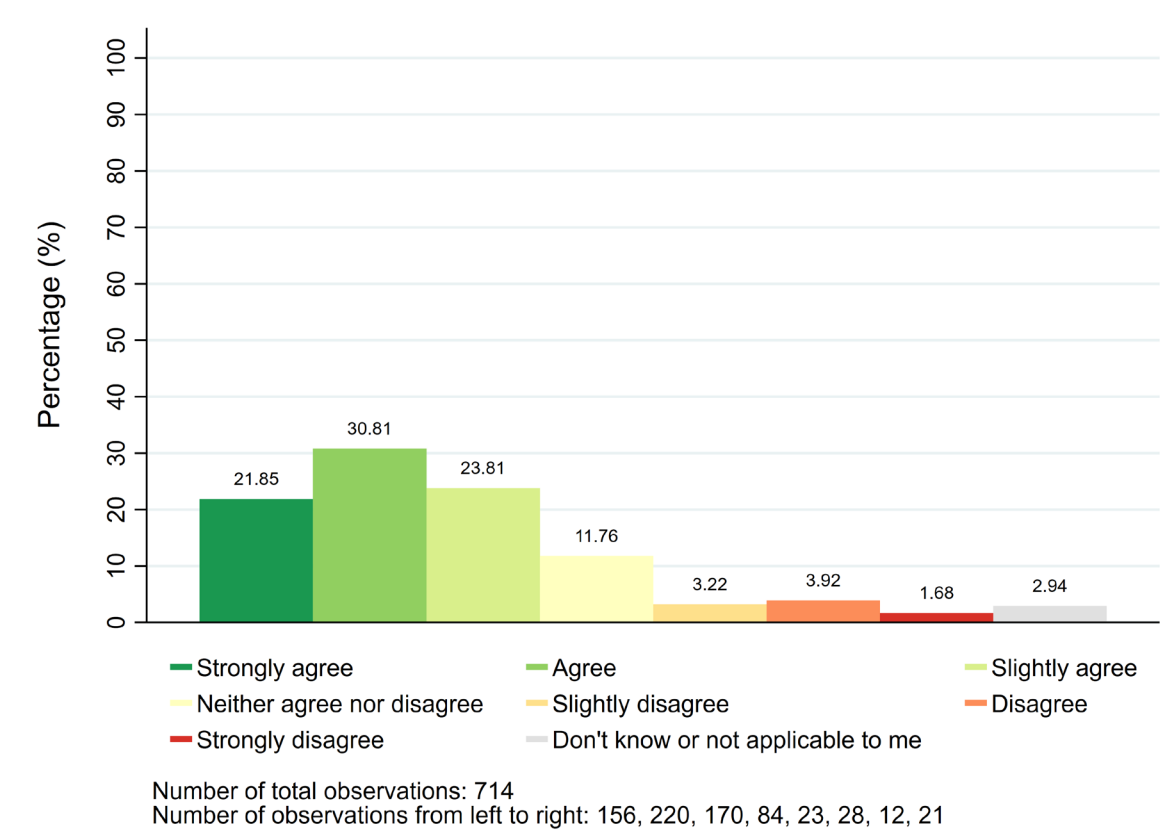
In addition, in the 2019 annual survey, members were asked if they agreed that Q has positively impacted their and their colleagues' knowledge and skills. In response, 72 per cent said that Q positively impacts their knowledge and skills, and 56 per cent said the same for their colleagues' skills and knowledge.

Figure 14: Q has helped to develop knowledge and skills for improvement from the 2019 survey[46]



46 Question text: *Membership of Q has helped me to develop my knowledge and/or skills for improving quality.* (asked to respondents who had been members of Q for more than one year) and *Membership of Q will help me to develop my knowledge and/or skills for improving quality.* (asked to respondents who were members of Q for one year or less).

Figure 15: Ability to share knowledge and skills of improvement[47]



Increasing knowledge and improving improvement skills by attending training offered through Q

Participants often noted the training opportunities offered as part of Q and the value they provide, both directly in terms of benefiting those who attend the training, but also indirectly as the learning from training sessions is often spread within members' organisations, including to non-members (Northern Ireland DD, CS5, CS7, CS12, phase 3 INT15, 2019 survey, Q Team INT3).

> *Increased access to training. Data training and liberating structures this year were excellent, and skills learnt have been embedded in my day to day work.* [2019 survey respondent]

When exploring the direct impacts of attending learning and development opportunities, the post-site visit surveys completed by attendees demonstrate some of the value in terms of gaining learning. Attendees at the Flow Academy site visit (held in September 2019) said that they were aware of additional reading on the topic and thought they have learned new techniques for engaging staff and holding meetings. Attendees of the Jaguar (held in July 2019) and Health Improvement Scotland

47 Question text: *As a result of my membership of Q, I am able to share my knowledge and skills for improving quality in health and care with others quality.* (asked to respondents who had been members of Q for more than one year) and *As a result of my membership of Q, I will be able to share my knowledge and skills for improving quality in health and care with others.* (asked to respondents who were members of Q for one year or less).

(held in September 2019) site visits reported that their knowledge and skills improved after the visits. In addition, sub-analysis of the 2019 survey indicated that members attending Q visits feel better able to undertake improvement activities than those who have not participated in visits. The analysis showed that 83 per cent of respondents who had attended a Q visit agreed that Q supports them to undertake improvement work compared to 69 per cent of members who had not participated in a visit.

Many participants discussed how they have applied the learning and resources obtained from attending Q learning and development sessions to develop or refine training offered within their organisation (Northern Ireland DD, 2019 survey, 2018 survey, CS6, CS12). For example, an interviewee for the Northern Ireland deep dive discussed how a data masterclass session offered to Q members was popular in the interviewee's region. Since this training session, a local Q member has used and adapted what they learnt to create their own session for their organisation, which is accessible to both Q and non-Q members (Northern Ireland DD). This sharing of learning obtained through Q training courses is also demonstrated in three case studies (Box 11 to Box 13). The first focuses on the benefits gained by a Q member from attending the Liberating Structures workshop, and more generally across the evaluation the Liberating Structures workshops were often mentioned by participants as being useful; many respondents to the 2019 survey reported using the learning from these sessions in training offered within their organisation.

Box 11: Using Q to develop a successful training course

An associate director for QI at an NHS Foundation Trust described how attending a Q site visit at the Royal College of Engineers was integral to the successful development of a QI training course in their organisation.

The interviewee described how attending the event, which entailed a series of workshops, enabled them to engage with innovative ways of looking at and framing healthcare improvement. The interviewee reflected that the event exposed them to 'design thinking'[48] and the 'Double Diamond design process',[49] which are ways respectively of enabling individuals to solve problems through creative solutions and of helping divide programmes into processes to support their design. They were then able to take this learning forward to develop the material for their internal QI training course. In addition, being part of the Q network enabled the individual to attach the 'Q badge' to internal training resources, something that proved highly valuable for the members of staff who attended and for developing confidence in the training course.

Currently, the internal training programme created after attending the Q visit offers 'bronze' and 'silver' training in QI, which enables attendees to gain confidence in how to lead and develop their own improvement projects. In addition, the interviewee described a silver network meeting that enabled members to develop knowledge around QI and psychological safety, as well as around co-production and data for improvement. The interviewee described future plans for the programme, which included the development of 'gold' training. This will encourage the formation of a network of individuals to lead and coach others in the improvement of delivery services.

The interviewee was very positive about the impact that the programme has had and described how this high level of training has enabled individuals to successfully finish QI projects, with several new high-impact projects currently in the pipeline. In addition, the training has supported a change in language around improvement within the organisation to one that is more open about and confident with QI. It has also helped to develop stronger relationships between the Trust Board of Directors and Q as they are better able to see the value Q can provide.

As of January 2020, the training course has trained 600 members of staff in leading projects, with 110 active projects registered and aligned to priority areas in the trust's clinical and organisational strategy.

48 Design thinking is an iterative approach to challenge preconceived assumptions and redesign problems to create new and innovative solutions. It consists of five phases: empathise, define, ideate, prototype and test. Further information can be found at: https://www.interaction-design.org/literature/topics/design-thinking

49 The Double Diamond design process is a way of developing creative solutions and consists of four stages: discover, design, develop and deliver. Further information can be found here: https://www.justinmind.com/blog/double-diamond-model-what-is-should-you-use/

Box 12: Using methods from a Liberating Structures workshop to inform an improvement programme

An improvement advisor for a Health and Social Care Trust in Northern Ireland described how learning gained from Q workshops has informed their organisation's own improvement programme. Although the interviewee herself did not attend a Q workshop, this case study demonstrates how learning from Q may be disseminated more widely across organisational networks.

The interviewee described how colleagues who had attended a Liberating Structures Workshop offered by Q were able to pass on this training by providing an internal workshop at the Trust. Liberating Structures offers adaptable microstructures, which enable groups to change the way they interact, enabling everyone at a meeting to be involved in the discussion. The interviewee described the benefits of her colleagues attending this workshop, as they were able to use some of the methods and techniques from Liberating Structures in QI training that they then delivered for the Trust as part of the Trust's improvement strategy. One such method, the TRIZ method,[50] encourages individuals to identify ways of achieving the worst possible outcome as a way of offering innovative ways to think about solutions. In addition, Liberating Structures approaches were used in a brainstorm meeting to identify ways to improve service user involvement in the organisation's improvement work, which ensured that all participants provided ideas.

The interviewee described how this had been very helpful for her to think about successful ways in which to engage staff in the QI process. The interviewee reflected that Liberating Structures techniques were generally very good for 'icebreaker' activities and they plan to continue to incorporate Liberating Structures methods into the Trust's programmes.

50 The TRIZ approach aims to encourage 'heretical thinking' to stop 'counterproductive activities and behaviours' to allow innovative thought and ideas to be shared. Further information can be found at: http://www.liberatingstructures.com/6-making-space-with-triz/

Box 13: Attending an Appreciative Inquiry workshop helped to increase staff engagement and motivation

The interviewee, an improvement manager at an NHS Trust who joined Q in 2017, described how attending a workshop on Appreciative Inquiry,[51] offered through Q, gave them the knowledge to introduce new techniques for staff engagement into their organisation.

The interviewee described how they attended a workshop on a method called 'Appreciative Inquiry', which was felt to be particularly beneficial to their role at the Trust. Appreciative Inquiry adopts a strength-based model, which encourages individuals to identify positive experiences they have had at work and how they were involved in making this happen. As an improvement manager, the interviewee is brought into teams to run workshops and activities around problem-solving and team building. They described how Appreciative Inquiry enabled them to engage with teams more positively around their improvement work and shift their thinking away from negativity to celebrate their achievements instead.

The interviewee described one specific example, where they were able to use Appreciative Inquiry to engage with the patient transport team at the Trust. This team were undergoing a major transition, moving back into the NHS after being previously run by a private organisation. This had resulted in several structural changes within the team, leaving staff feeling disengaged and demotivated at work. The interviewee incorporated Appreciative Inquiry into the workshops they ran for the team. This enabled staff members to feel more positive about their place within the organisation and encouraged them to engage with, and take responsibility for, the changes that were taking place at work.

The interviewee also reflected on how their confidence in their ability to run workshops on Appreciative Inquiry has increased as a result of attending the workshop. It was felt that the workshop was an opportunity to gain a greater understanding not only of what Appreciative Inquiry is but also how it can be applied to practical problems that the interviewee faces in her work. This gave the interviewee the confidence in their ability to implement Appreciative Inquiry methods in their organisation.

Along with the existing Q training opportunities, a small number of Q members reported in qualitative survey responses and interviews that they would like some additional learning and development resources (Q Team INT9, Stakeholder INT5, 2019 survey), which also reflects how members valued existing opportunities. One QI expert suggested that these opportunities can either be provided through Q or that Q could approve learning and development sessions provided by external parties as sessions that are of high quality (QI INT1). Providing and approving learning and development opportunities could help Q to maintain professionalism within quality improvement by framing quality improvement as a type of work that requires a specific skill set, which a quality improvement stakeholder suggested is an area in which Q provides a unique benefit (QI INT1).

51 Appreciative Inquiry is an approach to leadership development and organisational change that helps individuals or groups develop a 'shared vision for the future'. Further information can be found at: https://cvdl.ben.edu/blog/what-is-appreciative-inquiry/

Using connections made through Q to share knowledge and skills

The connections made across the Q community by members (see Section 3.1) were thought by many members to support and facilitate the sharing of knowledge and learning from other organisations about different approaches to improvement (Wales DD, CS3, CS14, stakeholder INT4, site visit INT2, site visit INT3, Q Exchange, phase 1 INT17, Phase 3 INT7, phase 3 INT14, Q team INT9, 2019 survey, 2019 citizen ethnography, Ling et al., 2018). In particular, members discussed the value of learning about good approaches to QI (and what makes them successful) and how these could be adapted and implemented in other organisations, as well as learning from other Q members about how to overcome barriers to improvement (Q Exchange, stakeholder INT4, phase 1 INT17, site visit INT3). One member also expressed that being connected to the Q community kept them up to date with what is happening in terms of improvement across the country and this provides a direction and framework for implementing local improvement activities (Phase 3 INT14). A small number of participants specifically mentioned how the opportunity to use free resources is particularly helpful in developing and sharing knowledge.

> *It's not just about the Wales network, for me, it is about being able to learn about what people are doing elsewhere. It is just somewhere to go to broaden your horizons sometimes.* [Wales deep dive, INT3, August 2019]

Case studies of learning from connections made through Q are provided in Box 14 and Box 15Box 15. The first case study shows how two members met at a Q national event and have maintained and developed their working relationship over time, enabling them to learn from each other as they work on improvement activities in different areas of the UK. The second discusses a similar aspect, in which a Q member made connections during the co-design workshops for Q, which have been developed over time and have involved visiting each other's organisations to learn about their approaches to improvement.

Box 14: Q provides valuable connections[52]

Two members of the Q founding cohort, both involved in improvement in their professional work, described how they met through a speed dating consulting activity at a Q national event and that they have continued to support each other's work since this.

Both reported that learning from and supporting each other had helped them to work more effectively in their organisations and that, professionally, the relationship had proved to be 'a game changer'. It had helped both in thinking about how to conceptualise and shape improvement work and in thinking about specific topics. It had contributed to their practice and leadership and they reported that professionally it was 'the most important relationship I have' and informed 'how I am on a day-to-day basis'. Learning from different parts of the country also allowed reflection on what works well and what could be different in their regions and encouraged system-wide thinking and understanding system dynamics.

One of the members reported a particular value in connecting with people outside their immediate network. At the personal level, they agreed that having an external viewpoint had provided them with headspace. They also reported that being part of Q, and their interactions, had helped them negotiate the various 'tribes' (i.e. professional siloes/groups and hierarchies) in the improvement world. They reflected on whether as Q matures it may not allow such strong interpersonal bonding initiated through national events. They emphasised the importance of having a positive mindset where Q members would actively seek out opportunities to learn and to contribute to others. Linked to this was a willingness to show vulnerability about what you might not be sure of. Newer members may not be bringing this maturity into Q; the large scale of Q may 'dilute the great conversations'.

This case study speaks strongly to the importance of Q providing a 'home for improvers' (both were improvement practitioners), where they might become more resilient, more mature and braver practitioners. Both members agreed this had tangible benefits for their organisations, as well as for them as individuals.

52 This case study was previously published in the interim evaluation report (Ling et al., 2018).

Box 15: Contacts made during the Q co-design workshops led to learning from other organisations

A member of the founding cohort of Q, based in Scotland, discussed how the connections he made at the co-design workshops for Q have been developed over time. These have led to visits to other organisations and the learning from this has been implemented within the interviewee's organisation.

Our interviewee outlined that during the co-design workshops for Q in 2015, he made several new connections with other founding members based in Scotland. While the interviewee reported having met most of these individuals before the workshops, without the events he would not have had the opportunity to have conversations with these other founding cohort members and to learn about the improvement work they undertake in their organisations.

These contacts have developed into more solid working relationships since 2015, and our interviewee discussed several instances where his clinical staff visited other organisations to learn about their improvement work, in a similar format to Q visits. The interviewee and his staff have since taken the learning from these visits and implemented changes in practice within their organisation. He felt that these changes would not have happened without the visits to other organisations and that the visits would not have been possible without the conversations and contacts made at the Q co-design workshops.

One example of a change in practice occurred after our interviewee visited a hospital in Glasgow. It was felt that the relationship that was developed before the visit between our interviewee and the other founding Q member led to open and honest conversations about the pros and cons of the way that improvement is run at the Glaswegian hospital. Because of this initial visit, the interviewee recommended that clinical staff in his organisation also visit to learn from the hospital in Glasgow. These visits also offered the chance to spend the day getting to know how another improvement system works and for clinical staff to speak with others in similar roles. The visit was specifically focused on learning about how the hospital delivers its ambulatory care, which is offered at a scale the interviewee did not know was possible beforehand. Because of this learning, the interviewee's organisation has since adopted some of the ambulatory care principles used in Glasgow, for example, moving ambulatory care into the acute ward. The interviewee felt that the clinical staff would not have been on board with these changes had they not been on the visit. Our interviewee believed that the changes made to the ambulatory care had led to patient benefits, such as a reduction in inappropriate hospital admissions.

The case study below (Box 16) demonstrates how a Q member hosted a site visit to the FCA, which enabled the attending Q members to learn about how the FCA works, encouraging some members to apply to the academy and to better understand how best to evaluate FCA programmes. The visit also supported the development of new connections as Q members attending represented various organisations from across the UK who would not usually cross paths.

Box 16: Hosting a Q visit to the Flow Coaching Academy

The interviewee, a founding Q member and lead in Quality Improvement at a teaching hospital, hosted a Q visit enabling Q members to find out more about the Flow Coaching Academy (FCA). This led to the creation of new connections between attendees, the sharing of knowledge on the FCA and facilitated organisations to apply to the FCA.

The one-day event, held in central London, started with an introduction to the FCA, a programme that builds team coaching skills and develops capabilities that empower frontline staff to improve patient outcomes and flow through the healthcare system. Attendees at this event were exposed to how the programme works and the learning that had been developed from the programme's implementation within ten academies across the UK, all contributing their insights back into the programme. Attendees were also able to attend a live 'Big Room' meeting[53], which enabled them to see the process in action. At the end of the event, FCA staff shared how they were now evaluating the impact of their work and went on to speak about its current successes.

The event was attended by a range of Q members and greatly facilitated improved connections between the different members, as well as with staff from the FCA programme. For example, the interviewee describes how Q members, who had attended from King's College London, had been interested in joining the FCA programme before this event. On attending, they were able to find out more about the programme, reinforcing their ambition and facilitating their application to join. In addition, Q members attending from West Kent, who had raised a particular interest in patient frailty care, were connected to staff at Imperial College London who were able to offer knowledge on this type of specialist training. Finally, Q members attending from Scotland, who were interested in evaluating their improvement work, were able to gather information on how to undertake evaluation as the FCA programme develops in Scotland.

The interviewee reflects that, like FCA, the strength of the Q network comes from the members who are involved, in the connections they have and the opportunities that they can create. They are receptive to the Q community approaching them again in the future for another site visit.

Learning resources

Learning for Q members sometimes took the form of learning materials, such as reports, online resources and webinars, that have helped members in their improvement work (CS11, 2019 survey, 2018 survey). These resources and the ways that members describe benefiting from them have been discussed above in Section 2.2.5.

Support to access online resources and connections through the Q community have helped at the planning and evaluation stage of QI projects in the organisation. [2019 survey respondent]

In the NHS we are used to short-term, often quick fix projects. The resources available through Q have helped me develop and communicate an ethos of 'continuous improvement'. [2018 survey respondent]

53 Big Room meetings bring together a range of stakeholders from across the patient pathway into one room to discuss and test improve patient flow. Further information can be found at: https://www.health.org.uk/funding-and-partnerships/programmes/flow-coaching-academy

Box 17: Overhauling a GP practice's staff appraisal process

A GP, based in the South West of England, discussed how he had changed the surgery's approach to staff appraisals based on a Health Foundation report he discovered at a national Q event.

This interviewee outlined how the appraisal process within his surgery needed updating, as many staff members had not had formal performance reviews for years and our interviewee felt the appraisal process was seen as a 'tick-box exercise'.

During the 2017 national event, the interviewee picked up a report from a stand, published by the Health Foundation, called *What's getting in the way? Barriers to improvement in the NHS* (The Health Foundation, 2015). This evidence scan provided guidance and advice on how to start establishing a culture of learning and improvement within organisations.

Based on the information in this report, the interviewee collated a summary of how it could be applied to the appraisal process within his GP surgery, which he presented to the surgery partners. The partners agreed to provide the interviewee with ring-fenced time to work on improving the process.

As of November 2019, the interviewee was halfway through applying the new appraisal process to staff. Although there have been challenges in ensuring the ring-fenced time is provided for this work, the interviewee has reported positive impacts on staff. They include clearer job descriptions and responsibilities, greater operational autonomy for nurses and a greater number of physiotherapy appointments for patients.

This was demonstrated in another case study in which a Q member attended a national event and picked up a Health Foundation report on barriers to improvement in the NHS. This report gave the member the guidance needed to develop the approach to changing the appraisal process in the GP practice in which they worked (Box 17).

Q Exchange

For most bidding team members, it was felt that Q Exchange offers the opportunity to gain new skills and knowledge not only about their project topic but also other topics (by reading the project webpages and engaging with teams at Q events, for example) as well as helping to focus their improvement ideas into a better-defined project plan (2018 survey, 2019 survey, Q Exchange, stakeholder INT5).

For those who offered support to bidding projects, most of the positive responses highlighted that this group felt they have gained additional learning and knowledge from doing so, such as learning about new improvement approaches, what is taking place in other parts of the country, new methodologies and the areas in need of improvement (2019 survey, stakeholder INT5). Some respondents to the 2018 and 2019 surveys also felt it increased their knowledge of writing successful funding bids (2018 survey, 2019 survey).

> *I think engaging with the ideas in the exchange allowed me to see the problems and solutions from different perspectives and take learning relevant to my own role and circumstances.* [2019 survey respondent]

> *I did my reviews, I did my vote and I offered some support. Having that central point where you can go and see what the current thinking is, what people are working on, what's the energy being exercised on*

from a QI perspective, what's important to people working in health and social care. [Stakeholder INT5, November 2019]

3.3.2. Personal benefit

In addition to developing skills and knowledge, Q members often reported developing personal and professional benefits from Q, such as greater confidence with improvement, empowerment and feeling valued in their work to a greater extent. These thoughts were also expressed by service user members of Q, although views were slightly more mixed within this group.

Confidence and empowerment

Participants often reported that engaging with the Q community and learning more about improvement contributes to feelings of greater confidence and empowerment in implementing improvement activities in member's organisations, such as offering QI training (site visit INT2, Phase 1 INT18, Phase 2 INT9, Phase 3 INT12, Q team INT3, stakeholder INT1, 2019 survey, 2018 survey, Q Exchange, Wales DD, Ling et al., 2018). One interviewee thought this confidence comes, in part, from the positive and friendly culture within the Q community and how resources are created in an easily accessible and understandable format (Phase 3 INT12). A member of the Q team felt that this confidence relates to Q members feeling a greater sense of identity in terms of improvement, encouraging members to be more collaborative and ambitious (Q team INT3).

I can see that Q has given individuals in my organisation the pride, confidence and energy to pursue improvement work at a different level to what I had seen previously. I now see a difference in departments who have a Q compared to those without. [2019 survey respondent]

A specific example of this was seen in the survey completed by attendees of site visits. For the Jaguar and Health Improvement Scotland site visits, many attendees felt that their confidence in applying what they have learnt from the day was high. However, although attendees at the FCA visit reported gaining knowledge, the confidence they felt in implementing the learning after the day was low.

There is a plausibly and commonly implied view among Q members that confidence strengthens a belief in agency (the justified expectation that personal actions will lead to the intended outcomes) and in turn, a sense of agency helps improvers to actively apply improvement lessons they learn (for example, from site visits). This may often relate to individual actions but it can also apply to team working or addressing more systemic problems. For example, Q Exchange also demonstrates how Q supports the development of confidence for members who are seeking to work collaboratively. Many participants reported that submitting a bid to Q Exchange boosted their confidence and belief that their project has value (Q Exchange). Although a small number felt that Q Exchange may lead to a drop in the confidence of bidders as they felt they were competing with 'big hitters' (Q Exchange).

I feel like I'm personally on a different level now than I was before. I've just been known as a statistic most of my life, I'm not used to having a voice, so having this voice and for that voice to be heard and helped is massive to me. I don't think they've [the Health Foundation] realised how much they've helped me grow. [Q Exchange FG2, September 2018]

Service user engagement

For some participants, there was a feeling that Q supports and encourages the involvement of service users in Q itself and improvement more

broadly, both directly and indirectly (South West DD, Q Exchange, 2019 survey, 2018 survey, Phase 3 INT11).

> *The national team have been a real support to patient leaders and patients that have attended events, they have supported in ways others do not and I think this is shown in the way people talk about Q and The Health Foundation.* [2018 survey respondent]

When looking at direct impacts, a small number of service user respondents to the 2019 survey felt that Q represents the needs of patients well, for example, by empowering them to start their own improvement work, building networks and allowing service users to be meaningfully involved in improvement, rather than to complete a tick-box exercise.

Q has indirectly supported improved patient and public engagement through the funding of Q Exchange projects. For example, the project 'Patients are equal partners in Quality Improvement', our first Q Exchange case study (Annex K), is providing training to patients on improvement methods to give them the confidence and knowledge to allow them to provide useful feedback and guidance for frontline professionals designing improvement projects. This project is also supporting healthcare professionals to better understand where and how patients can add value to their improvement projects (South West DD, Q Exchange).

However, two other health service users responding to this survey did not feel the same way and expressed the need for Q to better support the needs of service users to engage more meaningfully with Q and identify ways to encourage more service users to join Q.[54] This was also discussed in Section 2.3.3 above, which describes barriers that Q members and service users in particular face in engaging with Q. Some felt that while Q has achievements in supporting patient-led projects and Q Lab has effectively involved service users, in general Q activities there is little service user involvement and the voices of this group were not heard within the community (Phase 2 INT10, Phase 1 INT5). One interviewee felt that this is, in part, due to the small number of service user representatives within the Q community (Phase 1 INT5). By better engaging with service users, Q may be able to increase the development-related benefits that this population of Q members realise through Q.

> *Most health care professionals have no idea what coproduction is. Q can help develop some resources so that people understand how to do co-production…. It needs to give hard and crunchy information about how to find patients, how to ask them to be involved, what reasonable adjustments need to be made, where to get information about benefits…. Some patients struggle to establish credibility. They may be well known by one local trust, but not by the CCG or STP or other local trusts. Q could develop bits of work to help patients put something in a portfolio/ on a CV to help establish credibility.* [2019 survey respondent]

3.4. Supporting: Creating a supportive platform for QI to thrive

The 'supporting' aspect of the theory of change involves Q members in supporting each other and influencing the improvement

54 It should be noted that the question about service user benefit had only 20 respondents and so care should be taken when interpreting results.

context. We take this to include factors such as peer and organisational support and access to resources and expertise to facilitate the development of a supportive improvement environment. While some of these aspects relate to points discussed earlier in this chapter, we include them in more detail here with more of a focus on the supportive characteristics. Thus, this section covers how Q helps to create a supportive context for QI and subsequently raises the visibility of, and priority placed on, QI in organisations.

3.4.1. Creating a supportive context for improvement

A supportive context creates sufficient stability and support to allow other parts of the system to interact more efficiently and effectively than would otherwise be the case. Q can support improvement in two ways. The first way is through directly adding value by providing activities and resources that Q members use to support their learning and skills development, as we have discussed. The second way is when Q creates value indirectly through allowing interactions which then add value.

This supportive context can be understood through the lens of 'platform economics'. A platform such as Uber, for example, does not add value itself; value is only created when drivers and passengers meet. We, therefore, think that there is merit in applying 'platform thinking' to considering the design of Q (as well as looking for more direct benefits from events and activities). We also think, and the interviews reinforce this, that the strength of the 'platform' (in this sense) is enhanced by being organised alongside events and activities that have their own direct benefits (although this complicates still further the task of identifying the value created by Q as an initiative). Members have emphasised the importance of events and activities for building QI capacity in general and for the role of Q in particular. Indeed, the case studies and deep dives suggest that the 'platform' function of Q is enhanced by the activities and events function and vice versa.

Related to Q strengthening the supportive context for improvement, respondents for two of the deep dives felt that Q has helped to increase the momentum and acceleration of QI within their organisations (South West DD, Northern Ireland DD). An example from the Northern Ireland deep dive is the ability to explore the approaches to improvement happening in other parts of the UK: such exploration is thought to be much more difficult without Q. Other interviewees for this deep dive also reported how they felt Q is a 'home' or 'hub' for improvement in the region and that it encourages members to support each other in their improvement work, including helping those new to QI to enter the improvement environment (Northern Ireland DD). The value was often seen to lie in catalysing change, but it was also noted that Q provides a place of psychological safety.

> *Q didn't start the shift, but they put their shoulder to it, so it could go faster and quicker.* [South West deep dive INT2, March 2019]

> *I see it as acting as that supportive platform to continue to attract people to continue to support them on their improvement journey and to give them access to ongoing levels of development. It's much more about peer support, about speaking to people with similar problems, about psychological safety where you can say to somebody 'look I don't know what to do with this anymore, have you been through this position?'* [Northern Ireland deep dive INT1, May 2019]

Participants frequently mentioned how Q and the Health Foundation have credibility within the health and care system, and how that

supports this platform for QI (Northern Ireland DD, 2019 survey, Q Exchange, Ling et al., 2018). Participants of the earlier stages of the evaluation referred to having the metaphorical and physical 'Q badge' of credibility, which is thought to be particularly beneficial when working on raising awareness of QI with senior leaders (Ling et al., 2018). Although improved status for QI will not directly transfer to improved health services, the ability of Q to create an 'emotional retreat' alongside the propagation of more technical knowledge and skills, and expansion of networks, can support change in the health system (Ling et al., 2018).

> *I like the way people are proud of Q and as I go around I often see people wearing the Q badge.* [Stakeholder INT2, December 2017]

However, although there has been a success in creating Q as a basis for supporting improvement, it is not yet able to deliver change across the system at scale (see Chapter 4).

Q Exchange as supporting a platform for improvement

It was highlighted by multiple members that Q Exchange, in particular, is effective at creating a platform to support QI (Q Exchange, 2019 survey). For example, participants expressed the view that Q Exchange offers the opportunity to fund new, untested ideas that would face challenges obtaining funding elsewhere. Traditional funding bodies, we were told, often require more formal evidence behind the idea to be submitted (Q Exchange, 2019 survey). Some participants also felt that Q Exchange offers support to groups traditionally underrepresented in funding opportunities, such as those working outside of academia or those in primary care, as well as funding different types of projects (Q Exchange, 2019 survey).

Most participants felt that without the support of Q Exchange, their improvement projects would have been very challenging to implement or could not have gone ahead at all (Q Exchange). Many bidding teams to Q Exchange felt that their projects would run on a much smaller scale and over a longer period if they had not received the funding (Q Exchange). In addition, without funding the projects may not have been able to reach their 'full potential', e.g. faced difficulties in creating tailored resources or not have the resources to conduct an evaluation. A small number of participants felt that their project could not have gone ahead at all without funding from Q Exchange. For example, the teams could not acquire the relevant staff (and dedicated time) to work on the project (Q Exchange).

3.4.2. Greater visibility of improvement

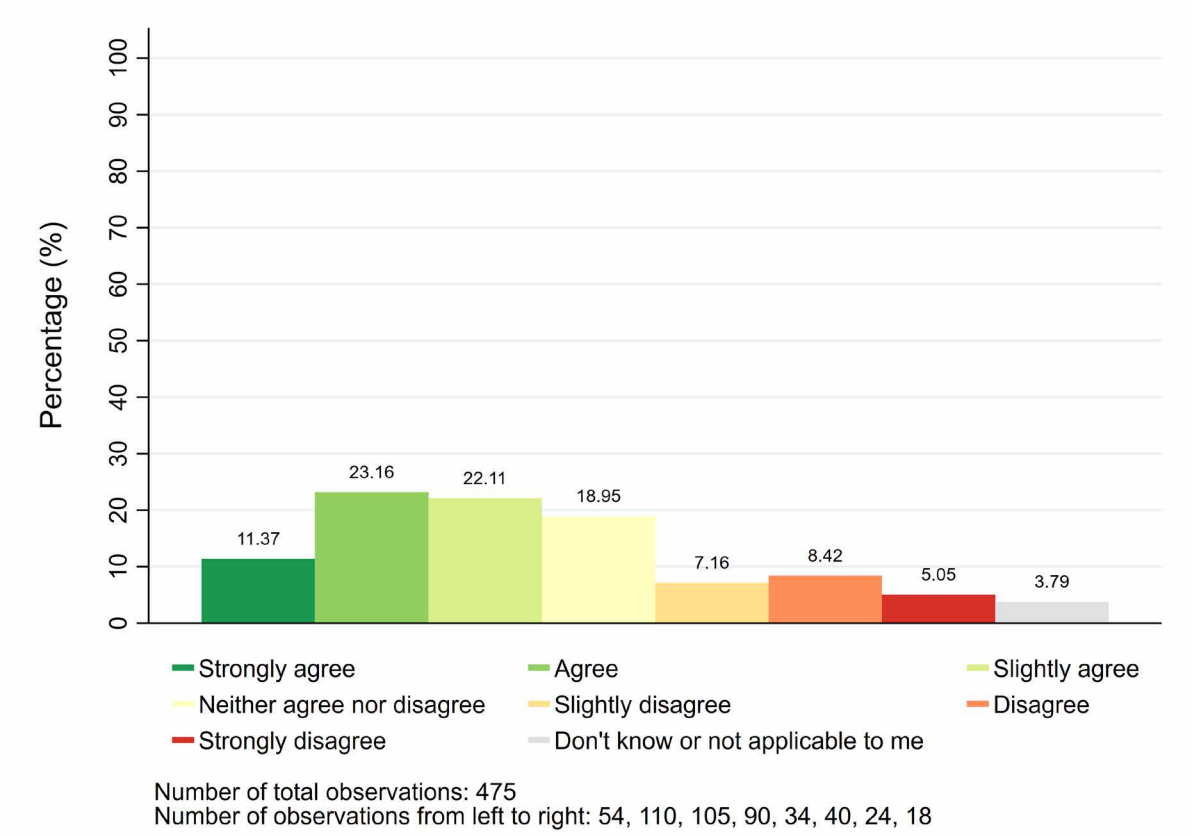
Many participants felt that Q has led to greater recognition of the value that quality improvement can provide their organisation and that as a result greater priority is placed on improvement within organisations (Wales DD, phase 2 INT9, stakeholder INT5, 2019 survey, 2018 survey).

> *[Q has] reinvigorated QI, put it to the forefront and put it on people's agenda. That's what it did for me, put it higher up on the agenda, got it on our staff brief, our training. It also made me think about the processes I was doing and whether there was QI in there.* [Stakeholder INT5, November 2019]

> *Q has had a big impact on raising the profile of QI in my organisation as we now have several Q members who not only support each other but have broadened the QI support network locally with other Q members we each know.* [2019 survey respondent]

In the 2019 annual member survey, participants who had been Q members for one year or more were asked whether they felt that Q has helped them to increase the visibility/ profile of improvement activities. Over half of respondents (57 per cent) agreed to some extent that members were supported by being members of Q to increase the visibility of improvement work (Figure 16). Interestingly, when comparing results of this question from the 2019 survey to engagement with Q resources, it suggests that 44 per cent of respondents who reported only occasionally use Q resources are not confident that Q increases the visibility of improvers in their organisation or professional network. This is higher than for members who actively participate with Q activities (28 per cent) and who lead Q activities (12 per cent). In addition, respondents who had been members of Q for one year or more were asked whether they felt Q positively impacted the visibility of improvers in the health system. Two-thirds of respondents (66 per cent) agreed to some extent with this statement. As with visibility of improvement within organisations, we compared the responses to this question in 2019 to the engagement with Q resources. This suggested that 32 per cent of members who occasionally use Q resources do not feel confident that Q increases the visibility of improvement in the UK health and care system, compared to 11 per cent of members who both actively engage and lead Q activities. These results seem to suggest that Q is better able to increase the visibility of improvement with national bodies compared to healthcare provider organisations; however, this view may vary depending on members level of engagement with Q, with those who are more engaged (either actively participating or leading activities) viewing Q as increasing the visibility of improvement both at an organisational and system level.

Figure 16: Confidence that membership of Q has helped members to increase visibility/profile of improvement activities within member organisations from the 2019 survey[55]



Q Exchange as a way to further increase the visibility of QI

Many participants discussing bidding for Q Exchange felt that the platform of Q Exchange meant that they were able to demonstrate the importance of their project not only within the Q community but also within their organisations, and this has led to their projects becoming more of a priority within organisations (Q Exchange, 2018 survey). In particular, and as discussed in Section 3.1, it was felt by a small number of members that having the Q badge attached to the projects is a supporting factor in raising awareness and getting organisational buy-in for the projects (Q Exchange). For those projects that were proposed in bids but did not receive funding, participants felt that the legitimisation of projects gave the teams credibility to seek funding elsewhere (Q Exchange).

> *Within our organisation…it [Q Exchange] has been really helpful to show a concrete action of the work we are doing, and it has been well received outside of the organisation. Executives and non-executives have been receptive to this in developing the profile of the teams work and visiting conversations from a different*

55 Question text: *Membership of Q has helped me (or my colleagues) increase the visibility or profile of improvement activities within my organisation or professional network.* (asked only to respondents who had been members of Q for longer than one year).

angle and to encourage engagement from leadership and demonstrate the importance. [Q Exchange FG3, November 2019]

3.4.3. Creating a safe space for improvement

Participants often commented that Q provides a safe space for improvement, allowing members to feel confident and comfortable in sharing ideas and receiving feedback from critical friends, enabling the creation of an open platform for discussion (Q Exchange, stakeholder INT2, Q team INT9). This peer-to-peer support is thought to be particularly helpful for those working in isolation (Ling et al., 2018, CS5, Q team INT9). Two individuals described the Q community as being 'warm' and 'open', contributing to the feeling of having a safe space (stakeholder INT2, Q team INT9). It was also felt by a small number of members involved in Q Exchange that Q offers time out of busy working days to allow members to reflect, think and share knowledge with other members, which is not offered by other organisations or initiatives (Q Exchange).

But there are other people who are working in organisations where that's not on their agenda and that's when I think it can feel quite isolated for individuals…. You get no peer support. Whereas in something like Q, you've got people who can give you some advice, even if it's only backup, it's alright, it will be better next week, type of thing. [Phase 3 INT1, October 2017][56]

The Q community…can be a safe place to come to share ideas at a time when the NHS is struggling. [Phase1 INT14, March 2018]

However, there were a small number of respondents to the 2019 survey who did not share this view and felt excluded from the Q community due to their job role or because of a lack of other Q members in their organisation, making it difficult to effectively engage with the community.

56 This quote was previously published in the interim evaluation report (Ling et al., 2018).

4 Impact on the health and care system

The previous chapter focused on the impacts felt by Q members themselves. This chapter explores whether Q has yet achieved impacts at the organisational and system levels. We also cross-analyse and reflect on the four deep dives. A summary of this chapter can be found in the box below.

- While Q has contributed to raising the profile of QI at an organisational level, it has also contributed to raising the profile of improvement at a regional and national level, with some viewing Q as a national 'hub' for improvement.
- Q has faced challenges in engaging organisational and system leaders. Many leaders outside of Q were not aware that Q is available to them as a resource and organisational leaders were not aware of who the Q members are in their organisation. There were also concerns that Q is not as aligned with the key priorities of the NHS as it should be, leading to it being viewed as 'outside' the system.
- While improving patient outcomes and benefiting patients is not a direct aim of Q (but is the ultimate goal through supporting improvement work), a number of the funded Q Exchange projects (in particular) have led to improvements for patients. For example, better diagnosis of sepsis, safety improvements in a maternity unit and improved access to healthcare services for patients living in remote areas.
- Cross-analysis of the deep dives shows that while some geography and context-specific factors are critical to how improvement is embedded and viewed across different regions and nations of the UK, some barriers to engagement and impacts of Q are much the same across these areas.
- The similarities across the four deep dive areas include: a lack of time acting as a barrier to engaging with Q; while networks of improvers existed before Q, the establishment of Q has allowed these relationships to become deeper and extend over a larger area; and greater importance is now placed on improvement work by organisations and system leaders.
- One of the key differences noted across the deep dives is the development and maturity of the healthcare improvement system in each area, with Scotland and Northern Ireland appearing to be further ahead than the South West of England and Wales. This has led to several differences in the way Q has embedded itself in these areas of the UK and different levels and types of support for members involvement in Q.
- Overall, up to the end of this evaluation period, Q has had a limited impact on the health and social care system due to the lack of engagement with system leaders and priorities. However, it should also be remembered that at the time of writing, Q is less than five years old and creating impacts at the system level take time. The Q team at the Health Foundation are aware of the work that needs to take place in this area, and this is a key focus of Future Q for 2020–2030.

The interim evaluation report highlighted how the impact of Q on organisations and the healthcare system in the UK was unclear at that point for several reasons. These include the then short length of time Q had been established (limiting the ability for it to have influenced at an organisational and system level), the potential lack of visibility of these types of impacts or whether these impacts were not happening at that time (Ling et al., 2018). The combination of a shift in the evaluation to a summative viewpoint and the fact that Q has progressed and matured since 2018 has enabled the evaluation team to give more attention to identifying the organisational and system impacts of Q.

The guidance of the EAG as the evaluation entered a more summative stage in 2018 was that due to the inherent complexities involved in measuring the scale and spread of improvement across a whole healthcare system, the evaluation should not lose sight of understanding the processes at work and should use case studies and vignettes to illustrate examples of the impacts that were emerging. We have also considered what might be leading indicators of impact. These may be derived from understanding the causal pathways along which it is anticipated that Q will impact the health and care system:

- Does Q do more than simply replicate what would have happened (i.e. with no added value)?
- Do participants engage?
- Were new relationships formed as a result?
- Do they add to members' understanding of improvement?
- Is quality improvement more visible?
- Were these improvements acted upon?
- Is there evidence of improvements for patients or the system?

We have argued that Q has established something new in the healthcare improvement landscape in the UK. In general, participants in the evaluation agreed, feeling that Q is offering something new within health and social care (Ling et al., 2018). While some were originally sceptical about the role Q could play in creating a national network of improvers and in improving health and care delivery, interviewees from the first stage of the evaluation believed that Q was creating a unique role within the landscape (Ling et al., 2018).

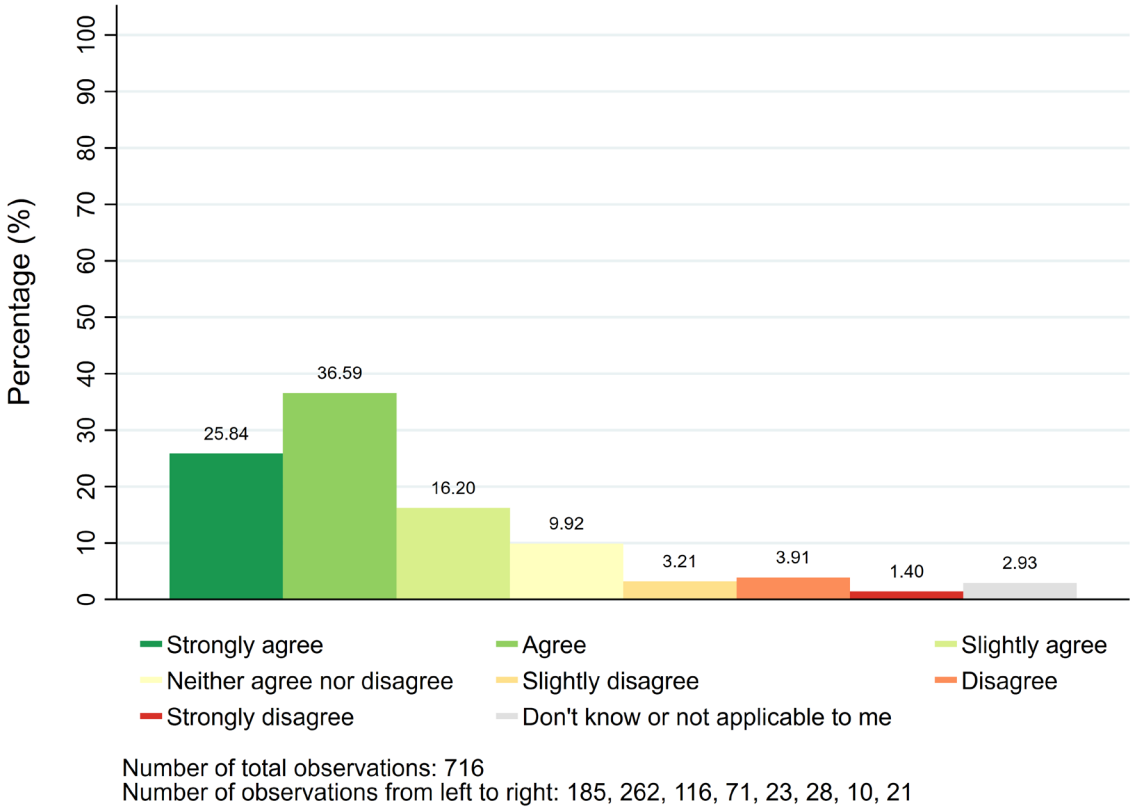
> *I think it [Q] provides…or it has the potential to provide a nice kind of net that sits right across the top of the system and allows people to come off the deep focused pieces that there are parts of the system that they are operating with. And maybe travel along some of the lines that are on top of the net, to see how other systems work and to see how others, who are facing similar challenges, are able to do that.* [Phase 1 INT6, November 2016][57]

This was also reflected in the annual member survey findings. In 2018, 63 per cent of members agreed that they felt they contributed to something that benefits the quality of health and care in the UK as a result of being a Q member. This increased in 2019 when members were asked the same question, with 79 per cent of members agreeing that being a part of Q benefits the quality of health and care in the UK (Figure 17). Interestingly, when comparing the responses to this question with the time spent on Q, almost one-third (30 per cent) of respondents spending less than one day on Q disagreed to some extent that Q benefits the health and care system in the UK.

57 This quote was previously published in the interim evaluation report (Ling et al., 2018).

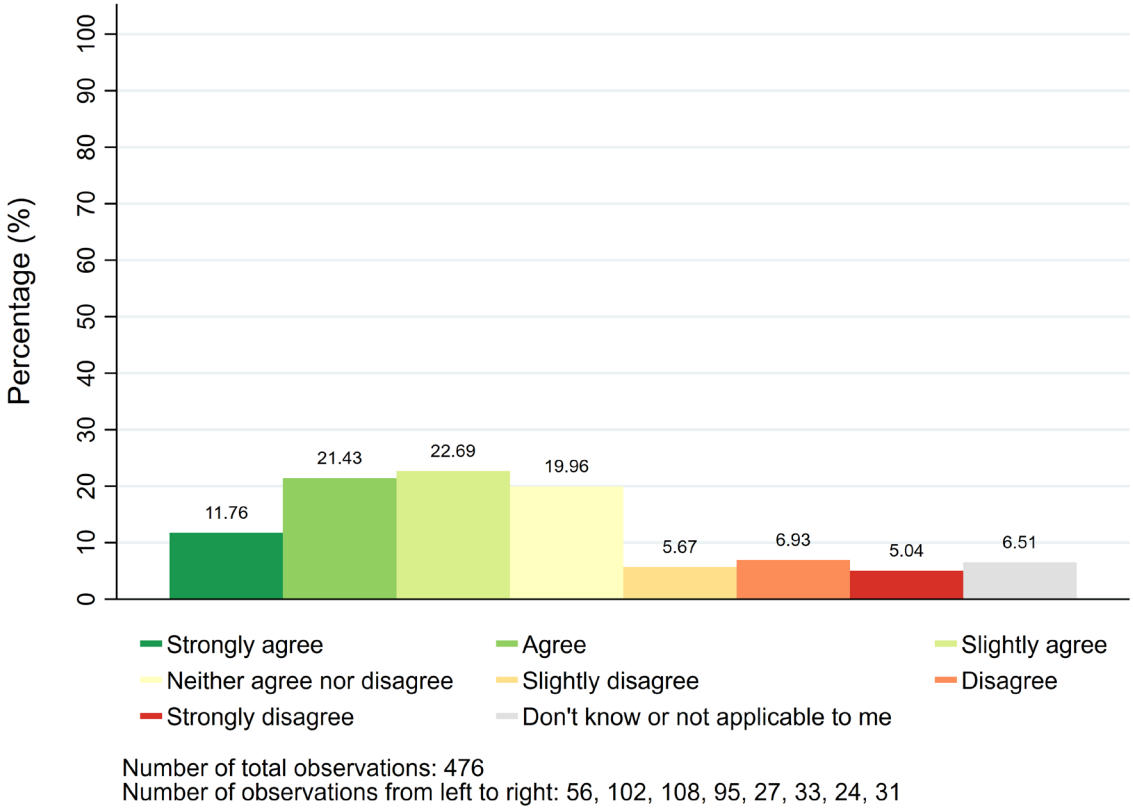
This is much higher than members spending more than one day on Q, which ranged from 0 per cent to 6 per cent disagreement with this statement. In addition, in 2019, over half of respondents who had been members of Q for one year or more (56 per cent) felt that Q has positively impacted health and social care in their organisation (Figure 18). For both questions, the responses were compared to the level of engagement with Q resources. This showed that 42 per cent of members reporting occasional use of Q resources in the 2019 survey did not agree that Q benefited the quality of care provided by their organisation, compared to 25 per cent for members leading Q activities and 18 per cent of members actively participating in Q activities. Similarly, albeit a lower percentage of responses, 37 per cent of members occasionally using Q resources disagreed that Q benefited the quality of care delivered by the health and care system at a national level compared to 24 per cent for members leading Q activities and 23 per cent of members actively participating in Q activities.

Figure 17: Confidence that being a part of Q benefits the quality of health and care from the 2019 survey[58]



58 Question text: *I am confident that through being part of Q I contribute to something that ultimately benefits the quality of health and care in the UK.* (Group A) and *I am confident that through being part of Q I will contribute to something that ultimately benefits the quality of health and care in the UK.* (Group B).

Figure 18: Confidence that membership of Q has positively impacted the quality of health and care provided by members' organisations from the 2019 survey[59]



Further evidence that Q may be changing behaviours and outcomes at the organisational level is that both were closely associated with members' confidence. We also know that Q members report increased confidence with their improvement skills. Increasing confidence is also associated with presence, self-efficacy, expectancy, self-esteem and trust (Bandura, 1988; Gist & Mitchell, 1992; Kay & Shipman, 2014). Increasing confidence may prove to be a leading indicator of improvement, but it would be reasonable to suppose that without other changes in the system, although increased confidence might be necessary, it would not be sufficient by itself. In the following section, we explore additional critical factors: visibility in the system and alignment with system priorities.

Consequently, there is still uncertainty as to whether Q has led to changes at the health and care system level, with some members (and those outside of Q) feeling that Q has not led to tangible changes on the front line of healthcare delivery (Phase 2 INT10, Phase 3 INT3, Phase 3 INT6, Phase 3 INT7, Stakeholder INT1, Stakeholder INT4, Q Exchange, South West DD, Wales DD, Q team INT9, Q Exchange, QI INT2, QI INT3, QI INT4, Ling et al., 2018).

59 Question text: *My or my colleagues' participation in Q has resulted in a positive impact on the quality of health and/or care that my organisation or professional network delivers.* (asked only to respondents who had been a member of Q for longer than one year).

I know that there are people who are doing good work in the NHS in the UK…but I think it's a bit early for Q to be able to claim on a widespread basis that it's influencing improvement. [Phase 1 INT10, July 2017][60]

A large number of participants engaged in the evaluation up to the publication of the interim evaluation report considered that it may then have been too early in Q's lifetime for it to be influencing processes at the system level, but they were confident that these impacts would become visible in the near future as the momentum around Q and membership numbers increased (Ling et al., 2018). Participants engaged in the latter, more summative stage of the evaluation were able to share some thoughts on the impact Q has had at the organisation and system levels. However, many participants, particularly external QI experts, noted the challenges Q faces in engaging leaders within the system and there were differing opinions as to whether Q aligns with other improvement strategies across the UK, which we will discuss here.

4.1. Q helps to raise the regional and national profile of improvement

In Chapter 3, we discussed how Q is considered by its members to have contributed to greater awareness of improvement within organisations, and many participants felt that this also extends to the profile of improvement on a regional and national level (South West DD, Northern Ireland DD, Wales DD, Phase 1 INT18, stakeholder INT5, 2019 survey). This view is supported by the 2019 survey in which 66 per cent of respondents that had been members of Q for one year or more agreed to some extent that Q has contributed to the visibility of improvers in the UK health and care system.

The deep dives provide examples of how Q helps accelerate, and raise the profile of, QI in different areas of the UK. In the South West of England in particular, interviewees felt that Q has helped to shape what improvement looks like in the region and has accelerated the rate of improvement work, although noting the recent challenges in maintaining momentum among Q members and implementing the Commons model (South West DD). In Northern Ireland, participants highlighted the value in exploring what is happening in terms of improvement in other UK nations and feeding this back into the national improvement work in the country (Northern Ireland DD). In Wales, it was felt that Q has led to less duplication of improvement activities as members were more likely to be aware of what others are working on and be able to work together and learn from each other, rather than implementing the same project in isolation without sharing learning (Wales DD).

Q didn't start the shift, but they put their shoulder to it, so it could go faster and quicker. [South West deep dive INT2, March 2019]

Having the platform to have the conversation, having the platform to challenge, having people…to get that elevation of showing that quality improvement is just as important as leadership and other aspects within the system. Putting it firmly in the Boards of our organisations thought patterns, [that]…it isn't just about the money or the performance…reinvigorated QI, put it to the forefront and put it on people's agenda. That's what it did for me, put it higher up on the agenda, got it on our staff brief,

60 This quote was previously published in the interim evaluation report (Ling et al., 2018).

> *our training. It also made me think about the processes I was doing and whether there was QI in there.* [Stakeholder INT5, November 2019]

Relatedly, interviewees from Northern Ireland reported how Q supports the creation of a national platform for implementing QI, often referring to Q as a central improvement 'hub' for the nation (Northern Ireland DD). This platform is created through the provision of support to members to learn about improvement and how best to implement new projects, as well as through the new connections developed through Q (Northern Ireland DD).

4.2. Q faces challenges in engaging organisational and system leaders

While a small number of participants felt that system leaders were aware of Q (Phase 3 INT12, stakeholder INT5), a larger number report that Q has struggled with engaging system leaders, in part because this has not been a priority for Q since it was established. This means leaders are often not aware of the opportunities Q can provide their staff, who the Q members are in their organisation and cannot align the work that happened through Q with system and organisational priorities (South West DD, Wales DD, Q team INT9, Phase 3 INT6, Phase 3 INT7, Q Exchange, QI INT2, QI INT3, QI INT4).

> *It was evident to me at the beginning that in not one single visit, in one site anywhere in 3 years, did I meet with the executive team in any of those sites – not once did they mention Q…. When I went to Skipton House [NHS England and Improvement], in no single occasion did anyone…mention Q as a way to create confidence for change or confidence from spread. This was a misstep because it was a large investment, but there's no sense of strategy. When I met with Qs, very rarely did they mention approaching executives.* [QI INT3, January 2020]

> *I think Q would be seen by those people that know about it as a way of connecting people, but not as a way of connecting them to priorities.* [QI INT4, January 2020]

Some interviewees discussed how Q is not aligned closely enough to policymakers at a local and regional level, contributing to Q being seen as an 'outsider' by them and others in the system and creating challenges in communicating how Q can support improvement work to decision makers (Wales DD, South West DD, Phase 3 INT6, Phase 3 INT7). The lack of alignment of Q with NHS priorities is also thought to contribute to policymakers and other key leaders finding it difficult to place where Q fits in the system, and that these leaders may not take advice and guidance from a group they may see as outsiders and 'treading on other people's patches' (Phase 3 INT6, Q Exchange). In Wales, this disconnect between Q and leaders in the system is thought by a few members to be due to few individuals in leadership roles, such as chief executives and chief operating officers, being members of Q themselves (Wales DD). Similarly, it was suggested that Q members often join Q as individuals, rather than as representatives of their organisations, and this may reinforce a disconnect between activities that members take part of through Q and their 'day jobs' (Wales DD, Stakeholder INT1).

> *Within the health boards, Q is very much under their radar – people join as individuals, not as a member of their organisation and they don't connect their Q membership with their wider day role.* [Wales deep dive INT8, October 2019]

One QI expert interviewee discussed the challenges that Q faces in reaching

system-level engagement when improvement work in the NHS in England more generally is not highly valued. Many leaders, it was said, were not seeing the benefit QI can provide, particularly for the big challenges faced by the NHS (QI INT2). However, the expert interviewee also suggested that awareness of QI had increased among management and leaders, so the Q team should now be looking to put Q on the radar of leaders (QI INT2).

The challenge of engaging leaders was highlighted by an interviewee from Wales, who discussed the difficulties faced in engaging the Welsh Health Boards with Q (Wales DD). While efforts have been undertaken in recent years by Q members to better engage the Health Boards, it was felt that this has had limited success, in part due to the differing priorities of Q and the Health Boards. There were also challenges faced by the Northern Welsh Health Board as it is in special measures that make engaging in wider improvement difficult (Wales DD).

Despite this, two members of the Q team continued to feel that Q is aligned with system priorities, that those in the system were starting to see the value Q can provide in supporting strategic system priorities for system leaders and country partners of Q, and that Q is designed to be complementary to other modes of improvement (Q team INT2, Q team INT9). It was noted by the Q team at the Health Foundation that Q is not intended to be the single answer to the challenges faced by the NHS, but that Q has an important part to play in improving relationships between organisations involved in improvement and contributing to learning about what works in improvement. An example shared by one Q team member was of an outpatient survey conducted by the Q team, which identified national areas of priority that needed support in terms of outpatient care; the team are now looking at ways to fund projects in this area (Q team INT2).

It should be noted that the Q team is aware of the lack of engagement with organisational and system leaders, such as with sustainability and transformation partnerships (STPs) and integrated care systems (ICSs). The Q team has highlighted this as an area for the team to focus on in the coming years (Q team INT9). It was noted by one Q team member that, when Q was first established, a conscious decision was taken to not engage organisational leaders with Q due to concerns that Q members would be called on as a 'standing army', placing an extra burden of work on top of their day jobs (Q team INT9). This interviewee explained that now Q has a larger number of members, with some organisations having many members, this concern has reduced, and the Q team will be actively engaging with chief executives and boards to share what Q is and the opportunities it can offer, so that those leaders were aware of the Q members within their organisation (Q team INT9). Given the level of investment from the Health Foundation and NHS England and Improvement, interviewees highlighted the importance of demonstrating that system leaders are aware of Q (Q team INT9, QI INT2).

However, it is also worth noting that views differ as to the extent to which Q aligns with national and regional priorities. For example, some interviewees for the Wales deep dive felt that Q is well-aligned with other improvement initiatives in Wales, in part due to the same individuals being involved in other improvement programmes in addition to Q (Wales DD). In particular, interviewees for this deep dive noted the overlap between Q members and those involved in Improving Quality Together (IQT) training and Improvement Cymru. It was felt that this overlap encourages the different initiatives to mutually support one another, to share learning amongst different initiatives and connect those with improvement experience within and outside of Wales.

However, while some interviewees expressed this overlap and connection between initiatives as a positive outcome, one interviewee from Wales felt that this limits the engagement of Q to those already involved and knowledgeable about Q and improvement, rather than engaging a wider group of individuals (Wales DD).

> *We weren't starting from scratch; there were some networks around. Q has built on what was there already but taken it outside of Wales.* [Wales deep dive INT6, September 2019]

Other participants did not agree, suggesting that Q is disconnected from other improvement initiatives. Drawing on the Wales deep dive again, some interviewees felt Q is not aligned with the Improvement Cymru national programme. While it was acknowledged that the work of Q often runs in parallel to that of Improvement Cymru, there is a problem in that Q members were not always involved in design and leadership of this programme, as well as the initiatives having different agendas and priorities, which creates a disconnect between the two (Wales DD).

> *We also had a number of national programmes focusing on different clinical services or sectors. Q runs parallel with all of that. One thing we probably haven't really made the opportunity to create is the connection between Q, its members and the programmes that are delivered nationally.* [Wales deep dive INT2, August 2019].

4.3. Q Exchange is said to have had tangible impacts on health and care delivery, as well as patient outcomes

The collaborative nature of Q Exchange and the financial support offered have led, we were told, to several tangible impacts occurring because of projects funded in 2018, both on service delivery and patient outcome (Q Exchange, Q team INT10). These impacts are described in the annex on Q Exchange (Annex K) and will also be discussed more briefly here.

Our first Q Exchange case study, Quality Improvement Partner Panels, which offers QI training to patients, has seen impacts on improving the design of QI projects in the South West of England. This includes improvements to a sepsis identification programme in Cornwall, in which the trained patients advised the healthcare professionals designing the programme to extend the sepsis identification process to A&E walk-in patients, as well as those attending A&E by ambulance (Q Exchange).

Another Q Exchange case study focusing on Hexitime, a timebank allowing professionals to exchange time for improvement work, demonstrated several positive impacts as a result of individuals being able to exchange time and support. For example, a maternity unit facing challenges was visited by a doctor and midwife from another maternity unit that had recently made safety improvements. The sharing of their knowledge and learning from this process contributed to the struggling maternity unit coming out of special measures (Q Exchange).

Finally, a project funded by Q Exchange in 2018, NHS Near Me, offering video consultations in rural Scotland reported a few positive patient outcomes (Q Exchange). For example, a teenager with mental health illness and who struggles to leave home was able to access medical care through the video consultations. In addition, a patient living in a rural Scottish island was able to set up a two-way consultation with multiple healthcare professionals, which meant he did not need to make multiple, long journeys and the care provided was improved as the conversation was held with multiple clinicians (Q Exchange).

It should also be noted that a small number of participants (eight respondents) in the 2019 annual survey expressed concerns that they have not seen any impacts of the funded Q Exchange projects and were unsure as to whether project teams were appropriately held accountable for spending the funding on the proposed projects (2019 survey).

> *I am curious about the accountability, £30k is a huge sum, and I would be curious to see the outputs of some of the funded programmes – especially ones I was more sceptical about.* [2019 survey respondent]

4.4. Cross-analysis of and reflections on the deep dives

The deep dives conducted in Scotland, the South West of England, Northern Ireland and Wales provide valuable insight into the sub-UK differences in how Q has established itself and integrated into members wider improvement work. Here, we provide a summary of each of the deep dive sites in turn and reflect on the similarities and differences between the areas to provide an insight into how and why Q has varying dynamics and ways of working in different parts of the UK. While we are aware this analysis perhaps extends beyond the focus of this chapter discussing the system impact of Q, we feel it is a valuable way of understanding what causes Q to 'land' differently across the UK and why this is important in contributing the wider impacts of Q.

4.4.1. Scotland

For the Scotland deep dive, seven interviews and four focus groups were conducted with members, as well as a light touch review of the literature and documentary evidence. This was a pilot of the approach to the deep dives and so the format and structure of the data collection and reporting (see Annex C) are slightly different from the other three.

Scotland has a different improvement landscape to the rest of the UK, and particularly England. This is, in part, due to what was described as a different approach to understanding what 'improvement' involves and its importance relative to wider policy goals. In addition, in Scotland there is a heavier focus on patient safety and collaboratives compared to England, which, by contrast, has a greater focus on commissioning, measuring outcomes and competition. This particular focus for Scotland is perceived by our respondents to have led to a culture in which there is a greater ability to share learning and experiences, as well as a willingness to take risks and try new approaches. In addition, Scotland was described by almost all the people we spoke to as starting its improvement journey slightly earlier than the rest of the UK, so the system is more mature. A consequence of this, it was noted, was that within the system leadership there was a representation of those who understood what improvement involves and what value it might offer. Participants particularly referred to the establishment of the Scottish Patient Safety Programme as being an important initiative in progressing improvement in Scotland, alongside other initiatives and organisations, such as the Safer Patient Initiative, HIS, iHub and the Scottish Quality and Safety Fellowship.

This more visible and apparently stronger improvement landscape in Scotland has led to three key areas that differentiate it from the rest of the UK. Firstly, there is greater awareness of a variety of QI approaches practised across Scotland and many of these are visible on the front line of health and social care. Secondly, there is consistency in the implementation of QI practices, as well as consistency in leadership support for QI (from leaders within health and care, as well as political leaders). Thirdly, these efforts have led to improvement being more embedded

in day-to-day practice and the ability for new initiatives and programmes to survive political cycles. This creates a different context for Q members to do improvement work.

At the same time, Q was brought into a landscape that already had a strong pre-existing national network of improvers who were sharing their experiences and learning from each other. This led to some participants expressing concern that Q was not adding anything additional or of value on top of existing activities; however, most of our respondents did not feel this way. While participants recognised that they were already well-connected across Scotland through existing networks, the ability to connect with improvers in other areas and sectors of the UK is seen as valuable. As has been discussed elsewhere in this report, participants often reported that they viewed Q as a platform for improvement, which is further enhanced by the resources and activities offered as a part of Q.

Seemingly, as a consequence of improvement being embedded in health and care in Scotland, members highlighted the support they have from their organisation and managers in terms of conducting improvement work, including taking part in Q activities and resources. In contrast with England, many members were able to take time off to attend Q activities, such as events and visits, with some not needing to ask permission to do so.

Despite the progress improvement has made in Scotland in the past decade, and the contribution of Q to this, members still noted some barriers to engaging with Q (many of which are shared across our deep dives). While members did feel that they can make new connections across and outside Scotland, a number noted that it can be quite difficult to identify relevant members with the same interests. In addition, rurality and a lack of time are thought to be barriers to engaging with Q and connecting to other members.

When asked what was needed in Scotland to support Q to have a positive impact on members, participants felt that recruitment to Q needs widening to encompass a broader range of people, particularly those from primary care, social care, the voluntary sector, those early in their careers and those outside of the health sector. A theme particularly expressed in this deep dive was the importance of widening recruitment to ensure Q does not become an 'exclusive club'. In addition to recruitment, participants felt that, in Scotland, Q could better integrate with other programmes and organisations (e.g. the Scottish Improvement faculty, the Royal Colleges and HIS) and make better use of technology, which was seen as particularly important to engage members living in rural Scottish areas.

4.4.2. South West of England

To develop the South West of England deep dive, we conducted six interviews with stakeholders who have been involved and have had experience with Q over a long period, including at the regional level. Without intending this, all our interviewees were based in Devon and their day roles were both within the NHS, such as improvement/safety leads and clinicians, and outside of it, such as independent consultants. The full South West of England deep dive can be found in Annex D.

The description provided by interviewees of what the improvement landscape looks like in the South West of England was very different to that of Scotland. Improvement was often described by members as being varied across the region. While some counties in the South West were seen to be leading improvement in the region, others were seen to be further behind. Across the South West, improvement was thought to draw upon a largely conventional set of approaches; it was felt that more innovative approaches to improvement were not used and tried-and-tested processes

have been used for many years. In addition, interviewees highlighted the vital role the South West AHSN has played in driving and leading improvement; however, recent changes to resource availability has had negative implications for this role in particular and, it was said, for Q more generally (discussed later in this section).

A small number of interviewees noted, as we have earlier, that the Scottish improvement landscape is more mature than in the South West, and as a result, some improvers in the region looked to Scotland for guidance. For example, local improvers have been sent on the Scottish Leadership Programme and creation of the South West patient care collaborative was based on a similar Scottish model.

In terms of Q in the South West of England, our interviewees, as in the other deep dives, outlined that networks of improvers existed before Q. However, it was felt that Q has enabled these relationships to develop further and for new connections to be established across the region. These connections have been used by members to support each other in their improvement work, such as to set up new improvement projects and to set up the Reimagining Health and Social Care SIG. Together, alongside improvement efforts outside of Q, this has led to a feeling in the South West that a greater priority is now placed on improvement and this type of work is now valued by a wider range of people, including system leaders.

Despite this, Q has faced challenges in engaging members in the South West recently. Interviewees feel that this is primarily due to resource constraints on the South West AHSN. The AHSN was seen to have played a vital role when Q was first rolled out in the South West in recruiting members, motivating Q members in their work and creating a cohesive local community. The recent structural changes seen in AHSNs across England has led to the AHSN having less capacity to support the local Q community. Interviewees feel that this has contributed to reduced cohesion within the local Q network as there are fewer face-to-face meetings and events to bring members together. The South West of England has also seen challenges in creating a cohesive local community due to difficulties faced in setting-up the Commons model. This is described in more detail in the following chapter.

The other barriers faced by members in the South West in engaging with Q are the same as those faced by members in Scotland, i.e. difficulty finding time to dedicate to Q activities (including to set up the Commons), and the large size of the South West region and the rurality of some locations can make it difficult to connect to other members.

Interviewees provided several actions that could be taken to support Q to positively impact the South West of England. Many expressed the need for regional investment and support to help members to connect within the region and to bridge to other areas of the UK, as well as to key stakeholders outside of Q. In particular, the members we interviewed felt that the AHSN should return to the higher level of support it was providing when Q was first created, although it was acknowledged that this would be difficult given the change in priorities and resources for all AHSNs. Some members also felt that there should be more Q activities and resources available in the South West (both online and face to face), such as events and webinars. Similarly to the other deep dives, one member in the South West felt that recruitment to Q should be widened to involve those with different backgrounds, such as frontline staff and service users. Mapping of the membership in the region was suggested by this interviewee to identify those working in areas with fewer Q members to provide additional support to ensure they are not working in isolation.

4.4.3. Northern Ireland

Interviews were conducted with eight Q stakeholders in Northern Ireland from each of the five health and social care Trusts, which together provide coverage of all regions of Northern Ireland. The interviewees' day roles were primarily improvement based, particularly in improvement leadership roles within Trusts, as well as roles in the Northern Ireland government. The full deep dive report can be found in Annex E.

In comparison with the other deep dives, the improvement landscape in Northern Ireland was reported to be most similar to Scotland; in fact, interviewees saw Scotland as having a high standard of improvement that Trusts in Northern Ireland were working towards. In recent years, Northern Ireland has seen an overhaul in its improvement system, in particular with the creation of the Health and Social Care Quality Improvement (HSCQI) movement in spring 2019, as well as other initiatives and programmes. Within this overhaul, each of the five Health and Social Care Trusts have developed improvement infrastructure based on the Safety, Quality and Experience programme first implemented in the South Eastern Trust. There has also been a movement towards greater integration of health and social care. This has led to the development of a more mature and scaled-up approach to improvement across the nation, with interviewees highlighting that improvement is now seen as more of a priority and that there is greater collaboration across Trusts who used to work in silos.

This substantial overhaul of the improvement system has taken place in recent years and this timing has helped Q to be a part of that change, as was demonstrated in the way most interviewees referred to Q. Many interviewees described how the Q community in Northern Ireland is active and engaged, and identified two reasons in particular. Firstly, members felt that, while there are several other improvement initiatives ongoing in Northern Ireland, Q is unique in its offer. Members often highlighted the value Q activities and resources offered to members, particularly Q visits, events, and learning and development opportunities. Secondly, Q is frequently integrated into wider improvement work; for example, there are often members running a Q stand at non-Q events and the HSCQI website has a page dedicated to Q. Members also actively encourage others to apply to Q. These factors led to one member to describe Q as being a central hub or 'home' for improvement across Northern Ireland.

The offer of Q and efforts of members to integrate Q into ongoing improvement work has had several positive impacts. Members reported having developed new connections through Q, both within Northern Ireland and more widely across the UK, and that this had contributed to an increase in sharing learning and experiences. Members from Northern Ireland especially valued the learning and development opportunities offered through Q, such as site visits and workshops, and many have used what they learnt from these to develop and implement improvement-related learning and development opportunities in their organisations. This has allowed a wider group of individuals (including non-members) to learn about improvement approaches and techniques.

Members in Northern Ireland expressed fewer barriers to engaging with Q compared to other deep dive areas. Those that did describe barriers often referred to similar barriers as those seen in the other deep dive areas. Time to dedicate to Q was seen to be the main barrier, particularly for frontline staff. In addition, physical distance from the rest of the UK is seen to be a barrier for members connecting to the rest of the UK.

In terms of what members felt could be improved for Q in Northern Ireland, extending to Ireland was highlighted by nearly all interviewees. As mentioned earlier in this report, Q will be expanding into Ireland in 2020. Members also feel there could be better coordination of members and interest areas to allow members to find and connect with members of similar interests. One suggestion to achieve this is by setting up 'Q hubs' in each region of Northern Ireland (which would require funding and other resources).

4.4.4. Wales

The deep dive for Wales was developed based on interviews with eight Q members based across Wales, including Swansea and Cardiff, as well as more rural areas of North and West Wales. Their day roles varied from working as secondary care providers, Improvement Cymru and healthcare improvement/quality-related roles. The full Wales deep dive can be found in Annex F.

Interviewees described several other organisations and programmes relating to improvement that are ongoing alongside Q. This includes Improvement Cymru, Academi Wales, the All Wales Continuous Improvement Community and the Bevan Commission (these are each discussed in more detail in Annex F). However, none of the interviewees described the improvement landscape as a coherent set of interlocking activities. In comparison to Scotland and Northern Ireland, there was a sense that relationships were still maturing although becoming more coordinated. Some interviewees reported that work was often conducted within pockets across the nation, rather than being joined up. Some members felt that this fragmented improvement work highlighted a divide between the southern cities and the rest of Wales. In addition, it was said, compared to Scotland and Northern Ireland, efforts to integrate health and social care in Wales are further behind.

Many interviewees discussed the importance of a small number of health system leaders who are driving the improvement agenda in Wales. It was felt by members that these individuals heavily contributed to progressing improvement, such as holding events, creating QI hubs and financial investment in improvement. However, members also reflected on the risk associated with improvement being driven by just a small number of individuals, including the risk that they may become unable to perform this role.

This fragmented improvement landscape is reflected in how Q has established itself in Wales, with many members perceiving that the Q community has little visibility and presence across the nation. This is also reflected in the more limited detail collected for this deep dive compared to the other three; members were less engaged with both Q and with improvement activities more widely. This low visibility of Q was said to be due to their being a smaller number of Q members in Wales and more spread out compared to other areas of the UK. Consequently, the critical mass needed for members to function as a mutually supportive network was not present across many parts of Wales. Some members also noted that Q does not seem to have gathered the same amount of traction as other improvement initiatives in Wales, in part because Q perhaps does not align with the priorities of these other initiatives. This view was not shared by all respondents, reinforcing the sense that the improvement landscape is not homogeneous.

The other barriers for members to engage with Q are very similar to those previously described in the other deep dives, namely a lack of time and rurality making it difficult to connect with other members. In addition, some members feel that Q can be too restrictive in who can join

Q, leading to some members being one of only a very small number of Welsh members in a similar role, causing feelings of isolation from the rest of the community.

Despite the challenges faced by Q in Wales, members did outline several positive impacts they believed to have resulted from Q. As with the other deep dives, members felt that they have been able to create new connections, both to other members in Wales and to members in other parts of the UK. Q has also contributed to greater importance being placed on improvement across Wales and, subsequently, supported the creation of new improvement projects.

4.4.5. Sub-UK dimensions are critical to how improvement is viewed and how it is done, but some barriers to engagement and impacts of Q are much the same across the whole UK

As each of the summaries of the deep dives show, the improvement landscape in each area is different in several important ways, and subsequently the way Q has embedded itself (or not) in each region or nation differs. However, there are also equally important similarities across the UK that appear to occur despite other regional variation. These similarities and differences were briefly mentioned previously in this section and will be reflected on further here.

As outlined throughout this section, there are a few key similarities in each of the deep dive areas with Q. Firstly, a lack of time is a universal barrier to spending time on Q activities, which is likely to only worsen as the financial and resource burden on the NHS increases. Secondly, in the areas we covered in the deep dives, networks of improvers existed before Q was established; however, Q has contributed to developing and deepening these relationships. Thirdly, Q has contributed to organisations and system leaders placing greater importance and investment in improvement work in all the deep dives. While this is likely also a result of the wider efforts to raise the profile of improvement, members frequently expressed that they feel Q has contributed to this (also discussed in Section 3.4).

There are also similarities across the deep dive areas in respect to where members think improvements could be made to Q going forward. This includes the importance of widening membership to ensure individuals from a broad range of backgrounds, including outside of the health sector, can contribute their ideas, experiences and knowledge to the Q community. In addition, members feel there need to be easier, more streamlined ways of connecting to members with shared interests or knowledge as this is found to be difficult when using the member directory currently available on the Q website. Finally, all areas feel that more regional support is needed to support the development of a cohesive and joined-up regional Q community. While how this could be achieved differs across areas, e.g. AHSN support in the South West of England and creation of Q hubs in Northern Ireland, the sentiment is the same for all the deep dives.

There are also several interesting differences to reflect on how Q has integrated itself into each of the areas covered in the deep dives. Firstly, members from the three nations covered (Scotland, Wales and Northern Ireland) feel that the smaller populations of these areas compared to England makes it easier for improvement initiatives (particularly national initiatives) to be implemented and scaled up. This also relates to Q, as it is easier for a smaller number of people to be connected to one another and makes it easier to recruit a higher proportion of improvement experts.

The key difference appears to be caused by the extent of maturity of the improvement landscape before Q was established. For

example, as Q was created when the approach to improvement in Northern Ireland was being overhauled, Q has been integrated and embedded into many other improvement initiatives, which are not seen to the same extent in the other deep dive areas.

Overall, we can see that across the UK there is a broad set of activities and techniques that are seen to be part of the improvers' toolkit. However, how improvement is viewed, whether it is a priority and where it fits with supporting other priorities all vary. Improvement is both a set of techniques and a broader disposition and way of working. The former is more widely shared than the latter. Scotland and Northern Ireland appear to be further ahead in creating a mature improvement system compared to the South West and Wales. This has led to a few differences in how Q has been implemented and how the impacts of Q are articulated. It appears that system leaders in Scotland and Northern Ireland are more familiar with and supportive of improvement and enable staff to participate and drive improvement efforts. This is translated into support for Q members to engage with Q activities and resources, which is seen to a greater extent in these areas compared to Wales and the South West. Similarly, Scotland and Northern Ireland have a large number of different improvement initiatives. While this variety was also seen in Wales, these initiatives appeared to be fragmented, limiting the ability to share learning and experiences across programmes compared to Scotland and Northern Ireland. In addition, the South West improvement efforts, including Q, largely relied on the AHSN (rather than several different initiatives), which is now less able to support improvement due to changes in structure and finances. There are also differences in the language used to describe Q and the maturity of the impacts of Q. While Wales and the South West describe Q as enabling greater importance and priority to be placed on improvement, which is also seen in the other two areas, Scotland and Northern Ireland take this forward to describe Q as being a platform for improvement in the nation.

5 The design, governance and management of Q

Since its launch in 2014, Q has evolved and developed considerably. Not only has its membership increased rapidly but the range and variety of the Q 'offer' to members have also grown. As the content of Q activities has changed, so the design, governance and management of Q have evolved. In this chapter we reflect on this design, governance and management over the lifetime of Q, considering each of these elements in turn before reflecting on the future of Q. A summary of this chapter is provided below.

- Q was designed with its members from the very beginning; this was key in ensuring Q was designed around the needs of the members. The co-design phase of Q was ambitious but successful in the creation of a unique community of people committed to the improvement of health and care from across the UK.
- As the size of Q has grown, it has remained a community co-owned by the members and the Q team and funders/partners.
- Partnerships, such as with NHS England and Improvement, AHSNs and other country partners, have been vital in creating Q and allowing Q to progress to where it is today. Continuing to foster these relationships, as well as create new partnerships, will be important for the Q team going forward.
- The Q team at the Health Foundation have played a critical role in managing and supporting members and in developing Q over time. The team have been enthusiastic and dynamic and open to adopting new ways of working or approaches.
- The team has grown considerably since Q was first established and as the membership of Q has expanded.
- It will be important to consider how the existing Q team manages roles and responsibilities as the Q membership continues to expand but the team does not.
- There are several efforts in place to create regional communities of Q members, such as the Commons model, Q Convenors and Q Connectors. To date, these appear to have had little impact and attention should be focused on examining the future of such roles and how they can best be supported by the Q team.
- Most members of Q have little knowledge of the governance of the community and although some have awareness of the management of Q, many do not. For this reason, the evaluation data in this chapter is largely drawn from members of the Q team and Q members who hold governance roles.

5.1. Co-design was a critical part of Q's emergence and development

From its inception, Q was a novel initiative, distinct from what had come before. It was the first time that the Health Foundation had worked in partnership with NHS England, and the former had not previously attempted to create a network in this way and on this scale. Since the start, Q has been embedded within the Health Foundation and built on its long history of involvement with quality improvement.

> *Q is integral to the overall improvement strategy which we think about in terms of building evidence for what works in improving health and care, building infrastructure and capability building. Q is an example of the infrastructure we are trying to build to develop improvement across the UK. It is an important development of our history rather than something new, as the Health Foundation had other initiatives such as improvement fellows.* [Q team INT9, November 2019]

The establishment of Q began with, compared to the size of Q now, a relatively small membership of carefully selected members of the QI community who came together to co-design what the Q initiative would go on to be and to shape how it should function. As Q went on to grow and evolve, the role of the Q community has changed, but many of the Q team still saw co-design or co-production as central to the ethos of Q.

> *Like a lot of what we do in Q, we are trying to divide roles up a bit more, but everyone has a say in co-production and everyone's voice is heard – that is still embedded in the team.* [Q Team INT3, October 2019]

As Q moved from the initial design phase to the operational phase it inevitably was challenged to continue to maintain its co-design way of working, even as the membership increased. One way in which this spirit has been sustained by Q has been through local co-design, albeit on a smaller scale.

> *I mean in the founding cohort we weren't quite sure what Q was going to become. I think that's clearer for new members, but I think it's still unclear to us what that will mean to us locally. So, there is still that sort of local design phase, about how we meet support or whatever form we choose to collaborate across.* [Phase 1 INT9, July 2017][61]

Other approaches to co-design in more recent phases of Q have included members being consulted in the design and content of large national events. However, the initiative has moved on from wholesale co-design. Nevertheless, it remains evident that some members still want to be involved in decisions about the future of Q.

5.2. Partner organisations

From its inception, the design of Q has included the involvement of other organisations. NHS England and Improvement is a partner in the initiative (although less visible to members than the Health Foundation) and other organisations have also worked alongside the Health Foundation. In the design of Q, the role played by AHSNs has been particularly important in some regions of England, with different organisational supports in Northern Ireland, Scotland and Wales.

61 This quote was previously published in the interim evaluation report (Ling et al., 2018).

An especially visible example is in the South West of England where the AHSN has a history of engaging with improving quality. In such areas, there has been a close relationship between Q and the AHSN, with several Q members working at the AHSN. In such localities, interviewees noted the AHSN and Q members had a strong basis for working together, with shared and overlapping aims. However, more recently evaluators were told that the input from AHSNs had been threatened by recent changes in the configuration and funding of AHSNs, meaning that of late they have become less able to take on such a role. In the South West interviewees felt this had led to fewer events and fewer opportunities to bring Q members together. Although different areas in England have varied in the strength of support from the AHSN, most AHSNs have been involved in Q, including for a period being responsible for member recruitment. It remains to be seen how far the role of AHSNs will change and with what consequences for Q. In this climate, Q may need to find alternative partnerships to nurture local connections. For example, it might be necessary to fund local roles to continue local engagement and activity.

Partnership with other organisations is likely to become even more important in the future. It is therefore relevant to note that some interviewees reported that the design of Q, with various stakeholders and partners, has led to a lack of clarity regarding the respective responsibilities of the Health Foundation, Q, AHSNs and NHS Trusts.

5.3. The governance and management of Q

As Q continues to grow, it is important that stakeholders and members are satisfied and can engage with the Q initiative, and the Q governance model is central to ensuring governance of Q is effective. Interestingly in our research, it was evident that the governance and management of Q are aspects of the initiative that are largely invisible to most members. The core Q team were very aware of the governance model and the theory of change, although there were differences of focus even within this group. It is perhaps unsurprising that during the evaluation the research team noted that many Q members were not aware of the governance structure of Q unless they were a member of the Q team or a Q member with a role within the governance structure. Knowledge of Q management also varied; while those who had attended national events or had been involved in activities such as applying to Q exchange for funding frequently had contact with members of the Q team, others had not.

During the timescale of this evaluation, the Q team has grown from a small team to some 22 individuals. This has not only involved changes to roles but also an inevitably greater division of labour within the team and a consequential need to ensure that information is effectively shared. The adjustments and changes to the ways of working within the Q team have been successfully managed with new management tools being introduced as required.

There are quarterly governance board meetings with associated reporting and consultation. With members, there is a continuous stream of two-way information between the Q team and Q members. There is now a dedicated Q website with news and updates for Q members. Emails follow a coordinated communications plan (also harmonised with the wider Health Foundation communications plan), with communication between the Q team and Q members now much more organised and planned than was the case initially. In addition, there are communications about large events, each with message boards to enable Q members to communicate about the

events. We have also observed that the Q team makes a considerable effort to respond to all members who contact them directly.

As Q has developed and increased in membership and scope, the demands on the Q team have increased in relation to obtaining and managing feedback.

> *I think as a whole our ability to collect and respond to large groups or to large numbers of member feedback is not…we don't have a lot of time to do that…. It's hard because if we think about what Q is we're going to get varying responses. And then responding individually to different people is quite time-consuming and we went through a phase last year where a lot of the components hadn't been set up. And so [it] was…decided that we need to focus more on delivery.* [Q team INT7, July 2017][62]

It is clear from accounts from both the Q team and Q members that the Q team are frequently interacting with members and are available and visible to members. Members are complimentary about the interactions and contacts they have had with members of the Q team (Stakeholder INT5). These personal relationships have remained an important part of the glue binding Q together (although this interpersonal glue would be unlikely to scale up in the same way with a membership of 10,000, compared with some 3,500 at the time of writing).

Within the Q team, there is a consideration as to how roles will evolve going forward, as Q grows in membership and activities. There is a recognition that while more organisational capacity may be needed to accommodate a growing membership, it may not be sustainable to continue to grow the Q team within the Health Foundation. Adaptations in roles and structure will be needed. For example, Q Labs has been developed as a separate stream of work, but over time there will be a need to consider, for example, a shared and more integrated communications role.

The Q team has developed as it has increased from a small group of committed individuals to a large team with identified responsibilities and ways of working. The Q team have been dynamic and open to change.

> *I think we are definitely as a team very flexible and adaptable and amenable to change and I think that is where we are lucky in that sense it is not like we…only want to do things one way. So, I think we are quite a dynamic team that we could adapt, and we have adapted…. I think what has gone well is the team itself – the team are very, very good and very, very committed and I think it is quite rare to find a group of people all very, very capable and who are very, very passionate…. We have actually got a very, very high performing team.* [Q team member [redacted], October 2017]

However, it is noteworthy that while Q has many stakeholders, the Q team has until the time of writing (January 2020) remained closely embedded in the Health Foundation.

> *For a partnership programme, it has some ownership within the Health Foundation.* [Q team INT9, November 2019].

However, there is a view that as Q grows, the management and communications team will need to find new ways of working. One possibility is that Q leadership should become more distinct from the Health Foundation over time.

62 This quote was previously published in the interim evaluation report (Ling et al., 2018).

> *From the start, Q was slightly distinct within the Health Foundation's improvement ambitions. That has matured and evolved over time. The Q team are now trusted to get on with smaller decisions and the governance structure has evolved. The Health Foundation has been happy for the Q team to progress with things themselves…. We now have an approach where Q can become more distinct from the Health Foundation over time.* [Q Team INT3, October 2019]

While the relationship with the Health Foundation will be important, so too will be the relationships with other strategic partners, which, arguably, have been underemphasised in existing governance arrangements.

> *We have been having some conversations internally about funders and strategic stakeholders and making sure we give attention to the community and that they still have involvement and ownership over Q…. In the first part of Q, we were heavily member focused. The future Q process has brought us more to think about the platform owners and strategic partners. I don't think we have got this balance yet. As we progress, we will be able to distinguish between members who are heavily and less engaged. The new role [Associate Director for Professional Development and Community] will be about developing the community and community connections from a strategic point of view. We need to still keep the members at the heart of Q.* [Q Team INT3, October 2019]

The Q team's approach to the day-to-day management of Q has evolved in the light of Q developing in new, and not always anticipated, ways.

> *It [Q] has evolved tremendously and well beyond what I and others involved at the founding stage would have thought. It started as a safety-focused initiative and the 5,000 fellow's initiative. In as much as there was a clear articulation of what Q would be and what it should achieve, through X (name redacted) and the co-design process and involvement of partners and involvement of the Health Foundation, it has developed a range of strands that we hadn't anticipated.* [Q team INT9, November 2019]

The earlier flatter structures of the Q team, and sometimes less formalised decision making, prompted an interest in more innovative ways of team working; this included weekly and monthly meetings and use of Huddle (an online document management system). Respondents often mentioned ways of working that had been adopted, such as 'agile', 'Kanban' and 'Scrum' working.[63] This included, for example, a half-hour standing meeting every Monday during which each workstream gave a two-and-a-half-minute update on progress and aspirations. Despite these efforts to achieve Lean management, the number of meetings came up both in an interview and in a focus group.

> *We have a lot of meetings and a lot of face-to-face contact…. I think frequency and purpose of meetings needs to be re-looked because I don't think we are working as efficiently as we could. I think we could probably optimise that better.* [Q team member [redacted], October 2017][64]

With greater certainty about the future of Q has come greater job security and a move away from fixed-term contracts. This has strengthened the institutional memory of the team.

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63 For an introduction to these terms, see: https://www.agileweboperations.com/scrum-vs-kanban

64 This quote was previously published in the interim evaluation report (Ling et al., 2018).

> *We had people on fixed-term contracts until recently, so we had a lot of staff turnover. This has changed now, and we have permanent contracts. These previous types of approaches need to be replaced. Knowledge can easily be lost within a small team, particularly when you are working fast and don't have time to put together the organisational infrastructure.* [Q Team INT3, October 2019]

At a senior level within Q, there has been a stable leadership, and one interviewee stressed the importance of continuity at that level.

It has also been evident to the evaluators how the Q team have taken on board feedback from the evaluation team. The same can be said of feedback from Q members, for example from questionnaires collected after events. Where feedback has been offered, the team has frequently reflected on practices and have not been afraid to make changes as a result.

5.4. Connecting Q members at the local and regional levels

The design of Q includes national and local dimensions. The initial co-design phase focused on the national programme of Q but in the implementation phase, the importance of local sites began to emerge. Here, we discuss the pilot of the Commons model, the introduction of the Q Convenors and Connectors, and the future design, governance and management of Q.

> *One of the things I really like was the development of the local Q. We have the Wessex Q and I don't know how much that was nationally driven. The Wessex Q has worked incredibly well, the national stuff is fantastic, but it is that thing around one drop in a large ocean. The local Q is a drop in a pond…. The local stuff, I followed up on 80 per cent of the connections I made, but the national ones I probably followed up on 20 per cent. Partly time and distance, but I'm also probably a bit of a dinosaur and I prefer face to face. I can do the IT and over the phone, but if I'm wanting to really understand something and get to the bottom of how something actually worked. You can do it over Skype, but it's not as accurate and it is harder* [Stakeholder INT5, November 2019]

5.4.1. The Commons model

From the inception of Q, there has been a challenge to find appropriate governance arrangements that can support many members to engage while also maintaining some capacity to steer such a large initiative. Over time, there has also been the need to design a governance arrangement that can be successfully implemented and adaptable to Q as membership numbers grow. Unsurprisingly, an initiative as distinctive as Q has required bespoke governance arrangements.

> *I think it's [the governance model] less important at the beginning…. As it gets bigger and more…in that cohort of 250 people most people could know most people. Once you get up to 5,000 or whatever, there are mechanisms and processes that mean it doesn't get diverted in the wrong direction. So, I think it kind of gains importance over time and with maturity.* [Regional convenor INT1, November 2017][65]

Anna van der Gaag was commissioned to research what sort of conceptual and practical underpinning might be used for designing a local and regional governance approach that

65 This quote was previously published in the interim evaluation report (Ling et al., 2018).

could help a growing number of Q members to articulate and act upon their shared interests within the wider governance of Q. The model she proposed towards the end of 2016, during the first wave of regional recruitment, was one of regional and national 'Commons'. In response, the Q project team explored and then piloted a Commons model in which members would take on a shared responsibility for nurturing the conditions under which ideas could be jointly explored and improvements tested and shared. The idea was that such a model could be adapted to local and regional characteristics, for example to enable Q members in one geographical area to work together to make decisions and to build on historically successful ways of working or existing local partnerships. The Commons model also encourages Q members to self-organise within their own region. This relies on members actively engaging with and contributing to the Q community in their local area. This Commons approach was piloted in three areas of England across 2018: in the South West, the West and North East North Cumbria.

The creation of the Commons model idea was linked to the creation of the Q Convenor role, in which three Convenors were established in the same areas of England as the pilot Commons model (the Q Convenor role is discussed in more detail in Section 5.4.2). The Commons model also saw the development of the Commons Stewardship Group for each pilot area, consisting of a small group of people who take more of a leadership role in coordinating the Q network in their region, of which the Q Convenor is the chair (van der Gaag, 2016). The Commons Stewardship Group is a concept that drew upon theories of the commons and how acting in the common interest might be nourished and the 'tragedy of the commons' avoided. The 'tragedy of the commons' is

where a lack of effective rules to support working together means that mutual benefits are not achieved.[66]

This evaluation primarily explores the pilot of the Commons model in the South West of England, rather than the other two sites, due to one of our deep dives focusing on the South West. Therefore, we recognise that there may be variation in the other two pilot sites in the way the Commons model was implemented and established itself. In the remainder of this section, we discuss participants views on and experiences with the Commons model in the South West of England. However, it should be noted that when asked directly about the Commons model, participants were often unfamiliar with it or did not fully understand what it aimed to do. As a result, the data in this section is drawn from a small number of participants.

In the South West pilot site, the Commons model, as discussed in Section 2.3, was considered by interviewees as interesting and a 'good idea', praising the ethos of the model and the encouraging Q members to share experiences and ideas (South West DD). It sought to enable a national focus, through Q team-led initiatives, guidance and leadership at the national level but also allowed for local variation and autonomy, which was considered by many to be important (Ling et al., 2018).

> *We can run it as we wish but then we would communicate as we go along all the time. So, we're feeding back and feeding in and you know that you know so it's a high autonomy but high communication back to the centre.* [Regional FGD2, December 2016][67]

However, its implementation was considered to be difficult and some felt there had been disappointing progress in this area, with the idea having faded from view in more recent years after being piloted in 2018 (South West DD, Q Lab INT1). One challenge in the South West had been establishing the time to set up the group. This was hampered by the fact that members of the Commons Stewardship Group were volunteers so trying to fit the role around their other jobs, leading to a lack of momentum in setting up the model (South West DD Q Lab INT1). Related this, and particularly specific to the South West, was the recent structural changes to the local AHSN, which, we were told, previously provided a lot of support to the Q community in the region. However, more recently, the AHSN had been less able to do so due to fewer resources and thus has not been able to support the development of the Commons as much (South West DD). The group also struggled to engage with Q members locally, particularly those members already less engaged with Q, and with the local STP, which could have supported the Commons Stewardship Group to reach out to local Q members (South West DD, Q Lab INT1).

> *Locally, Q has failed quite considerably as a Q community in the south west. You find lots of people connected to Q, attending things, you find another Q member and you chat about it, but that is the extent of it. It's not self-generating any work or self-generating even internally within organisations that I've been involved with. This has been a great shame. We were one of the test beds for the oversight of Q and we were doing the Commons Model. Whilst the thoughts around that and the*

66 https://q.health.org.uk/about/governing-the-community/

67 This quote was previously published in the interim evaluation report (Ling et al., 2018).

initial start-up of that was well received by enthusiastic members, but that group was so busy that they didn't have time to implement any of the ideas that were coming out of that. [Q Lab INT1, August 2019]

To overcome this challenge of a lack of time to establish the Commons mode, it was felt that there should be a 'kind of mother ship…that's kind of got an oversight' in the form of the Health Foundation with guidance and direction from a national level (Ling et al., 2018; Q team INT11).

That's one of the attractions of the commons model, to me, is that it does provide guidance down to quite a detailed level to those who require it and wish it but it's going to give flexibility and freedom to those who, perhaps, have a slightly different way of operating, perhaps for historical reasons or perhaps because of who they have in that region. [Governance INT1, January 2017][68]

5.4.2. Q Conveners

Creating a regional capacity to connect members is an important element in plans to grow the Q community. In 2017, the role of Q Convener was established in three areas (North East Cumbria, West of England, and South West). The Convener role is described as providing a 'local ambassador' to help shape Q locally and is a paid (but part-time) role. Q Conveners have, for example, supported regional masterclasses and other activities and, as in the South West, actively sought to link Q activities to the local STP.[69] They also chair the Q Commons Stewardship Group for each of their respective regions (described in further detail in the previous section).

The lessons from Q Conveners are mixed. Regions without Conveners found other ways of creating a sub-UK level of organisation, either by drawing upon an existing infrastructure (Scotland) or by the role being carried out but not as a Q Convener (Northern Ireland). Similarly, the role of AHSNs in providing regional level support also varied. In other regions (Wales, for example) there was a concern that there was a need for a strengthened pan-Wales capacity.

In areas with the Convener role, there was often a lack of clarity of the nature of the role and uncertainty about any benefits. A lack of time to peruse opportunities suggested by Q members and a lack of money to host or run events were reported as challenges experienced by those who had taken on the role. Ambiguity in the scope and potential of the role, even from those who held these roles, suggests further guidance or support may be needed to enable those in Convener roles to fulfil their potential.

The Convenor stuff didn't really go anywhere I don't think. I'm very practically focused, and the convenor role didn't really have a real purpose for me. We had some good conversations and I think we progressed further than other areas, but I'm not quite sure what it was set out to achieve, other than speaking about some issues. I can't remember what the aims were. There were some conversations about influencing how money was spent nationally. We had 6 meetings as a group and I don't think we got much further in

68 This quote was previously published in the interim evaluation report (Ling et al., 2018).

69 Sustainability and Transformation Partnerships are where NHS organisations and local councils work together to offer more efficient healthcare services and to jointly plan the healthcare of local residents. For more information, see: https://www.england.nhs.uk/integratedcare/stps/

deciding how we would go about making changes. It was just an experiment really. [Phase 1 INT17, November 2019]

5.4.3. Q Connectors

The Q Connector role is voluntary and involves providing information and contacts while promoting relationships and partnerships. The person would be a readily available point of contact for Q members wishing to connect or share. In any one region there might be two or even six connectors. Q provides Connectors with training and support to help develop their skills in network building, but it is an informal and flexible role.

From member interviews and the citizen ethnography exercise, it appears that the role of Q Connector and Q Convenor have had mixed success. In some regions, Q Connectors and Q Convenors have been active, and have helped Q members in their region connect based on similar interests (Q Exchange, Stakeholder INT5). However, in other areas, these roles have been much less active (Stakeholder INT3, CS11), with some Q Connectors and Q Convenors themselves admitting that they were unclear on the role and that they have not undertaken much activity in that role (Phase1 INT7, Stakeholder INT4, Q Exchange).

5.4.4. Future design, governance and management of Q

As the membership continues to grow, the design, governance and management of Q will need to continue to change. As seen in this chapter, these arrangements have evolved and developed over the lifetime of Q.

The roles of Connectors and Conveners are important, but to date have lacked wide enough adoption to develop regional and local capacity throughout the UK. Given the challenges reported in this chapter with these roles, we suggest further consideration is needed to explore how each of the roles works and the contribution they can make to the governance of Q. While the aim to maintain local variation and build on different regional pictures remains a convincing one, perhaps greater support and guidance are required from the central team to support these relatively new roles at least in their set up and initial implementation. There is a clear tension in getting the right balance between regional independence and freedom to adapt to the local context and ensuring support and central guidance can be given from Q management. What remains clear from participants is the wish that Q retains its central principles operating both at a national and local level. In the next and final chapter of the report, we explore the future of Q further and look at conclusions from the evaluation.

6 Conclusions and recommendations

In this final chapter, we synthesise the findings from the previous chapters to derive overall conclusions and, based on these conclusions, identify a set of targeted recommendations. These recommendations are specifically related to the five evaluation questions that underpin this evaluation. These are repeated in the box below.

We also take this opportunity to reflect more broadly on the insights and lessons from the initiative; important though the evaluation questions are, they do not exhaust the lessons that can be learned from Q. In doing so, we consider more generally than in our specific recommendations how to make sense of Q and what it might tell us about the future of improvement. First, we address the evaluation questions.

- How effective is the ongoing governance, design and management of Q?
- How well does the Q community and infrastructure meet the needs of members?
- To what degree is Q providing support, enabling connections and development of expertise, and mobilising members to lead and undertake improvement more efficiently and effectively?
- What impact has Q had on the wider health and care system across the UK?
- Is Q achieving or contributing to sustainable improvement in health and care across the UK and, if so, how?

6.1. How effective is the ongoing governance, design and management of Q?

The governance, design and management of Q represent a distinctive and well-founded approach to building capacity for improvement in the health and care system of the UK. Co-design was both a timely innovation and essential to Q's successes. The Health Foundation has played a critical role both in the design of Q and as a key stakeholder. NHS England has been less visible but has played an important role. AHSNs were particularly important in the early stages of Q but their future role is less certain. Efforts to organise and structure engagement 'from below' (such as the Commons) have had mixed results. Relationships with pre-existing organisations and structures have been generally well-handled without necessarily maximising potential synergies. The central Q team should be commended for their creativity and energy in helping manage Q.

It is important to understand the context in which Q was designed. Whether or not we agree with Braithwaite (Braithwaite, 2014) that Quality Improvement in the mid-2010s had 'stalled', the intention behind Q was to design an approach to improvement that both added something new to the landscape of improvement – a community of improvers – and provided a platform to connect existing approaches. Q was preceded by a wide range of improvement activities in and around the NHS including, in England, the Modernisation Agency, which was followed by the NHS Institute for Innovation and Improvement, which in March 2013 was in turn followed by NHS Improving Quality. Meanwhile in Scotland, NHS Quality Improvement Scotland was established in 2003, building on previous experience and developed into HIS in 2010. As described in the deep dives, similar efforts are found in Northern Ireland and Wales (although the improvement landscape differs in each case). In addition to these public sector-led activities, a range of non-public bodies and institutes have supported improvers and championed the 'science of improvement', notably the Institute for Healthcare Improvement and the International Society for Quality in Health Care (ISQua). Despite these efforts, there was little convincing evidence that the quality gap between what was technically feasible and what could be delivered at scale was reducing (Walshe, 2007). Q was not designed to supersede or to replace these various activities, nor was it created to collect evidence to 'prove' that quality improvement had measurable impacts. Rather it was designed to provide support for networks and relationships across organisationally separate groups and strengthen opportunities for learning and collaboration with the purpose of improving health care systems or outcomes for patients.

Expert commentators noted that 'before Q it was difficult to create networks around QI' (QI INT1) and identified a lack of capacity to deploy and spread improvements across large systems or even within single organisations (QI INT3). The work of improvement organisations, while important and valuable, often involved a 'special inner core of activists' rather than an embedded system of support (QI INT5). The achievements of Q should be measured against these perceived challenges: networks have been created around QI; a capacity to work across the system has been established; and improvement is more likely to be seen as a

shared responsibility and less the preserve of a 'special core of inner activists'.

Q did not emerge fully designed from its first year. Rather, Q moved through phases: first, a co-design phase involving the founding cohort in 2015; second, the tenfold growth in members and creation of an established way of working (2016–2018); and third, a period of further consolidation associated with the maturing of relationships, growing familiarity and experimentation with new ways to engage and shape activities (2018–2020). We noted in our interim report that the ability to adapt across these phases required a certain nimbleness of, and responsiveness to, management and leadership. This has continued.

Guiding the design of Q throughout this process was the Q theory of change. The Q team put considerable effort into developing this as a tool to guide decision making internally and to guide the management of Q more generally. The evaluation team was also involved in reviewing and developing the theory of change since it also provides a guide to the evaluation. As a means to guide the thinking of the Q team and communicating to key stakeholders (the leadership of the Health Foundation and NHS Improvement in particular), it was largely successful. However, as a communication tool to explain Q to its members, it was less visible and was rarely referred to spontaneously. When directly asked, members expressed only limited awareness and use of it. We conclude that Q's use of its theory of change was well-suited to supporting Q team's thinking but was less effective in communicating the design to members.

Governance at the centre was further strengthened by the Q Joint Governance Group, including stakeholders from across the UK and director-level input from the Health Foundation, with oversight of strategic, staffing and budgetary questions. However, the visibility and role of NHS England and Improvement is often unclear to members. In addition, the EAG provided a forum for exploring and challenging the work of the evaluation team. Less formally, the Health Foundation exerted a 'halo effect' such that their positive reputation and brand lent both credibility and legitimacy to Q.

The governance and design of Q in relation to regional bodies in England and bodies in Scotland, Wales and Northern Ireland continue to evolve. This will develop further as Q becomes established also in the Republic of Ireland. AHSNs in England played an especially important role in recruitment and continue to be important in England (with significant variation across the regions of England). There is currently a two-tiered approach to governance, and it is recognised both at the central level and the sub-UK level that regional autonomy is important in providing responsiveness and engagement but the UK-wide branding and resources (including networks) are valued. These relationships continue to be managed with goodwill and mutual support.

In 2018, as discussed, there was the promotion of a 'Commons' model of governance (which sought to articulate how the mutual interests of a community of improvers might be nourished and protected) that could also be sensitive to more local and regional characteristics and help Q 'land' at the local level. It also articulated the idea that Q was concerned with protecting the Commons and supporting the public good. This was an important concept. However, the concept of the Commons has been less in evidence since 2018 and it has been difficult to establish what consequences the approach had in practice. The roles of Connectors and Conveners, described earlier in this report, are important but have not yet matured with sufficient scale or capacity to develop a regional and local capacity throughout the UK. Nor has it yet

developed a significant digital capacity to promote a Commons online. There will be a continuing variability of approach across the UK but as the scale and complexity of Q grows, this dimension will need to develop or risk the central Q team becoming overwhelmed. A balance has been achieved between a single Q brand with a UK-wide platform and the expressed need for bottom-up approaches that respect the uniqueness of improvement places in each locality and this will need to continue to develop to match the future ambitions of Q.

6.1.1. Recommendations

Priorities to change:

Q Connectors and Conveners point to the importance of regional and local mechanisms to socialise and mobilise Q engagement. However, there is only patchy evidence of impact and continuing uncertainty around these roles currently and the role (or variations on it) should be developed further as part of building and connecting the community in the coming years. This should include a digital dimension.

- ASHNs in England have played an important role in Q and in some areas the link between Q and ASHNs has been strong. Yet the ASHN role is changing and different AHSNs give differing priority to Q. In some regions of England, members view AHSNs as crucial yet in others, there can be an active regional dimension with much less AHSN involvement. Creating an effective approach that respects regional differences but ensures support across the UK is critically important.
- For England and Northern Ireland, Scotland and Wales, refreshing and re-energising the relationships with founding members (and now with the Republic of Ireland) will need to go hand-in-hand with a growing membership and engaging with system priorities.

To consider:

- Commons model revisited – the pilot Commons model was an innovative and interesting approach that, as we have discussed and based on respondents' comments, did not achieve the desired traction. However, in the view of the evaluation team, it would be worth revisiting the idea of developing shared responsibilities for addressing common problems and emphasising an approach to governance based on supporting how improvers can act collectively to pursue mutual interests in health and care systems.
- The Q team should review its use of the theory of change and its role in communicating the design of Q to its members to continue its use as a management tool, but not its use as a communication tool for members.

To continue:

- The Health Foundation should reflect upon the success of the Q team's leadership and management and ensure their approach continues to be fit for purpose in the light of the challenges facing Q as it grows in scale and (most likely) complexity.

6.2. How well does the Q community and infrastructure meet the needs of members?

This evaluation has tended to engage the more active members of the Q community, but even allowing for this bias, most members report very positively about the activities and resources made available through Q. However, behind this positive view is a complicated story in which there are many 'member journeys' and these differ both from each other and often, for each member, over time. Members typically engage with only a small number of activities (but the 'packages' they select vary) and report positively on these. Members like the opportunity to engage differently. The Q infrastructure is also positively viewed with, for example, the recruitment process is seen to be fair (even by unsuccessful candidates) and (according to most respondents) involving proportionate effort. As membership increases the existing infrastructure will come under strain and among the most feasible solutions to this would be to continue to develop the digital infrastructure.

Q has supported its members to learn, overcome isolation, improve skills, gain confidence and collaborate. This has been achieved in large part through establishing an infrastructure connecting members and a set of activities to support meaningful engagement. Resources are needed to deliver events and other activities. Some of these require only limited resources (RTCs) while some require periodic efforts (e.g. Q visits) and others require substantial and continuous resources (e.g. Q Lab). In addition, sustaining a visible and positive profile and the brand also requires considerable effort. The infrastructure to support this is therefore crucial. The organisational capacity required to deliver this infrastructure is considerable. The evidence from members is that these activities are appreciated and (by and large) made use of. The range and variety of the offer are perceived to be helpful and to provide different routes into Q that suit the varying circumstances or needs of members. Based on the evidence to date, there is no part of this offer that clearly provides less value for money than other parts. However, as Q grows there will be opportunities to test where, if anywhere, the greatest and least value is created (possibly though a discrete choice experiment). The infrastructure has successfully supported the initiative to date.

Q also provided a long-term and stable infrastructure such that members might partially disengage for a time and then re-engage when pressures were less intense. The experience from Scotland suggests that this long-term stability of infrastructure for improvement helps not only to forge a sense of purpose but also allows a leadership cadre to emerge over time. In ten years, many of Q's more long-standing members are likely to be in positions of influence, possibly changing how Q 'lands' within the health and care system. In the meantime, members appreciate the opportunity to engage with Q at different levels, often reflecting the pressures they face in their day-to-day work. However, other members resent the idea of 'free-riders' who benefit from Q but contribute little and there is a case for establishing some minimum level of commitment expected from all Q members. However, resolving the 'free-rider' problem is only a small part of ensuring that Q meets the needs of its members and the bigger challenge is that Q members do not have a neatly segmented and stable set of needs. Q members respond differently to time

pressures, changing NHS priorities and new evidence. Perhaps even more important is that Q members have different learning styles and preferences. We spoke to members who like learning online, while others get their energy from events and some prefer one-to-one conversations.

Infrastructure is also required to support recruitment and onboarding processes. Members in 2016–2017 had differing views about whether or not the recruitment process was unreasonably onerous, but it was widely regarded as fair and well-managed (even by most unsuccessful candidates) and their subsequent 'onboarding' was seen to be helpful. Subsequently, processes were streamlined and are perceived to work well. Membership profiles have remained similar since the founding cohort.

Infrastructure is about more than the organisational capacity to deliver activities and recruitment. The co-design process left a legacy; it created a sense of ownership, belonging, and identity: Q 'has concentrated energy having some elements of a mass social movement' (QI INT1). As broadly supported in our data, this quickly led to 'a buoyant, self-conscious community of people that have each other's addresses and phone numbers [creating] a common bond around purpose' (QI INT3).

If members' needs were homogeneous, it would be easy to identify which activities add the most value and recommend that they are prioritised. For example, RCTs are less frequently used than other activities, but they are inexpensive to run and require only a limited infrastructure. For a small number of members, they have been highly beneficial and inexpensive. However, we have heard (infrequently) of members who have been frustrated with efforts to make contact and this reflects on the quality of their Q experience. Also, some members trying to engage with SIGs have had mixed experiences. Similarly, accessing learning materials can be less easy than some members would like. On the other hand, national events and Q exchange are very highly thought of by members (but expensive).

The question of value for money is relevant and important but difficult to answer. The planned budget for Q in 2020/21 is some £3.7m. This equates to a little over £1,000 per member and a total NHS and social care budget of some £140bn in 2019. Members' activities may incur additional costs as their time is charged either to their host organisations or (in some cases) even to their own holiday time. Members may also be able to draw down additional resources (for example, accessing journals) at no significant additional cost, adding to the value of the Q offer.

The intended benefits of Q are stated to be mainly 'upstream': delivering greater capacity for improvement that would have a ripple effect through the whole health and care system. Each 'ripple' will be dependent for its impact on other factors that are outside of the influence (and budget) of Q. We have seen throughout this evaluation that these effects on improved services are reported to be varied but significant. This challenge for a conventional cost–benefit analysis will continue but there will be future opportunities to make economic calculations. In particular, as senior managers and budget holders become more familiar with Q (a key aim for Q in coming years), it will be possible to assess their willingness to pay. Also, as Q becomes more directly connected to changing how services are delivered, future evaluators will be able to conduct cost–consequence analyses. It is also clear that the varied nature of members' needs and preferences currently makes a 'one-size-fits-all' approach for Q undesirable; in developing the suite of activities on offer, the Q team has been responsive to the needs of members. However, it is not clear which activities are most valued, nor how members would trade off among

these if resources were more constrained. Further work with members should be done to understand trade-offs and identify which activities, or perhaps which combinations of activities, would provide the greatest value and Q resources allocated accordingly. For example, members have always felt that national events add great value, but they are also very expensive; what other activities or support would members be prepared to sacrifice if resources were constrained?

A further challenge relating to infrastructure is that Q has grown more than tenfold from the founding cohort to a group of over 3,000 members and now plans to grow towards 10,000. It will need to grow the organisational capacities required to sustain these social relationships. This will most likely be decided not only by what the Q leadership does (and how well resourced it is) but also by the willingness of Q members to self-organise. Locality and region, always important to the success of Q, will become even more crucial.

6.2.1. Recommendations

Priorities to change:

- Q offers members a valued infrastructure for recruitment and engagement, but this will need to be reviewed, initially by the Q team but in close collaboration with regional partners and members, in the light of continuing increases in scale, the need for regional involvement in recruitment and discussions about how rigorous the recruitment process should be.
- We have discussed why a simple value for money study of Q is not feasible. However, as the scale and reach of Q grows, the evaluation lead of the Q team should commission an economic analysis to include: understanding the willingness to pay for Q among system leaders; assessing the costs and consequences of high impact activities; and conducting a discrete choice experiment to more precisely understand how members trade-off the benefits they perceive from different activities (i.e. going beyond understanding that they like every free good that is offered).

To consider:

- Q has thrived based on the time and effort put in by members and this effort has always been unevenly distributed. Q team and members should consider whether they want to give the more active contributors to Q some form of recognition or establish a minimum level of effort required by Q members.
- Learning materials are well regarded but some members report they are difficult to navigate and should be improved.

To continue:

- The Q team should continue to recognise and refine its understanding of how distinct groups of members have differing needs, priorities and learning styles, and continue to develop this in its communications.
- Q Exchange and site visits are highly regarded and should be continued (with possible incremental improvements) by Q leadership.
- Members continue to show loyalty and trust to Q and the existing branding and communications that support this should be continued.

6.3. To what degree is Q providing support, enabling connections and development of expertise, and mobilising members to lead and undertake improvement more efficiently and effectively?

While it is hard to put a monetary value on participation, members engaging with this evaluation report high levels of satisfaction with, and appreciation of, their experiences as members. Time is reported to be the main barrier to further participation, but this may be a proxy for a lack of priority given to the work of Q by members or their managers. Members feel better connected, more visible and more confident in their work as improvers in the health and care system. Q is reported to be a warm and supportive community.

The intuition in the early 2010s that there existed a potential cohort of improvement activists who would commit time and energy to co-design Q, and that others would join them with active engagement over subsequent years, was brave but well founded. Members signed up and brought with them the necessary skills and commitment for a well-functioning community to develop. Improvers are perhaps more comfortable than most with emergence and uncertainty, and, in particular, the founding cohort demonstrated a tolerance for improvisation and relationship building. These relationships, as Q has grown, and the infrastructure developed, have cohered into a platform for improvement. The result has been the creation of something new and distinctive in the improvement landscape in the UK: an 'upstream' platform that is stable, relationship building, linked horizontally and vertically, with a strong member identity and brand, and rooted in the health and care services.

The appetite for engaging with improvement was apparent and social network analyses showed early in the life of Q that the aim of creating fresh connections and relationships was working. The SNA conducted in the first stage of Q described a dramatic shift towards new relationships and networks. These were both 'bonding' (connecting people already close) and 'bridging' (linking people previously distanced from one another). We tracked many of these early changes through our SNA. For methodological and practical reasons, it was not possible to replicate the SNA in later years, but our interview data and focus groups show that continuing growth of bridging and bonding was highly appreciated by members. New relationships did not necessarily distract from efforts to improve health and social care elsewhere in the landscape of improvement activities in the UK. Indeed, in the various parts of the UK, 'non-Q' initiatives often interacted helpfully with Q. However, there were other situations where the synergies were not apparent. The design of Q meant that not only were vertical relationships established, connecting different levels in health and care, but also that there was a perception that horizontal relationships linking different disciplines were also developing: 'The special sauce of Q is that it is more interdisciplinary than other organisations.' (QI INT3) Q created opportunities to bring together people from disciplines including Organisational Development, QI and process improvement, complexity theory and engineering design. Q was designed to allow disciplines to collaborate more fruitfully than in the past.

New members often anticipate that Q will be beneficial to them and see forming networks and connections as one of the greatest anticipated benefits; Q reduces the isolation those in healthcare improvement roles often experience.

Over time, despite pressures on their time, many members engage actively in well-received activities where they report that networking is one of the main benefits. Some even commit their own annual leave time to attend.

Communications is an important contributor to the sense of purpose and perception of value that Q has for its members. Formal communications, for example through email, are focused and care is taken not to swamp members. Informal feedback from the Q team is highly valued and feedback from events shows that face-to-face engagement works well. Within the regions and localities, communication is variable. All this is symbolised in the pride with which many members wear their Q lapel badges.

As discussed previously, time and cost (and not lack of relevance or quality) are referred to as the most common barriers to participation in Q. However, there are also concerns that relevance and practical outcomes are not always sufficiently visible to justify the time members put into Q. Members are mobilised, informed and feel more confident to 'do' improvement. In the following section, we consider whether this is contributing to sustainable improvement in the UK health and care system.

6.3.1. Recommendations

Priorities to change:

- Q members feel connected, enabled and empowered by Q, and continuing this is fundamentally important for future success. However, Q members should also challenge each other to ensure that what may be relevant and important to them is also important to other stakeholders in the health and care system.

To continue:

- The variety and style of Q activities, and the communication of these, continue to be well regarded by participants and should continue to provide a platform for mobilising and supporting a significant cohort of improvers.

6.4. Looking forward: what impact could Q have on the wider health and care system across the UK? Will Q contribute to sustainable improvement in health and care across the UK?

In the years since Q was launched, Quality Improvement has continued to become more prominent in teaching, organisations, professional bodies, and among policymakers (General Medical Council, 2017; Jones et al., 2019; Jones & Woodhead, 2015; Nair et al., 2016; NHS Improvement, 2016b; Zarkali et al., 2016). It now has its own dedicated research institute, the Healthcare Improvement Studies Institute (THIS Institute) (The Health Foundation, n.d.-c), alongside more long-standing health improvement bodies. Despite this evidence of wider activity, there remains a case for the continued growth of Q. This case is both negative and positive. The negative case is that important measures of quality in the wider health and care systems across developed countries have been frozen for twenty years; more of the same might not shift this. The positive case is that Q has a particular ability to change the work that improvers do. Improvement happens because people change what they do in a purposeful and informed way, and Q has demonstrated a capacity to achieve such change. We should not expect Q to have achieved substantial change in just five years. However, we should expect that in the coming five years, when healthcare leaders are looking to improve the system, they draw upon Q members' skills and mobilise the assets that Q has created. At the same time, we should expect Q members to take a lead in identifying what sustainable and effective improvement looks like. We should expect that Q both supports and shapes system priorities, and Q demonstrably contributes to the most promising efforts to improve quality within the health and care system and supports further studies into improvement. This should come to define the long-term impact of Q; quality improvement is more impactful, sustained and better understood.

The context of Q is as discussed in Chapter 1, quality improvement activities do not regularly improve quality. A systematic review of PDSA cycles shows that improvement activities are often implemented poorly (Valgreen Knudsen et al., 2017). Famously, it has been argued that quality improvement does not always improve quality (Dixon-Woods & Martin, 2016). Efforts to use incentives to achieve improvements in healthcare have also had mixed results (Himmelstein et al., 2014). Neither improvement techniques nor incentives are sufficient to deliver consistent improvement (although both have their place). In our view, techniques and incentives succeed only if they can change the way improvement work is done; if people have the confidence, space, skills and resources to put into practice the improvement tools. We are clear that Q introduces members to new ideas and approaches, establishes new relationships and builds confidence; the cultural capital needed to command attention, collaborate and identify solutions is not automatically generated by the routine working of the health and care systems and might even be undermined by it. In our view, it provides a missing element in improvement that techniques and incentives will not on their own provide. Q can provide the cultural capital improvers need to do their work. Further research is needed to fully understand this and to be able to answer the questions: 'what do improvers do when they act as improvers?' and 'under what circumstances is this successful?'. 'Improvement' in general, and 'Quality Improvement' in particular, involves a kind of activity that includes the use of techniques, measurements, concepts and outlooks on the

world. Simultaneously gaining confidence in these while navigating organisational change (for example, bringing the language of Lean management or PDSA into a clinical setting) is almost inevitably challenging.

If Q has been successful at providing Q members with the technical, symbolic and organisational resources (i.e. the cultural capital) for improvers to act, what they do with these resources is another question. It remains unclear how far Q is set up to deliver system-wide improvement at scale in the health and care system. As Q grows, it is intended by the Q team that it should also align more closely with system priorities. The excitement of developing ideas at the cutting edge of improvement, and of testing approaches at the margins, will need to be balanced with strengthening the core routine business of delivering health and care priorities. This may disappoint the more pioneering spirits within Q but at the same time enthuse others.

Aligning with system priorities should not mean simply becoming an extension of the management reach of system leaders. Rather, at both local organisational levels and at national policy levels it involves Q actively negotiating ways in which Q members could both apply and improve their skills developed through their membership of Q and connect these to delivering organisational and system priorities. Q members would need the skill and authority to help build the room for such negotiation and Q should become more fully focused on driving change into the wider health and care system.

6.4.1. Recommendations

Priorities to change:

- Q members should seek greater visibility at senior levels of Trusts, other health and care organisations and the NHS. NHS England and Improvement, the Health Foundation and the Q team should actively support and facilitate this.

To consider:

- Q team should consider, with members, whether recruitment criteria might be adapted to include members with special skills in influencing decision makers.

To continue:

- Q should continue to be a resource that independently sets its own improvement agenda.

6.5. Wider reflections: making sense of Q in the wider context of improvement

The full significance of Q is not exhausted by addressing the evaluation questions. The story of Q has implications for a wide-ranging set of questions relating to how to achieve sustainable improvement at scale in health and care systems. It has implications for how to release new energy for improvement and how to forge a lasting social movement or network for change. In a meeting of the EAG, Q was described by one member as an 'audacious' initiative. Has this audacity been rewarded?

6.5.1. Unlocking increased energy for improvement; unfreezing habits and inspiring new behaviour

We have completed our evaluation of Q from 2016 to 2020 and, as far as the data allowed, addressed the evaluation questions. In addition to addressing the direct research question posed in 2016, we reflect here how Q can continue to deliver the positive impacts on its members and beyond, and the challenges it may face in doing so. While Q's purpose, aims and approach remain broadly the same as outlined in the theory of change, putting these into practice while the scale and ambition of Q grow will need to be carefully considered. This

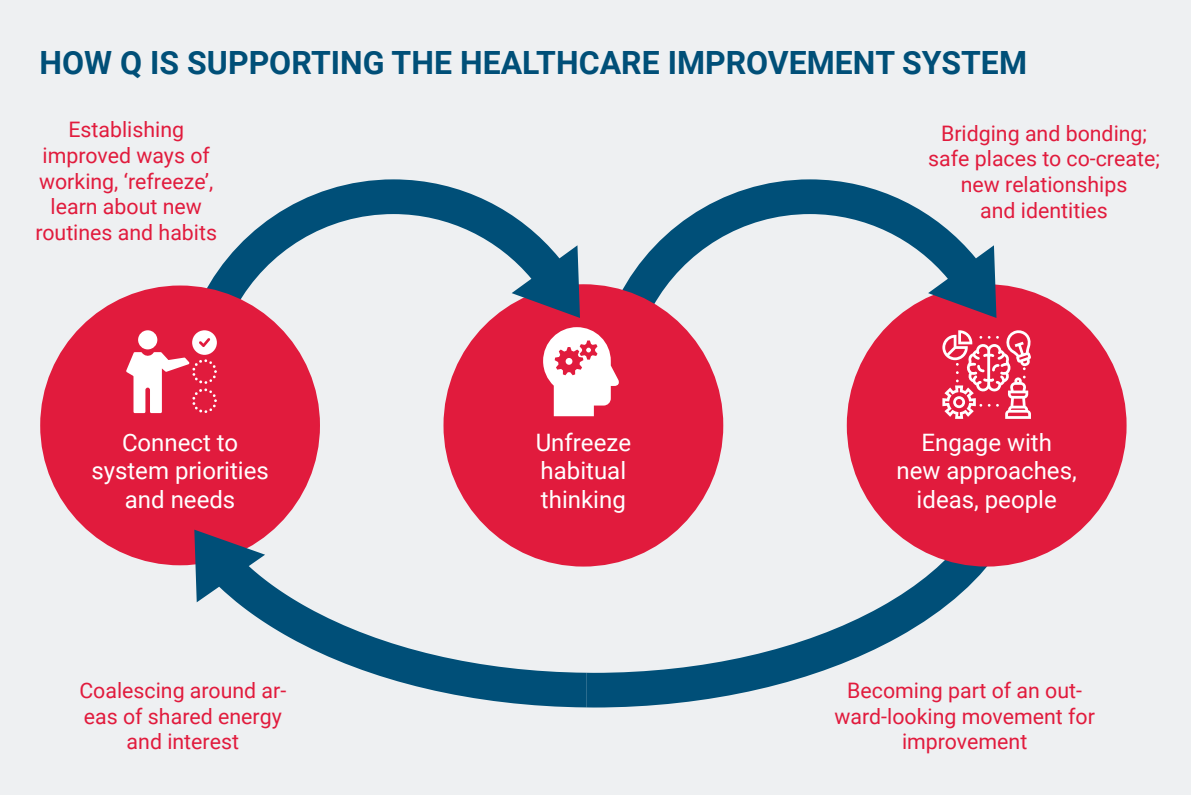
provides an opportunity to revisit and update the theory of change in light of the continuing evolution of Q.

When people in the health and care system 'do' improvement, they are doing a very particular kind of work. They are taking time out of their routine tasks and focusing on how to do these better. Specifically, they are drawing upon a distinct set of techniques, concepts, ways of working and bodies of evidence to think in new ways about the problems they face in their organisational setting and how these might be addressed. It involves drawing upon ideas which have their origins outside of healthcare and then socialising these ideas so they can make sense in a health and social care setting. This requires an elaborate set of skills and knowledge, and an ability to navigate the peculiar power relationships and organisational structures that form health and social care systems. However, in addition to the formal knowledge of techniques of improvement and measurement that are fundamental to the process of improvement, they also involve tacit, informal and often unconscious processes. These are part of what Bourdieu describes as the 'habitus' of the social world (Bourdieu, 1977). Although not originally focused on health and care settings, this describes the ingrained dispositions of people working there. It is evident in how improvers perceive the world and their role within it. It reflects their position in society more generally but also their place in a health and care system. It is the way that individuals perceive the social world around them and react to it. It might be thought of as 'the way we do things around here' but it is also 'the way we change things around here'. It precedes and shapes how improvers engage with improvement tools. As a result, it should be unsurprising that, left to their own devices, heroic individuals working on their own, perhaps armed only with new ideas learned from a recent fellowship overseas, should fail to achieve lasting change. What we have learned is that it is at least possible to create a set of relationships and resources that will help improvers become more confident in their skills and their understanding of improvement and to be inspired to act differently. This is a process that involves unfreezing habitual thinking, engaging with new ideas and eventually creating new routines around an improved system. We describe this in Figure 19 below.

Q contains within itself a radical approach to addressing the two legs of improvement; on the one side, the formal technical tools and measurements and on the other side the informal, tacit, and unconscious dispositions. By connecting individuals and groups in new ways – both bridging and bonding – to introduce new ideas and as part of an outward-looking 'movement for improvement' (Waring & Crompton, 2017), Q links these two dimensions in potentially practical ways. Ideally, as a 'movement for improvement', Q helps participants work together in new ways that allow sustainable improvement at scale across the whole system. In our view, this will only be realised when the movement aligns its goals with the priorities of the wider system.[70] This would be an approach to 'doing' improvement that is focused on changing the work that improvers do by mobilising connections and stimulating learning. Through Q Labs and Q Exchange, for example, Q members show not only engagement with new groups and individuals but also report new behaviours. Habitual dispositions can be (and are) unfrozen and new possibilities entertained by improvers with the self-confidence to believe that they can deliver practical change. Individuals working

70 Note that this is what distinguishes a 'movement for improvement' from a social movement where, in the latter case, the purpose of the movement is to challenge and change those system priorities.

Figure 19: How Q unfreezes habitual thinking and creates increased energy for improvement



as peers with other improvers can support a sense of agency in others and groups can forge a new sense of purpose around particular improvement projects. This is not trivial, and it has wider implications for understanding how change happens in complex organisations.

Agency is therefore central to understanding what Q has achieved. Agency reflects both the capacities and resources individuals have and their perceptions of their capacities and resources. Agency can be enhanced both by developing new skills and resources and by increased self-confidence in using them. Being part of a movement or group such as Q can both increase confidence (and this is consistently seen in member surveys) and make new tools and techniques available (through access to web-based material, site visits, workshops at national events and so forth). Accomplishing greater agency is challenging and requires psychological and emotional support. An indication of this interest in agency is the popularity among Q members of workshops and materials based on Liberating Structures. These have been run at many national and regional events and are consistently referred to positively in feedback. The Liberating Structures approach aims to provide individuals with an understanding of how structures can be too inhibiting or too loose.

6.5.2. Is Q an underutilised asset?

If Q has the potential to unlock previously untapped energy for improvement, why has it not been even more successful in achieving change at the front line of health and care in the UK? It was suggested by one experienced

observer that 'national bodies don't utilise even 10 per cent of Q's potential' (QI INT5). Another interviewee described how rarely, if ever, Q was mentioned as a resource in multiple encounters they had with NHS leaders (QI INT3). Another QI expert interviewee noted that 'The first thing you would want to think about when setting up a new improvement project is to think and identify the local Q members as they can help develop and test ideas. Q basically offers free consultancy, but it is not well known among senior leadership, clinical or non-clinical, for England. England is particularly poor at profiling that kind of thing.' (QI INT2)

Q in its early years focused on building and strengthening relationships among Q members internally. During this time important and strategic relationships have developed with AHSNs in England (although these vary) and with strategic agencies in Scotland, Wales and Northern Ireland (as described in our deep dives and earlier in this report). However, in an increasingly interdependent world, the value of Q can be enhanced by strengthening relationships with many bodies, which at a minimum should include:

- STPs and ICSs (in England only).
- NHS England and Improvement, NHS Wales, Healthcare Improvement Scotland and, in Northern Ireland, the Public Health Agency Northern Ireland.[71]
- Medical and nursing Royal Colleges and healthcare professional bodies.
- Health Education England (and counterparts elsewhere in UK).
- THIS Institute at the University of Cambridge, and other organisations concerned with constructing, codifying and calibrating improvement knowledge.

This would reinforce the case for the leaderships of health and care bodies to view Q as a substantial resource available to them in their organisations. For Q members, this could mean no longer having to find time for improvement activities at the margins of routine work but to have time and resources made available in pursuit of organisational goals. Q members' aspiration to spend more time on Q-related activities could be met with opportunity. Agency, involving Q members having both capability and time, could be enhanced.

> *I would argue that Q needs to be seen as an available instrument for leaders in the NHS and social services to give energy to the strategic imperatives that will continue to surface in the nation.* [QI INT3, January 2020]

6.5.3. The future of Q; five key tensions to manage

For Q to build a long-term platform to support improvement in health and care in the UK, it requires Q to simultaneously do things that may be in tension. Q will need to:

- Both build networks and relationships on the one hand and engage with those in positions of professional and organisational power on the other; both a movement and a resource.
- Continue to identify novel approaches and innovative ways of working, but at the same time provide support for long-term learning based upon routinised working; both at the cutting edge and the core of the health and care system.
- Both strengthen links among people and groups who already know each other and

71 It can be noted that as of 1 April 2020 Q is receiving funding from the Public Health Agency Northern Ireland.

create opportunities for new groups to be formed; both bridging and bonding.

- Combine and mobilise both experiential knowledge of service users and improvers and the formal evidence from research; both tacit and technical.
- Be both top-down (responding to what system leaders want) and bottom-up (drawing upon the experience and insight of those delivering services); responding to signals from both above and below.

In reality, the tensions are challenging but can be more or less well-managed. In this section, we consider each in turn.

Q will need to both build networks and relationships on the one hand and engage with those in positions of professional and organisational power on the other; both a movement and a resource

The first five years of the Q journey saw more attention given to building relationships and networks than to engaging with the formal hierarchies of power in the health and care systems. This was, in the view of the evaluation team, both valuable and necessary to establish a new platform for improvement. During this time, Q members may only have spent two or three days a year on Q activities. Almost all this time was taken with developing relationships with other people on Q-related activities. We recommend that the balance should shift to enabling Q members to engage with decision makers in their organisations and the wider system. We further recommend that increased responsibility for engaging with decision makers should be supported by bodies such as AHSNs, ARCs and the Health Foundation itself to promote Q's potential benefits to 'old power'. In addition, we recommend that leaders of Trusts, STPs and ICSs (and their counterparts in Scotland, Northern Ireland and Wales) should actively reach out to Q members, especially those within their organisations. We recommend that the Health Foundation should establish a series of engagements with the leaders of the national health and care systems in England, Northern Ireland, Scotland and Wales to apprise them of the opportunities for collaborating with Q.

Q will need to continue to identify novel approaches and innovative ways of working, but at the same time provide support for long-term learning based upon routinised working; both at the cutting edge and the core of the health and care system

Q aims to both disrupt existing ways of working and drive new behaviours into the system. This has been called 'rocking the boat while staying in it' (Bevan, 2013) and relates also to creating 'rhythms of learning' in how improvement works. Q tells us that in improvement, disruption and stability work in a subtle and complex way with (and not necessarily against) each other.

Improvers work across organisational settings, making iterative changes and often trying out several approaches simultaneously. They are often restless and this drives their efforts to improve. They are often on the lookout for the next great idea. If, in addition, the organisational context they are working with is constantly changing, or if reforms are not completed before the 'next new thing' arises, then there is little chance to improve. Constant flux hollows out improvement. Therefore, Q should be both an advocate of change and support environments where improvements are given time to settle down and establish themselves.

We recommend that Q members experiment with how they might make use of the Q platform to create sufficient stability so that they can simultaneously disrupt old ways and yet consolidate new ways of working for

long enough to learn. We recommend that academic research should explore how Q might best support both dynamic approaches to improvement and sustainable approaches to learning. We recommend that leaders in health organisations consider how to better balance letting '100 improvement flowers' flourish while ensuring that learning is consolidated and spread.

Q will need to both strengthen links among people and groups who already know each other and create opportunities for new groups to be formed; both bridging and bonding

Q leadership has been remarkably successful at mobilising and organising Q members in support of the broad objectives of Q. This reflects successful efforts at not only the national leadership of Q but also the regional and local leaders. However, the leadership of Q (both central and distributed) will need to adapt to deliver change in an interdependent world, forging new relationships with local system leaders, engaging with flagship institutions, such as THIS Institute and other research communities active in the quality improvement space, as well as NHS England and Improvement. These all require different strategies of engagement. In the conceptual language of Putnam, this involves leadership for both bonding and bridging (Putnam, 2000).

> *There's something about leadership and leadership styles. Not just the heroic leader, but different forms of leadership and adapting to leadership styles. I think there's something about political skills, being aware of when to move and when not to move, how to exploit situations and get resources, distribute power. That's a mechanism to bring about change. Those things come about with experience and with time. It's not just about being pink and fluffy, but about confronting people and power.* [Stakeholder INT1, November 2019]

We recommend that Q actively promotes leadership training and works with organisations who already have well-developed leadership development programmes, with a view to strengthening leadership in improvement and connecting this to transformational and system change.

> *I think there should be a Q component for the preparation of young professionals and for junior doctors. They would love it, and it's a little-tapped resource in the NHS.* [QI INT3, January 2020]

Q will need to combine and mobilise both the experiential knowledge of service users and improvers and the formal evidence from research; both tacit and technical

In creating a more diverse and inclusive platform for improvement, Q in its early years emphasised the importance of experiential knowledge. This was especially the case in Q Lab but was also true more generally. It is worth acknowledging that knowledge that is available on the front line about how to support improvement often does not find its way into research evidence and formal knowledge. This prompted one of our expert interviewees to wonder whether Q has remained true to evidence and science. The evaluation team has found evidence (in Q Lab documentation, in Q Exchange applications, in the content of material made available online, etc.) that would go some way towards answering this question affirmatively but even so, the relationship with the academic literature on improvement should be clarified. This is a recommendation for the Health Foundation and Q leadership.

Q will need to be both top-down (responding to what system leaders want) and bottom-up (drawing upon the

experience and insight of those delivering services); responding to signals from both above and below

The dilemma has been well stated: 'The risk is that if you unbalance your focus you become fragmented, too loose, but if you hold too tightly to your focus you're ineffective because you don't solve the problems for people on the ground' (Q INT1). The risks of relying solely on either top-down or bottom-up are understood but it is less clear what a hybrid approach might look like.

It is worth stressing that Q members do not have a clearly different agenda to the current priorities of the NHS; the aims of more upstream, preventive, integrated and patient-centred health and care are not contentious. Furthermore, current policy documents are positive about the future role of quality improvement. The question concerns how Q should work with system leaders to agree to an improvement framework that could evolve. One interviewee noted, 'there's a potential vacuum there because things are happening so quickly and I'm not sure people are capturing the learning from the first wave of integrated care systems (ICSs)…. The way people have been allowed to invent the future without legislation on what they can and can't do is incredible. It makes more potential for Q to achieve impact.' [Stakeholder INT1, November 2019]

6.6. Summary recommendations

In this concluding section, we draw together the recommendations made throughout this final chapter.

These recommendations are designed to strengthen and complete the cycle of improvement described in Figure 19 above.

Table 9: Summary of recommendations

	Priorities to change	To consider	To continue
Governance, design and management of Q	Q Connectors role – little evidence of impact and uncertainty around the role Q Convenors role – little evidence of impact and some uncertainty around the role AHSNs – played an important role in Q in England. In some English regions, members view AHSNs as crucial; in others, there can be an active regional dimension with much less AHSN involvement. Creating an effective approach that respects regional differences but ensures support across the UK is critically important	NHS England and Improvement could play a more visible role in Q governance, bringing added legitimacy without being perceived as exerting excessive control Commons model – pilot Commons model does not seem to have worked, yet a governance model for regional Q is needed as it grows The Q team should review its use of the theory of change and its role in communicating the design of Q to its members to continue its use as a management tool but end its use as a communication tool for members	The Health Foundation should reflect upon the success of the Q team's leadership and ways of working and ensure their approach remains fit for purpose in light of the challenges facing Q as it grows in scale and (most likely) complexity

	Priorities to change	To consider	To continue
Q community and infrastructure	Q offers members a good infrastructure for recruitment and engagement, but this will need to be reviewed, initially by the Q team but in close collaboration with regional partners and members, in the light of continuing increases in scale, the need for regional involvement in recruitment and discussions about how rigorous the recruitment process should be Members appreciate a variety of routes to engagement. However, as the scale and reach of Q grows, the evaluation lead of the Q team should consider conducting a discrete choice experiment to more precisely understand how members trade-off the benefits they perceive from different activities (i.e. going beyond understanding that they like every free good that is offered)	Q has always thrived on the basis of the time and effort put in by members and this effort has always been unevenly distributed. Q team and members should consider whether they want to give the more active contributors to Q some form of recognition Learning materials are well regarded but some members report they are difficult to navigate and should be improved The Q communication strategy was not a focus of this evaluation but could be included in future evaluations of Q.	Q Exchange and site visits are highly regarded and should be continued (with possible incremental improvements) by Q leadership Members continue to show loyalty and trust to Q and the existing branding and communications that support this should be continued
Support for members to undertake improvement work	Q members feel connected, enabled and empowered by Q, and continuing this is fundamentally important for future success. However, Q members should also challenge each other to ensure that what may be relevant and important to them is also important to other stakeholders in the health and care system		Continue offering members flexible packages to support a broad suite of skills and knowledge including technical, leadership, persuasion, collaborating and learning Q activities continue to be well regarded by participants and should continue to provide a platform for mobilising and supporting a significant cohort of improvers

	Priorities to change	To consider	To continue
Contribution to improvement in health and care across the UK	Q members should seek greater visibility at senior levels of Trusts, other health and care organisations, and the NHS. NHS England and Improvement, the Health Foundation and the Q team should actively support and facilitate this	Q team should consider, with members, how recruitment criteria might be adapted to include members with special skills in influencing decision makers	Q should continue to be a resource that independently sets its own improvement agenda
Cross-cutting recommendations/ tensions to manage	Q should: • Both build networks and relationships on the one hand and engage with those in positions of professional and organisational power on the other; being both movements for mobilising members and a resource for the wider health and care system. • Continue to identify novel approaches and innovative ways of working, but at the same time provide support for long term learning based upon routinised working; both at the cutting edge and the core of the health and care system. • Both strengthen links among people and groups who already know each other and create opportunities for new groups to be formed; both bridging and bonding. • Combine and mobilise both the experiential knowledge of service users and improvers and the formal evidence from research; both tacit and technical. • Be both top-down (responding to what system leaders want) and bottom-up (drawing upon the experience and insight of those delivering services); responding to signals from both above and below.		

6.7. Strengthening the contribution of improvers to UK health and care; a judgement

Has the effort and money put into Q not only by its funders but also by its members been worth it? Does the evidence from this evaluation justify the substantial commitments made to the future of Q? It should be clear by now that no algorithm can provide an unassailable answer. However, a judgement is required and offered.

In our view and reinforced by our close relationship with the Q membership, treating improvement in health and care as an exercise in mastering techniques of measurement and change misses at least half the route to impact. There remains a persistently substantial gap between the quality of care that is clinically and technically possible, even within existing funding, and what is delivered. If Q can help reduce this gap even by small increments, it is a sound investment. We believe that this is happening in places and because of Q. Demonstrating that this can be done at scale, can meet the varied needs of Q members and their localities, and delivers value for money are all incomplete tasks.

We know that many efforts to improve quality at scale and across the health and care system have been at best patchy. Reasons for this are not well understood. Even the best projects

do not seem to be easily transferable to other localities or teams. For the quality gap to be closed at scale, health and care organisations and staff need to attend not only to the techniques of improvement but also to what improvers are doing when they try to improve: what motivates them, the skills they bring to bear, the relationships they draw on for support and resilience, the authority and legitimacy they exude, and the trust they generate. This creates the context for improvement – the ingrained skills and dispositions – that improvers draw upon in developing their practice. A movement such as Q can, in principle, attend to such matters in a way that formal training or fellowships, important though they can be, do not. Evidence of success lies in the self-confidence and self-efficacy of improvers who have engaged with Q. We believe that in addressing this context for improvement, Q has made an important and valuable contribution to the landscape of health and care improvement and is an important step towards delivering an improvement capacity at scale across the health and care system. Understanding how to simultaneously meet the varied needs of members and deliver at scale is an unfinished project.

Also, sustaining such a movement as Q has substantial costs and barriers. The various stakeholders have committed to further support this for the coming decade. However, sustaining the energy and commitment of a growing membership, separated from the early pioneers by many years, will require both an effective infrastructure, good governance and strong, distributed leadership. Q is a systemic approach to improvement that is nested within other systems and its future success will be contingent upon these. Its design equips it well for this difficult role in overcoming these challenges, but its infrastructure will need to continue to develop.

Despite its strengths, we see Q as an underutilised asset. Q provides a reserve of energy, skills and relational power that can be mobilised and worked with in addressing the major challenges facing the health and care system today. This is not a matter of subjecting Q members to hierarchical controls 'from above' (however defined), but it is a matter of working collaboratively towards common and shared goals. The IHI dimensions of quality continue to capture these shared goals well: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity. In making better use of Q, system leaders can simultaneously add further to the resources and prestige that Q brings, and Q members can continue to develop their improvement practices and strengthen further its reputation as a home for improvers.

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