Moving improvement forward in UK health and care

An evaluation of the Q Initiative 2016–2020
Identifying a need for a community of health and care improvers

Quality improvement involves identifying and assessing a problem, understanding its systematic causes, implementing an improvement and assessing the extent to which the improvement has succeeded. It is therefore, as is often said, a journey and not a destination.

The techniques for managing quality improvement only represent part of what ‘doing improvement’ involves; it also involves the so-called ‘human’ factors of personal skills, relationships, authority and resilience, all of which are needed to apply the improvement tools in health and care settings.

Learning improvement techniques has often meant becoming an ‘improvement fellow’ or visiting a centre of excellence, but in recent years there has been a growing sense in the UK and beyond that for improvement to work in health and care, these techniques need to be embedded within the wider healthcare system with greater shared understanding and support for improvement. Knowledgeable individuals are highly valuable but on their own they only have limited impact.

The idea of Q emerged to create an initiative built around a community of improvers. Community members would support one another in developing, sharing and applying improvement that could help effect change on the frontline. Q was not intended to replace all other improvement activities but was meant to support these and provide a ‘home’ for improvers across the UK’s health and social care system.

RAND Europe’s independent evaluation of Q not only assesses the impact the initiative has had on its members and on its wider contributions to healthcare improvement but, since 2016, it has also provided evidence and analysis in real time to support and inform the ongoing design and management of Q.

This evaluation is likely to be of interest to policymakers, improvement practitioners and researchers concerned with how to improve health and care in the UK, as well as those with a wider interest in understanding how to build a capacity to learn, improve and create effective communities or networks.

What is Q?

• As of April 2020, Q is led by the Health Foundation and supported by partners across the UK and Ireland. Its aim is to foster continuous and sustainable improvement in health and care through connecting its members across the UK, to encourage and promote learning, and share knowledge and experiences.

• It is an initiative connecting people who have improvement expertise across the UK. By creating a national community of improvers and supporting them with a set of networking and development activities, grant funding opportunities and an improvement lab, Q hopes to contribute to a sustainable environment of improvement across the health and care systems of the UK (and, from 2020, Ireland).

• Q was created in 2015, with 231 members who were involved in designing Q along with the Health Foundation. As of January 2020, it has more than 3,500 members from a range of backgrounds. Members include, but not exclusively, staff on the frontline of healthcare, improvement leads, service user representatives and policymakers.

• Q now has indicative commitments for funding until 2030 and the aim is to grow the membership of Q to some 10,000.
What Q does well

A respected and appreciated home for improvers

Q has established a positive profile among improvers in the UK health and care system. In our view, achieving such a substantial and positive profile in half a decade is notable and required brave decisions by its stakeholders alongside effective communication. Q members share a strong sense of identity and feel mutually supported. Q provides a wide range of opportunities and support, including giving members access to resources, activities and the means to connect with each other and share learning (for more details see pages 4 and 5).

More widely, Q has helped raise the profile of improvement in health and care and strengthened the understanding of what improvement might contribute. The demographics of Q members have widened over time, from the first 231 nominated members in 2015 to over 3,500 members in January 2020 who come from a range of different backgrounds and locations and with varying improvement experience.

A means to share, learn and gain confidence; building self-efficacy

We believe that building a community of improvers who have confidence in their own knowledge and in their ability to deliver improvement is critical to creating sustainable improvement at scale. Q has successfully supported this by connecting members to each other and bridging to a wider community, making it easier for lessons and good practice to spread. It has also helped to create a cadre of improvers who not only feel more confident about their skills and their ability to achieve change, but also feel that improvers have a voice and that improvement has a visible role in the health and care system. We describe this as building self-efficacy.

The connections made through Q have also been used to support ongoing improvement work and help create improvement projects. Q Exchange was highlighted by members as a successful collaborative approach to bidding for funding, which has led to the creation of connections to implement the Q Exchange projects.

Practical knowledge mobilisation on the ground

We are beginning to see the influence of Q in specific actions, for example in changing patient experiences, resulting in fairer or more efficient care, or improving outcomes. It will always be difficult to map such actions across the whole system since there is no reporting mechanism linking change to Q and, furthermore, in most cases Q is only one of several factors making change possible.

Q has supported members to develop in several ways. It has contributed to the sharing of knowledge by offering learning and development opportunities, such as Liberating Structures workshops (mentioned by many of the research participants) and other online resources. In addition, Q Exchange, Q visits and relationships made through Q were seen as ways of learning about experiences in other parts of the UK and to learn from other members’ work. Q members say that the collaborative nature of the Q Exchange funding programme and the financial support offered through this have led to a number of tangible impacts. For example, projects funded by Q Exchange have led to improvements in a sepsis identification programme in Cornwall, enabled patients living in remote areas of Scotland to access healthcare through video consultations, and allowed healthcare professionals to exchange time to support each other’s improvement projects.
How Q supports its members:

**Q events** are run on a national, regional or local level, often focusing on a particular topic and/or with a keynote speaker who is a recognised individual working in improvement.

**Q Exchange** is a funding programme that launched in 2018, with a second round of funding awarded in 2019 and a third round planned for 2020. It offers improvement projects, selected by a vote of members of the community, up to £30,000 in funding.

**The Q Lab** brings Q members and others together to make progress on specific complex challenges facing organisations across the sector by developing and testing improvement ideas in practice.

**Online special interest groups** connect members and share resources on a specific topic. Currently there are 47 active groups, covering topics from particular health delivery areas such as Urgent and Emergency Care, well-being, such as well-being at work and staff well-being, and tools and methods, such as Big Data.

**Q visits** to external organisations aim to provide Q members with insights into quality improvement and learning approaches that are being used in other organisations.

**Randomised Coffee Trials** offer members the opportunity to be randomly paired with another Q member to discuss (in person or remotely) ongoing projects or other areas of interest.
| Liberating Structures training is offered to members through workshops and a special interest group. This covers techniques for setting up meetings, events and conversations. This training is frequently mentioned by Q members as useful. |
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| Access to the **Quality Improvement Connect WebEx series**, which has global improvement leaders speak about their area of expertise within quality improvement. To date, this has involved more than 1,000 organisations and 88 universities from 62 countries. |
| **Webinars** on a range of quality improvement topics that Q members can attend and organise. |
| **A Creative Approach to Problem Solving toolkit** that provides Q members with 25 methods of creative and collaborative problem solving. |
| Access to journals and learning resources. Members have access to, and the ability to publish in the BMJ Quality & Safety journal and BMJ Open Quality journal. Resources to support Q members writing journal articles are also provided, such as the Institute for Healthcare Improvement Open School. |
| Access to the **member directory**, which is an online directory of all Q members that can be filtered by area of interest and location. Members are able to message other Q members through this website. |

**Connecting Q locally** funding programme supports Q members to build networks across the improvement landscape. Members can apply for £5,000–£20,000 to undertake a project to aid local network development, hold events or site visits to support development of new connections, or organise activities and resources for Q members around a particular topic.
How Q can improve

Q has established itself as an important resource, supporting a cadre of improvers with skills, new relationships and self-confidence. However, to deliver change at scale across the health and care system there is a need to build on these achievements in the following ways.

Engage organisational and system leaders more actively with Q and respond to system priorities

When decision makers in national, regional and local settings face hard choices about how to allocate resources or to deliver services in new ways, they do not instinctively look to Q members as a resource that might help them. Some organisation leaders were not aware of the Q members in their organisation (and the expertise and connections they might offer). Q is not, and was never designed to be, an implementation arm of the NHS leadership, but Q members are committed to supporting collaborative improvement and currently it is an underutilised asset. Stronger connections with system leaders would simultaneously help Q members to be given time and resources to use their improvement skills and give local leaders access to a network that can support delivery. This would then naturally lead to a closer alignment of health system priorities and Q activities and resources.

Examine the use of resources to add the most value possible

It would be helpful to reflect on how Q resources are used by members. While members appear to appreciate the range of resources currently available, it is less clear whether doing more of some things and less of another would result in greater value. For example, as the scale and reach of Q grows, Q should consider conducting a discrete choice experiment to more precisely understand how members trade off the benefits they perceive from different activities and resources (i.e. going beyond understanding that they like every free resource that is offered).
Maximise opportunities to collaborate with different agencies across the UK

There are a variety of organisations in England, Northern Ireland, Scotland, Wales and Ireland that provide important support to the work of Q. In England, for example, Academic Health Science Networks (AHSNs) have played an important role in Q so far, particularly in some regions where the link between Q and AHSNs has been very strong. Yet the AHSN role is changing and AHSNs give differing priority to Q. Creating an effective approach that respects regional differences but ensures support across the UK is critically important.

Q was never designed to be a ‘sole provider’ of improvement support and from its creation there was an expectation that it would build relationships with other organisations. This has been largely successful to date and relationships with organisations such as Healthcare Improvement Scotland and AHSNs in England have created synergies across organisations that provide added reach, networking opportunities and access to resources. However, the capacities and resources of these organisations may change, and Q leaders and members will need to ensure that Q is organised to both respond to such changes and maximise the mutual benefits from these relationships.

Review the Q infrastructure

Overall, the infrastructure of Q has been remarkably resilient, supporting a tenfold increase in membership and significant expansion of activities and resources. However, in the face of further considerable growth ambitions and scale, it is important to consider what is needed to preserve the quality of Q activities, its profile among health providers and policymakers, and its responsiveness to members.

Ensuring the Q Lab impacts are more visible

The Q Lab pools the best available evidence about an issue and draws on the 'hive mind' of Q to gain practical wisdom from patients and practitioners; two Q Lab projects have been run at the time of writing. The Q Lab process was often thought of as positive, with the ability to engage with a range of expertise. However, some participants were unsure about the impact it sets out to achieve and whether this has been realised. To address this, the Q Lab leadership will need to continue to experiment in how to involve diverse expertise (including expertise by experience) and build partnerships that can support delivery as well as understanding.
How this study was conducted

As an embedded but independent evaluator commissioned by the Health Foundation, RAND Europe has been a ‘critical friend’ of Q from 2016 to 2020. The first two years of this evaluation were primarily formative in approach, focusing on how Q was designed and established, and feeding the data back to the Q team to further inform Q’s design. The later stages of the evaluation took a more summative approach, focusing on the impact of Q on members, as well as health and care organisations and the health system more widely.

The study builds on an evaluation conducted by RAND Europe on the first co-design phase of Q, published in 2016. A report of the interim findings of the second phase evaluation was published in 2018. In the same year, RAND Europe also published a separate evaluation of the first Q Lab project. The present report was written in January 2020 and thus the data and findings relate 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.

The study has involved nearly 200 interviews and focus groups, 13 surveys, several case studies and deep dives of Q in different areas of the UK, citizen ethnography, review of key strategic and improvement literature, observations at Q events and Q team meetings, and a social network analysis of connections between Q members.