Evaluation of the Second Phase of the Q Initiative 2016–2020

Interim Report

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Q is an initiative connecting people in health and social care from across the UK who have an expertise in, and commitment to, improvement. It is led by the Health Foundation, with further funding and support provided by NHS Improvement. In 2016, RAND Europe was commissioned to conduct an independent evaluation of the second phase of the Q Initiative. This is planned to cover a four-year period and to be completed in 2020. This document is an interim report in year 2 of the evaluation. In turn, the evaluation builds upon a previous evaluation of the first stage of Q, the findings of which can be found in An Evaluation of the First Phase of Q (Garrod et al. 2016). This report was written in January 2018 and the data and findings relate to the context of Q at that time.

The ongoing evaluation is intended to help guide the learning of the Q project team and wider stakeholders as they continue their implementation of Q across the UK.

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# Preface

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We are grateful to the Q members who continue to provide invaluable and thoughtful input to our work. We continue to appreciate the open and frank relationship fostered by the Q project team in both their formal and informal interactions with the evaluation team. Q as an initiative seeks to nurture a spirit of openness, and this spirit has been apparent in our engagement with stakeholder organisations and individuals involved in supporting Q.
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACO</td>
<td>Accountable Care Organisation</td>
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<tr>
<td>AHSN</td>
<td>Academic Health Science Network</td>
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<td>AMR</td>
<td>Antimicrobial Resistance</td>
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<td>AQuA</td>
<td>Advancing Quality Alliance</td>
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<td>BMJ</td>
<td>British Medical Journal</td>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>CLAHRC</td>
<td>Collaboration for Leadership in Applied Health Research and Care</td>
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<td>DT</td>
<td>Director’s Team</td>
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<td>EAG</td>
<td>Evaluation Advisory Group</td>
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<td>EQ</td>
<td>Evaluation Question</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>GIRFT</td>
<td>Get It Right First Time</td>
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<td>HIW</td>
<td>Healthcare Inspectorate Wales</td>
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<tr>
<td>HSC</td>
<td>Health and Social Care</td>
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<td>IHI</td>
<td>Institute for Healthcare Improvement</td>
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<td>MCA</td>
<td>Micro-system Coaching Academy</td>
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<tr>
<td>NAO</td>
<td>National Audit Office</td>
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<td>NENC</td>
<td>North East North Cumbria</td>
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<td>NES</td>
<td>NHS Education for Scotland</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>The National Institute for Health and Care Excellence</td>
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<td>NIHR</td>
<td>National Institute for Health Research</td>
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<td>OD</td>
<td>Organisational Development</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>QI</td>
<td>Quality Improvement</td>
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<td>RCT</td>
<td>Randomised Coffee Trial</td>
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<td>RQIA</td>
<td>Regulation and Quality Improvement Authority</td>
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<td>SIG</td>
<td>Special Interest Group</td>
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<td>SNA</td>
<td>Social Network Analysis</td>
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<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
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<td>TDA</td>
<td>Trust Development Authority</td>
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<tr>
<td>ToC</td>
<td>Theory of Change</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<td>USA</td>
<td>United States of America</td>
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<td>Glossary of terms</td>
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<tr>
<td>Co-design</td>
<td>A design process where designers, users and other stakeholders work together to understand a problem and generate solutions.</td>
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<td>Evaluation Advisory Group</td>
<td>The EAG provides high-level advice and constructive challenge to the design and delivery of the evaluation, to help ensure it meets its overarching aims and objectives. The EAG will ensure a balance between academic rigour and actionable learning, and will advise the Health Foundation on their approach to sharing insights, which will be relevant within the wider academic and policy context.</td>
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<tr>
<td>Host or employing organisation</td>
<td>The organisation(s) where the members of the Q founding cohort work or volunteer, or to which they are otherwise connected. For some, but not all members, this will be a frontline NHS provider organisation.</td>
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<tr>
<td>Patient leader</td>
<td>People who combine commitment, understanding and experience of improvement with their perspective as a patient or carer, or as a leader within an organisation that represents patient and public perspectives.</td>
</tr>
<tr>
<td>Q project team member</td>
<td>Employees of the Health Foundation who work on Q or have decision-making responsibilities relating to Q, and other non-Health Foundation consultants involved in the ongoing development of Q who work with the Health Foundation.</td>
</tr>
<tr>
<td>Founding member</td>
<td>Individuals who were recruited in 2015 to assist in the co-design of the Q Initiative.</td>
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<tr>
<td>Phase 2 member</td>
<td>Individuals who were recruited to Q during the national pilot recruitment drive in September 2016.</td>
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<tr>
<td>Phase 3, Wave 1/2/3/4 member</td>
<td>Individuals who were recruited as part of the regional recruitment drive led by the three pilot AHSNs in March, May, July and August of 2017.</td>
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Executive summary

Background to the Q Initiative

Q is a diverse and growing community of people with professional or personal interests in supporting continuous and sustainable improvement in health and care in the UK. Since Q’s inception in 2014, the Health Foundation has provided leadership, funding and the necessary organisational infrastructure, and NHS Improvement (and previously NHS England) has given support, further legitimacy and funding.

Q is part of the Health Foundation’s response to profound and long-standing challenges and has deep roots in previous improvement work. Proximal causes for the development of Q included the response to the Mid Staffordshire NHS Foundation Trust care failings between 2005 and 2009 and the subsequent Berwick Review into patient safety in August 2013, which aimed to put learning at the heart of the NHS. In this context, the Health Foundation, alongside NHS England, set up the Q Initiative to connect and otherwise empower a UK-wide improvement community across healthcare.

The Q founding cohort comprised 231 members recruited in the summer of 2015. Founding members attended three two-day ‘design events’ in the second half of 2015, to help shape the design and development of Q.

RAND Europe carried out an independent, embedded evaluation of Q during its first phase from spring 2015 to January 2016 (Garrod et al. 2016). Subsequently, RAND Europe was commissioned to provide an independent evaluation of Q, starting in 2016 and reporting in early 2020. This is the interim report of that evaluation, documenting progress towards two overarching evaluation aims:

1. To provide evidence and analysis to support strategic decision-making and inform the ongoing design and management of Q.

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.

In support of these aims, the evaluation seeks to answer five key evaluation questions (associated sub-questions are detailed in Appendix 1):

A. How effective is the ongoing governance, design and management of Q? How has Q Lab\(^1\) progressed during the period of this evaluation?

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\(^1\) The Q Lab is an initiative that brings Q members together to work on a specific health and/or social care challenge for a year. More information can be found at (as of 3 May 2018): https://q.health.org.uk/q-improvement-lab/
B. How well does the Q community and infrastructure meet the needs of members?
C. 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?
D. What impact has Q had on the wider health and care system across the UK?
E. Is Q achieving or contributing to sustainable improvement in health and care across the UK and, if so, how?

A mixed-methods approach was used for this evaluation, including stakeholder interviews and focus groups, surveys of members and unsuccessful applicants, observations of Q events and project team meetings, citizen ethnography\(^2\) at Q events and a review of relevant documentation and literature. The first two years of the evaluation have been considered primarily formative, and emerging findings have been communicated to the Q project team on a regular basis.

In the second two years of the evaluation, a primarily summative approach\(^3\) will be taken in order to deliver a rounded assessment of the current and potential impact of Q in the final evaluation report, to be published in 2020.

Findings

**Governance, design and management of Q**

Over the two-year period covered by this report, Q has moved from being a concept that was still in development to a large community engaging with each other and with a range of activities. While the community is expected to grow further, and while the Q ‘offer’ is under regular review, the initial phase of co-design is over and new members are joining a tangible initiative rather than something that remains primarily an aspiration.

A key challenge facing the Q project team is how to have effective and coherent governance and leadership arrangements for a community of (at the time of writing) 2,149 members while also following an ethos of being member-led and bottom-up. It is important to note that this scaling up of operations has, despite challenges and risks, been well managed by the Q team. The Health Foundation and NHS Improvement have invested significant resources and have their own internal accountability requirements to ensure that their money is well spent and this has implications for how governance is discussed within Q. Similarly, members have contributed time and energy to shaping the initiative, and likewise expect to see their contribution being used. Beyond the Q membership, other organisations and collaborators also have legitimate expectations of Q. Q therefore should have both direct accountability to those funding it and more diffused (but real) accountability to its members and their employers/host organisations.

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\(^2\) Citizen ethnography in the context of Q involves Q members at Q events noting interesting observations they saw or heard.

\(^3\) A summative evaluation focuses on the outcome of a process and generally occurs at the end of a programme (in comparison to a formative evaluation, which occurs as the programme is ongoing).
In response, the Q project team have explored an approach to accountability modelled on the ‘commons’, 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. How these conceptually interesting and engaging ideas should be expressed through the organisation of Q is still in development. The philosophy behind this model reflects another aspect of Q that has been of importance to members: how they should relate to both the national and local dimensions of Q. While members see the national scale of Q as a key positive attribute, they most typically interact locally and regionally. It has therefore been important for the Q team in particular to consider both the national and local dimensions of Q and, if the ‘commons’ model is to be developed further, to reflect these dimensions when considering how best to allocate responsibility and authority within Q.

The current infrastructure of Q operates within a two-tiered system, with Northern Ireland, Scotland, Wales and the regions of England making up one layer of coordination, and the central Q team providing overarching support for communications and so forth. This organisational capacity has been appreciated by the local implementing partners. From the outset, support in communications, branding, event management, activity organising, and developing an online presence has been effective – and seen to be effective by members.

Q has now accomplished its regional roll-out with a membership nearly ten times that of three years ago, from 231 founding members in 2015 to 2,149 members as of May 2018. Q has continued to grow throughout this time, with developments such as the Q Connectors (a network of members who have taken on a voluntary role to support Q members in their regions to connect and engage with the wider community) and the Q Marketplace (now Q Exchange, a funding resource to allow members to pitch their projects to the wider community for funding). A new phase of recruitment, to be implemented on a rolling rather than staged basis, is expected to start in spring 2018. While the original co-design phase might be over for the most part, the project team needs to ensure that members remain engaged in ongoing design decisions.

There is also general support for a commons model of governance, but this is still developing as an organisational form. Meanwhile, Q Connectors and the Q Exchange are intended to help strengthen the sense of an initiative growing ‘from below’. Overall, with some areas for improvement, the Q infrastructure meets – and is felt by its members to meet – the needs of the Q community.

Management of Q exists at multiple levels, from the day-to-day running of Q processes to making strategic decisions about its future direction, and includes how the Q project team itself operates. We have observed the Q team at close quarters from near its beginnings as a small, fluid team to its current much larger and more structured form, with clearly defined work-streams and responsibilities. This has been accompanied by a shift from working with founding cohort members to explore opportunities to delivering those activities. Inevitably this requires more attention to project and risk management. The Q team is

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4 The commons model theory, developed by Elinor Ostrom, outlines how people can co-produce and make the most out of commonly held assets and resources. This is one model the Q team are considering for the future of Q. For more information see (as of 3 May 2018): https://q.health.org.uk/about/governing-the-community/
still evolving the best management approach as it navigates this transition. This includes how best to balance inclusive decision-making with speed of response and clarity of direction.

The scale and nature of change have both been considerable and throughout these changes the Q team has remained purposive and well coordinated. Members have felt engaged with Q, regional partners have collaborated, and accountability to the Health Foundation and NHS Improvement has been maintained.

Conclusion

From its inception, Q was expected to support improvers to learn, overcome isolation, improve skills and collaborate for effective improvement in health and care. These goals remain fundamental to its purpose. The infrastructure required has developed as Q has evolved and has generally been regarded as helpful and sufficient by both members and others.

Overseeing a tenfold growth in membership, rolling out a regional strategy, organising a set of new activities, and initiating an online community without experiencing significant problems in the governance, design and management of the initiative is a significant achievement for the Q project team. However, there are new – and equally challenging – governance, design and management issues, which are identified in our recommendations.

Recommendations

- This is a good moment for the Q team, supported by the evaluation team, to review the theory of change and the Q theory of learning with the intention to update both in the light of the past two years’ experience, what members are now saying and doing, and how the needs and priorities of the health and care system are evolving.

- This will trigger further thinking about how the local, regional and UK-wide dimensions of Q can be managed to best integrate top-down and bottom-up approaches. Alongside this is a further question about how best to balance meeting the short- and medium-term preferences of members, their employers/host organisations and funding bodies with meeting the long-term needs of the healthcare system. This should then involve the Q team with regional partners but should also draw upon both the membership and the regional and national commons.

- In the light of these considerations, the Health Foundation should reflect upon the success of the Q team leadership and ways of working to ensure that it is still fit for any new design and governance issues emerging from these recommendations.

Q recruitment and membership

Our evaluation also examines the recruitment, membership profiles and regional aspects of Q. With regards to recruitment, interviews and focus group discussions show a very clear agreement that this is generally viewed as well managed. New members often viewed the recruitment processes as long, complex and unnecessarily time consuming. However, others thought this was not always negative since individuals who persevere through the application process would be highly motivated and engaged. Neither of these conflicting views was obviously dominant. Unsuccessful applicants predominantly understood why their application was declined and would consider applying again in the future. Going forward, recruitment will be primarily a centrally managed process.
Membership profiles have generally remained the same since the founding cohort. Through interviews and focus groups, it was considered that perhaps Q could widen its audience and encourage more groups not currently well represented within Q to join, such as patient representatives. Although some of these underrepresented groups have increased in numbers, many others have not. On a related point, a minority view was that Q was elitist (in a negative sense). The majority of members work in full-time healthcare improvement roles and have frequent face-to-face contact with patients or service users.

**Conclusion**

The infrastructure to recruit and support an evolving community, to support new activities and allow connections and communications to flow will need to remain under periodic review. There are positive views about the fairness of recruitment, for example, and the organisation supporting participation at events and other activities works well. As Q evolves, the Q team and members will want to ensure that the infrastructure supports the variable needs and interests of members and delivers an appropriately diverse membership, as well as connecting members efficiently.

**Recommendations**

- Q offers members a good infrastructure for recruitment and engagement. However, the recognition that this will need to be reviewed has already been anticipated by the Q team and others. This review should be taken forward initially by the Q team, but very quickly also 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 onerous the recruitment process should be.

- Q responds to the varying preferences of Q members by offering them flexible packages for engagement. Members are reflective about wanting to engage more with Q while recognising that in the short run they may lack the time to do so. However, there are two challenges to be addressed by the Q team and members. Firstly, whether or not there should be a minimal acceptable level of engagement for a Q member (and a common core of activities that all Q members should engage with). Secondly, to what extent Q should resemble a club that provides a range of activities that members consume (or not) and, conversely, how far it should aim to be a community that is characterised by groups and individuals choosing to create things together. The needs that can be met by participating in activities may be different from the needs that can be met by co-creating a community. The design of the Q offer should take care to account for these (not necessarily incompatible) challenges.

**Experience of Q members**

The evaluation addresses members’ experiences of Q, including their engagement, use of activities and resources, and potential barriers to their participation. Engagement of members is variable but often high, with those members with currently low levels of engagement expecting to do more in the future.

In common with longer-standing members, new members often expect (as identified through surveys) that Q will be beneficial to them. Focus groups and post-event reviews show that these expectations are largely met. Members see forming networks and connections as one of the greatest benefits of Q as it
reduces the isolation those in healthcare improvement roles often experience. Activities and resources are frequently well received and participation in activities has generally been high (with maximum numbers allowable attending). Networking and forming connections is often the most commonly cited reason for enjoying and benefiting from these events and resources.

Time and cost are referred to as the most common barriers to participation in Q. This is illustrated by some members taking annual leave to attend events. There are also some concerns that utility and practical outcomes need to be more visible to both individuals and their host organisations to justify the time members put into Q.

**Conclusion**

Successive cohorts of Q members feel increasingly clear about the aims of Q. They anticipate that they will find Q helpful especially in developing networks but also in accessing expertise, and in this they are not disappointed. Time and cost are common barriers to greater participation in Q, with a small number of members volunteering the information that they need to take annual leave to attend events. There are also some concerns that utility and practical outcomes are not always sufficiently visible to justify the time members put into Q.

**Recommendations**

- Q activities and opportunities to network are highly valued by members and the processes by which these have been established and communicated should be continued.

- It is too early to fully understand which activities are most valued and how members would trade-off among these if resources were more constrained. Further work with members should be done to understand these trade-offs and identify which activities, or perhaps which combinations of activities, would provide the greatest value to members and host organisations. Understanding this will be important for the coming years. For example, members have always felt that national events add great value but they are also very expensive: what are the opportunity costs of these events with regard to other Q activities?

**Impact of Q on the health and social care landscape**

We may consider levels of results for Q. The first lies in equipping individual improvers with the support, networks, skills and confidence needed to be effective. The second is that Q helps establish organisational settings that are amenable to improvement through their culture, governance and incentives. The third is that Q should, as it matures, come to influence and respond to the national mandates, policy and regulations that establish the national setting for improvement. These levels are apparent in the theory of change but it is often hard to articulate how they relate to each other in practice, especially in relation to the national setting. A key question for the final evaluation will be to consider whether Q activities are appropriate and sufficiently well powered to both support and accommodate national-level changes.

The impact Q seeks to have on the health and social care landscape is to create a supportive and vibrant ‘home’ that supports learning and improvement activities. Therefore, as evidence of the impact of Q, we consider whether such opportunities have been established and used. However, we recognise that the final Q impact of interest is upon the quality of services and, indirectly, outcomes for patients. Through case
studies and examples provided by Q members from interviews and focus groups, the evaluation is building a picture of how Q is having an impact on the day-to-day work of members. In the case studies undertaken and insights from interviews and surveys to date, this primarily occurs through Q providing opportunities to network and make connections, and so creating a foundation upon which collaborations can be built. Members commented that they could not have formed these connections without Q. However, in our case studies this is often the extent to which the influence of Q is directly visible, becoming less central after these initial relationships are formed. Our survey also provides a basis for understanding that there are a rich range of opportunities supported by Q to impact on the health and social care landscape. Developing a deeper understanding of how, and how far, this is achieved will be an important and growing part of the final stage of our evaluation. Members often also report a positive impact on their personal development, such as increasing knowledge and improving leadership skills.

Barriers to implementation were also highlighted. For example, Q may not always bring together members with similar interests or roles, and small improvement teams often have difficulty in engaging frontline staff. Sustaining change is also often seen as a barrier to widespread impact.

Members themselves report that the wider impacts Q has on the health and care landscape are often unclear or invisible. Some note that this is because effects are hard to directly attribute to Q. Many stakeholders also commented that it may simply be too early in Q’s lifetime for it to have had widespread impact, and there was continuing optimism that there is the drive and potential for Q to be successful. This is compatible with the learning theory of Q, which anticipates a sequence moving from individual learning to shared learning with others and finally to learning and change at the organisation and system level.

**Conclusion**

Through case studies and examples provided by members in interviews and focus groups, it is clear that Q is having some impact on the day-to-day work of members. This primarily occurs through Q providing opportunities to network, creating a foundation upon which collaborations can be built. There is patchy but growing evidence that out of these collaborations, members are better able to address important improvement challenges. However, these activities take place ‘below the Q radar’. Furthermore, it is unclear how and how far Q should aim to support them. Opportunities to do so might be available through Q Connectors and the Q Exchange, and these might deliberately develop a pattern of building on Q-initiated collaborations.

Although Q is often viewed as being a distinct and unique entity in the healthcare landscape, the wider impacts it has on the health and care landscape are often less clear and there is as yet no single agreed Q viewpoint of what Q-driven change would look like in the healthcare system. The challenges to understanding this are well known (diffused impacts, multi-causal processes, uncertain timeframes) but Q has the opportunity to build more learning and action into this aspect of its work. In order to explore this
dimension of achieving impact, a relatively simple framework could be used to shape learning across the Q community.  

Whatever framework is used it is likely that it should include attention to the relationship between Q and the wider priorities of the health and care system. For example, the key reference point of health policy currently is the Next Steps on the Five Year Forward View; but whether and how Q should engage with this is unclear.  

Recommendations

- As part of the review of the theory of change and of the Q learning theory, consideration should be given to how Q can develop a meta-learning theory of how to maximise impact on the wider health and care system, including the role of Q-initiated networking that then evolves beyond the formal reach of Q.
- The Q team and Q members should engage more directly with the priorities of the health and care system and balance these with bottom-up (including patient-led) priorities.
- The Q team, in collaboration with the evaluation team and other interested parties, should agree an adaptation to the evaluation protocol that aims to capture more indirect and system-level impacts in order not only to contribute to learning but also to be oriented towards making summative conclusions in the final report.

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5 For example, we might follow the logic of Seelos and Mair (2016), by arguing that the meta-learning of the Q community should focus on:

- Are we framing our improvement problems correctly?
- Are we getting to solutions that work?
- Are we able to get others to adopt and collaborate in delivering improvement?
- Are we clear about unintended (and negative) consequences?
- Are improvements compatible with wider service priorities and expectations?
- Are improvements compatible with management priorities and capacities?

6 It is obviously not the case that Q should become the implementation arm of the Five Year Forward View. However, key challenges contained within the latter reflect many of the same deep-rooted challenges to improvement that Q seeks to address. One question is whether addressing these should be part of the aim of Q, or would this unnecessarily narrow down the Q vision (and perhaps make it seem a more partisan initiative)?
1. Context and aims

1.1. Introduction

This chapter will provide an overview of what the Q Initiative is, what it aims to do and how it plans to do this. In addition, the development of Q since its creation in 2014 will be outlined. The evaluation questions are set out, as well as a summary of the methods used throughout the evaluation and their possible limitations.

1.2. Why Q?

Box 1. What is Q?

<table>
<thead>
<tr>
<th>What is Q?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q is an initiative led by The Health Foundation and supported by NHS Improvement to connect people with improvement expertise from across the healthcare landscape. Its mission is to ‘foster continuous and sustainable improvement in health and care’ through connecting members to allow learning and sharing and using members’ knowledge to tackle the challenges faced by the healthcare system today.²</td>
</tr>
<tr>
<td>Q is co-owned and co-designed by the Q members themselves. Q members are individuals with improvement experience and have a range of backgrounds, from those working on the frontline of healthcare to patient representatives and policymakers. It is also designed to connect and support other improvement activities that are not formally part of Q. As of May 2018, Q has recruited 2,149 members through a selective application process.</td>
</tr>
<tr>
<td>For Q to accomplish its mission, it offers members (at varying stages of implementation):</td>
</tr>
<tr>
<td>• <strong>Randomised Coffee Trials:</strong> An initiative by which Q members can be randomly paired with another Q member to discuss (in person or remotely) ongoing projects or other areas of interest.</td>
</tr>
<tr>
<td>• <strong>Q Visits:</strong> These are visits to external organisations with the aim of providing Q members with insights into quality improvement and learning approaches that are being used in other organisations. Q visits have taken various forms to date, including immersive visits, study days, open days and workshops, and have included visits to sites such as GlaxoSmithKline, Prostate Cancer UK and the University of Cambridge.²</td>
</tr>
<tr>
<td>• <strong>Events:</strong> Q events can be on a national, regional and local level for all Q members or for those with specific interests. Previous events include a workshop on the foundation of quality improvement in health and care.</td>
</tr>
</tbody>
</table>

² The Q Initiative homepage is (as of 3 May 2018): http://www.health.org.uk/programmes/the-q-initiative
² See (as of 3 May 2018): https://q.health.org.uk/get-involved/past-events/?filter_event_type=visit
improvement, networking events for improvement fellows and Q members and masterclasses.

- **Talks**: Q members can attend and organise their own talks on quality improvement either face-to-face or online. The talks so far have included a range of topics, such as quality improvement for beginners, quality improvement in mental health and communities of practice.9

- **Special Interest Groups (SIGs)**: These are online groups with a dedicated message forum for members to connect and share resources. SIGs are also able to organise their own webinars. As of January 2018, there are 37 active SIGs, including groups focusing on particular health delivery areas (e.g. Urgent and Emergency Care; Radiotherapy), methods and tools (e.g. Process Visualization in the NHS; Evaluation) and particular cross-cutting activities (e.g. Medicine Management; Reducing Diagnostic Errors).

- **A Quality Improvement Connect WebEx series**: Set up in 2014, these WebEx series allow experts from across the world to speak about their area of expertise of Quality Improvement to Q members. So far, this has involved over 500 organisations and 40 universities from 50 countries.10

- **Journals and learning resources**: Members of Q have access to the BMJ Quality & Safety journal, BMJ Open Quality journal, the Institute for Healthcare Improvement and the Institute for Continuous Improvement in Public Services.11

- **The Q Exchange**: A £450,000 pilot funding programme that will launch in April 2018. Q members will be able to pitch project ideas up to a value of £30,000, to be voted on by Q members at a live event in late 2018.12

- **Creative approaches to problem-solving toolkit**: This toolkit provides Q members with methods of creative and collaborative problem solving.13

Established in 2016, Q Lab brings together Q members to use their knowledge and expertise to tackle one single challenge across a year. Although related to Q, it is a distinct entity. The aim of Q Lab is to ‘develop new insights and ideas on a topic’ and support member collaboration and skill development.14 The first topic Q Lab is addressing is ‘peer support available to all’, with the aim to identify what is needed to allow effective peer support to ensure long-term health and wellbeing. Starting in April 2017 and running for a year, this pilot will test whether the approach Q Lab takes can make progress in solving this highly complex healthcare challenge. The Q Lab has broken its activities down into three stages: 1) research and discovery (April–July 2017), 2) developing and testing ideas (August–December 2017) and 3) capturing learning and next steps (January–May 2018).15

Q reflects the expectation that by better connecting and otherwise enabling people with improvement expertise across the UK it will be possible to nurture and sustain improvement across the health and care system. A more immediate influence was the response to the Mid Staffordshire NHS Foundation Trust care failings between 2005 and 2009, published in the 2013 Francis Report, and the following Berwick

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9 See (as of 3 May 2018): https://q.health.org.uk/get-involved/talks/
10 Quality Improvement (capitalised) refers to a set of quality improvement approaches and methods which, by convention, are capitalised by practitioners. We use the capitalised version here to refer to this distinct set of structured QI methods, rather than initiatives to improve quality more generally.
12 See (as of 3 May 2018): https://q.health.org.uk/get-involved/journals-and-learning-resources/
13 See (as of 3 May 2018): https://q.health.org.uk/get-involved/q-exchange/
15 See (as of 3 May 2018): https://q.health.org.uk/q-improvement-lab/
16 See (as of 3 May 2018): https://q.health.org.uk/q-improvement-lab/lab-1-peer-support-available/
Review into patient safety in August 2013. This latter review highlighted the importance of creating a learning culture and recommended the creation of a nationwide NHS Improvement Fellowship scheme. This was accepted by the Government at the start of 2014. In response to this, the Health Foundation, alongside NHS England, set up the 5000 Safety Fellows initiative in Spring 2014. This scheme was further developed in autumn 2014 through use of a co-design structure, in which a cohort of Quality Improvement experts and other stakeholders participated in designing the initiative.

The development of Q also responds to the results of earlier programmes, including those supported by the Health Foundation, which could demonstrate only patchy evidence of effectiveness (Ling et al. 2010). The reasons for these uneven and often unsustainable results were varied and the Q Initiative is not expected to address all of these equally. They include inadequate or incomplete implementation, short-term projects that never bedded down, correctly identifying approaches that worked elsewhere but failing to take local context into account, and, finally, failure to engage and learn from those whose engagement and understanding are critical to success. We also know that innovations frequently fail to deliver anticipated benefits (Herzlinger 2006). In the light of these known challenges, how was Q developed to create a landscape where challenges and recognised weaknesses might be better managed and overcome?

### 1.3. The development of Q

In March 2015, the 5000 Safety Fellows initiative was rebranded as Q to reflect the shift in focus from safety to quality. In April 2015 nominations were opened amongst partner organisations to select the founding cohort of members, of which 231 were chosen. Design events were held in Birmingham, Glasgow and London in July, September and November 2015 respectively. After the theory of change was modified in response to these design events, the document *A Proposed Operating Model for Q: Shaped by the Founding Cohort and Other Experts and Stakeholders* (THF 2016a) was released in November 2015. RAND Europe published its evaluation of this co-design phase in February 2016 (Garrod et al. 2016). In summer 2016, *recruitment* was opened to a somewhat wider audience (comprising the employees of specific organisations and graduates of selected healthcare improvement courses) resulting in the addition of Phase II pilot members. The Q membership body moved to open recruitment for the Phase 3 cohorts – with the recruitment process implemented by Academic Health and Science Networks (AHSNs) – in March 2017 (Wave 1), May 2017 (Wave 2), July 2017 (Wave 3) and November 2017 (Wave 4).

Since Q’s inception in 2014, the Health Foundation has provided leadership, funding and organisational infrastructure, and NHS Improvement (and previously NHS England) has provided support and funding. Both have contributed profile and legitimacy. Q is implemented in Scotland in partnership with The Improvement Hub (ihub) and NHS Education for Scotland (NES); in Wales in partnership with 1000 Lives Improvement (the national improvement service for NHS Wales); and in Northern Ireland in partnership with the Health and Social Care Safety Forum (HSC Safety Forum), part of the HSC Public Health Agency.
The activities and resources offered to members have expanded since the launch of Q. This has included a series of welcome and annual events for members; the launch of Special Interest Groups (SIGs) for members to discuss areas of professional and thematic interest; the introduction of site visits to provide Q members with learning opportunities; access to resources such as the *BMJ Quality & Safety* journal; and a regular WebEx series, currently hosted by Health Improvement Scotland, involving international speakers on Quality Improvement topics.

The governance structure of Q has also developed since the co-design phase. This has included the involvement of AHSNs in the recruitment process for members. April 2017 also saw the recruitment of the first Q Connectors, a growing group of Q members who have taken on a voluntary role in supporting the connecting of ideas and individuals within and between regions. Connectors are offered training and support from the central Q team and other Connectors, and act as a point of contact for Q community members in their region who would like to further engage with the Q network. The paid role of Regional Convenor, where a member acts as a local ‘Ambassador’ for Q and helps tailor Q to regional priorities and interests, was also piloted in 2017.

**Q Lab** was developed further as a concept and then Q Lab itself was launched in the spring of 2017. During its set-up and the selection of the first topic, the Q Lab reflected the Q ethos by emphasising that the design and approach should be co-produced with engaged stakeholders. This way of working was to persist throughout the period being evaluated. The Q Lab has developed significantly since this time and now comprises a core team with independent offices. The Health Foundation commissioned RAND Europe and the University of Cambridge to conduct a formative evaluation, which began in May 2017. In this Interim Report on Q, we address the Q Lab in so far as it is relevant to the design, activities and consequences of Q, but the RAND/University of Cambridge evaluation team will report more specifically on Q Lab in a separate evaluation.

Table 1 provides an overview of key events in the development of Q and this evaluation.
Table 1. Timeline of Q development

<table>
<thead>
<tr>
<th>Event</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Francis Report is published</td>
<td>February 2013</td>
</tr>
<tr>
<td>The Berwick Review is published</td>
<td>August 2013</td>
</tr>
<tr>
<td>The UK Government accepts recommendations for an improvement fellowship</td>
<td>January 2014</td>
</tr>
<tr>
<td>The Health Foundation and NHS England sets up the 5000 Safety Fellows initiative</td>
<td>July 2014</td>
</tr>
<tr>
<td>The co-design of the 5000 Safety Fellows initiative begins</td>
<td>September 2014</td>
</tr>
<tr>
<td>The first theory of change is drafted</td>
<td>October 2014</td>
</tr>
<tr>
<td>The 5000 Safety Fellows initiative is rebranded as Q</td>
<td>March 2015</td>
</tr>
<tr>
<td>Nominations for the Founding Cohort of Q are opened</td>
<td>April 2015</td>
</tr>
<tr>
<td>RAND Europe begins its Phase 1 evaluation of Q</td>
<td>April 2015</td>
</tr>
<tr>
<td>Nominations for the founding cohort close (231 members recruited)</td>
<td>May 2015</td>
</tr>
<tr>
<td>Birmingham design event</td>
<td>July 2015</td>
</tr>
<tr>
<td>Glasgow design event (idea of Q Lab presented)</td>
<td>September 2015</td>
</tr>
<tr>
<td>London design event</td>
<td>November 2015</td>
</tr>
<tr>
<td>Co-design phase of Q ends</td>
<td>November 2015</td>
</tr>
<tr>
<td>A Proposed Operating Model for Q: Shaped by the Founding Cohort and Other Experts and Stakeholders is released</td>
<td>November 2016</td>
</tr>
<tr>
<td>Dedicated Q Lab team is created</td>
<td>February 2016</td>
</tr>
<tr>
<td>Full Phase 1 evaluation report published by RAND Europe</td>
<td>February 2016</td>
</tr>
<tr>
<td>Initiation of Q Lab design phase</td>
<td>July 2016</td>
</tr>
<tr>
<td>Q Lab development paper published</td>
<td>July 2016</td>
</tr>
<tr>
<td>Phase 2 recruitment opens (216 new members)</td>
<td>July 2016</td>
</tr>
<tr>
<td>RAND Europe begins second phase of the Q evaluation</td>
<td>July 2016</td>
</tr>
<tr>
<td>Phase 3 Wave 1 recruitment opens (352 new members recruited)</td>
<td>March 2017</td>
</tr>
<tr>
<td>Q Lab design phase ends</td>
<td>March 2017</td>
</tr>
<tr>
<td>RAND Europe begins separate evaluation of Q Lab</td>
<td>March 2017</td>
</tr>
<tr>
<td>First Special Interest Group (SIG) is set up</td>
<td>April 2017</td>
</tr>
<tr>
<td>Q Connectors scheme is launched</td>
<td>April 2017</td>
</tr>
<tr>
<td>First Q site visit</td>
<td>April 2017</td>
</tr>
<tr>
<td>Phase 3 Wave 2 recruitment opens (554 new members)</td>
<td>May 2017</td>
</tr>
<tr>
<td>Q members given free access to British Medical Journal articles</td>
<td>May 2017</td>
</tr>
<tr>
<td>First regional convenor recruited</td>
<td>June 2017</td>
</tr>
<tr>
<td>Phase 3 Wave 3 recruitment opens (431 new members recruited)</td>
<td>July 2017</td>
</tr>
<tr>
<td>Phase 3 Wave 4 recruitment opens (363 new members recruited)</td>
<td>August 2017</td>
</tr>
</tbody>
</table>
1.4. Context and aims of this evaluation

This report provides an important and timely opportunity to independently review the progress of Q. As previously noted, RAND Europe carried out an independent, embedded evaluation of the Q Initiative during its first phase (spring 2015 to January 2016). That evaluation looked at both the success of the design process and the potential for success for Q, while also providing continuous feedback to the Q project team (Garrod et al. 2016).

Subsequently, RAND Europe was commissioned to provide an independent evaluation of Q from 2016–2020. This would be primarily formative in nature for the first two years (2016–2018), meaning the evaluation team would feed real-time findings and recommendations to the Q project team in order to support learning and inform the development of Q, while taking care to maintain a necessary level of independence to preserve evaluation rigour. This document is the interim report covering this first phase of the evaluation.

This report documents progress towards achieving the two overarching evaluation aims:

1. To provide evidence and analysis to support strategic decision-making and inform the ongoing design and management of Q.
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.

In support of these aims, the evaluation seeks to answer five key evaluation questions, and related sub-questions. These five questions are:

A. How effective is the ongoing governance, design and management of Q? How has Q Lab progressed during the period of this evaluation?
B. How well does the Q community and infrastructure meet the needs of members?
C. 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?
D. What impact has Q had on the wider health and care system across the UK?
E. Is Q achieving or contributing to sustainable improvement in health and care across the UK and, if so, how?

The full list of evaluation sub-questions is presented in Appendix 1. At this stage in the evaluation we can make informed judgements about how far, and how successfully, Q has progressed in relation to questions A–C, but we can do this less fully for questions D–E. These latter, more summative questions will be explored in greater depth in the second and final report of this evaluation. However, in exploring the current status of Q we also ask how well prepared it is to deliver in relation to all five questions, and what, if any, changes might be needed.

Following the interim report, the intention of both the evaluation team and the Health Foundation is to further adapt and focus these evaluation questions and sub-questions in the light of the developing nature of Q and the separation or the evaluation of Q Lab. These adaptations will reflect the shared intention of the evaluation team and the Health Foundation that the second two years of the evaluation (2018–2020) should focus more on understanding the consequences and impacts of Q on both members and the wider
health and care system. In this sense, as it progresses from the interim report in 2018 to the publication of the final evaluation report in 2020, the evaluation will become less formative and more summative in nature.

1.5. Methods

The methods selected for the first two years of the evaluation (2016–2018) reflect the need to balance the aims of providing useful and real-time findings to the evaluation team to inform the ongoing development of Q, while also gathering sufficient data about the current and potential implementation and experience of Q to inform the second two years of the evaluation (2018–2020).

A variety of both quantitative and qualitative methods have been used during this evaluation to ensure the most robust and reliable results are gathered:

- Review of project documentation provided by the Health Foundation.
- Review of key literature relating to Quality Improvement approaches.
- Observations by the evaluation team at Q events and Q project and governance meetings.
- Semi-structured interviews (n=55) and focus group discussions (n=19) with a range of stakeholders, including Q members, unsuccessful applicants, external stakeholders and the Q project team.
- Case study interviews with Q members (n=4).
- Two rounds of citizen ethnography18 with Q members at welcome events.
- 11 surveys of incoming Q members and unsuccessful applicants.
- Social network analysis of connections reported by incoming Q members.

For a detailed overview of the methods used throughout the course of the evaluation and consequent limitations, please see Appendix 2. Box 2 below provides details on the number of interviews and focus groups conducted during the first two years of the evaluation and Table 2 provides information on the number of survey responders.

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18 Citizen ethnography has been used twice so far throughout the evaluation of Q. It involves Q members providing ‘light touch’ ethnographic observations by observing, making sense and taking notes at Q events.
Box 2. Number of interviews and focus groups

<table>
<thead>
<tr>
<th>Number of interviews and focus groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q members (interviews, n=27, focus groups, n=10)</td>
</tr>
<tr>
<td>Q project team members (interviews, n=10, focus groups, n=4)</td>
</tr>
<tr>
<td>External improvement stakeholders (interviews, n=2)</td>
</tr>
<tr>
<td>A member of the governance group (interviews, n=2)</td>
</tr>
<tr>
<td>Unsuccessful applicant (interview, n=1)</td>
</tr>
<tr>
<td>Non-members (focus group, n=2)</td>
</tr>
<tr>
<td>Q lab volunteer group (interview, n=3)</td>
</tr>
<tr>
<td>Steering group members (interview, n=2)</td>
</tr>
<tr>
<td>College of Assessors (interview, n=2)</td>
</tr>
<tr>
<td>Regional AHSNs (focus groups, n=3)</td>
</tr>
<tr>
<td>Q member case studies (interviews, n=4)</td>
</tr>
<tr>
<td>Regional convenors (interviews, n=2)</td>
</tr>
</tbody>
</table>

Table 2. Number of Q member survey respondents

<table>
<thead>
<tr>
<th>Survey</th>
<th>Number of respondents</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual survey March 2017</td>
<td>175</td>
<td>8.4%</td>
</tr>
<tr>
<td>Phase 1 – baseline</td>
<td>211</td>
<td>10.1%</td>
</tr>
<tr>
<td>Phase 1 – end of year</td>
<td>165</td>
<td>7.9%</td>
</tr>
<tr>
<td>Phase 2</td>
<td>130</td>
<td>6.2%</td>
</tr>
<tr>
<td>Phase 3 Wave 1 new members</td>
<td>307</td>
<td>14.7%</td>
</tr>
<tr>
<td>Phase 3 Wave 1 unsuccessful applicants</td>
<td>17</td>
<td>0.8%</td>
</tr>
<tr>
<td>Phase 3 Wave 2 new members</td>
<td>455</td>
<td>21.8%</td>
</tr>
<tr>
<td>Phase 3 Wave 2 unsuccessful applicants</td>
<td>27</td>
<td>1.3%</td>
</tr>
<tr>
<td>Phase 3 Wave 3 new members</td>
<td>327</td>
<td>15.7%</td>
</tr>
<tr>
<td>Phase 3 Wave 3 unsuccessful applicants</td>
<td>12</td>
<td>0.6%</td>
</tr>
<tr>
<td>Phase 3 Wave 4 new members</td>
<td>261</td>
<td>12.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,087</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The formative nature of this stage of the evaluation meant that data and findings were shared with the Q project team as periodic updates. Members of the evaluation team also regularly attended Q project monthly team meetings in order to observe the development and governance of Q, and to provide

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19 Focus group numbers refer to the number of focus groups undertaken, not the number of participants.
comments on emerging findings from the data collection activities. Due to the formative nature of the evaluation, these findings and consequent recommendations from the evaluation team tended to be fairly granular (for example, discussions of members’ experiences of the application form, and the experience of AHSNs implementing the recruitment process) rather than offering a holistic assessment or strategic recommendations, such as those presented in this report. A more extensive non-public report was also presented to the Q team in February 2017 to provide a synthesis of all findings from the first year of the evaluation.

The findings from all data collection processes were analysed individually and synthesised into one narrative with common themes identified (which will be discussed throughout the rest of this report). The selection of data is driven by the evaluation questions and then synthesis is achieved through two steps. Firstly, at the level of each methodology (the survey, for example) findings are brought together and overall conclusions established. Secondly, synthesis across methodologies is achieved through an iterative drafting process where team members critique and review emerging findings. The resulting draft is then reviewed extensively (including for completeness and balance) by the Health Foundation, independent Health Foundation reviewers, and independent RAND quality assurance reviewers. Approaches to data collection (such as the role and profile of interviewees and interview protocols) were adapted throughout the evaluation in light of emerging themes. The majority of interviews and focus groups were transcribed and analysed using NVivo 10; others were manually coded and analysed by members of the evaluation team.

An Evaluation Advisory Group (EAG), comprised of academics with expertise in healthcare research and evaluation (external to the evaluation team or the Health Foundation), is convened twice a year to provide additional input and act as a ‘critical friend’ to inform the development of the evaluation.

1.6. Limitations

As with any evaluation, it is important to be aware of the limitations of the data collection methods and analysis used. Below, we discuss five key limitations to the evaluation; more detailed discussion of limitations relating to each data collection method can be found in Appendix 2.

Firstly, our approach made extensive use of interviews and focus groups to understand the experiences, perceptions and choices of those most directly involved in planning, co-producing, implementing and being a member of Q. The strength of this approach is that it helps to probe in depth the feelings and experiences of members. But its limitation is that perceptions may have certain systematic biases (for example, a possible social desirability bias in focus groups where participants may feel unwilling to express negative views on what others see as a ‘good thing’), possibly leaning towards an optimistic assessment of progress. On reflection, our sense is that focus group participants were not significantly influenced by such biases. There may also be a level of response bias inherent in the profile of members who choose to participate in surveys, interviews and focus groups. We see no reason to expect non-response bias but lack the data to verify this. However, the risk of further non-response bias will be monitored closely during the second, summative stage of the evaluation and mitigating actions taken if necessary. We are beginning to see lower response rates to our surveys (and, on occasion, focus groups) so this risk may require greater management.
Secondly, given the distributed nature of Q, in which local communities and networks play a significant role in shaping the activities on offer for members, there may be regional variation in the member experience of Q that has not been picked up by the evaluation methods employed.

Thirdly, the staged nature of the evaluation to date (in which members have been interviewed on a rolling basis over the course of the two evaluation years to provide ongoing learning for the Q team) means that either members’ views on the implementation of Q may have changed, or views may relate to elements of the Q offer that have themselves changed by the time that they are reported. This has been considered in the analysis where appropriate, and the month and year of the interview/focus group reported throughout for clarity.

Fourthly, at this stage of the evaluation we still know little about the wider impact of Q. This reflects the technical difficulty of measuring diverse and diffused impacts, and also the still early stage in the development of Q, with key elements of the Q offer (including the Q Exchange and Q Regional Convenor role20) remaining in development or having been operational only for a short time. It also reflects a choice to focus evaluation resources at the early stage of Q’s development on understanding the emerging activities and how well these activities were performed. Now, however, resources will need to be refocused to understand the impact these tasks are having on the wider healthcare system. We therefore do not seek to present a clear assessment of the impact of Q in this interim report (see Chapter 6 for further discussion of this topic). Furthermore, understanding the long-term sustainability of Q is limited by the absence of a clearly defined and operational generic measure of sustainability.

Finally, the formative and embedded nature of this stage of the evaluation may risk bias on behalf of the evaluation team. In this regard, the evaluation team has taken active care to balance the need for strong and healthy working relationships with the Q team and two-way data sharing with the need to retain a necessary level of independence to preserve evaluation rigour. The input of the external Evaluation Advisory Group and two additional quality assurance reviewers from RAND Europe has acted as an additional check in this regard.

Table 3 summarises our assessment of the caveats to our approach.

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20 Q Convenors are ‘local ambassadors’ appointed to support, shape and develop Q at a local level. The North East North Cumbria, West of England and South West AHSN’s are currently piloting the convenor role. For more information, see (as of 3 May 2018): https://q.health.org.uk/about/governing-the-community/
1.7. Structure of this report

This report is structured as follows. Chapter 2 draws on data from the evaluation and puts Q in the context of the wider health and social care landscape, and outlines the logic and theory of change underlying the development of the Q Initiative. Chapters 3, 4 and 5 discuss the main research findings, analysed and presented thematically based on their relevance to the development of Q. Chapter 6 presents the early evidence relating to evaluation questions D and E and explores the potential for impact on members’ work and the wider health and social care system. Finally, Chapter 7 draws out conclusions and maps the findings from the research against the evaluation questions. A full description of methods used and the survey results can be found in Appendices 2 and 3 respectively.
2. Q in context

2.1. Introduction

This chapter seeks to place Q in the wider context of efforts to improve health and care in the UK. This is important for direct reasons related to the intended outcomes of Q:

- To complement and not duplicate all or parts of other initiatives or programmes; Q aims to strengthen related activities through signposting, resourcing, sharing knowledge and building a supportive environment.
- To enable Q members to continue to engage with their own established and valued connections and networks relating to geographical, professional or subject-area activities.\(^{21}\)

However, it is also important for more indirect reasons. In particular, Q is rooted in the NHS and is dependent on others to help deliver improvements in health and care. This is especially true for the aim of building and nurturing a supportive environment for improvement. We therefore are interested in both the direct consequences of Q for members (for example, in better team leadership, the use of more appropriate improvement tools, and the use of soft skills to influence change) and the indirect consequences (for example, contributing to an environment where improvement approaches are nurtured and resourced, making regulation more supportive of improvement practices, and building an evidence base to help decide if and when and how to use improvement approaches).

How Q engages with, adapts to, and seeks to shape this wider context is therefore of fundamental importance. In this chapter we first discuss the key features of the environment (in a section that is necessarily more generic than the rest of this report); we then discuss the initiative’s theory of change before analysing the extent to which the initiative is evolving a clear strategic orientation towards this. We will return to this question in Chapter 7. We start with a brief discussion of the origin of the Q vision.

2.2. The origin and scale of the Q vision

The Q vision is ambitious. As articulated in the Q theory of change, its mission is to drive sustainable improvement in health and care across the UK. Key to such an accomplishment would be to support a health and care system ‘devoted to learning and improvement’. Previous efforts to achieve an at-scale shift

Evidence that such a change is happening would be members of the Q community reporting that in their working life they are part of a health and care system that is increasingly amenable to improvement and nurturing, rather than stifling, improvement efforts. As one external stakeholder interviewee noted:

…I guess my definition of the current aim [of Q] is to have a national network of people who have got experience, varying experience and motivation for quality improvement, to I guess use each other to learn from each other, to share learning, to improve kind of the speed of adoption and spread of certain things, and to help crack some of the challenging things that haven’t been cracked before. [Phase 1 Int 5, September 2016].

To contribute to this system change, Q aims to offer not only ‘top-down’ system-level support but also ‘bottom-up’ support to people identifying solutions locally and trying to scale them up more widely. This thinking underpinned not only the theory of change but also the whole co-design phase of Q: it was assumed that the complex system dynamics of healthcare meant that no simple top-down intervention could direct the unpredictable outcomes of self-organizing interactions across multiple locations. But it could hope to support and better inform individuals working within that system:

We’re a little bit isolated, I mean, I’m working solely in [redacted] although I’m working in regional Improvement Programmes as well. But I think it’s useful just to open your mind to what’s happening elsewhere, hear about things that might be useful to try out locally. And just to keep networking with people so that you can get new ideas and actually keep challenging yourself as to whether you’re actually on the right track, I think. [Scotland FDG1, September 2017]

There are consequences for both the delivery of Q and its evaluation arising from this need for both top-down and bottom-up aspects and these reappear in a variety of forms throughout the development of Q. They include the challenge of how best to manage being both local and UK-wide in a landscape populated by powerful and sometimes competing organisations. One member referred to this challenge of individuals learning in a crowded landscape as piecing together a ‘jigsaw’:

So I think there’s an absolute need for something. I think my challenge with all of these different things is how the jigsaw pieces fit together for collective benefit. So I think you know there are a variety of different things going on, both across the AHSN network, NHS England, NHS Improvement, Healthy London Partnership and kind of the Health Foundation Q for example, and I think that there’s a definite need. I think the challenge is maximising the impact, both in terms of by best...
harnessing some action from it and there’s a network and so what people get together and learn and share, so what does that translate into. There’s that challenge. Then also I think there’s how does it kind of slot in with everything else so we don’t have more confusion, if that makes sense? [Phase 1 Int 5, September 2016]

From the outset there was a gravitational pull towards emphasising the importance of ‘softer’ cultural and learning factors across a large community of improvers. An immediate impulse behind the initiative was the call to recruit ‘5000 Safety Fellows’ in response to a recommendation put forward in the 2013 Berwick Report. The Berwick Report was itself a response to the Francis Report into the serious failings in Mid Staffordshire Hospitals, which made almost 300 recommendations mostly concerned with regulation and standards. In contrast, Berwick emphasised human factors and this was crucial to shaping the Q Initiative. To be clear, the initiative was not questioning the need for regulation and standards. However, it was asserting the equal importance of more nebulous factors – such as personal and shared culture and values – in achieving better care. This sense that, if successful, Q would support a system with improvement as a core element is described by one interviewee:

I don’t know whether Don Berwick said it but in the future we will all have two jobs; that will be doing the day job and improving the day job… and that should be intrinsic to everything we do, whether at our level or the policy level or at operational or service provider level…. [External stakeholder Int 1, November 2017]

2.3. Q in the health and care landscape

Keeping in mind these origins in system strengthening (both top-down and bottom-up), shared culture and values, and connecting and supporting people with shared interests in improvement, it is important to understand the wider landscape within which the initiative continues to evolve. Indeed, for some members, linking Q to core organisational challenges is the key to its success:

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 Int 6, November 2016]

We might, therefore, think of three levels of results for Q. The first lies in equipping individual improvers with the support, networks, skills and confidence needed to be effective. The second is that Q helps establish organisational settings that are amenable to improvement through their culture, governance and incentives. The third is that Q should, as it matures, come to both respond to and seek to shape the national mandates, regulations and priorities relevant to improvement in health and social care. These levels are apparent in the theory of change but it is often hard to articulate how they relate to each other

22 THF (2015).
in practice. A key question for the final evaluation will be to consider whether Q activities are appropriate and sufficiently well powered to support these national-level changes.

At the UK level the policy-makers’ high-level view of where the challenges lie is clear, and for the NHS in England it is described in the 2017 ‘Next Steps on the Five Year Forward View’. This includes commitments to:

- Wider and easier access to General Practice.
- Improved accident and emergency performance and in particular improved patient flow.
- Integration through service redesign with a leading role for Sustainability and Transformation Partnerships (STPs) in delivering this (with a small number of STPs moving towards becoming Accountable Care Organisations).
- Strengthened patient, public and community engagement in service redesign and delivery.
- A prevention-led approach to reduce demand for services and allow care to be delivered.
- More care out of hospital alongside a ‘whole person’ and whole population approach, rather than segmenting or subdividing the population by conditions or age.
- Condition-specific improvements (with cancer and mental health being emphasised).
- Protecting funding for transformation alongside collective leadership and governance to share and manage risks between commissioners and providers.

There is no expectation that Q should engage fully and equally with all current policy priorities (and certainly not that it should follow the ebb and flow of policy minutiae), but there remains a question around whether and how Q engages with major items of policy in the UK. In Scotland, it has been argued, there is greater attention given to improvement, and a smaller and less formal system has allowed a continuous focus on quality improvement with measurable benefits in priority areas such as reducing the numbers of stillbirths. Putting to one side the evidence that inequalities and other important health outcomes have proved difficult to improve in Scotland (and recognising that a number of our interviewees in Scotland questioned the Nuffield findings), there remains something significant in the claim that ‘Scotland has a longer history of drives towards making different parts of the health and social care system work together. It has used legislation to get these efforts underway, while recognising that ultimately local relationships are the deciding factor – there is much for England and Wales to learn from this.’

Much the same could also be said of Northern Ireland. A question for the final evaluation of Q is whether and how more integrated working and legislative support should be part of efforts to create a ‘health and care system devoted to learning and improvement’.

In addition to the policy environment outlined above, Q is operating in a context of acknowledged financial difficulty. In 2016, the Head of the National Audit Office (NAO) stated:

> With more than two-thirds of trusts in deficit in 2015–16 and an increasing number of clinical commissioning groups unable to keep their spending within budget, we repeat our view that financial problems are endemic and this is not

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24 Ibid.
sustainable. It is fair to say aggressive efficiency targets have helped to swell the ranks of trusts in deficit over the last few years. The Department, NHS England and NHS Improvement have put considerable effort and funding toward stabilising the system, but have a way to go to demonstrate that they have balanced resources and achieved stability as a result of this effort. Therefore, value for money from these collective actions has not yet been demonstrated. [Amyas Morse, head of the NAO, 22 November 2016]

There is a wide range of improvement approaches that might address this financial challenge. Ham & Alderwick suggest that in response to these pressures strong ‘place-based’ responses are needed:

_The NHS is facing growing pressures, with finances deteriorating rapidly and patient care likely to suffer as a consequence… providers of services should establish place-based ‘systems of care’ in which they work together to improve health and care for the populations they serve._ [Ham & Alderwick, 2015, p.3]

We would argue that there is indeed a new politics of place emerging (with Sustainability and Transformation Partnerships (STPs), emergent Accountable Care Organisations (ACOs), and AHSNs being important parts of this) and NHS England sees local places playing a fundamental role in transformation:

…”Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required.”

However, place-based approaches would only be one of many possible responses. Others include ‘Getting It Right First Time’ (GIRFT) and mobilising the potential of whole system flow approaches. The environment of Q is therefore likely to be not only one of financial difficulty but also one where a range of plausible responses jostle for attention within Q (and beyond). Strongly functioning place-based responses are likely to be a part of the solution (most likely coordinated through STPs). But, it is also a world where local efforts will need to be supported by wider, large-scale changes supported nationally but implemented locally and yet delivered at scale. These are being shaped by profound changes in how healthcare is delivered. Engaging with delivering deep transformations in promoting radically new models of care can also be thought of as a ‘social movement’. According to NHS England:

_There are many factors that can assist and enhance the creation of the right conditions for large scale change. The world in which we are operating is increasingly dynamic where we are faced with many complex dilemmas. Across the world, change is happening at a faster rate and becoming more ‘disruptive’ through the use of digital tools. It is increasingly being seen that the most effective leaders of change are those who can build and use networks to create relationships. Research suggests that being_
an effective change agent is now less to do with traditional hierarchical power or positional authority and more to do with ability to influence through a network. Utilising social movements may help us build our networks and encourage support for our transformation efforts. Social movement thinking is about building activists: connecting with people’s core values and motivations and mobilising their own internal energies and drivers for change.\(^29\)

A more recent development in the context of Q is the work of Care Quality Commission (CQC). In June 2017 it published ‘Driving Improvement’, in which its Chief Inspector of Hospitals wrote\(^30\):

One of the first steps on an improvement journey starts with changing the culture of the organisation. Typically, trusts rated as inadequate are disjointed organisations. That may be a disconnect between clinicians and managers, between medical and nursing teams, between specialist and general services, or between different hospitals in the same trust. The priority for leaders is to bring all the elements of the trust together. This is best done by engaging and empowering staff – underpinned by shared values.

And he went on to say:

The feedback we received suggests that inspection does help improvement. As well as identifying problems and helping trusts develop improvement plans, reports can give a rigour and discipline to improvement work as well as giving clinicians and managers the boost to make changes.

In England, CQC therefore provides part of the system within which and through which Q might work. In addition to the CQC and healthcare providers, the ‘system’ includes: the Department of Health and Social Care; regulators in addition to CQC such as Monitor, the Trust Development Authority (TDA) and The National Institute for Health and Care Excellence (NICE); commissioners such as NHS England and clinical commissioning groups (CCGs); social care commissioners and providers; patient representatives; and patients and the wider public. While the origins of Q lie in part in a hope to rebalance the reliance of the system on regulation and inspection with more quality improvement processes, the more recent commitments of CQC to an improvement agenda represent a wider set of potential opportunities to bring improvement more fully into the heart of how the system works. Meanwhile in Scotland there has been a longer effort to bring inspection and improvement together in Health Improvement Scotland.\(^31\) Similarly, the RQIA (Regulation and Quality Improvement Authority) in Northern Ireland, established in 2005, is responsible for registering, monitoring and inspecting health and social care services in Northern Ireland, while encouraging improvement in their quality. In Wales, healthcare services are inspected and regulated by Healthcare Inspectorate Wales (HIW).

Meanwhile, the ambitious goals for health and social care services across the United Kingdom can only be delivered with an innovation friendly NHS. The literature (and arguably policy-making) relating to

\(^{29}\) NHS England (2017b).

\(^{30}\) For more information, please see (as of 3 May 2018): https://www.cqc.org.uk/sites/default/files/20170614_drivingimprovement.pdf

innovation and to improvement has historically been separate. AHSNs, among other organisations, are expected to help reconnect improvement issues (such as patient safety) and innovation (such as accelerating access to new treatments). Both innovation and improvement benefit from a culture of curiosity and interest and a capacity to generate and use evidence. Both require governance and accountability arrangements that reward investment in long-term transformation over meeting short-term financial goals.

In summary, the context for Q includes:

- Financial pressures.
- Opportunities to more closely link health and social care priorities to improvement practices (c.f. Scotland).
- A variety of plausible improvement approaches jostling for attention.
- Place-based solutions requiring regional supports and national mandates.
- A new relationship emerging between improvement and inspection.
- Innovation and improvement becoming institutionally linked.

The potential contributions of Q to this wider context are varied but may be characterised as:

- Providing improvers with the confidence, skills and relationships to persevere in a challenging UK-wide setting.
- Helping develop and spread technically proficient tools for improving how care is delivered today (improving what is done).
- Promoting novel ways to improve the sustainable and equitable delivery of health and social care (e.g. Q Labs) (improving how it is done).
- Exploring radically new ways to reimagine health and care within a transformed national setting (changing what is done).
- Encouraging an approach to regulation and inspection that rewards improvement.

These potential contributions are apparent in the Q theory of change. As Q has matured, both its activities and intended impacts have become clearer and therefore this has presented an opportunity to revisit the theory of change.

2.4. Theory of change

A theory of change is a structured articulation of how an intervention is expected to lead to social change.\(^{(52)}\) It is not intended to capture everything about a programme or initiative and nor is it a detailed project plan. Its value lies in supporting and communicating a coherent explanation and discussion of the

\(^{(52)}\) For more information on Theories of Change, there are many sources of practical advice including (as of 3 May 2018): http://www.theoryofchange.org/what-is-theory-of-change/ and https://www.nesta.org.uk/sites/default/files/theory_of_change_guidance_for_applicants_.pdf

For an important step back and reflection on why and how theory contributes to improvement, see Davidoff et al. 2015. Meanwhile, for their application in delivering and evaluating complex interventions, see De Silva et al. 2014.
purpose and modalities of a programme or initiative. Constructing a theory of change helps to articulate the logic underlying the inputs and processes and how these are expected to contribute to the target outcomes; it also recognises the interdependence of these different processes and the wider implementation context and helps to identify assumptions. Producing a theory of change can assist both the implementing organisation and wider stakeholders in better understanding the logic underlying the intervention activity and recognising potential risks and possible alternative outcomes.

The Q theory of change is a summary representation of what Q is trying to achieve and how, as well as the activities that are planned. It is also an opportunity to make explicit, and reflect upon, the assumptions about how change is to be achieved and where the barriers and enablers lie in the wider context of Q. Developing and using the Q theory of change has helped to both evolve the Q approach and facilitate discussion about it. It has become part of the way in which the Q team talk about and discuss their approach. It has also been an important narrative via which Q is communicated to other stakeholders, including Q members. At the time of writing this report, the Q theory of change was as outlined in Figure 1 below.

The Q theory of change should be easy to use and helpful for both those wishing to understand Q and those wanting to help it work more effectively. In the period under review it has provided good service in both respects. The terminology of connecting, mobilising, supporting and developing has informed how both Q leaders and members spontaneously talk about Q. The categories of effective initiative delivery, a learning and improvement infrastructure, a health and care system devoted to learning and improvement, and a continuous and sustainable improvement in the health and care of all people are helpful ways to frame what the initiative does and, to some extent, they help to shape the evaluation.

However, there is another line of thinking that is apparent in Q’s approach to delivering change: viewing learning as a key driver of improvement. This was a significant theme from the initial stages of the design of Q. It was also apparent in the importance attached to learning in the Berwick Report – and subsequently in how the Berwick Report was drawn upon to shape the thinking behind Q. The idea of a large-scale training course or a faculty was rejected in favour of learning taking place in and through the regular tasks of achieving change and improvement. These more implicit earlier ideas became much more explicit following the Q Learning Theory Workshop in July 2017, led by NHS Horizons.33

The subsequent documentation following the Q Learning Theory Workshop emphasises that ‘Learning is at the heart of Q. It’s an initiative inspired before all else by the Berwick Review vision of a NHS devoted to continual learning and improvement’34 and goes on to stress that ‘Learning, action and change are inherently interwoven’ and that the ability to learn can be consciously strengthened through an initiative like Q.

The learning theory in many ways helps to enrich and make sense of the Q theory of change. As it is, the theory of change is more linear on paper than is experienced on the ground. At two workshops to support a review of the evidence behind the theory of change (in July and November 2017) there was considerable

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33 For more information, please see (as of 3 May 2018): https://q.health.org.uk/about/learning-in-communities/
34 NHS Horizons (2017).
comfort and ease in identifying the activities of Q but less clarity about the causal mechanisms likely to drive change towards the right-hand side of Figure 1.

At a stocktake meeting between the evaluation team and the Q team on 19 December 2017, it was agreed that it would be helpful to revisit the theory of change in the coming months as part of the refocusing of the evaluation questions. While the learning theory is not a substitute for the theory of change, there is, in the view of the evaluation team, an opportunity to integrate these two foundational views of Q, along with the evidence presented in this report, to create the next version of the theory of change. This should be seen not as a failure of the theory of change but as a natural evolution in the light of growing understanding and the emergence of new evidence. In the following chapters we describe some of this evidence.
Figure 1. The Q Theory of change

Q – what we aim to achieve and how

MISSION: To drive sustainable improvement in health and care across the UK

EFFECTIVE INITIATIVE DELIVERY
- A sustainable governance and funding model
- Compelling and recognisable brand and offer to attract participants
- Recruitment of a diverse range of participants to achieve a critical mass
- Clear and widely understood charter of participation
- Ongoing co-design, evaluation and feedback

A LEARNING AND IMPROVEMENT INFRASTRUCTURE
- Activities to enable peer support and leadership to improve contexts
- Opportunities to develop and spread knowledge, skills and expertise
- Systems to enable discovery, visibility, connection, exploration, sharing and collaboration
- Processes and spaces for coordinating, co-developing and spreading improvement

A CONNECTED COMMUNITY LEADING TO MAKE QUALITY IMPROVEMENT ROUTINE
- CONNECTING
  - Developing flexible, enticing connections within and beyond the community
- MORELING
  - Collaborating efficiently to organise, understand, promote and spread improvement activities
- SUPPORTING
  - Supporting each other and influencing improvement contexts
- DEVELOPING
  - Learning individually, together and engaging others in learning

A HEALTH AND CARE SYSTEM DEVOTED TO LEARNING AND IMPROVEMENT
- Organisational culture, policy and conditions that enable improvement
- Widened access to CAPABILITY and understanding of improvement
- Capacity and leadership for improvement at sufficient scale and scope across the system

CONTRIBUTE TO CONTINUOUS AND SUSTAINABLE IMPROVEMENT IN THE HEALTH AND CARE OF ALL PEOPLE IN THE UK

ACTIVITIES AND OUTPUTS

SCOPES OF IMPACT

21
3.1. Introduction

Addressing the design, governance and management of Q is fundamental to the two high-level evaluation questions:

1. To provide evidence and analysis to support strategic decision-making and inform the ongoing design and management of Q.

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.

As Q increases in size and scope, securing effective governance and management inevitably becomes more challenging and those involved earlier on in the co-design phase will be expecting to see tangible outputs reflecting the time and energy they have put into the initiative. The Q governance model is critical to ensuring that governance is effective and members and other stakeholders are satisfied with the Q ‘offer’.

This chapter discusses the evidence collected through interviews and focus groups on the current governance and management of Q. Box 3 highlights the summary of the key findings in these two areas.
Box 3. Summary of key findings

- The difficulties of co-design have increased as Q has grown in scale, and Q may need to find new ways to engage members in its design and operation.
- Q seeks to balance accountability both ‘upwards and outwards’ to its funders and ‘outwards and downwards’ to its members.
- The governance system used in Q is often well received and could contribute to effective governance as Q grows.
- The Health Foundation retains primary ownership of Q, but regional partners still feel they have adequate autonomy.
- The Q convenor roles are still evolving and plans are in place for Q convenors to be more connected with each other.
- The Q team continues to be run effectively with a relatively flat hierarchy. As the team has grown it has become more structured, but there are some concerns over how decisions are made and how different parts of the team communicate with each other.
- The project team takes a reflective approach to its work, which needs to continue, and has highlighted areas of improvement.

3.2. Design

Q has now moved from the design phase to a more operational phase, and its operations consist of a number of activities. In addition, Q has now completed its full regional roll-out, resulting in a significantly larger membership. However, the process is not yet complete, with further components planned, including the Q Exchange, and a new phase of recruitment expected to start in spring 2018, although its exact form has not been finalised.

An important feature of the design of Q has been the commitment to co-design with members. This was most obvious in the first phase of Q, when there were three design events, but consultation with and involvement of members has continued since then, and there is a continuing ethos of co-production. However, with such a large membership, one Q project team member observed that the co-design from the first phase is not sustainable:

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. And so I think this should be a way for members to be more involved and perhaps that could be at a regional level through the commons group. And through giving support to the leading Q in a regional sense where they can put their own tone on it. Yeah, but I think the true co-design stage is over. [Q project team 7, July 2017]

However, both Q members and members of the Q project team felt that there was still the opportunity for members to play a role in the design and ongoing development of Q, albeit in a less formal way, and with particular reference to local activity:
To some extent it’s trying to create the conditions to enable them to, as you say, make those connections and come up with ideas for themselves as opposed to us saying ‘that’s a good idea’. [Q project team focus group discussion (FGD) 4, October 2017]

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 Int 9, July 2017]

Members are also able to get involved with designing individual activities. For example, one member interviewed spoke about their experience of helping to design a large-scale Q event in late 2017. The member had responded to an email that had been sent offering members the opportunity to get involved in co-designing the event, and was asked to help design a session when they expressed interest in a particular topic.

3.3. Governance

Q must answer to both its funders and its members

A key challenge facing the Q project team is how to have effective governance arrangements for a large and complex organisation with a growing volume of operations while also being responsive to, and inclusive of, a community of 2,149 members. The Health Foundation and NHS Improvement are continuing to invest significant amounts of money into running Q and have their own internal requirements to ensure that this money is well spent. While the Health Foundation leadership has been encouraging, there is understandably a perceived need across stakeholders to demonstrate progress.

I think it is perceived [by Health Foundation leadership] as very risky very innovative but very, very risky. …I think that it is risky potentially to the reputation because if it does not pan out the way it should that is a lot of money that does not produce much benefit. Risky because the future model of Q might have to change so if we do have a model where actually we are outside of the Health Foundation we might need to charge some sort of subscription to Q. …I think that is why we can’t make decisions so quickly because everything needs to get escalated upwards.… [Q team member 8, October 2017]

Similarly, founding members have contributed time and energy, and likewise expect to see outputs that they can connect to their input. Even outside the Q membership, there are expectations from people with an interest in healthcare improvement who have high hopes for Q but nevertheless provide another source of pressure. Q therefore has both hard accountability to those funding it and soft accountability to those who are part of it.

I think again it’s about the conversation between members and funders and investors, about well essentially what kind of relationship do we need to have to make a difference on the ground because actually maybe holding all the power, you know, may restrict their ability to deliver, similarly giving them all the power might be a real hindrance for them because they’re then having to write papers and all of that and all they want to do is get on with it and do the job. [Q team FGD4, October 2017]
The Q team has in practice addressed this by involving stakeholders in ‘the conversation’ to a considerable degree. To maintain conversations with its ‘financial backers’, there are quarterly governance board meetings with associated reporting and consultation. With members, there is a continuous stream of two-way information. There is now a dedicated Q website with news and updates, emails following a coordinated communications plan (also harmonised with the wider Health Foundation communications plan), and large member events each, typically, with its own conversations. We have also observed that the Q team makes a considerable effort to respond to all members who contact them directly.

The Q governance model is potentially an innovative solution to the governance challenge
Aware that governance was a major challenge in running Q, and that principles of ownership would underlay many of the other aspects of how Q is designed and run, the project team engaged one of Q’s members, Anna van der Gaag, to research how Q could be governed and to make recommendations for the future. 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 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. How these conceptually interesting and engaging ideas should be expressed through the organisation of Q is still in development. The philosophy behind this model reflects another aspect of Q that has been of importance to members: how they should relate to both the national and local dimensions of Q. While members see the national scale of Q as a key positive attribute, they most typically interact locally and regionally. It has therefore been important to consider both the national and local dimensions of Q and develop a model of accountability and engagement that reflects this.

Anna van der Gaag’s qualitative research included a narrative review of existing governance models, involving stakeholders from across the UK (Q project team, Q members and non-Q individuals working in improving quality). The purpose of the governance mechanism is essentially to protect the interests of the community by holding individuals working within it to account, particularly where their interests converge with or take advantage of the community (Q project team member 3, Int 2). Outlining a specific code of expected behaviour is important for a community of volunteers such as Q, which is reliant on commitment and goodwill. The current plan is to take a two-tiered approach to governance whereby the regions will act as one layer of coordination, and the national commons will bring all regions together.

At the time of its introduction, Q project team members discussed the governance model as something that was under development, with the work of Anna Van de Gaag often discussed. The Q project team acknowledged that further work was needed, for example on the development of terms of reference, before governance arrangements could be finalised.

The Q Lab team and regional partners have achieved a good sense of balance, providing support and guidance that recognises both the responsibilities of the Health Foundation and the need for a degree of regional autonomy
While NHS Improvement has an important role to play in shaping the overall approach of Q, the Health Foundation is clearly seen to have greater operational importance. The approach taken by the Health Foundation accommodates the fact that while members see the UK-wide dimension of Q as one of its key
strengths, they naturally group themselves regionally and interact more frequently at this level. This is also important given potential variation between regions with regard to the level of quality improvement experience; it was evident during data collection that different regions started from a different place, in relation to the extent to which the quality improvement community was already formed and linked. In some areas Q had cemented existing quality improvement networks, in others it had started to build a new network of individuals interested in quality improvement. It is therefore important to consider both the local and national dimensions of Q, and the commons model reflects that.

The proposed governance model was well received by the first three regional partners during December 2016 and January 2017. It was seen to create a cohesive structure for the wider implementation of Q, while allowing the regions a degree of autonomy. In the view of those regional partners, the commons model provides a structure that keeps all stakeholders together.

> It feels like someone needs to take responsibility for bringing that group together, for making sure that they’re talking about the right things and when they make decisions making sure that they are fed wherever they need to go. [Regional FGD1, December 2016]

> 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]

Similarly, one of the regional commons convenors approved of the level of local ownership of recruitment:

> I think having local ownership of [the recruitment process] I really liked that actually. I thought it allowed us to… So because of the process where we shortlist everybody, we had loads of applications and we had a big team, but we had a lot of opportunity to have collective conversations and I think that allowed us to know who the Q community were going to be. [Regional convenor int2, November 2017]

While the governance model allows regions some autonomy in how they wish to roll out Q, the Health Foundation is there to shepherd progress, as a ‘kind of mothership… that’s kind of got an oversight’ (Regional FGD3). For example, the Health Foundation will give direction on certain activities, but regions have flexibility on the delivery of these activities (as expressed by focus group participants from Region 3). In addition, the governance structure lays out a template for implementation, leaving regions to decide how to fit the commons model onto existing structures; for example, two regions (regional identifiers withheld) report intentions to create steering groups under the commons model. Both a Q project team member and a regional commons convenor felt that the relationship with the central team was an effective one:

> 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 Int 1, January 2017]
I must admit I absolutely love working with the Health Foundation. I love the events, everybody… I love the events that are put on, I think people are helpful, so I might not know what the answer is, but when I’m there people are always extremely helpful. I think it has the right level of, for me, creativity to help you think, I think this model is very different to anything we’ve done before. So I’m really happy with the input of the Health Foundation. [Regional convenor Int 2, November 2017]

In addition, the three pilot regional partners outlined their support for the governance model. They reported that it gives regions a sense of autonomy over their actions and their implementation of Q at a regional level, but provides a template upon which best practice could be shared across the country. One regional partner believed that they would have a high level of autonomy in running Q provided they do not use the brand inappropriately, they maintain communication with the Health Foundation and they adhere to the rules and contractual obligations (Region 2).

Common kind of shared asset base stewardship approach. So, how that is working, it’s very collaborative, very shared approach, decision-making, multi-stakeholder approach to shared decision-making and I think there’s a specific proposal in there for a central stewardship group, supported by regional stewardship groups. [Regional FGD3, January 2017]

Nonetheless, although Q fits with the AHSNs’ strategy, it is not their only focus. One regional partner explained that AHSNs have a:

Broader remit… and Q can fit into the facilities of the AHSNs and the aims of the AHSNs. [Regional FGD3, January 2017]

Regional partners and the Q project team see the Q brand as belonging to the Health Foundation, and that maintaining quality is important. The Q project team is aware of the risks of diluting the Q brand as it spreads to the regions, particularly if ‘the quality differs in different organisations’ (Q project team, regional roll-out focus group). For example, one area wanted to use branding similar to but different from the Q branding for people who were not Q members but had similar interests, and the project team did not allow this. The Q project team aims to mitigate the risks to the Q brand in a number of ways, namely by maintaining good relationships with the regions, sharing materials, and through contractual measures.

I think that the important thing is that there is some kind of regional voice and it’s up to us to decide how and what kind of power then do we give them if it’s unclear then yes, we should as a team, go back and think about what remit do we give them. [Q team FGD4, October 2017]

Finally, during the process of re-licensing AHSNs in late 2016 and early 2017, there were some concerns regarding AHSNs’ future capacity to move Q forward. Some Q project team members were also concerned that AHSNs may not be the best-placed organisations to conduct Q activities (given their responsibilities and resources) or may not have the same reach as Royal Colleges (the Royal College of Physicians, for example), and that support might not be consistent across the AHSNs, particularly at a time of wider uncertainty about the role of AHSNs. Some AHSNs noted that they had been paying for time spent on Q, as the allocation of £20,000 from the Health Foundation had been spent on assessing applications (although not all partners paid assessors, rather providing payment in kind); in addition, the
delivery of regional welcome events for new Q members was seen as potentially unsustainable in light of likely overall budget reductions (Regional FGD1, December 2016). Following the Phase 3 Wave 4 recruitment round in August 2017, responsibility for recruitment will return to central level. One regional convenor expressed disappointment at this and felt that local knowledge would be lost by this change in approach; they believed Q was a good way for AHSNs to be networked with those involved in quality improvement within their region. However, it is important to note that most of these views were being captured at a time when the role and resources of AHSNs was under discussion and there is likely to be less uncertainty in the months following the publication of this report.

In addition to the Q convenor role under pilot, the Q Connectors represent a further potential mechanism to maintain the regional aspect of Q while also facilitating exchange across regions and linking Q members to the wider national community. Q Connectors are a growing group of Q members who have taken on a voluntary role in supporting the connecting of ideas and individuals within and between regions. Connectors are offered training and support from the central Q team and other Connectors, and act as a point of contact for Q community members in their region who would like to further engage with the Q network. The first Q Connectors were appointed in April 2017.

The regional commons convenor roles are still being established

The role of regional convenor was launched in April 2017. It is a paid position (requiring approximately 10 days per year) and is intended to support the development of Q at a local level. The regional convenor acts as a local ambassador and helps to tailor the implementation of Q to regional priorities and the particular interests of local members. Three were recruited in early 2017 in order to pilot the role, and two of them were interviewed by the evaluation team.

Regional convenors were recruited through AHSNs and national improvement organisations. At the moment, the regional commons are being piloted. There was a lack of common understanding amongst the Q project team focus group about how regional convenors would feed into national governance, and how their roles were similar to and different from that of the Q Connectors. Both the regional commons convenors that we interviewed said that the governance model was still evolving:

So this is all a bit about working together to find out. So I was having this conversation with Anna [Van der Gaag], so I know before I go off and do anything I will check it to make sure that I’m fitting with the model that people are expecting. But I think it is a bit of suck it and see, a bit like the design of Q was, and that’s fine sometimes. [Regional convenor Int 2, November 2017]

Both convenors approved of the governance model (although this is perhaps unsurprising given that they were willing to take on their roles):

The governance model doesn’t worry me enormously, but I think it’s one of those things that you need to do and do well as maturity comes. I think it’s less important at the beginning, you know at the end of the day it’s a network of people who are doing stuff anyway and if they get up and run with something, that’s what you want them to do. 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. So it hasn’t worried...
me too much yet, but I would expect it going forward. [Regional convenor Int 1, November 2017]

I have no problem with the model and I really like it, I think it’s a very different way of doing it, so I have no issue with the concept, I think the practicality of getting it to work needs some exploring and actually I needed to check out some things with the Health Foundation to make sure they were happy. [Regional convenor Int 2, November 2017]

The convenors had thought that their role would be to interact more with other regional convenors than had so far been the case in practice:

I think it’s evolved. I would have quite liked there to have been a kind of national Q convenor group. I’ve not seen that yet, but that’s been understandable. …When [there] were just the first three, there was quite a lot of interaction between those first three. [Regional convenor Int 1, November 2017].

I think it’s a mixture of bringing back from the national level stuff that other places are doing their own governance and then also facilitating the process. [Regional convenor Int 1, November 2017]

I’m not entirely sure how we fit in. I had a second, I must say, when I first applied, and this might be something that I just talk rather naturally, but I imagined and I thought that there would be a role for a sort of central function around key convenors that actually… When I say a central function what I mean is the key convenors would have an opportunity to meet up and actually make sure they were leading their areas in the way that they needed to be led, because it’s very easy when you’re geographically isolated to go off and do your own thing, which might not be a bad thing actually, but it’s about understanding. There must be some core stuff we have to make sure is consistent to the model. [Regional convenor Int 2, November 2017]

A Q project team member agreed that this had been limited but noted there was a plan for the future:

Probably the next year or so will be another interesting phase of design because we’ll have finished the first round of recruitment. We’ll be thinking about the roles of regions and how the centre links up those. [Q project team 7, July 2017]

3.4. Management

Management demands are changing

Management of Q exists at multiple levels, from the day-to-day running of Q processes to making strategic decisions about its future direction, and includes how the Q project team itself operates. The way in which Q is managed flows from how it is governed and designed. It perhaps reflects an increasing desire to demonstrate actual and potential impact to the Health Foundation and NHS Improvement.

The Q project team maintains an open ethos, although this is harder as the team grows

We have observed the Q team at close quarters from near its beginnings as a small, fluid team to its current much larger form, with clearly defined work streams and responsibilities (Q project team Int1, Q
RAND Europe

project team Int4). This has been accompanied by a slight shift in philosophy from enthusiasm for new ideas and experimentation to a more balanced approach also taking into account management of risks both to Q and to its key stakeholders. Similarly, while at meetings there is still very much the tone of all people being able to contribute and all contributions being welcome, there is more of an understanding of different people being focused on different parts of Q.

One Q project team member highlighted what they saw as the high capability of the team:

_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 they 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]]

However, one interviewee did not express the openness that we had observed at the start of our involvement with Q in April 2015:

_I don’t think collectively if we were all to stand up in a room and say do you feel you can voice all your concerns right here I do not feel that many people would be able to put their hands up no._ [Q team member [redacted]]

A project team focus group participant did think that there was still an element of emotional connection between team members:

_A distinctly different culture and I don’t mean this in any negative way, but it’s a very emotionally attached team; we’re very aware of how we’re feeling, we talk about how we’re feeling. …We’re very in touch and it really impacts everyone as well. If there are a few people in the team that are feeling a little bit wobbly it has a significant impact on other people and how we respond and how we feel and that’s got lots and lots of benefits; it does have some negatives as well, that you get this flow of emotions that will cascade through the team._ [Q team FGD4, October 2017]

**Lack of clarity around decision-making is emerging as an issue for the Q project team**

The environment described so far in this chapter can make it harder to make decisions, in the knowledge that when constructive ambiguity is resolved in one particular direction there will be a large number of detractors whatever the resolution. In practice, this means that a Q project team already attempting not to make too many decisions centrally, for fear that this goes against the principles of communal decision-making, can be reluctant to make decisions even when it is best placed to do so.

_Yes I have spoken to a few people about this and I think that because Q is still considered quite risky from the Health Foundation prospective I think that is why there seems to be anxiety around sign off of decisions and so on and that is why everything does get escalated. I think it is a difficult one to address and change because I don’t see that appetite will change I think people want to have a real firm grip on Q which is a bit odd._ [Q team member [redacted]]

Nearly all participants mentioned uncertainties regarding the process of decision-making within the Q project team. Although there is a perception amongst staff members that they belong to a non-hierarchical
organisation, there is also an accepted reality that some key decisions need to be made by senior members of the team. Several respondents felt there was often confusion as to who should make decisions and when senior input was required. Team members at the focus group and in an interview agreed that there was a problem knowing who had the power to make decisions, but there was some slight disagreement over the extent to which this was because of the team having a flat hierarchy:

I think there is confusion about the levels of responsibilities that the work streams have. . . . So sometimes work streams say that something needs to go via somebody else but that person does not sit in the work stream. So at what point do people decide whether something needs to be signed off by somebody else and at what point do work streams have the authority to get on with things. I think that is the bit that is really unclear. . . . So say for example one person in the team has a kind of new and innovative idea I don’t think that they would feel empowered to just get on with it. I think it would be that this needs to be checked with somebody else so there is a lot of checking of things. . . . For each different decision is a different answer which I think can be okay but it means that people just don’t know and there is a constant state of confusion. [Q team member [redacted]]

Some improvements to ways of working are possible

Many commented on how large the Q project was and the number of people working on it. Interviewees reported on the development of more structured reporting and communication between the different work streams enabling different elements to work effectively and know what each other were doing. 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.\(^35\) This included, for example, a half-hour standing meeting every Monday during which each work stream gave a two-and-a-half minute update on progress and aspirations. 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]]

I think we’re quite heavy on meetings for what I would have expected. I do agree that actually there are very few that I come out of and think that was a waste of time, so I do agree with that, but I think there’s something that I’ve noticed more in recent weeks is that despite the fact that actually we’re lucky enough to have lots of face to face time with one another. We still often don’t communicate about some important things and some of those important things still get lost. [Q team FGD4, October 2017]

In the focus group, one project team member was impressed with the team’s ability to work at pace but felt that some internal tasks took too long:

\(^{35}\) For an introduction to these terms, see (as of 3 May 2018): https://www.agileweboperations.com/scrum-vs-kanban
I think generally as a team our ways of working are really great. I haven’t seen the way we do it here in any other job but I do think there’s something around we’ve got really good at delivering what we need to do; we work at a really fast pace and like some of the stuff that I think we’ve achieved in like a quarter takes some people like a whole year, so there’s that really good side of things, but then at the same time I think where we can improve slightly is how we work around internal things. So I’m thinking Joint Governance Group, board paper, like that sort of stuff, that feels a lot more laborious weirdly enough than like some of our Q stuff which is like so much huger, it’s just really odd, so and maybe we have a structure for like doing the Q stuff but we don’t have the structure for doing papers and governance and that side of things, so maybe that’s something to think about as a team anyway. [Q team FGD4, October 2017]

One Q project team member felt that the working relationship with the Q Lab could be closer:

I think our relationships with Labs [sic] could be more clearly and explicitly defined as sometimes they are involved and sometimes they are not involved and I think they find it difficult as well…. They are all fantastic but sometimes it is just difficult to know when they should be involved in something and when they should not. So I often under or over engage with Labs I haven’t quite found the future spot yet. [Q team member [redacted]]

Level of reflective thinking
The Q team has continued to take on board findings and recommendations from this evaluation, alongside data from other sources, including its own experience and some primary data collection through event surveys and feedback forms. This demonstrates the team’s reflective approach to the design and operation of Q. We have provided quarterly updates and recommendations based on the evidence we have collected from the evaluation. In our experience, this is taken seriously and project team members engage fully in discussions. Overall we have seen an increasingly clear connection between evaluation recommendations and Q team responses, although these are from time to time contested, with one Q project team member commenting:

We created a table of responses to the evaluation recommendations and that’s had quite a mixed uptake. [Q team member [redacted]]

The project team has documented our recommendations and their responses and actions. The recommendations have been at varying levels, so a quantitative analysis could be misleading; however, the team has responded to almost all recommendations in detail, and planned actions where appropriate. We do not know the extent to which these actions have been put into practice, as this has not been explicitly documented, and no actions have been proposed to alter Q’s course radically.

The project team understandably can struggle with the volume of data being collected, and in our view has a tendency to want to understand, interpret and use every piece of data rather than only collecting and analysing data relevant to questions they need to answer.
4. Recruitment and membership of Q

4.1. Introduction

Over the two-year period covered by this report, Q has moved from being a concept that was still in development – albeit with a first cohort of 231 and significant progress having been made through a period of co-design – to a large community engaging with each other and with a range of activities. While the community is expected to grow further, and what Q is offering its members is under regular review, the initial phase of mass recruitment is over and new members are joining an initiative with a coherent identity and goals rather than something amorphous and without clear direction. In this light, in this chapter we outline our evaluation of the design, regional roll-out and recruitment process of Q and how these have evolved as Q has come to fruition.

Box 4. Summary of key findings

- Some aspects of the recruitment process were well received, others less so; members often commented that the application was time intensive and complex, although this allowed them to reflect on their experiences of the work they had done in quality improvement.
- Unsuccessful applicants often viewed the recruitment process as less straightforward and more effort than is justified compared to successful applicants, but most understood why they weren’t successful and would consider reapplying in the future.
- The profile of Q membership has remained fairly similar since the founding cohort, with most members being in full-time healthcare improvement roles.

4.2. Recruitment

Three Q recruitment phases have taken place at the time of reporting, as depicted in Table 4. Founding cohort members (Phase 1) were nominated by relevant organisations. Members of certain healthcare organisations and graduates of selected Quality Improvement courses were eligible to join as Phase 2 members. Phase 3 members were recruited locally through AHSNs (rolled out by different AHSNs as different waves). From 2018, recruitment will proceed on a centrally managed, rolling basis.
Table 4. Q recruitment phases

<table>
<thead>
<tr>
<th>Phase/wave</th>
<th>Completed</th>
<th>Successful applicants</th>
<th>Unsuccessful applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Founding</td>
<td>2015</td>
<td>231</td>
<td>N/A</td>
</tr>
<tr>
<td>Phase 2 (pilot)</td>
<td>September 2016</td>
<td>216</td>
<td>11</td>
</tr>
<tr>
<td>Phase 3 Wave 1</td>
<td>2017</td>
<td>352</td>
<td>32</td>
</tr>
<tr>
<td>Phase 3 Wave 2</td>
<td>May 2017</td>
<td>534</td>
<td>62</td>
</tr>
<tr>
<td>Phase 3 Wave 3</td>
<td>July 2017</td>
<td>431</td>
<td>23</td>
</tr>
<tr>
<td>Phase 3 Wave 4</td>
<td>October 2017</td>
<td>363</td>
<td>11</td>
</tr>
</tbody>
</table>

The phase process was reviewed by the Q team after each wave (with a more substantial review planned for 2018). The evaluation team also discussed emerging findings about members’ experience of the recruitment process and made specific recommendations to the Q team, which were acted upon. During the lifetime of the Q Initiative, member recruitment was initially managed centrally and, in later waves, by AHSNs. Strengths and weaknesses were identified for both approaches. Where recruitment was managed centrally, some felt that local networks and local knowledge were lost. For others, when AHSNs managed recruitment it was felt the approach taken could, unintentionally, restrict the diversity of Q membership.

In the following sections the views of new members and unsuccessful applicants are outlined.

**Members’ experience of the application process**

Both Phase 2 and 3 members found the application process to be straightforward (Figure 2), with unsuccessful applicants more likely to view the process as less straightforward. Similarly, successful applicants were more likely than unsuccessful applicants to view the application process as a justifiable amount of effort (Figure 3).
Figure 2. Straightforwardness of the application process

I found the application process for Q straightforward.

Figure 3. Effort required during application process

Applying for Q took more effort than I expect being a member of Q to justify.
However, during interview some members noted that the application process was long and labour intensive and, in addition, they would have welcomed more information regarding the rationale for selection. In other phases participants also commented on the length of time completion of the application form required:

*So, personally I didn’t find the application difficult. I just think it’s reflective but I think it did take me quite a long time, you know, you put some ideas down and you write, and then you take your head away and then you come back to it again. So, I think it took me a good few days to complete it.* [Liverpool member FGD1, November 2017]

For some the lengthy application process was seen as a positive as it encouraged consideration and effort before applying to become a member of Q, and therefore ensured a high level of engagement from those who did become members:

*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. There is so much available it is overwhelming. Q seems like a different approach and that appealed to me.* [New member survey, Phase 3 Wave 1, March 2017]

**Unsuccessful applicants**

While most unsuccessful applicants understood why they had been rejected (see survey results from Wave 3 unsuccessful applicants conducted in March, June and September of 2017; Figure 4), some respondents felt to some degree that it was unclear and/or disputed the reasons.

**Figure 4. Understanding of reasons for unsuccessful applications**

I understand the reason(s) why my application was unsuccessful (even if I don’t necessarily agree with them).

![Bar chart showing the understanding of reasons for unsuccessful applications among Phase 3 Wave 1, 2, and 3 unsuccessful applicants.]

Nevertheless, among unsuccessful applicants there remained a high likelihood of reapplication in future rounds (Figure 5).
4.1. Membership profiles

At the start of this evaluation, in November 2016, the evaluation team recommended that the Q team should make a clear decision about the target group or groups for the membership of Q. Subsequently – but not necessarily consequently – this has been reflected in the changing nature of Q membership, with more patient representatives and carers included. Phase 1 recruited 9 members who identify as patient leaders/carers/volunteers, Phase 2 recruited 30 and Phase 3 recruited 26 across the four phases. However, it should be noted that this increase could be attributed to a change in the recruitment process, with Phase 1 members being nominated by Health Foundation partners, Phase 2 only being open to specific people and Phase 3 being open to anyone who wished to join who was from the recruitment areas and had relevant experience. This may have made it more likely that patient representatives would have joined in Phases 2 and 3 rather than in Phase 1. However, it should be noted that other groups, identified early on as weakly represented in Q membership, do not seem to have grown. For example, members whose job role was in social care when they applied to Q only total 11 across all recruitment phases.

Over the period of the evaluation the composition of Q membership has evolved. Phase 2 contained an increased proportion of people who cared for a disabled adult or had a disability themselves compared with Phase 1. The second cohort also contained more members working for national or governmental organisations and fewer working for acute providers. By Phase 3 Wave 2, the number of women members had increased (Figure 6) and the spread across age bands was evening out (Figure 7). Generally, however, Q member characteristics remain similar across the recruitment waves, as indicated by the annual and new member’s surveys throughout 2017.
Figure 6. Gender of Q members

Figure 7. Ages of Q members and unsuccessful applicants

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36 12 members (0.6 per cent of respondents) selected ‘prefer not to say’.
Professional diversity in Q

Across all phases, the majority of Q members spend a large proportion of their time in paid employment in roles directly related to improving health and care quality, as shown in Figure 8.

Figure 8. Number of hours a week in paid employment spent working directly in improving health and care quality

Approximately how much of your time in paid employment is currently spent in work directly related to improving health and care quality?

<Insert chart here>

Throughout the evaluation, participants have expressed diverse views about the preferred mix of profiles amongst Q members. They often expressed the desire to include members with a range of professional roles (e.g. clinicians and patient representatives) but also with particular expertise – to solve a particular problem, for example. Others approved of a more exclusive selection process, to ensure that there was a shared professional expertise in quality improvement.

The optimal level of exclusivity for Q membership was often discussed by members, with diverse views becoming apparent. For example, in the applicant survey for Phase 2 members, 36 per cent agreed Q should be open rather than having an application process, while 39 per cent disagreed and 25 per cent were neutral. Members who took part in the interviews and focus groups were sometimes concerned that Q was becoming elitist, and that the high bar for recruitment might discourage those with something to contribute from applying. One citizen ethnographer recorded having been told by a Q member prior to the welcome event that Q membership seems to be for the elite. Some respondents felt it should be selective, whilst others felt membership should be broader:

Inside the UK I think the plan was to make sure it wasn’t like an exclusive club and that’s maybe how it felt in the initial stages. It was an exclusive club of people who
have had to draft out a very detailed application and some people felt they may be weren’t good enough in being able to join and so that would have initially made some people feel quite left out even if they were doing really good quality improvement work. I think it’s much more inclusive now and perhaps that’s a good thing. And I would imagine that now it’s less exclusive then it’s viewed as something that is a very good thing to be a part of; that people who aren’t members probably feel that they could be a part of it and if they did then they would gain good benefit from it. [Phase1 Int 10, July 2017]

…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? [Annual Survey, March 2017]

Some members also raised wider concerns about a lack of diversity among members. When asked what types of profiles should be recruited into Q, some stated that it is necessary to look beyond healthcare professionals and the healthcare context and recruit from other sectors and backgrounds (as is happening to a small extent in Scotland, with members drawn from the housing and education sectors). Founding members tended to believe that Q lacks patient representatives and individuals working in social care and nursing, although this balance was addressed to an extent in subsequent phases. Throughout all phases, the majority of Q members have face-to-face contact with patients/service users in their current role (Figure 9).

Figure 9. Frequency of face-to-face contact with patients/services

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

- Yes, frequently
- Yes, occasionally
- No

<table>
<thead>
<tr>
<th>% of respondents</th>
<th>Phase 1 - baseline %</th>
<th>Phase 2 %</th>
<th>Phase 3 Wave 1 new members %</th>
<th>Phase 3 Wave 1 unsuccessful applicants %</th>
<th>Phase 3 Wave 2 new members %</th>
<th>Phase 3 Wave 2 unsuccessful applicants %</th>
<th>Phase 3 Wave 3 new members %</th>
<th>Phase 3 Wave 3 unsuccessful applicants %</th>
<th>Phase 3 Wave 4 new members %</th>
<th>Phase 3 Wave 4 unsuccessful applicants %</th>
</tr>
</thead>
</table>
**Social network analysis**

Data on relationships between Q members was collected through the member surveys. Data was collected from Phase 3 members of all waves from their entry survey and from Phase 1 and 2 members through the annual survey conducted in March 2017.\(^{37}\) At the time of writing, we do not therefore have the data from a later time point in order to evaluate change in the wider Q membership as a result of Q, although observations on the relative connectedness of different populations (for example, regions or recruitment cohorts) can be made.\(^{38}\) In this regard, the data provides a ‘snapshot’ of the connectedness of the network at this moment in time and, in doing so, provide a baseline for future analysis of the change in the scale and nature of connections between members as Q matures.

Figure 10 shows the reported relationships of the Q network as of January 2018 (including members from Phase 1, Phase 2 and Phase 3 Waves 1, 2, 3 and 4). Nodes represent Q members, and they are connected by a line if one of them reported in a survey that they had a connection to another. Node colours indicate which Q recruitment phase they are from and the size of nodes\(^{39}\) represents the member’s *betweenness centrality* (a measure of how 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).

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\(^{37}\) The question wording was:

> 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.

\(^{38}\) A separate analysis of the change in members’ reported connections was undertaken during the evaluation of the one-year co-design period. See Garrod et al (2016).

\(^{39}\) In order to make the graph accessible, minimum node size was set at 3 and maximum node size at 40.
There were 1730 connected members of 2150 total members\(^6\) who reported a connection, or for whom someone else reported a connection. The members with the highest betweenness centrality are from Phase 3 Wave 2 and Phase 2, with a few key individuals from Phase 3 Wave 1 and Phase 1.

The largest number of connections reported was 83, which related to a member of the Q team. The largest number of connections reported for a Q member independent of the Health Foundation was 73. Some 420 (19.5 per cent) had no reported connections at all, half (54 per cent) had at most three connections and 90 per cent at most 14 connections. At the other extreme, 1 per cent of members had at least 41 connections. Figure 11 shows the distribution of the number of connections reported by members.

\(^6\) This total includes the 2149 current members and one member who passed away after joining Q.
Figure 11. Distribution of number of connections for members.

Table 5 outlines the mean and median number of connections for members in different geographical regions and different recruitment cohorts. It is important to note that as the data for Phase 1 and 2 members was collected after they had been members of Q for some time, they had more time to make connections than Phase 3 members, who were surveyed upon entry to Q and before welcome events had taken place.
Table 5. Average number of connections for members

<table>
<thead>
<tr>
<th>Grouping</th>
<th>Mean number of connections</th>
<th>Median number of connections</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>South</td>
<td>7.7</td>
<td>5</td>
</tr>
<tr>
<td>North</td>
<td>7.8</td>
<td>5</td>
</tr>
<tr>
<td>Midlands and East</td>
<td>4.9</td>
<td>3</td>
</tr>
<tr>
<td>Wales</td>
<td>6.3</td>
<td>3</td>
</tr>
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<td>Scotland</td>
<td>9.3</td>
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</tr>
<tr>
<td>Northern Ireland</td>
<td>3.6</td>
<td>2</td>
</tr>
<tr>
<td>Phase 1</td>
<td>9.9</td>
<td>6</td>
</tr>
<tr>
<td>Phase 2</td>
<td>8.5</td>
<td>5</td>
</tr>
<tr>
<td>Phase 3 Wave 1</td>
<td>7.9</td>
<td>6</td>
</tr>
<tr>
<td>Phase 3 Wave 2</td>
<td>6.1</td>
<td>3</td>
</tr>
<tr>
<td>Phase 3 Wave 3</td>
<td>3.9</td>
<td>2</td>
</tr>
<tr>
<td>Phase 3 Wave 4</td>
<td>1.3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5.8</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

As the table shows, average Q members in the North and South of England and Scotland have more connections than those in Northern Ireland, Wales, London and the Midlands and Eastern region. Figure 12 shows the network with members coloured by region.
There was also notable variation amongst recruitment cohorts with regard to the number of connections of members, with members recruited in Phase 3 Waves 1 and 2 reporting the highest number of connections, markedly higher than the average member who joined as part of Phase 3 Wave 4. In terms of mean number of connections, this equates to 5.8 connections across the full Q membership at the point of entry of Phase 3 Wave 4, slightly less than the mean of 8.6 calculated upon the entry of the Phase 3 Wave 1 cohort and 7.6 calculated upon the entry of the Phase 3 Wave 2 cohort.

There are a number of reasons that could explain the decrease in average number of connections across the Phase 3 recruitment cohorts: it is possible that as Q grows in scope, incoming members are being drawn from a wider pool of persons interested in quality improvement, rather than Quality Improvement practitioners with numerous existing professional relationships; it is possible that with a larger number of Q members available, respondents were less likely to list all their connections, or were unaware that their existing contacts were also members of Q; and due to lower numbers of survey responses amongst later cohorts, it is possible that some connections between members were missed.
5. Members’ experience of Q

5.1. Introduction

This chapter draws on data from interviews and focus groups with members undertaken at community events throughout 2016–2017, as well as member and unsuccessful applicant survey data. It provides a summary of the way in which members are engaging with Q, their experience of membership to date and their plans for involvement in Q going forward. Responses indicate continuing positive engagement with Q and also identify what is highly valued and where challenges are perceived. Box 5 highlights the key findings identified throughout the evaluation relating to Q’s provision of support and connections, the development of expertise and the mobilisation of its members.

Box 5. Summary of key findings

- Members often desire to commit time to Q but can be unsure of how best to do this and comment that the time commitment should be flexible.
- Members are on the whole positive about the potential of Q, although for some this remains potential rather than actual benefit.
- The community events are perceived to be key to facilitating connections between members, although with concerns about their sustainability in the long term.
- Lack of time and the need to use annual/unpaid leave are the primary barriers to involvement in Q.
- Some members indicated that they could see the direct benefit of Q to them and commented that Q was not what they expected it to be.

5.2. Member engagement with Q

As Figure 13 demonstrates, since Phase 3 Wave 2 there has been a cohort-upon-cohort increase in the proportion of new members (with the exception of a small decrease for Phase 3 Wave 4) indicating in response to the survey that their desired level of activity was to be ‘actively participating in a range of activities, but not helping to organise’ (ranging from 45.1 per cent of Phase 1 members to 60.1 per cent of Phase 3 Wave 3 members). There has been a concurrent decline in the number reporting that they would
be ‘contributing significantly to help shape and lead activities’ (from 24.5 per cent of Phase 1 and 36.5 per cent of Phase 2 members to 16.9 per cent of Phase 4 Wave 4 members).

Figure 13. Desired level of activity in the coming year

As depicted in Figure 14, the median and most common answer given by incoming members across all recruitment waves to the question of how much time they would like to spend on Q over the next year was 4–6 days. However, for surveys undertaken after members had been in Q for a short while (the survey answered by Phase 1 members at the end of their first year, and Phase 1 and Phase 2 respondents to the annual survey), the most common answer was 1–3 days. Nonetheless, for all cohorts, respondents’ answers were distributed relatively evenly across the three middle bands (covering 1–3, 4–6 and 7–10 days), with a not insignificant minority wishing to spend more than 10 days participating in Q. Very few respondents expected to spend less than 1 day on Q activities.
Some Q members interviewed early in the evaluation noted that they were willing to become more involved in Q than they currently are, but were unsure how best to commit their time, or of what was required of them. Despite the majority aligning with the overt aims of Q, some members struggled to see what Q was aiming to achieve. While in general members continued to express a high level of support for the initiative, frustrations emerged amongst some founding members concerning the aims and direction of Q, and members’ involvement in it. Against the wider context of members’ commitment to Q it is hard to judge the importance of this, given that developing Q was always likely to be complicated, uncertain and difficult to explain.

Nonetheless, some respondents believed that members’ understanding is likely to grow over time, and it was also felt that the model presented by the Health Foundation in January 2016 was always likely to evolve. Others called for more clarity, while recognising that Q was a journey (Phase 1 member FGD1, May 2016), and felt that more direction was needed from the centre in order to understand the level of commitment expected of members and to stop them from becoming disengaged after events (Phase 1 Int 5, September 2016). This tension between valuing flexibility and emergence, on the one hand, and wanting central direction, on the other, has been a theme among members from the outset of Q. However, it remains a live and important issue and the concern with Q ‘feeling quite vague’ was mirrored in September 2017 by a founding member:

*I think [the event] was very much as the initiative of Q community has always been and [as] the founding cohort... in the three different sessions, I would start upbeat but by the end of the second day I was left wondering what on earth was coming next and I’m left a little bit like that today. I am still left feeling quite vague… this needs to be*
something in addition to what we do in [redacted]… or there’s no point in us being here. [Scotland FGD2, September 2017]

Amongst founding members, expectations of how much time members should commit differed: some thought it should be flexible, with the ability to dip in and out as workload shifted (Phase 1 Int 3, August 2016), whilst others felt it required more concrete commitment and that they needed direction (Phase 1 Int 2, August 2016, Phase 1 Int 5, September 2016):

*It ought to be more directive, it needs to be clear on what it’s doing and it needs to be clear on what it’s asking people to do.* [Phase 1 Int 2, August 2016]

*I think you need something that’s more flexible that people can come in and out of and be more organic because otherwise you’re just making it elitist, you’re just make it for a few and I think it’s really important that people have the ability to be able to dip in and out of it.* [Phase 1 Int 3, August 2016]

We know that this tension has deep roots. Findings from interviews earlier in the evaluation demonstrated that Q members were unsure of the expected level of commitment, with some believing involvement should be flexible (Phase 1 Int 3, August 2016, Phase 2 Int 4, February 2017); others thought that Q members should be told the level of commitment that is required of them, believing that otherwise people will go to the events, listen to the speakers but then return to their day jobs without having had the opportunity to do anything else related to Q (Phase 1 Int 5, September 2016). One focus group discussion between members also discussed the need for a clear structure and rationale behind Q membership in order to make a stronger case to management to ring-fence the time needed to implement quality improvement initiatives in their employing organisation (and also to help account for the time spent at events).

However, some Q members interviewed early in the evaluation also appreciated flexibility and aim to get involved in Q as and when they have time. Similarly, new members interviewed in the latter half of 2017 did not tend to report that they were unclear about Q and its aims. They did, in addition, speak positively with particular reference to the ‘flexibility’ of Q as a strong draw, allowing them to treat it as a resource – ‘plugging in to something that’s already going on’:

*I think there’s enough backbone already in it that people feel they’re on something that’s already moving. I feel like I’m on something that’s already in train so I don’t feel an onus on me. I know that there is an onus as a Q member for your own development and your support of others and things like that but I don’t feel that I have to set anything up. It feels like I’m plugging in to something that’s already going.* [Phase 3 Int 1, October 2017]

*I think that’s the perfect approach, it’s a non-threatening [unclear] on my list and if I’ve got no time, I can just literally [unclear] or if I’ve got more time, ‘Let’s do a project’… It’s there, it’s waiting for me, it’s not pushing, and pushing, it’s not ramming down my throat. It’s there for me when I need it.* [Scotland member FGD1, September 2017]

Members not only engage for different reasons but they view Q as having different purposes and theories of change. As we see in the following section, there are also different expectations about the benefits
members might expect. Given that Q is an initiative, and not a programme, there is room for different approaches to co-exist side by side and this can create a helpful abrasion of ideas; however, it can also lead to confusion and misunderstanding among members and consequently among wider stakeholders. We will return to this question in our concluding chapter.

Early during the roll-out of Q, members expressed concern about the effectiveness of communication from the Q project team. We have heard in some member interviews that communication between the Q project team and Q members has not been entirely effective for some and this is evident from the small group of member interviewees who struggled to define the aims of Q, or their role as part of the initiative. With a rare exception, we have not heard these concerns in more recent interviews.

5.3. Use of activities and resources

As discussed in Chapter 3, the number of activities has expanded since the co-design period. In addition to the welcome and annual events, at the time of writing there are 34 active SIGs and six site visits had been conducted, the latter involving 115 members. As of April 2018, the main Q Twitter page has almost 7,000 followers.

> There is content, there is more interesting stuff now than there was at the start. So, I'm getting to learn more now than I did right at the start and that's quite helpful.
> [Phase 1 int10, July 2017]

**Events and face-to-face meetings**

Notably, interviewed members and focus group participants expressed positive feelings about the welcome events, and the role of face-to-face meetings more broadly. When developing the case studies, it was observed that many of the events that resulted in impact reported by members were the result of serendipitous encounters at member events. One founding member expressed concern that the opportunity afforded to the founding cohort, who spent six days co-designing Q in 2015, would not be scalable for others given the decreased opportunity for face-to-face contact (Phase 1 Int 11, July 2017).

Results from post-welcome event surveys conducted by the Health Foundation show that, in general, Q members enjoyed the welcome events, giving an average score of 8.17 out of 10. When asked, 75–95 per cent of responders would attend future events. Members commented on the positive atmosphere of the events, including positive senses of engagement, energy and community:

> One Q staff member and one Q member in a highly animated discussion about different OD [Organisational Development] techniques and philosophies. So engaged that they had to run for the bus! [Citizen ethnographer 3 Liverpool, November 2017]

From the free text responses to the surveys, it is clear that the primary reason for members enjoying these events is the networking opportunities, both with old contacts and new people. Ensuring there is adequate time for networking was often a comment members would leave for those designing Q events in the future.

Although time spent on networking was seen as beneficial, there were mixed comments on the content of the day. Common responses to the question on what advice the members would give to future Q event
designers often mentioned that the content should provide more practical information, such as learning from best practice and sessions on the methodologies themselves.

In addition, members often commented that the content should be more tailored and specific to certain interests and should bring together people who work in similar areas. Multiple responders suggested collecting information about attendees before designing the event so particular sessions could be targeted at topics that groups of members would be interested in, bringing them together to form connections.

The most common reasons cited for not being able to attend a welcome event were work or other commitments, as well as being on annual leave. No members responded that their lack of attendance was due to their organisation not supporting them, or because they lacked interest in the event. The former may be surprising considering the multiple comments in member interviews and focus groups suggesting that employers are not always fully supportive of attendance at Q events. However, when in this situation, it appears that some members (who may not necessarily represent a typical sample) choose to take annual leave to attend the event and pay any expenses themselves, such as this member who attended the Liverpool National Event:

…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]

**Site visits**

At the time of writing, Q site visits are a fairly new activity, although the evaluation observed enthusiasm for them at the Scotland welcome event. Six site visits have so far taken place with a total of 115 attendees. Some members also commented on the utility of the wider materials offered by Q, disseminating them amongst colleagues (Phase 1 Int 4, August 2016, Phase 2 Int 6, July 2017).

As a specific example, we report here on our observations of the site visit to the Sheffield Microsystem Coaching Academy (MCA) in July 2017. This provides some richness to understand how site visits work. The event was short (10 a.m. to 1.30 p.m.), dense and fast-paced, and generated high levels of engagement throughout. Engagement with a session on relational coordination was especially high, with participants reporting that they would like to learn more about it. Attendance was high and participants seemed very pleased with the day’s learning. Participants engaged in lively discussions throughout the day – responding both to the speakers as well as to each other. The quality of conversation within the sub-group sessions was high, with participants eager to share their own learning and experiences in relation to common challenges.

Participants had given prior thought to how they might share their learning from the day more widely – some were coming with the specific aim of applying what they learned to current programmes or work in their organisations and feeding it into their existing networks, and some Q members from the Greater Manchester region had already set up a webinar to follow the site visit, in order to share learning with other Q (and AQuA) members in the region.

It was observed that most participants had chosen to come to the event because of prior work around coaching or microsystems. Some had already heard about the MCA, and were therefore very excited to be
given the opportunity to visit and learn from the MCA faculty. Towards the end of the day, quite a few participants expressed interest in applying for the FLOW programme, having been persuaded of its value. Overall, the visit to the MCA offered the opportunity to fill a specific knowledge gap relevant to Q members.

**Randomised Coffee Trials**

In the same vein, Randomised Coffee Trials (RCTs) were also viewed positively by members for their ability to facilitate connections (Phase 1 FGD2, May 2016). As of November 2017, 188 Q members had registered for an RCT, with a reported completion rate of 28 per cent.

> 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 [unclear] get in touch, it’s helpful. It’s more knowledge than you would have had to start with so it adds value. [Phase 3 Int 1, October 2017]

Members also reported feeling confident about feeling able to ‘cold call’ other members should they want advice on a particular subject, although these members had not yet done so.

> So, I think it’s feeling comfortable to ask and answer questions is probably a key part of this and I know enough people well enough to reach out. You might say then would I have reached out without the Q network? Yes, I would have done. But I think doing it within Q means there is an opportunity for us to be visible and to consolidate our skills and efforts and to draw others in. To make others feel part of something substantial. [Phase 2 Int 2, November 2016]

One member queried whether the feeling of ‘permission’ to contact other members would endure in the longer term, following the initial excitement over Q (Phase 1 member FGD2, May 2016).

**Q Lab**

A separate evaluation of Q Lab is being conducted by the University of Cambridge and RAND Europe; this began in May 2017 and produced an interim report in October. A separate and final report is due in mid-2018. The focus of this first year of Q Lab has been on peer support, and discussions about next year’s topic are well advanced. Although there are two separate evaluations, the two projects are closely connected and an evaluation of Q cannot ignore the work of Q Lab. In this short section we highlight some of the key issues.

The Q Lab is funded by the Health Foundation and NHS Improvement and was launched in the spring of 2017. The aim is to test whether the Lab approach is likely to become an effective, valuable way of developing ideas or interventions to support improvements at multiple levels of the health and care system in the UK.

Emerging from the Q community, the Q Lab supports improvement efforts aimed at tackling complex and previously intractable challenges in healthcare. It is inspired by an understanding of social innovation labs worldwide. It intends to leverage the expertise, skills and diversity offered by the Q community (although it also goes beyond the Q community for both insight and supporters) and it is organised around one single improvement challenge at a time. The expectation is that each successive challenge will
be explored over a 9–12 month period by a wide range of people in the UK, with the aim of achieving a deep understanding of the issue, generating ideas and testing promising solutions for improving users’ and providers’ experiences of healthcare. It is intended to introduce a new space for bringing creative thinking, imaginative insights and tested solutions into the UK’s improvement landscape.

The first Q Lab addresses the topic of peer support, with the challenge being formulated as follows: What would it take for effective peer support to be available to everyone who wants it, to help manage their long-term health and wellbeing needs? From this pilot the funders and the Q Lab core team hope to learn whether the Q Lab approach shows potential to generate ideas and insights that can be used to improve healthcare throughout the UK. However, identifying the right lessons to be learned from this pilot will be difficult; an innovative concept such as Q Lab is a quintessential example of the kind of complex improvement system where links between cause and effect are difficult to make. Understanding the potential of the Q Lab approach and the issues in scaling up thus requires careful inquiry into both the Q Lab’s direct impact on the people involved in its work and the Q Lab’s indirect, non-linear and longer-term systemic outcomes.

There are several distinguishing features of the Q Lab approach

Through observations, interviews and the survey we identified several distinguishing features of the Q Lab approach:

- **Engagement and collaboration.** The Q Lab team achieved considerable success in engaging with a broad range of people working across the health and care system in the UK, including patient and service users, healthcare professionals and improvement experts.

- **Creative culture.** Creativity has been often mentioned as one of the key features of Q Lab and the Q Lab team has emphasised the creative aspect of Lab by adopting techniques and exercises led by design thinking and accompanying written outputs with appealing materials, images and other visual outputs.

- **Matching evidence and ‘lived experience’.** During the research phase, the Q Lab team tried very hard to gather both traditional ‘codified’ knowledge on peer support and ‘un-codified’ tacit knowledge in the form of lived experience.

- **Emergent and fast-paced.** One of the features of all Labs is the emergent and fast-paced nature of the process through which they are intended to produce their outcomes; this has both benefits and risks.

**Q Lab evaluation aims**

The Q Lab evaluation seeks to address the question: Is the Q Lab approach likely to become an effective, valuable way of developing ideas or interventions to support positive change at multiple levels of the health and care system? Key methods and data collection applied in the evaluation include:

- Ethnographic observations at the Q Lab team’s office and at key events.
Semi-structured interviews with Q Lab team members, Q Lab participants and other stakeholders.

Focus groups with the Q Lab team and Q Lab participants.

Surveys of Q Lab participants; survey round 1, conducted as of August 2017, resulted in 66 responses (a response rate of 50 per cent); the second round is live.

Quantitative and qualitative Social Network Analysis (SNA).

Supplementary document review to support the other data collection and analysis activities of the evaluation (for this interim report we used Q Lab documents to retrieve information on the design and set-up phases of the Q Lab).

Already it is clear that Q Lab has successfully applied creative ways of engaging with a diverse groups of both Q members and others across the UK. This, as was hoped, provides an additional way to support Q in achieving its aims. In particular, Q Lab has established a creative culture that resonates and reinforces Q’s efforts to support learning and innovation in improvement work. In this sense it adds a particular dimension to the work of Q. In our (unpublished) interim report for Q, we concluded that the Q Lab team performed this role in a flexible, fast-paced and inclusive way. We also identified the opportunity to more consciously bring ‘lived experience’ into the design and running of the Lab. We also saw opportunities to learn from the first year in finding more direct routes to achieving identifiable impacts on health and social care.

Structured learning and feedback

The Q Lab evaluation includes an ethnographic dimension along with interviews and focus groups and we also have feedback and learning events every five weeks (as much for the evaluation team as the Q Lab team). This creates a five-weekly cycle, as represented in Figure 15.

**Figure 15: Evaluation feedback cycle**

In this way we have identified Q Lab practices around engagement, creative culture, bringing lived experience into the frame, and maintaining an emergent and fast-paced approach.
Survey and social network analysis

The survey included a question intended to allow us to carry out some analysis of the networks supporting the Q Lab. This question provided a starting point for social network analysis (SNA). Additionally, through qualitative interviews, we are exploring whether these relationships are perceived by Q Lab participants to be the sort that best support the aims of the Q Lab. Understanding the nature and quality of the relationships generated by the Q Lab (both between the Lab team and the participants and among the participants) is an important part of the evaluation and is key to achieving a comprehensive description of the Lab approach.

The qualitative element of the SNA will allow us to explore in great depth the type of relationships generated in the Lab participant group, how they are being used and mobilised, and how they affect the Q Lab’s outcomes. It will also offer an opportunity to explore the ‘routes to engagement’ (i.e. through what means and processes individuals become involved in the Q Lab work) and how these evolved during the Lab lifecycle. The quantitative element of the SNA will aim to identify trends and patterns in the different types of relationships and routes to engagement among a wider group of participants.

The current stage of the SNA is being conducted as follows:

- Between January and March 2018, we interviewed 18 Q Lab participants, sampled to include different experiences and level of engagement. The sampling was guided by responses to the survey conducted in July–August 2017 as well as the Q Lab team’s experiences of interacting with participants.

- We propose replacing the currently planned interviews with Health Foundation staff with a focus group, to allow greater opportunity for interaction.

- Based on the findings from the interviews and focus groups, we will design survey questions to test hypotheses formed from the interviews and to capture relevant aspects of engagement/involvement/relationships at a larger scale.

Note that the quantitative part of the SNA conducted in the first survey will not be repeated, as the aim is to look at how the network functions rather than how it grows. As described above, the snapshot of the network from the summer will be used as an input to the qualitative part of the SNA.

Q and Q Lab

Given the emergent nature of each, there is some ambiguity about the exact relationship between Q and Q Lab. With the second topic being selected by Q Lab and the theory of change of Q being revisited, there is room for some re-alignment. However, it could be argued that Q as a whole and Q Lab in particular involve establishing spaces where abrasion between competing ideas produces creativity. Neatly defined boundaries are not necessary or desirable. However, at the same time there is a need to minimise replication and maximise opportunities for synergies such that there can be a rapid recycling of ideas between Q and Q Lab, allowing for their continuous refinement.
5.4. Barriers and challenges to participation

Members often report lack of time as a key barrier to spending more time on Q. Despite the aforementioned recognition of flexibility, a number of participants raised cost and time as challenges to participating more deeply in Q, over and above using the resource when required. Figure 16 shows the number of members reporting protected time and study leave in relation to Q. A small group of members also raised this point with the evaluation team at the Liverpool national event, also commenting that they were unsure of the amount of time that would be available to spend on Q. Later cohorts were also decreasingly likely to report that they had protected time, although Phase 3 members reported more study leave than those from Phase 2.

Figure 16. Support from employers to participate in Q events and activities

Among the 59 people who responded to the survey at the end of Phase 1 as well as the annual survey, there was no statistically significant change in the level at which they wanted to be involved in Q, but their actual involvement was on average 0.6 levels lower than desired. 42 For the 27 Phase 2 members who responded to both the entry survey and the annual survey, their desired commitment as reported in the

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41 'Annual leave' was removed as an option for the Phase 2 survey, as it is not specifically 'support' from an employer, but around half of those who selected 'Other' specified annual leave, so it was reinstated as an option for later surveys.

42 In this analysis, we treat the responses as three ordered levels, from bottom to top: occasional use of a small number of resources and activities; actively participating in a range of activities, but not helping to organise; contributing significantly to help shape and lead activities.
annual survey had gone down by 0.4 levels compared to their answer upon entry to Q, but their actual commitment had been 0.9 levels lower.

While events appear to be on the whole well received, one member spoke about the need to demonstrate active benefit from the welcome event:

*I think the challenge everybody faces nowadays is actually getting time off to come and do a day like this…. I am always conscious of the fact that you need to be getting something out of a day…. And I’m quite comfortable that today was about an introduction and an evolution, what it is we want out of it but I don’t think I could come back to too many days around this programme because like I say, it was lovely to meet people but I feel I would need something more concrete to take away the next time.* [Scotland member FGD2, September 2017]

This was exacerbated for some members by the need to demonstrate the utility of the time spent on Q to senior figures in an organisation, particularly given that the benefits of Q may only become more apparent in the longer term (Phase 1 member FGD2, May 2016). As already noted, it was observed at a welcome event that a number of members had funded their own travel and attended using annual leave. Whilst this indicates a level of commitment to Q, it may not be a sustainable for ongoing engagement with events.

One participant raised the utility of engaging with senior figures in order to demonstrate the benefits of membership of Q:

*I think in that sense it would actually be useful to have… some people who may be higher up in some of the Health Boards, so that they can see exactly the use of it as well because… you’ve either got someone at the top who is great, who understands it and supports it, or you have somebody who’s really sceptical and, therefore, it’s actually really difficult to get anything done, won’t make the changes. So yeah it needs to be… some way of engaging them in what we do.* [Scotland FGD1, September 2017]

While some members noted the utility of Q in helping to connect quality improvers in more rural or isolated regions with the wider community (Scotland FGD1, September 2017), a few also pointed out that the location of events could make it difficult to attend, or to justify travel and time costs.
6. The impact of Q on the health and social care landscape

6.1. Introduction

This chapter discusses the findings of the interviews, focus groups, case studies and citizen ethnography conducted from 2016 to 2017. It provides an overview Q’s impact on both the day-to-day work of its members and the wider health and social care landscape. Box 6 highlights the key findings.

Box 6. Summary of key findings

- There are key case studies and examples which show that Q has had an impact on the day-to-day work of its members.
- The impacts of Q primarily arise through the development of new networks that were unlikely to form without Q.
- Some members find it difficult to connect with members of similar interest and to implement learning from Q into their organisation.
- There is anecdotal evidence suggesting that Q has had an impact on the wider health and social care system, and many members are optimistic that this will increasingly happen as Q develops. It will be important to rigorously capture these – often indirect – impacts for the evaluation.

6.2. The impact of Q on members

Case studies and other examples of impact

During October 2017, multiple interviews were conducted to develop case studies of particular work in which those involved benefitted from being a member of Q and perhaps could not have undertaken their project without being a member. These case study vignettes can be found in Boxes 7 to 9 below. A further, larger case study of Q in Scotland is still being completed at the time of writing. It is designed to reflect the contribution that the different experiences of Scotland, Northern Ireland, Wales and the regions of England bring to Q and how Q might best respond to these.

The case studies show the impact the networking opportunities provided by Q can have on members’ day-to-day improvement work. However, despite the positive impact of meeting and connecting with people of similar interests, it is evident that Q had less of a direct influence on the projects after the
members had begun to collaborate; attributing impact to Q is therefore difficult in that the role of Q was most likely necessary but not sufficient. Despite this, when asked about how the various resources offered by Q would be used in the future (such as learning resources and connections with other members), members often said they were planning to use them for the particular case study project being discussed (as well as other future collaborations). In other words it seems that even when benefits are being delivered outside of Q, Q is providing a platform and resources to support learning and improvement. Our small group of case studies therefore suggests (but does not prove) that Q is starting to work as intended, at least for some members.

Box 7. Case study 1

**Introducing duty of candour to doctors**

A Q member working as a Regional Liaison Adviser for the General Medical Council has described how Q has contributed to the setting up a duty of candour teaching programme for doctors.

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 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 a 6-month period and aims to improve doctor’s knowledge of the duty of candour. It is hoped that this programme will empower doctors and allow them to apply what they have learnt 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.43

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.

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Box 8. Case study 2

Q Connector Powered Improvement

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, implement quality improvement techniques into an existing improvement programme in primary care settings in Bath and North East Somerset. 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 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 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 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 implementation of the NHS ambition to reduce inappropriate antibiotic prescribing by 50 per cent by 2020/21. Understanding these networks will 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 a great opportunity 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 was invaluable, particularly as the expertise within the workshop was so varied – some of the reflections included that AMR networks probably use the term ‘network’ very loosely and opportunities exist to improve the effectiveness of such networks. Q Connectors also identified opportunities to use the Network for Health website to support AMR networks, and 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, and other collaborators, to capture the global Twitter activity relating to AMR within World Antibiotic Awareness Week in November 2017. Connecting within Twitter is a yet 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.
Box 9. Case study 3

Q provides valuable connections

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.

Both reported that learning from and supporting each other had helped them to work more effectively in their own 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 also 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 own regions and encouraged system-wide thinking and understanding system dynamics. In particular, it highlighted the value of ‘connect, mobilise, support’. One of the members reported a particular value in connecting with people outside their own 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 own interactions, had helped them negotiate the various tribes 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 not feeling ‘entitled’ as a Q member and having a positive mind-set 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.

In addition to these case studies, Q members often referred to specific projects or improvement work in which Q has had an impact. As with the case studies, such projects have often come together through networking and forming connections at Q events, with members then collaborating without much further influence from Q. For example, an interview with a Phase 1 member shows the impact from forming connections at a design event:

…at one of the design events, I met up with… [redacted] and so what we’ve managed to do from that is now an email cohort of Q initiative people in Scotland and the monthly sort of webinars on quality improvement stuff. [Phase 1 Int 3, August 2016]

Other members are developing improvement projects that align with the aims and activities of Q, such as this member from a Phase 1 focus group:

The main area that I am taking Q forward is through, we have an enquire network which is a project that was set up through the AHSN looking at coordinating the quality improvement delivered in higher education institutions and we’re going to align Q with that to sort of give a framework, give a web page and identity within the [region] so that’s really all I’ve done in terms of that. [Phase 1 member FGD1, August 2016]
Perceptions of benefits of Q

Figure 17 and Figure 18 show that the vast majority of members are confident that they will benefit from joining Q upon commencement of membership. Continued confidence in the benefits of membership was also apparent in the annual survey (answered by respondents from Phase 1 and Phase 2 cohorts), although there was a small decrease over time in the level of confidence reported by members who responded to two surveys.44

Figure 17. Belief that Q will be beneficial for members

I am confident I will benefit from joining Q.

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44 When asked whether they were confident that they will benefit from joining Q, among the 45 Phase 2 respondents who answered both surveys, 25 deteriorated their answer, 16 answered in the same way and 4 ameliorated their answer. When asked whether they were confident that, through Q, they would be contributing to something that will ultimately benefit the quality of health and care in the UK, among the 44 Phase 2 respondents who answered both surveys, 24 deteriorated their answer, 16 answered the same in both surveys, and 4 answered more positively in the second survey. In the next year of Q, we will explore this further.
As can be seen in the case studies and other examples above, members often describe the positive impact Q has had on their day-to-day work. There are recurring themes which emerge when interviewing members and conducting focus groups as to how the experiences of being a Q member is directly impacting them, primarily through forming connections and personal development.

**Q members making new connections**

The most common benefit noted by members was, as identified in the first design phase of Q (Garrod et al. 2016), the ability to make connections with other professionals with an interest in improving quality, both to learn from them and to provide a specialist knowledge resource should a Q member have questions about a particular project or topic. A number of members reported having made and leveraged useful connections with other members (Phase 1 Int 6, November 2016, Phase 1 Int 7, January 2017), primarily through Q events.

> 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. So, you might have like a hit if it was just ordinary conferences but it certainly has facilitated, I think much better chances of finding someone you can actually take work forward to.  
>  [Phase 1 Int 11, July 2017]

Face-to-face interaction at events was seen as a key part of facilitating these connections. For example, at the end of one roundtable during the North East North Cumbria (NENC) welcome event, there was a
discussion of how valuable such opportunities for healthcare professionals to come together are, because they leave participants feeling ‘inspired’ to continue their quality improvement efforts, and to ‘keep bashing away’ at things.

Providing this networking time has allowed some members who may have lacked networking experience to improve these skills and become more confident in their ability to form connections (Phase 1 FGD1, May 2016). Forming networks has allowed collaboration between members with common interests and the initiation of improvement projects within their organisation, which was particularly highlighted in the Phase 1 member’s focus group:

On the positive side I made some good useful connections that have been useful, specifically I made a connection with somebody else who is setting up a new national clinical audit, another member came to me for advice so we met up face to face and continue communication since then around information sharing and then likewise as well I have helped with putting an NIHR grant application together with another Q member, again based, that’s more a kind of research based network. So that’s been good. [Phase 1 FGD1, May 2016]

I brought some of that learning back to the [redacted] Scheme and applied it. [Phase 1 FGD1, May 2016]

A number of members noted that Q had helped them to forge connections within their regions. Some also noted that they had connected with people within their own organisation interested in quality improvement, of which they had not been previously aware (Southwest welcome event survey responder). Members often comment that without Q, such networks could not have formed or they would not have had access to the resources needed to set up any improvement projects with the members they met:

Well I suppose, as I said within Scotland we have now got a little network, we wouldn’t have done before and that’s very useful contacts. [Phase 1 Int 3, August 2016]

Similarly, interviewees and focus group members were also enthusiastic about the professional diversity of Q providing an opportunity for collaboration between different disciplines in order to work across the ‘whole patient journey’ (Phase 2 Int 8, August 2017) and reduce tribalism (Scotland FGD2, September 2017).

I think it’s 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 or whatever it is. [Phase 2 Int 8, August 2017]

Even if these connections were not providing direct impacts in terms of improvement projects, members commented that they felt as though they could make use of contacts in the future, should they need to:

…I know that if we are going to set up something then I know that we can contact these people, and 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]

A small number of interviewees from among patient representatives and members with academic backgrounds also spoke of Q as a platform from which they could disseminate their own research or views to a wider audience of stakeholders.

**The benefit Q provides for members’ personal and professional development**

In addition to the impact Q has on networking and forming connections, members also make reference to the impact Q has on their personal development. Q members often refer to the impact on their knowledge and leadership skills (Phase 1 FGD1, May 2016, Phase 2 Int 6, July 2017). One Phase 2 member described how understanding the Q theory of change has impacted her day-to-day decision-making and thought processes:

> Q and Health Foundation as a whole has helped me to change how I tackle my day-to-day job, that I think has helped me be more successful. Because I would look back before I understood all of that psychology of change stuff, I look back and I think ‘Well before, I would have done it that way. But now I wouldn’t do that’. Now I think a lot more about engagement, who do I need to engage with? Who are the influencers in the system, who do they know? What are the networks? They need to all come together. [Phase 2 Int 6, July 2017]

In addition, members refer to Q increasing their status within the improvement community:

> …So there is an element of validation I guess in terms of when you’re out in an improvement community, the fact that you’re a Q member marks you out as having done something extra, if you like, because you’re extra interested…. [Phase 3 Int 1, October 2017]

> I like the way people are proud of Q and as I go around I often see people wearing the Q badge. [Q member who was interviewed in role as external stakeholder, December 2017]

Members also highlighted the role of Q in providing a support network and reducing the ‘isolation’ of quality improvement work, thus helping to build resilience (Scotland FGD2, September 2017) around quality improvement work within their home organisations (see the case studies in Section 6.2 for specific examples). This was mentioned by a junior doctor member specifically relating to the ability to use the network to support some continuity in projects despite junior doctor rotation, and by one member in a rural region.

> 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 back up, it’s alright, it will be better next week, type of thing. [Phase 3 Int 1, October 2017]

> I think what I found is if you speak to people in Wales, or if you speak to people in Scotland the problems are always the same and I think it is about, so for example,
we’ve been thinking about training and maybe setting up a training programme in our region. Last week, I think I had a randomised coffee trial with [redacted] [and found] that they actually already had done that, and they were like, ‘You just go and copy Scotland. That’s what we do.’ I mean, it’s kind of, you know, it’s really good to talk to people who have done things so you don’t feel isolated. [Liverpool member FGD1, November 2017]

There’s bits from time to time that you need to maybe focus 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 member FGD1, September 2017]

So, in fact, it’s quite an isolated profession, Quality Improvement, and if you’re practicing an advanced level, you tend to get deployed into pretty messy areas where things have failed…. And working in that way, it’s very easy I find, to go from one commission to the next without actually getting the chance to stop and contrast and think about, ‘Is this the system that’s failing massively? Is it my own practice? Have I approached that well?’ And what Q has really added for me, is a very deliberate design end to my work plan, to create opportunities to have those conversations. So that was a major kind of attraction for me, that was the thing that I probably hoped for the most, more so than access to specialist knowledge, it would be the peer support. [Phase 1 Int 6, November 2016]

Some members reported that Q adds a ‘badge’ of credibility (Phase 2 Int 1, October 2016, Phase 2 Int 2, November 2016), particularly when senior people are aware of their involvement. One member also spoke of the ability for Q to help make quality improvement a ‘tangible’ goal when discussing potential projects with senior figures within a healthcare organisation, and as a source of personal confidence (Phase 1 Int3, August 2016).

Clearly status and pride among improvers do not automatically translate into actual improvement of services. However, in the current context of health and social care, the possibility of creating a supportive ‘emotional retreat’ that also provides technical skills and accessible networks, can, in the right enabling environment, drive change in the wider health and care system.

Barriers to improvement

Although the examples discussed above show that Q can have a positive impact on members’ working lives, the evaluation has highlighted some barriers to healthcare improvement: Q not always bringing members of similar interests together, barriers to implementation and the struggle to sustain any changes that are made.

Views collected after welcome events, the annual surveys and new member surveys throughout 2017 as well as interviews suggest that some members struggle to connect with individuals who have similar interests or similar roles within healthcare:

So my main interest in Q is around knowledge sharing and I am yet to meet someone with my own nerdy interest in data and data science through this. So don’t know if that’s because the people here but I just don’t connect with the right people yet, more
because they’re part of the group or they don’t exist. So I still feel that’s, for me that’s unfilled potential. [Phase 1 member FGD1, May 2016]

This lack of connections with like-minded members may be acting as a barrier to improvement, since members are less able to share ideas and experiences that could work in their specific role:

Wider networking but could build connections suited to interest and share learning - we have lots of wonderful patient focused outcomes – but not easy to understand how to share with colleagues of a similar interest. [Annual survey, March 2017]

Throughout Q members’ experiences, the struggle to implement improvement methods within their organisations appears to be a theme. This is often linked to a lack of engagement with clinicians and other frontline staff as to the importance of improvement, possibly because the majority of improvement initiatives are not going to lead to rapid changes, but take time and money to be implemented and have effects that don’t appeal to hospital management or clinicians:

Trying to convince others is the biggest barrier. Trying to design conversations which start with QI saving money as this is top of everyone’s list. [Citizen ethnographer 4 Liverpool, November 2017]

…These are the things which are not handed over to the managers, because this is something which is not going to immediately reduce the length of stay or reduce the waiting times, etc. It will take a while. It will do it eventually but these are not the things which are immediate. [Liverpool member FGD1, November 2017]

However, the primary barrier to improvement implementation described by Q members is often the lack of capacity they have in their small improvement teams to implement the changes they would like to make (Phase 1 FGD1, May 2016, Phase 1 Int 3, August 2016, Liverpool member FGD2, November 2017). The small teams within hospitals often find it difficult to implement and diffuse change across their organisation, despite often having good ideas, collected through Q:

I think that’s, I was thinking that as well; they’ve found a great connection with other people that have that interest and passion but, and you go back to your organisation and you feel very lonely again that contributes to failure to get anything happening locally because actually what you need is other likeminded people with some skills that you can connect with to deal with your local issues. [Phase 1 member FGD1, May 2016]

You’re there and everyone’s really hyped up and it’s like yes, this is what we want to do but it’s how do you take all of that and put it back where you are when you go back alone? [Liverpool member FGD2, November 2017]

…number one there’s trust. That’s a big, huge thing. So it doesn’t matter what we’re trying to do, if there isn’t trust and respect for what people are doing, it’s really, really difficult to embed that change to make it sustainable. [Liverpool member FGD2, November 2017]

It may be that although Q does provide resources and activities, these may need to be centred on an area other than networking to allow practical steps to be taken in implementing change. Similarly, although
some improvement initiatives are able to thrive, there is often a difficulty in sustaining these changes in the long term, possibly due to the difficulty of maintaining engagement with key individuals:

So now I may engage a bit more and then I think that’s the problem, it is maintaining engagement and getting people to engage the first time when they are so busy that’s a problem and that particularly goes for people the health service. [Phase 3 Int 3, November 2017]

As highlighted in the previous section, a barrier to improvement is a lack of engagement from healthcare professionals, and a Phase 1 member commented on how engaging senior health professionals could also help to embed improvement practices:

My reflection on my role now in the executive team and previously in an executive team is that you really need people in those executive roles who are chief execs or clinical execs or they are chief operating officers. You need those people to have a really strong understanding of improvement work. I think what it could do is centrally, the Central Q Team could understand better what the agenda of the executive teams is and then it could try and recruit members of the executive team into the organisation and then it could support them to deliver on what they need to deliver. [Phase 1 Int 10, July 2017]

Disengagement with Q

Despite the diversity of expectations of Q among members, very few have expressed concerns to the evaluation team (despite many opportunities). However, a small minority of members raised more significant concerns about the implementation of Q. It is also important to bear in mind that interviewees who were more negative about Q may have been more likely – or, alternatively, less likely – to agree to engage with the evaluation team.

Over the course of the interviews, a number of members also expressed dissatisfaction about different aspects of Q, or reported a lack of engagement with the Q offer more generally.45 There is no coherent and consistent set of reasons for disengaging, making it hard to pull out clear messages. However, disengagement and ‘naysaying’ are best regarded as ‘red flags’ indicating that attention should be given rather than as solutions.46

Early in the development of Q, some interviewees found it difficult to demonstrate the benefits of being involved (Phase 1 Int 8, January 2017), or did not feel they received any ‘personal benefit from it’ beyond meeting people from their region, instead suggesting they had a personal responsibility to contribute to improving the system (Phase 1 Int 2, August 2016). Two members linked this specifically to the large amount of resources that they perceived to have been spent on Q without seeing any direct impact (seeing ‘where the change is’):

45 This included a set of interviews conducted in the second year of the evaluation in which a subset of members who were considered the most and least engaged (based on their answers to the survey question on their expected future level of engagement with Q) were also specifically sampled in order to explore these dynamics more closely.

46 Lawrence (1954).
One interviewee expressed particular concern about the role of patients and patient representatives in Q, on the grounds that Q was not involving patients in the improvement processes. At time of interview, the interviewee did not expect this to improve in the future:

…I’m really, really tired of saying, ‘Where are the patients here?’ and, ‘What’s the role of the patients in this?’ Well I think I know what the role of patients is, it’s to contribute to this stuff on an equal basis really, but I don’t think Q, I still don’t think Q is taking those patient/service user end of informant in this remotely seriously. I’m getting really tired of it actually…. [During a presentation about Q] It was mentioned somewhere, but it was one of the worst obvious cases of box ticking I’ve ever seen; we have to mention patients otherwise they’ll complain. But it doesn’t feel as though there’s any real engagement with patients at all to me and it’s felt like that from the beginning. I was very close to leaving twice. [Redacted]

The interviewee went on to comment that the only reason they have stayed a member of Q is to ‘keep banging the drum’ about patient involvement in Q and healthcare improvement. It was suggested that this could be facilitated by Q recruiting a greater number of patient representatives (the situation may have improved since the interview was conducted as there are now approximately 50 Q members who identify as patient and public voice representatives). Another patient representative interviewed did not share these views, and was more positive about the impact of Q.

One Phase 3 member described how their lack of engagement was in part due to Q not being what they expected it to be, as they had believed that Q would be more connected to the local AHSN than it actually was. In addition, this member was unable to prioritise Q above their day job and so struggled to attend events and other activities, which made them less motivated to get involved. The member commented that this situation was unlikely to change in the future unless Q changed the way it interacts with them:

Unless something different happens and somebody engages me in some way to do something, which would have to be fairly [redacted: region]-centric probably to get my attention, I would probably not get engaged moving forward. [Phase 3 Int 4, December 2017]

Although the members discussed and quoted here were less engaged in Q than most others, there was still some optimism that this could change in the future. Another Phase 1 member saw Q as still being too young to see the value, but thought this would change in the future:

…there’s still an evolutionary process here, both in terms of how the network functions and what it functions for. So I still think we’re not that long out of the design…. I think it’s still difficult to imagine its value just now because as I say I still think it’s a very fledgling concept. But there’s a lot of potential there I think if we can begin to find ways to work more purposefully and explore some of these issues about connecting behaviours that create more opportunity for exchange in flow of information and knowledge, then it’ll begin to have its own vibrancy. [Phase 1 Int 8, January 2017]
6.3. The impact of Q on the wider health and social care system

As can be seen in the examples and case studies above, Q appears to have had a positive impact on some members’ work. However, the wider impact that Q has had on the health and social care system is not so clear. This might be because: a) it is too early to tell; b) it is happening but is not visible; or c) it is not happening. We suspect that there are elements of all three, meaning: a) we anticipate more evidence of wider impact in the coming two years; b) the evaluation should be adjusted to provide more attention to making such change visible; and c) there should be some adjustment in the prioritisation and focus of Q to support these outcomes.

Members often suggest that Q provides something new in the health and social care landscape (Phase 1 Int 6, November 2016, Phase 1 Int 7, January 2017, Phase 3 Int 1, October 2017):

I think it 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 Int 6, November 2016]

When Q was first set up, some individuals were more sceptical as to the original role it could play within the healthcare landscape:

Nothing like this has ever worked before why would this now. [Q member who was interviewed in role as external stakeholder, December 2017]

However, even the more sceptical individuals no longer hold this view: the external stakeholder above went on to comment that experience of Q suggests that it may be working in a way in which other initiatives have not. As Q evolves and becomes more established, the distinct role it plays is likely to become more important in making wider impacts in health and social care, especially as some members comment that they could not have made the connections they have without Q, or it would have been much more difficult (case study 1, October 2017, Phase 1 Int 7, January 2017).

Despite Q often being viewed as providing unique opportunities, most members agree that, although there is an impact on their day-to-day working, it has not yet had a wider impact on the health and social care landscape (2017 annual survey and new member survey responses, Phase 1 Int 1, July 2016, Phase 1 Int 10, July 2017, Citizen ethnographer 4 Liverpool, November 2017).

Disappointed that impact is not obvious yet, other than networking, no obvious impact. Hard to see where all the design work from the initial year went. [Citizen ethnographer 4 Liverpool, November 2017]

I know that there are people who are doing good work in the NHS in the UK, in all other countries who aren’t members of Q 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 Int 10, July 2017]
However, this was not always seen as a negative result as members often commented that it may still be too early for Q to have had widespread impact, and were confident that this would happen in the future (March 2017 annual survey, new member surveys throughout 2017, Phase 1 Int 8, January 2017, Phase 1 Int 10, July 2017, Phase 1 Int 4, August 2016, Phase 1 Int 6, November 2016, Phase 3 Int 1, October 2017, Citizen ethnographer 1 Liverpool, November 2017, Q member who was interviewed in role as external stakeholder, December 2017). Some members describe that momentum and strength is present in Q already, and this just needs to grow to have a wider impact, which it likely will as Q expands and takes on new members:

I would anticipate it having increasing impact at a local and national level in the UK and building momentum, as people make use of their membership at Q and attend events and develop their networks and start to work together on problems. I think the formal structures of health services in the UK are really not helpful for people working together and Q fills that space very well, so I would anticipate it growing in impact. [Phase 1 Int 10, July 2017]

Although members often agreed that Q lacked a wider impact, they also described methods that could be implemented to help improve this. One idea that arose multiple times during interviews was the need for Q to have greater regional development and to focus on local improvement more (Phase 1 Int 7, January 2017, Phase 2 Int 2, November 2016, Scotland member FGD2, September 2017, Phase 1 Int 5, September 2016).

I think there’s been varying different approaches from the regions in terms of how they’ve harnessed their Q initiative participants…. I think the biggest challenge is probably it needed to become real, and probably vibrant and alive in smaller regions, so I’ve always been, from the kind of word go, but it’s great to have something that’s national, but it has to be regional to hold onto something, if that makes sense. So you can see some challenges or benefit, and kind of almost challenge people, not in a kind of management way but in a maximising impact way, otherwise the challenge is that you have a network of people, and I think this was a bit of a challenge with some of the Q participants. [Phase 1 Int 5, September 2016]

The other underlying need highlighted by members for Q to have a wider impact is a change in culture to create the optimum environment for improvement initiatives to thrive. There are multiple ways identified through interviews with members and external improvement experts to drive this culture change; one Phase 1 member describes the language barrier between those in improvement roles and clinicians:

I think it’s made me much more aware about what’s going on and I think what I have learnt is that a lot of quality improvement is going on but it’s not called quality improvement. So I think for example, our radiographers have been intimately involved in our project here but if you ask them about quality improvement they would probably say they don’t really know. We’re talking different languages I think, I think that’s kind of what my view has changed in that we need to all kind of get

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Q is already addressing this aspect of regional development to an extent through the roll-out of its regional convenors and Q Connectors who aim to bring together Q members and improvement projects across regions.
together and speak the same language because I think a lot of it is going on. [Phase 1 Int 9, July 2017]

This change in language can also be applied to how healthcare professionals define the term improvement, and how it is viewed from their perspective. For example, an interview with an external improvement expert highlighted how the term improvement can often coincide with the view that care is not at a high enough standard, which is not always the case:

Because I have heard it reported back, particularly when they start engaging citizens and service users in effect in activity, the whole concept, ‘Oh it needs to be improved does it so that must mean it’s bad, so obviously people are coming to harm’ type thing and so it would need careful handling and careful messaging … we need to be careful that we don’t play, inadvertently play into that narrative and possibly undermine what work there is ongoing there. [External Int 1, November 2017]

The idea of a shared language and an understanding of what improvement actually is could be extended to a better understanding of risk and the acknowledgement that improvement methods need to be tried and tested without a fear of failure. This was brought up by a Phase 3 member multiple times throughout their interview:

For culture to shift slightly so that any analytic research that’s conducted isn’t always focusing on things that go wrong; it’s actually focusing on what’s happened and what can go better and how we can improve quality and what can we look at financially, in terms of cost effectiveness, but importantly for patient safety, so I think it might just introduce a slight culture shift hopefully…. Also, the other thing that you pointed out is how do we, alongside the Q work, actually prepare people to understand their risk appetite and work at the level required because clearly, the person you’ve described has just seen a problem, felt that they’re trusted to come up with a solution and respected and given permission to do it…. I don’t have the tools necessarily to do that. How do we make that happen? [Liverpool member FGD2, November 2017]

Good collaboration across sectors and organisational boundaries between improvement experts, including Q members, and health professionals is often referenced as a way to strengthen the impact of Q (Phase 1 Int 10, July 2017, Phase 1 Int 4, August 2016). An interview with an external Quality Improvement expert highlights how those trying to implement improvement on a larger scale need to do so by collaborating outside their direct circle of work:

Because I think in your introductory remarks the issue has been when people have got too locked in this activity, their nose is pressed right up against the grindstone again as soon as they get back. And it’s working out a way by which they can, certainly in the first instance, have the space freed up to apply this new skillset in bettering the services. Not only that they provide personally or as part of the team but throughout their organisation and increasingly beyond the limits of their organisation. [External Int 1, November 2017]

The discussion about how Q can have a wider impact also leads to comments relating to how these impacts create sustainable, long-term change. This often relates to embedding the idea of improvement into the healthcare system so it can become second nature rather than an additional burden (Phase 3 Int 3, November 2017, Phase 1 Int 10, July 2017, Phase 3 Int 4).
7. Discussion, conclusions and recommendations

7.1. Introduction

This report has focused on five evaluation questions:

1. How effective is the ongoing governance, design and management of Q?
2. How well does the Q community and infrastructure meet the needs of members?
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?
4. What impact has Q had on the wider health and care system across the UK?
5. Is Q achieving or contributing to sustainable improvement in health and care across the UK and, if so, how?

We organise our discussion here in relation to these questions. This interim report offers an opportunity to take stock of the evaluation and how learning from evaluation activities can be best utilised by the Q team to inform the ongoing development of the initiative. As the evaluation moves into the second, summative phase, the evaluation team and Q project team should consider the ways in which the evaluation can best explore new and developing activity streams and provide ongoing learning for the Q team, while also retaining the necessary independence to provide an objective and balanced assessment of the position and impact of Q in 2020.

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

During the two-year period covered by this report, Q has moved from being a concept still in development to a large community that is today ten times the size it was two years ago. There has been a similar growth in the range and numbers of activities sponsored by Q. Such a transformation requires a nimbleness and responsiveness in how work is designed and managed and how effective governance is put in place.

During this time the governance, design and management of Q has evolved in line with these changes in scale and activity. Overall, the substantial and challenging transition of function and scale has been well managed and communicated. The Q team has remained cohesive and has developed a crisper division of labour in response to the growing complexity of tasks. This reflects well on the leadership of the team and
the use of ways of working that have given team members a clear sense of shared purpose and individual responsibility. Relationships with regional partners – and in particular relating to successive rounds of recruitment – have been well managed with continuing goodwill on both sides. The current governance of Q involves a two-tiered system, with the regional and national levels; organisations in each have successfully accommodated the need for shared direction and branding while ensuring adequate regional autonomy and variety. There is also general support for a commons model of governance, but what this means in practice is still evolving. Q is likely to make recruitment a more centrally managed process, with the establishment of Q Connectors maintaining a regional voice. Recognition of, and sensitivity towards, the distinctiveness of regions and nations within the UK has helped Q ‘land’ in the regional roll-out. 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. It is very likely this will continue to evolve and that the idea of a regional and national commons will be a part (as yet still emerging) of this. Addressing this has included having interactive activities at events, supporting SIGs and hosting social media interactions. New and well-run activities are appreciated by members and are settling down into a well-understood suite of offerings serving various needs. As this transition has evolved, the existing theory of change will most likely require some adaptation. At the same time, key stakeholders – and in particular the leadership of the Health Foundation and NHS Improvement – have been given the information and assurances they need to maintain their support.

Overseeing a tenfold growth in membership, rolling out a regional strategy, organising a set of new activities, supporting Special Interest Groups, and initiating an online community without experiencing significant problems in the governance, design and management of the initiative is a significant achievement. However, there are new – and equally challenging – governance, design and management issues addressed in our recommendations.

**Recommendations**

This is a good moment for the Q team, supported by the evaluation team, to review the theory of change and the Q theory of learning. The purpose is to update these in the light of the past two years’ experience for Q, what members are now saying and doing, and how the needs and priorities of the health and care system are evolving. Since the theory of change was developed with members, members should have the opportunity to contribute to any changes that the Q team might think helpful.

This will trigger further thinking about how the local, regional and UK dimensions of Q can be managed to best integrate top-down and bottom-up approaches. The Q team will be involved with regional partners but should also draw upon both the membership and the regional and national commons.

In light of these considerations, the Health Foundation should reflect upon the success of the Q team’s leadership and ways of working to ensure their approach remains fit for purpose should any new design and governance issues emerge from these recommendations.
7.3. How well does the Q community and infrastructure meet the needs of members?

From its inception, Q was expected to support improvers to learn, overcome isolation, improve skills and collaborate for effective improvement in health and care. This remains fundamental to its purpose, and in practice it supports activities designed to connect, mobilise, support and develop Q members and strengthen the improvement context. Alongside meeting these immediate needs, Q’s aim is also to establish a sustainable community that can meet longer-term needs, and this requires an infrastructure that can provide the skills and resources needed for sustainability and resilience. Resources are needed to support activities (e.g. Q visits) and regional and national events, to build and sustain a profile for Q, inform members, and to manage recruitment. An effective infrastructure is therefore crucial to the success of Q.

How Q might best meet the needs of its members is defined in a deliberately expansive way. As an ‘initiative’, rather than a project, there is no single narrowly defined pathway to impact but, rather, members and stakeholders are offered a wide variety of ways of working with each other involving a range of commitments. However, in an initiative there is an expectation that the whole should be greater than the sum of its parts and that there should be commonalities threading together the variety of activities.

Members have different views about whether the recruitment process is too onerous but it is widely regarded as fair and well managed (even by most unsuccessful candidates) and their subsequent ‘on-boarding’ is helpful. Q Assessors and others raised anxieties about the aims of Q not being sufficiently clear, but members report they have become clearer in successive waves (as the shape of Q has become more firmly established).

Membership profiles have generally remained the same since the founding cohort. Through interviews and focus groups, it was considered that perhaps Q could widen its audience and encourage minority groups to join, such as patient representatives, as some viewed Q as being elitist. Having a mix of views within Q can add to its creativity and energy, providing such views can be openly discussed in the light of a shared understanding of the ultimate aims of Q.

It is important to recognise that the needs of members are varied. Furthermore, each member may have different needs at different times. Q was never intended to be a ‘one-size-fits-all’ model and has offered a variety of ways of engaging, reflecting how much time an individual member could commit to Q activities. In developing these methods of engagement, the Q team has been responsive to the needs of most members but less so for the more critical members. In thinking about the variety of needs to be met, greater prominence could also be given to the views of patients and patient representatives.

**Recommendations**

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 onerous the recruitment process should be.
Q offers members very flexible packages for engagement but there are two challenges to be addressed by the Q team and members: what is an acceptable level of engagement for a Q member (and is there a common core of activities that all Q members should engage with); and how far should Q resemble a club that provides a range of activities that members consume (or not) and, conversely, how far should Q aim to be a community that is characterised by groups and individuals choosing to create things together. The needs that can be met by participating in activities may be different from the needs that can be met by co-creating a community. These are not necessarily mutually incompatible.

In taking these recommendations forward the views of more critical Q members and those of patients could be given more prominence.

7.4. 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?

Engagement of members is variable but often high, with most members with currently low levels of engagement expecting to do more in the future. For newer members, the Q team has successfully offered greater clarity regarding the aims of Q.

New members often expect that Q will be beneficial to them and see forming networks and connections as one of the greatest benefits; Q reduces the isolation those in healthcare improvement roles often experience. Activities and resources are frequently well received and attendance at events is high. Networking and forming connections is often the most commonly cited reason for enjoying these events and resources.

Time and cost are referred to as the most common barriers to participation in Q, with some members reporting taking annual leave to attend events. There are also some concerns that utility and practical outcomes are not always sufficiently visible to justify the time members put in to Q.

Recommendations

Q activities and opportunities to network are highly valued by members and the processes by which these have been established and communicated should be continued.

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 these trade-offs and identify which activities, or perhaps which combinations of activities, would provide the greatest value. 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?
7.5. 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?

Through case studies and examples provided by members during interviews and focus groups, it is clear that Q is having an impact on the day-to-day work of at least some members. This primarily occurs because Q provides opportunities to network and make connections, creating a foundation upon which collaborations can be built. However, this is often the extent of the influence of Q, with indirect benefits accruing outside the organisational setting of Q.

Members often commented that the networking opportunities Q provides are the most beneficial impact, but there is also a positive impact on the personal development of members, such as increasing knowledge and improving leadership skills. Q members often commented that they could not have formed connections or accessed resources without Q.

Although many positive impacts of Q were reported, some barriers to implementation were also highlighted. For example, Q may not always bring together members with similar interests or roles, and small improvement teams often have difficulty in engaging frontline staff. Sustaining change is also often seen as a barrier to widespread impact.

Although Q is commonly viewed as being a distinct and unique entity in the healthcare landscape, the wider impacts it has on the health and care landscape are often less clear. Some reported that this may be due to the difficulty of measuring the impact of Q, as effects are hard to directly attribute to it. Many stakeholders commented that it may simply be too early in Q’s lifetime to have had widespread impact, and there was optimism that there is the drive and potential for Q to be successful. With relation to the Q learning theory, Q has met the first two frames (‘me’ and ‘me and we’) as it has had an impact on individual members and allowed them to connect. However, it has not yet reached the third frame (organisations and systems) as its impact on the healthcare system as a whole is not yet visible.

Q is not sufficiently well-focused on driving change into the wider health and care system. The challenges to understanding this are well known (diffused impacts, multi-causal processes, uncertain timeframes) but Q has the opportunity to build more learning and action into this aspect of its work. In order to explore this dimension of achieving impact a relatively simple framework could be used to shape learning across the Q community.48

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48 For example, we might follow the logic of ‘When Innovation Goes Wrong’ (Seelos & Mair 2016) by arguing that the meta-learning of the Q community should focus on:

- Are we framing our improvement problems correctly?
- Are we getting to solutions that work?
- Are we able to get others to adopt and collaborate in delivering improvement?
- Are we clear about unintended (and negative) consequences?
- Are improvements compatible with wider service priorities and expectations?
- Are improvements compatible with management priorities and capacities?
Such a framework may be helpful in understanding the system strengthening aspects of Q. However, we might also be interested not only in how the existing system is strengthened but also in understanding how it might be transformed in a more fundamental way. Whatever framework is used, it should include attention to the relationship between Q and the wider priorities of the health and care system. While Q is not a delivery arm of the five year forward view, it is important that it should be relevant to these aims if it wishes to increasingly gain system-wide traction.

**Recommendations**

As part of the review of the theory of change and of the Q learning theory, consideration should be given to how Q can develop a meta-learning theory of how to maximise impact on the wider health and care system.

The Q team and members should engage more directly with the priorities of the health and care system and balance these with bottom-up (including patient-led) priorities. The evaluation team and the Q team, in collaboration with the Evaluation Advisory Group and other interested parties, should agree an adaptation to the evaluation protocol that aims to capture more indirect and system-level impacts in order not only to contribute to learning but also to be oriented towards making summative conclusions in the final report.
References


Lawrence, P.R. 1954. ‘How to deal with resistance to change.’ Harvard Business Review 49–57.


THF. 2016c. ‘Q Improvement Labs: Feedback from the Summer Workshops.’ As of 29 April 2017: http://www.health.org.uk/sites/health/files/Follow%20up%20from%20Q%20lab%20workshops.pdf


Appendix 1. Evaluation questions

There are five overarching evaluation questions. These questions have arisen, in part, from discussions between the Q project and evaluation teams, consultation with Q members and the report on the Q co-design stage (Garrod et al. 2016). Evaluation questions A and B largely serve the first evaluation aim and evaluation questions C to E largely serve the second aim. Each evaluation question has a number of sub-questions, which are outlined below. The evaluation also addresses a number of additional thematic questions related to Q’s implementation; questions F to J below.

Five overarching evaluation questions

A. How effective is the ongoing governance, design and management of Q (A.1–A.8)? How has Q Lab progressed from March 2016 to February 2017 (A.9–A.13)?

A.1. What is the leadership and governance model for Q and how effective is this in enabling a sustainable, engaged community? This includes understanding who is on the leading team and working regionally, how well they are working together and how the structure and processes could be improved.

A.2. What is the recruitment and ‘onboarding’ process and how effective is this? As well as understanding the diversity and the trajectory of total numbers recruited, this includes an assessment of how Q has managed the tensions inherent in the process. An example is the perceived need to avoid being inappropriately elitist while ensuring membership of Q is seen as high value.

A.3. Does Q achieve the intended diversity and range of members? An assessment of how well Q attracts and enables involvement and meets the needs of diverse members is important.

A.4. What is the model for ongoing design and strategy development for the initiative and how effective is this? This includes how member and stakeholder views are incorporated, and how evaluative feedback is responded to. It is also important to recognise whether Q moves away from decisions from the first phase, and if it did, why and was this justified?

A.5. What existing mechanisms exist to generate data and insight, how effective are they, and how might new mechanisms be established to support the development and evaluation of Q? We are also interested in how members experience the processes of data collection.

A.6. How is evidence and theory incorporated into the design and management of Q?

49 According to the Q project team: ‘Onboarding is the process of helping new members adjust to the social and technical aspects of their role within Q quickly and smoothly, enabling them to be effective members of the community.’
A.7. How, and how well, does Q manage its interface with key stakeholders, organisations, initiatives and networks? This includes whether employers/host organisations/resource holders are committed to supporting members to join and participate. We are also interested in how far Q is supported and seen as being aligned to the priorities of key partners and stakeholders.
A.8. Is Q seen to be value adding? Are the aims of Q clear and valued by stakeholders, and is Q attractive and compelling to non-members?
A.9. How are Q Lab being designed? How effective and efficient is this process?
A.10. What are the processes for involving stakeholders in design and how effective are these?
A.11. How effectively is the available evidence and insight being used to inform the design of Q Lab?
A.12. How has the co-design process developed since 2015 (and is it different for Q Lab than for Q overall)?
A.13. What evaluation framework and approach would be most suitable for the evaluation of Q Lab more specifically?

B. How well does the Q community and infrastructure meet the needs of members?
B.1. 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?
B.2. How do these activities change over time and what is driving this change (for example, the needs of members)?
B.3. Do members perceive Q to be playing a distinctive role in the improvement landscape, does this meet needs that are not met by other initiatives, and how do members value the things they are enabled to do by their participation in Q?
B.4. What is the level of engagement and satisfaction of members with the activities, resources, systems and spaces of the Q infrastructure, and of Q overall? The Q engagement strategy will also be closely aligned with this aspect.
B.5. To what degree are the components of Q (such as Q Lab) contributing to the overall success of Q?

C. 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?
C.1. How well does Q enable the development of meaningful connections? This element should include a social network analysis component and focus primarily on connections within the community, but also recognise important connections outside the community.
C.2. How well does Q (the community and infrastructure) provide support for improvement? Primarily to members, but also more widely. Support may include peer support from other members, ability to access resources and expertise, more explicit support from employers, etc.
C.3. How well does Q enable the development of skills, knowledge and expertise for improvement? Primarily of members, but also more widely.
C.4. How well does Q mobilise improvers to collaborate efficiently to organise, undertake, promote and spread improvement activities? Primarily members, but also more widely.
C.5. What are the unintended consequences of Q for members – both positive and negative?
D. What impact has Q had on the wider health and care system across the UK?
   D.1. To what degree has Q contributed towards achieving changes in organisational culture, policy and conditions that better enable improvement?
   D.2. To what degree has Q contributed towards achieving widespread capability and understanding of improvement? For members and more broadly?
   D.3. To what degree has Q contributed towards achieving capacity and leadership for improvement at sufficient scale and scope across the system?
   D.4. What new knowledge or outputs have been generated as a result of Q?
   D.5. How well does Q fit within the wider improvement and health policy landscape and what benefits or unintended consequences has it given for other relevant organisations or initiatives?

E. Is Q achieving or contributing to sustainable improvement in health and care across the UK and, if so, how?
   E.1. What, if any, direct contribution has Q made to improvements in quality of health and care and patient outcomes (through Labs, member-initiated improvement work, successful calls to action, influencing policy, etc.)?
   E.2. What does evidence from outside Q say about how the actual and intended impact of Q on members might lead to subsequent improvements in quality of care? Can this be quantified?

Additional questions

F. Regional roll-out: general questions
   F.1. How effectively has the relationship between the central Q project team and regional partners been managed, and how has it affected the efficiency and effectiveness of the roll-out?
   F.2. What contextual differences between regions, including but not limited to differences between the partners, are affecting recruitment, onboarding, governance, activities and outcomes?
   F.3. How is Q perceived differently between regions?
   F.4. How do regions work with each other and with the central Q project team? Are there effective lines of communication?
   F.5. How appropriate has the balance between autonomy and coordination been?
   F.6. How do differences between partners affect the operation of Q in their regions?

G. Regional recruitment and onboarding
   G.1. What is the recruitment and ‘onboarding’ process and how effective is this? As well as understanding the diversity and the trajectory of total numbers recruited, this includes an assessment of how Q has managed the tensions inherent in the process. An example is the perceived need to avoid being inappropriately elitist while ensuring membership of Q is seen as high value. (A2)
   G.2. Does Q achieve the intended diversity and range of members? An assessment of how well Q attracts and enables involvement and meets the needs of diverse members is important. (A3)
   G.3. How have recruitment criteria been applied, and has the balance between consistency and adaptability been appropriate?
   G.4. Which parts of the recruitment process add the most and least value in recruiting appropriate members for Q?
G.5. Is the way in which assessors are recruited, used and paid appropriate for the Q recruitment process and an efficient use of resources?

G.6. What are the costs and benefits to partners of contributing to Q?

H. Governance

H.1. What is the leadership and governance model for Q and how effective is this in enabling a sustainable, engaged community? This includes understanding who is on the leading team and working regionally, how well they are working together and how the structure and processes could be improved. (A1)

H.2. How do the governance arrangements balance encouraging positive behaviour by promoting values with discouraging negative behaviour by providing mechanisms for when things go wrong?

H.3. What is the role of the governance adviser and how effective is this?

H.4. To what extent are the responsibilities of the national and regional commons mutually understood and to what extent do they hold in practice?

H.5. Are regional and national aims for Q consistent with each other?

H.6. How effective is the compact/contract between the central Q project team and the regional partners?

H.7. How effective are the governance arrangements in the individual regions, and the guidance on which they are based?

H.8. How do existing regional networks and knowledge management systems affect the operation of Q in their regions?

H.9. Is the governance model appropriate for the structure of the Q network?

H.10. How does the governance model affect the way that the Q network is forming?

H.11. How do relationships between regional partners and conveners function?

H.12. How, and how well, does Q manage its interface with key stakeholders, organisations, initiatives and networks? This includes whether employers/host organisations/resource holders are committed to supporting members to join and participate. We are also interested in how far Q is supported and seen as being aligned to the priorities of key partners and stakeholders. (A7)

H.13. To what extent does the governance model for Q evolve with Q?

I. Activities

I.1. How is responsibility for Q activities shared between the national team, the regional partners and other stakeholders?

I.2. What types of activities are most appropriately designed and run regionally or nationally?

I.3. How does the regional/national nature of events affect their success?

I.4. How effective are mechanisms to ensure that regionally run events are consistent in quality and in the values they represent?

I.5. How is responsibility for activities supported by the governance model?

J. Labs

J.1. How are Q Lab being designed (including efficiency and effectiveness of the process)?
J.2. What are the processes for involving stakeholders in design, and how effective are these processes?

J.3. How effectively is the available evidence and insight being used to inform the design of Q Lab?

J.4. How has the co-design process developed since 2015 and what are the differences in this process between Q Lab and Q overall?

J.5. What are the skills required within the Q Lab team to effectively run the lab and does the team need to recruit any further?

J.6. How are topics for Q Lab chosen and how efficient and effective is the process?

J.7. To what extent do the Q Lab and the rest of Q complement each other and fit together?

J.8. What is key to the success of Q Lab and what can be adapted?

J.9. What type of evaluation framework and approach would be most suitable for the evaluation of Q Lab from March 2017 onwards?

J.10. How well are members and other stakeholders engaged in the lead up to the launch of the lab?
Appendix 2. Evaluation methods

Overview
RAND Europe and the Health Foundation have worked closely together to establish an independent but embedded evaluation. Neither organisation underestimated the challenge and throughout the evaluation there have been opportunities to step back and reflect not only on the progress of the initiative but also on the contribution of the evaluation to such progress. Alongside the benefit of providing stakeholders and decision-makers with ongoing and refreshed evidence was a potential risk to the independence of the evaluation. This has been managed by ensuring formal accountability to deliver against the evaluation protocol and RAND’s own Quality Assurance processes.

An overview of the data collection methods used in this evaluation and the evaluation questions they seek to address is provided in Table 6.
Table 6. Overview of data collection and the evaluation questions they seek to address

<table>
<thead>
<tr>
<th>Data collection</th>
<th>Evaluation questions (EQs; see Appendix 1)</th>
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<tbody>
<tr>
<td><strong>Document review</strong></td>
<td>• EQ A (Governance, design and management. Progress of Q Lab)</td>
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<tr>
<td></td>
<td>• EQ H (Governance)</td>
</tr>
<tr>
<td></td>
<td>• EQ J (Q Lab)</td>
</tr>
<tr>
<td>Literature review</td>
<td>• EQ A (Governance, design and management. Progress of Q Lab)</td>
</tr>
<tr>
<td>Attendance at events</td>
<td>• EQ A (Governance, design and management. Progress of Q Lab)</td>
</tr>
<tr>
<td></td>
<td>• EQ C (Connecting, mobilising members to lead improvement)</td>
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<tr>
<td></td>
<td>• EQ I (Activities)</td>
</tr>
<tr>
<td></td>
<td>• EQ J (Q Lab)</td>
</tr>
<tr>
<td>Semi-structured interviews and focus</td>
<td>• EQ B (Q community and infrastructure)</td>
</tr>
<tr>
<td>group discussions</td>
<td>• EQ C (Connecting, mobilising members to lead improvement)</td>
</tr>
<tr>
<td></td>
<td>• EQ D (Impact on wider health system)</td>
</tr>
<tr>
<td></td>
<td>• EQ F (Regional roll-out)</td>
</tr>
<tr>
<td></td>
<td>• EQ G (Regional recruitment and onboarding)</td>
</tr>
<tr>
<td></td>
<td>• EQ H (Governance)</td>
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<tr>
<td></td>
<td>• EQ I (Activities)</td>
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<td>• EQ J (Q Lab)</td>
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<td>Case studies with Q members</td>
<td>• EQ C (Connecting, mobilising members to lead improvement)</td>
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<td></td>
<td>• EQ D (Impact on wider healthcare system)</td>
</tr>
<tr>
<td></td>
<td>• EQ E (Contributing to sustainable improvement)</td>
</tr>
<tr>
<td>Citizen ethnography with Q members</td>
<td>• EQ A (Governance, design and management. Progress of Q Lab)</td>
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<td></td>
<td>• EQ C (Connecting, mobilising members to lead improvement)</td>
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<td>• EQ I (Activities)</td>
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<tr>
<td>Surveys and social network analysis</td>
<td>• EQ B (Q community and infrastructure)</td>
</tr>
<tr>
<td></td>
<td>• EQ G (Regional recruitment and onboarding)</td>
</tr>
</tbody>
</table>

**Document and literature reviews**

The evaluation team has undertaken a continuous review and cataloguing of documents provided by the Q project team throughout the evaluation. The aim was to trace the evolution of the different elements of the Q work streams, namely the Q Lab, the regional roll-out, governance, recruitment and activities, and to understand the work of the Q project team from meeting minutes and additional project documents. The review is not intended to provide a systematic account of the documentation provided by the Q project team.

A variety of search terms were used to collect wider literature on healthcare improvement from PubMed, including: healthcare, quality improvement, community of practice, social networks and social movement. Papers were excluded if they were from outside the UK or published before the year 2000. In
total, nine papers were included in this section of the literature review, in addition to three documents provided by the Health Foundation. This part of the literature review was conducted to explore the different theories of healthcare improvement that have been assessed and how these relate to and link in with Q.

**Attendance at events**

Throughout the evaluation process, members of the evaluation team attended a number of events in order to observe the implementation of Q and hold informal discussions with attendees. These events were:

- Community events in London and Leeds, May 2016 (JE, BG, TL, JN)
- Community event in London, October 2016 (EH, TL)
- Q Lab workshop in York and Leeds, September 2016 (JE and EH)
- Lab theory of change workshops, December 2016 and March 2017 (TL)
- North East North Cumbria Welcome Event in Newcastle, March 2017 (TL, BG, TD)
- Q site visit to Microsystems Academy in Sheffield, June 2017 (TD)
- West Midlands Welcome Event, Birmingham, July 2017 (JN, KS)
- Scotland Welcome Event, Edinburgh, September 2017 (KS, TL)

In addition, two members of the evaluation team (TL and one of BG, JN, LH or KS) regularly attended the Q project team monthly meetings at the Health Foundation premises in London, in addition to ad hoc meetings and community events where appropriate.

The evaluation team did not attend these events to make formal observations, but rather to inform the understanding of the context of Q and how it is governed (as well as gaining insights into the design and development of the Q Lab) and enable interactions with members. The observations made by the evaluation team during these events and meetings have informed the design of interview and focus group protocols and have helped support and explain findings gathered through other methods.

**Semi-structured interviews and focus group discussions with a range of stakeholders**

From August 2016 to March 2018, 55 semi-structured interviews and 19 focus group discussions were conducted with a variety of Q members and associated stakeholders. These interviews and focus groups are useful in gaining a deeper and more detailed understanding of the different perspectives of Q, how it is governed and managed and the impact it is having on its members.

The interviews and focus groups that were conducted up to December 2017 are presented in Table 7.

Except in cases where notes were taken, interviews were transcribed and analysed using NVivo 10.
Table 7. Number of interviews and focus groups (May 2016 to March 2018)

<table>
<thead>
<tr>
<th>Participants</th>
<th>Number</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Semi-structured interviews</td>
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<td></td>
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<tr>
<td>Founding members</td>
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<td></td>
</tr>
<tr>
<td>Phase 2 pilot members</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Phase 3 Wave 1 members</td>
<td>1</td>
<td>December 17</td>
</tr>
<tr>
<td>Phase 3 Wave 2 members</td>
<td>3</td>
<td>November 17 (n=2)</td>
</tr>
<tr>
<td>Phase 3 Wave 3 members</td>
<td>2</td>
<td>October 17</td>
</tr>
<tr>
<td>Phase 3 Wave 4 members</td>
<td>2</td>
<td>February 2018</td>
</tr>
<tr>
<td>Unsuccessful applicant (Phase 2) (non-member)</td>
<td>1</td>
<td>December 16</td>
</tr>
<tr>
<td>Case study interviews with members</td>
<td>4</td>
<td>October 17 (n=2)</td>
</tr>
<tr>
<td>Members of the lab volunteer group (founding members and non-members)</td>
<td>3</td>
<td>January 17 (n=2)</td>
</tr>
<tr>
<td>Q project team members</td>
<td>10</td>
<td>July 16</td>
</tr>
<tr>
<td>Steering group</td>
<td>2</td>
<td>August 16</td>
</tr>
<tr>
<td>College of assessors</td>
<td>2</td>
<td>October 16</td>
</tr>
</tbody>
</table>
### Focus group discussion

<table>
<thead>
<tr>
<th>Focus group discussion</th>
<th>Founding members</th>
<th>Phase 2 members</th>
<th>Phase 3 members</th>
<th>Mixed members</th>
<th>Non-members</th>
<th>Q project team members</th>
<th>Pilot regional partners</th>
<th>Citizen ethnography</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>May 16 (n=2) 3 participants and 5 participants</td>
<td>October 16 (5 participants)</td>
<td>March 17 (6 participants)</td>
<td>September 17 (n=2, 2 and 5 participants)</td>
<td>May 16 (n=2, 5 and 3 participants)</td>
<td>November 16</td>
<td>December 16 (n=2)</td>
<td>West Midlands Welcome Event, Birmingham</td>
</tr>
<tr>
<td></td>
<td>October 16 (6 participants)</td>
<td></td>
<td></td>
<td>November 17 (n=2, 4 participants in both)</td>
<td></td>
<td>November 16</td>
<td>December 16</td>
<td>Q National Event, Liverpool</td>
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</table>

### Q members and non-members

Some 26 interviews were conducted with Q members between May 2016 and March 2018. The aim was to explore member’s experiences of Q so far, whether Q was meeting their expectations and what impact Q has either had already, or could have in the future. For Phase 3 members, the interviews also explored their reasons for joining Q, how they felt about the recruitment process and what they expected of Q. To understand perceptions around the Q Lab, how it was developing and the potential impact of the labs, three members of the Q Lab volunteer group were interviewed. One interview was conducted with an individual who was unsuccessful in their application to understand their experiences of the recruitment process.

Member interviewees and focus groups were sampled using a random number generator, although some particular sub-groups of members (such as those from a particular phase or, during 2017, based on their level of expected engagement with Q) were first shortlisted. Once individuals were identified, they were
invited to participate in a semi-structured telephone interview via email. The interview protocols were developed to align them with the evaluation questions and to ensure they were appropriate for the individual being interviewed. Interviews were conducted by six researchers (EH, JE, TD, JN, LH or KS). Interviewers shared experiences throughout, with those new to Q listening in to more experienced interviewers before conducting interviews independently.

In addition, four case study interviews were also conducted with Q members (three founding members, one Phase 2 Pilot member and one Phase 3 Wave 3 member; one case study was based on two interviews with founding members). These individuals were identified through the free text survey answers in which they described a particular project in which Q was important for its success. The interviews were conducted by two researcher (KS and TL), with detailed notes taken by one other researcher (LH). These case studies are useful in understanding what impact Q has had on its member’s day-to-day work, as well as the wider healthcare landscape.

Ten focus group discussions were conducted with Q members (three with founding members, one with Phase 2 members, one with Phase 3 members and five with mixed members). Two focus groups were also conducted with non-members. Members were selected using a random number generator, subject to criteria ensuring the representation of certain sub-populations within Q. The focus groups were facilitated by one member of the research team (JN, TL or JE) and notes were taken by another member of the research team (JE, EH, BG, TD, KS or LH).

Q project team

Ten interviews have been conducted with the Q project team since May 2016. These were conducted by five members of the evaluation team (EH, BG, JE, KS or TL) and the protocols were tailored to the individual’s role.

Four focus group discussions with the Q project team have been undertaken, facilitated by a member of the research team (EH, TL or BG) with a second team member taking notes (LH). Two of these focus groups were with members of the Q Lab team, one focused on the regional roll-out up to December 2016 and the most recent group focused on the governance, management and impact of Q.

Other stakeholders

In addition to interviewing and conducting focus groups with Q members and the Q project team, other stakeholder interviews and focus groups were also conducted.

Interviews were conducted by five researchers (JE, BG, EH, JN and TL):

- Two interviews were conducted with the steering group (JE, EH or JN) to gain an understanding of their perception of Q’s governance, design and management.
- Two interviews were conducted with a governance stakeholder (BG and TL) to understand how the governance model was developed.
- Two interviews were conducted with members from the College of Assessors (JC or JE), along with three focus groups with the pilot regional partners (conducted by BG or TL). These were conducted to further the understanding of the recruitment process and how Q was rolled out regionally.
Two interviews were conducted with regional conveners of Q (both by JN) to understand the recruitment process and governance, at a national and regional level, as well as what governance may look like in the future.

Two interviews were conducted with external Quality Improvement stakeholders (TL and JN) to understand their perspective of what Q is, what their expectations are and what they believe the impact is.

**Citizen ethnography with Q members**

Citizen ethnography was conducted during two Q events: the Birmingham West Midlands Welcome Event in July 2017 and the Liverpool National Q Event in November 2017. Q members volunteered to be citizen ethnographers during these events. In Birmingham, seven individuals volunteered to be ethnographers and in Liverpool there were five. After the individuals had volunteered, a telephone call was made to all of them (except for one person at the Liverpool event who was unavailable) to ensure they understood what was required of them and to answer any questions they had. During the event, the researchers who attended (TL, JN and LH for Liverpool and TL, BG and TD for Birmingham) held a drop-in session at the start of the day for volunteers to answer any final questions they had. There was another drop-in session at the end of the event for volunteers to hand in their ethnography notes and reflect on how they felt the process went (some ethnographers chose to write up their notes after the event and email them to the evaluation team at a later date). Feedback was also taken from the ethnography volunteers to help the evaluation team improve the process for future events.

Citizen ethnography was used to pick up additional perspectives and experiences from Q members that may not have been identified by the evaluation team, allowing a collective reflection on the whole event and the feelings of Q members at a particular time. Volunteers were asked to note down observations that related to the following themes:

- Q members’ experiences to date
- What impacts has Q had on members’ work
- What are members’ expectations of Q?

Volunteers were also asked to record which theme the observation fell into, what the context was and what the observation was. Although the evaluation team had a record of the ethnographers’ names and email addresses, the volunteers were asked not to record any individual’s names.

**Surveys and social network analysis**

In total the evaluation team undertook ten online surveys, as detailed in Table 8. Two researchers (BG and CG) implemented the surveys and analysed the data and a third (KS) participated in the social network analysis (SNA).
The Phase 2 applicant survey and Phase 3 new member survey collected baseline data on respondents’ ability to do improvement work and their expectations of Q, as well as some information on the application process. The unsuccessful applicant surveys collected similar data, while delving deeper into how respondents had received feedback on their application, although response rates for these surveys were low in comparison to the successful members. The aim of the annual survey was to solicit the views of Q members on their interactions with Q, their experiences to date and the improvement landscape more generally.

The surveys also included a question about respondents’ connections to Q members so that we could conduct a social network analysis. Respondents were able to insert the names of Q members with whom they had a connection, in order to identify relationships between members (network ‘nodes’). If a single member reported a connection, this was treated as a reciprocal connection (it was not treated as a ‘directional’, or one-way, link). This meant that members recruited in later cohorts could report links to existing Q members recruited in earlier cohorts, which would not have otherwise not have been captured (as some members had not yet been recruited to Q when earlier cohorts completed the SNA question). The social network analysis was carried out using Gephi (www.gephi.org).

The extent to which social network analysis can capture a full picture of the network is subject to some limitations. Social network analysis conducted in this manner does not provide an indication of the meaningfulness of that relationship. It is possible that members may have approached this question in

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50 216 members and 11 unsuccessful applicants.
51 231 founding cohort members and 216 Phase 2 members.
different ways: some members may have listed a large number of tentative connections, while others may have chosen only to list deep relationships. A large number of connections may not necessarily indicate that the member in question’s professional relationships are useful, supportive or meaningful.

As the majority of Q members completed the SNA question upon entry to Q, the evaluation team have not yet been able to conduct an analysis of change in members’ networks as a result of Q, or of whether connections identified in early surveys endured. These dynamics will be explored further in the next two years of the evaluation.

For the Phase 2 application survey, members were asked to provide names rather than selecting from options, but this was unsuccessful as respondents largely considered this task too burdensome and skipped the question. In light of ongoing recruitment, the question asking new members to select the names of people with whom they had connections became unfeasible and the evaluation team received reports that it was slowing or crashing respondents’ browsers. This may have prevented some members from completing this question, although members were offered (and frequently returned) an alternative Microsoft Excel version of the survey.

**Synthesis of findings**

As with our previous report, the findings from each of the different data collection methods were analysed separately and subsequently synthesised into a single narrative. These findings are presented thematically, guided by the evaluation questions and themes emerging from the data. Multiple data sources provide evidence for each theme, and in this way it is possible to compare and contrast the findings from the different methods and different stakeholders.

**Limitations and caveats**

Table 9 summarises our assessment of the caveats to our approach.
### Table 9. Caveats to the evaluation approach

<table>
<thead>
<tr>
<th></th>
<th>Document review</th>
<th>Non-participant observation</th>
<th>Interviews</th>
<th>Focus groups</th>
<th>Surveys (including social network data)</th>
<th>Synthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was limited opportunity to interrogate data further</td>
<td>●</td>
<td>●</td>
<td></td>
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<td>●</td>
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<tr>
<td>We had limited control over available data</td>
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<td>Not all individuals interpret all questions in the same way</td>
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<td>● ●</td>
<td>●</td>
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<tr>
<td>Recall bias</td>
<td></td>
<td></td>
<td>● ● ●</td>
<td>●</td>
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<tr>
<td>Thematic analysis was performed and therefore it is not possible to represent all points</td>
<td></td>
<td></td>
<td>● ● ● ● ● ●</td>
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<tr>
<td>Sampling bias related to those who were willing or able to participate in the evaluation</td>
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<td></td>
<td>● ● ● ● ● ●</td>
<td>●</td>
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<tr>
<td>Semi-structured protocol meant not all questions were asked on all occasions</td>
<td></td>
<td></td>
<td>● ● ● ● ● ●</td>
<td>●</td>
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<tr>
<td>Time limitations meant that not raising a view was not the same as not holding a view</td>
<td></td>
<td></td>
<td>● ● ● ● ● ●</td>
<td>●</td>
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<tr>
<td>The sample size was small relative to the entire pool</td>
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<td></td>
<td>● ● ● ● ● ●</td>
<td>●</td>
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<tr>
<td>Potential non-response bias, where those who respond are not typical</td>
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<td></td>
<td>● ● ● ● ● ●</td>
<td>●</td>
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<tr>
<td>There may have been reluctance to air unpopular or minority views (social desirability bias)</td>
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<td>● ● ● ● ● ●</td>
<td>●</td>
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<tr>
<td>Views are restricted to those of the project team</td>
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</tbody>
</table>
Appendix 3. Survey results

This appendix outlines further selected results of the five surveys undertaken over the course of the first two years of the evaluation.

Figure 19 shows the extent to which respondents believe they have access to information and resources. Among the 71 people who responded to the end of Phase 1 and annual surveys, there was an average increase of 0.7 categories. For the 31 Phase 2 respondents, there was no statistically significant change.

**Figure 19. Access to information and resources**

It is easy for me to access the information and/or resources I need to be able to make improvements in the quality of health and care.
Figure 20 shows the ability to make local changes reported by respondents. There was no statistically significant change in those who responded to the end of Phase 1 and annual surveys. For Phase 2 there was a decrease in 0.5 categories. It is hard to see how Q could have had this effect and the responses may reflect the wider environment.

**Figure 20. Ability to make local improvements**

In my current role(s) I am able to make changes that could improve quality in my local setting and/or organisation.
Figure 21 shows the ability to make non-local improvements reported by respondents. There was no statistically significant change in those who responded to the end of Phase 1 and annual surveys. As with the previous question, Phase 2 respondents showed a decrease of 0.5 categories.

**Figure 21. Ability to make non-local improvements**

In my current role(s) I am able to make changes that could improve quality regionally or nationally.

![Chart showing the ability to make non-local improvements across different phases and waves.](chart)
Figure 22 shows the extent to which respondents report having the skills and knowledge they need for improvement. Among the 71 people who responded to the end of Phase 1 and annual surveys, there was an average increase of 0.6 categories. There was no statistically significant change for Phase 2 respondents.

Figure 22. Skills and knowledge

I have the skills and knowledge I need for the improvement work I want to do.

Annual survey March 2017
Phase 1 - baseline
Phase 1 - end of year
Phase 2
Phase 3 Wave 1 new members
Phase 3 Wave 1 unsuccessful applicants
Phase 3 Wave 2 new members
Phase 3 Wave 2 unsuccessful applicants
Phase 3 Wave 3 new members
Phase 3 Wave 3 unsuccessful applicants
Phase 3 Wave 4 new members

Strongly disagree  Disagree  Slightly disagree
Neither agree nor disagree  Slightly agree  Agree
Strongly agree
Figure 23 shows the support from their organisations reported by respondents. There was no statistically significant change in those who responded to the end of Phase 1 and annual surveys. However, Phase 2 members report an average 0.5-category decrease.

Figure 23. Support from own organisation

I get the support I need from my organisation for the improvement work I want to do.
Figure 24 shows the support from other organisations reported by respondents. This question was not asked in Phase 1 or 2.

**Figure 24. Support from other organisations**

I get the support I need from (an) organisation(s) other than my own for the improvement work I want to do.

![Bar chart showing support levels from other organisations across different phases and groups.](chart.png)
Figure 25 shows the extent to which respondents reported being part of strong, supportive networks. This question was not asked in Phase 1 or 2.

**Figure 25. Network membership**

I am part of a strong, supportive network of people working to improve quality across my region or nation.

![Bar chart showing network membership across different survey waves.](chart.png)
Figure 26 shows the extent to which respondents reported collaborating with diverse people. This question was not asked in Phase 1 or 2.

**Figure 26. Diverse collaboration**

I collaborate with diverse people within my region or nation (outside my profession and organisation) to do the improvement work I want to do.

- **Strongly disagree**
- **Disagree**
- **Slightly disagree**
- **Neither agree nor disagree**
- **Slightly agree**
- **Agree**
- **Strongly agree**
Figure 27 shows the extent to which respondents reported getting the support they need from their professional and wider networks. There was no statistically significant change in those who responded to the end of Phase 1 and annual surveys, or for Phase 2.

**Figure 27. Support from network**

I get the support I need from my professional and wider networks for the improvement work I want to do.

- Strongly disagree
- Disagree
- Slightly disagree
- Neither agree nor disagree
- Slightly agree
- Agree
- Strongly agree
Figure 28 shows the extent to which survey respondents believe they have access to key people for improvement work. This question was not asked in Phase 1 or 2.

**Figure 28. Access to key people**

I have access to people outside my region or nation, profession and organisation to whom I need to have access to do the improvement work I want to do.

- Agree
- Slightly agree
- Neither agree nor disagree
- Slightly disagree
- Strongly agree
- Disagree
- Strongly disagree
- None of the above
Figure 29 shows the extent to which respondents reported improvement is embedded in their organisations. This question was not asked in Phase 1. Phase 2 members report a 0.5-category decrease.

**Figure 29. Embedding of improvement**

Improving quality is embedded in my organisation.
Figure 30 shows the extent to which members reported feeling confident that they were suitable to be a Q member. This question was not asked in Phase 1.

**Figure 30: Member’s self-reported suitability for membership**

I am confident I am suitable to be a Q member.

![Bar chart showing member's self-reported suitability for membership across different phases.](image-url)