Strengthening the contribution of improvers to UK health and care?

An evaluation of the Q Initiative 2016–2020: Annexes

Lucy Hocking, Jennifer Newbould, Sarah Parkinson, Katherine Stewart, Amelia Harshfield, Tom Ling
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There are five overarching evaluation questions. These questions were designed, in part, between the RAND evaluation team and the Q team at the Health Foundation, with input from Q members during the co-design phase (Garrod et al., 2016). These research questions cover the two primary aims of the evaluation:

1. To provide evidence and analysis to support strategic decision making and inform the ongoing design and management of Q (the focus of the formative phase of the evaluation).

2. To assess the impact that Q has, primarily on members, but also on their organisations more widely; and to understand how this contributes to improvement in health and care quality across the UK (the focus of the later, summative phase of the evaluation).

Evaluation questions A and B focus on addressing the first aim, while questions C–E primarily focus on addressing the second aim. The evaluation also addresses a number of additional thematic questions related to Q’s implementation (questions F–J).

Each evaluation question has a number of sub-questions, which are outlined below:

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)?**

- 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.

- 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.

- 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.

- 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?

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1 According to the Q project team, ‘Onboarding is the process of helping new members to adjust to the social and technical aspects of their role within Q quickly and smoothly, enabling them to be effective members of the community.’
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.

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

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.

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?

How is Q Lab being designed? How effective and efficient is this process?

What are the processes for involving stakeholders in design and how effective are these?

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

How has the co-design process developed since 2015 (and is it different for Q Lab than for Q overall)?

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?

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?

How do these activities change over time and what is driving this change (for example, the needs of members)?

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?

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.

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?

How well does Q enable the development of meaningful connections? This element should include a social network analysis (SNA) component and focus primarily on connections within the community, but also recognise important connections outside the community.

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.

How well does Q enable the development of skills, knowledge and expertise for improvement (primarily of members, but also more widely)?
An evaluation of the Q Initiative 2016–2020

- How well does Q mobilise improvers to collaborate efficiently to organise, undertake, promote and spread improvement activities (primarily members, but also more widely)?
- 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?

- To what degree has Q contributed towards achieving changes in organisational culture, policy and conditions that better enable improvement?
- To what degree has Q contributed towards achieving widespread capability and understanding of improvement (for members and more broadly)?
- To what degree has Q contributed towards achieving capacity and leadership for improvement at sufficient scale and scope across the system?
- What new knowledge or outputs have been generated as a result of Q?
- 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?

- What, if any, direct contribution has Q made to improvements in quality of health and care and patient outcomes (through Q Labs, member-initiated improvement work, successful calls to action, influencing policy, etc.)?
- 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?

F. Regional roll-out

- 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?
- What contextual differences between regions, including but not limited to differences between the partners, are affecting recruitment, onboarding, governance, activities and outcomes?
- How is Q perceived differently between regions?
- How do regions work with each other and with the central Q project team? Are there effective lines of communication?
- How appropriate has the balance between autonomy and coordination been?
- How do differences between partners affect the operation of Q in their regions?

G. Regional recruitment and onboarding

- 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.
- 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.
How have recruitment criteria been applied, and has the balance between consistency and adaptability been appropriate?

Which parts of the recruitment process add the most and least value in recruiting appropriate members for Q?

Is the way in which assessors are recruited, used and paid appropriate for the Q recruitment process and an efficient use of resources?

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

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.

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

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

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

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

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

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

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

Is the governance model appropriate for the structure of the Q network?

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

How do relationships between regional partners and conveners function?

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.

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

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

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

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

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

How is responsibility for activities supported by the governance model?
J. Q Lab

- How is Q Lab being designed (including efficiency and effectiveness of the process)?
- What are the processes for involving stakeholders in design and how effective are these processes?
- How effectively is the available evidence and insight being used to inform the design of Q Lab?
- How has the co-design process developed since 2015 and what are the differences in this process between Q Lab and Q overall?
- What are the skills required within the Q Lab team to effectively run the lab and does the team need to recruit any further?
- How are topics for Q Lab chosen and how efficient and effective is the process?
- To what extent do the Q Lab and the rest of Q complement each other and fit together?
- What is key to the success of Q Lab and what can be adapted?
- What type of evaluation framework and approach would be most suitable for the evaluation of Q Lab onwards?
- How well are members and other stakeholders engaged in the lead up to the launch of the lab?
The evaluation team have worked closely with the Q team at the Health Foundation to develop a rigorous and embedded yet independent evaluation of Q. Throughout the four-year evaluation, there have been a number of points of reflection on the next steps of the evaluation, and the ability to change the methods used and the focus of the evaluation, as well as to reflect on the progress Q has made since 2016 and how the evaluation has contributed to this. While the risk of bias was present throughout the evaluation, this has been monitored and managed throughout, not only by the evaluation and Q teams, but also the EAG and by RAND Europe’s quality assurance reviewers.

A number of individuals from RAND Europe were involved in this evaluation from 2016 to 2020 and their roles in the data collection are outlined by referencing their initials:

- Tom Ling (TL)
- Jennifer Newbould (JN)
- Lucy Hocking (LH)
- Sarah Parkinson (SP)
- Cagla Stevenson (CS)
- Katherine Stewart (KS)
- Bryn Garrod (BG)
- Cloé Gendronneau (CG)
- Amelia Harshfield (AH)
- Talitha Dubow (TD)
- Jo Exley (JE)
- Emma Harte (EH)
- Catherine Saunders (CS).

An overview of the data collection methods used in this evaluation and the evaluation questions they seek to address is provided in Table 1.
Table 1: Overview of data collection and the evaluation questions they seek to address

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<td>• EQ H (Governance)</td>
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<td></td>
<td>• EQ J (Q Lab)</td>
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<td>Literature review</td>
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<td>Attendance at events</td>
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<td>• EQ I (Activities)</td>
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This section will provide an overview of each data collection method used by the evaluation team and how these were approached, implemented and analysed. We will also discuss the limitations of the evaluation in further detail.
B.1. Document and literature reviews

Throughout the evaluation, the team has reviewed many documents relating to the strategic direction of Q, provided by the Q team, as well as academic literature relating to quality improvement methodologies and approaches to situate Q within the UK's improvement landscape.

The aim of the review of strategic Q documentation was to follow the evolution of the different elements of Q. In the first half of the evaluation (the formative aspect), this focused on documents relating to Q Lab, the regional roll-out of Q, governance, recruitment and activities. It also involved review of Q team working documents, such as meeting minutes and other project-related documents. The review is not intended to provide a systematic account of the documentation provided by the Q project team. The latter half of the evaluation (the summative aspect) focused on documents relating to the future of Q, Q Exchange, Q Lab evaluation and the relationship between Q and the Health Foundation.

In the first phase of the evaluation, a search of academic literature was conducted to identify literature on healthcare improvement to explore different QI theories and how these relate to Q. A number of search terms were used in PubMed, including healthcare, quality improvement, community of practice, social networks and social movement. Only papers from the UK and published in 2000 or after were included. This saw nine papers included for this literature review, in addition to three other documents provided by the Health Foundation. Additional QI related literature was identified in 2019 to provide the evaluation team with any updates in discussions around QI. This took the approach of searching key organisational websites, such as the Health Foundation and the King’s Fund, snowballing from relevant documents and suggestions of key sources of literature from the Q team and the evaluation team.

B.2. Attendance at events

Members of the evaluation team regularly attended Q events throughout the evaluation to observe the implementation of Q and to hold informal discussions with attendees. These observations help to inform the understanding of Q in context and, in the first half of the evaluation in particular, how it is governed and designed. They also helped to inform the development of data collection tools, such as interview and focus group protocols, the citizen ethnography diary protocol and surveys, and have helped in analysing the results and embedding these in the context of Q.

The events attended by the evaluation team 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)
• National Q Event, Liverpool, November 2017 (JN, TL, LH)
• National Q Event, Birmingham, September 2018 (TL, LH)
• South West of England local Q Event, Innovating for Improvement conference, September 2019 (TL)

In addition, during the first half of the evaluation, two members of the evaluation (TL and one of BG, JN, LH or KS) regularly attended the monthly Q team meetings held at the Health Foundation in London. Members of the evaluation team also attended other ad hoc meetings and events where appropriate.

B.3. Semi-structured interviews and focus group discussions with a range of stakeholders

From May 2016 to January 2020, 154 semi-structured interviews and 26 focus group discussions were conducted with a range of Q members and other key stakeholders. The aim of this data collection method is to gain a detailed, deep and nuanced understanding of the different perspectives and experiences of Q, how it is governed and managed, as well as the impact it has on members and more widely on organisations and the system.

The types of interviews and focus groups are presented in Table 2. A small number of these interviews were conducted with the same individuals. Engagement the same Q team members and governance stakeholder took place because some of the leading team members were in the same role (or similar) throughout the evaluation, and it helped the evaluation team get a better understanding of how the strategy and priorities for Q has changed over the evaluation period. A small number of interviews with Q members were conducted with the same individuals but with a focus on different areas, for example, general member interviews and Q Exchange focused interviews. However, this was more of an exception to the rule rather than the aim of the interviews. We recognise the value in interviewing the same Q members over time in being able to explore changes in perceptions and insights over time. However, as we conducted a small number of interviews compared to the number of Q members (particularly towards the end of the evaluation), we wanted to ensure we collected the views from as many members as possible rather than a small number of members multiple times.
Table 2: Number of interviews and focus groups (May 2016 to January 2020)

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<tr>
<th>Participants</th>
<th>Number</th>
<th>Date</th>
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An evaluation of the Q Initiative 2016–2020

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<tr>
<td>Deep dives</td>
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<tr>
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<td>November 19</td>
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<td><strong>Citizen ethnography</strong></td>
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<td>Welcome Event, Birmingham</td>
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<td>Q National Event, Liverpool</td>
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<td>2019 diaries</td>
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</table>

**Q members and non-members**

Interviews with Q members were conducted between May 2016 and December 2019. These covered a number of areas, including members’ experiences of Q to date, the types of activities and resources used, if Q was meeting their expectations, what impact they believed Q to have had and what Q could do better in the future. One interview was conducted with an unsuccessful applicant (for Phase 2) to understand their experiences of the recruitment process. Members to interview were selected randomly, although some subgroups of members of interest, such as those from a certain recruitment phase or those underrepresented in the evaluation, were first shortlisted. Interviews were conducted by eight researchers (EH, JE, TL, TD, JN, LH, KS, SP) with another member of the research team present to take notes.
Experiences and reflections on Q Lab were explored through two sets of interviews throughout the evaluation. The first involved interviews with three members of the Q Lab volunteer group to understand perceptions of the idea of Q Lab, its developmental progress and potential impacts. The second set of interviews, with participants of the first Q Lab, explored their reflections on the Q Lab process and what impacts they thought had occurred since the first Lab ended.

In total, 23 interviews and 3 focus groups were conducted with applicants to the 2018 and 2019 Q Exchange funding rounds. One interview was conducted with a member of the Q Exchange team in April 2019 that aimed to provide the evaluation team with an update as to the design of Q Exchange (which was to change between 2018 and 2019) and to frame and support development of the protocol for the applicant interviews. The researchers conducted 11 interviews with applicants to the 2018 funding round (two of which were held with two individuals) in April–October 2019, and seven of these were with individuals who received funding. The aim of these interviews was to explore the thoughts and experiences of the application and voting process, the wider value of Q Exchange and the progress and early impacts of the projects. The other four interviews were held with applicants who were shortlisted but did not receive funding. Interviewees were selected randomly to participate in an interview. After interviewing a member of a project team, other team members from the same project were excluded from the random sampling to ensure we spoke to individuals from a range of teams. An additional ten interviews were conducted with 2018 winners to create four case studies of Q Exchange projects, allowing a deeper exploration of the experiences and impacts of Q Exchange in four areas of the UK, including how the funding supported development and implementation of the project, if additional Q resources were used in setting up and implementing the project, whether new connections were made when applying for funding and/or implementing the project, whether the project has been able to gain traction in their local area, how much support the wider Q community has provided the Q Exchange project teams and whether the project has started having a positive impact and is reaching its aims. The case studies were developed by conducting two to four interviews with members of the project teams. The project leader was initially invited to an interview and was asked to recommend other members of their team (or others) we could also be approached.

Case study interviews were conducted with members to generate 14 case studies (one case study was created using two interviews and one general member interview was made into a case study). The case studies were used to explore and understand the types of impacts Q has on member’s day-to-day work, as well as at a system level. These individuals were identified through their free text responses to the 2018 and 2019 survey question asking participants to share their thoughts on the impacts of Q, and one case study was generated from a general member interview. The interviews were conducted by four researchers (TL, KS, LH, SP), with detailed notes taken by one other researcher (LH, SP, CS). Table 3 provides a list of case studies. Each case study was sent to the corresponding interviewee for review to confirm accuracy and the level of anonymity provided. For consenting interviewees, we have provided the names of organisations relevant to the case study where possible.
Table 3: List of case studies

<table>
<thead>
<tr>
<th>Case study no</th>
<th>Case study name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introducing duty of candour to doctors</td>
</tr>
<tr>
<td>2</td>
<td>Q Connector Powered Improvement</td>
</tr>
<tr>
<td>3</td>
<td>Q provides valuable connections</td>
</tr>
<tr>
<td>4</td>
<td>Setting up online clinical supervision opportunities for GP nurses</td>
</tr>
<tr>
<td>5</td>
<td>Offering data masterclasses to local Q members</td>
</tr>
<tr>
<td>6</td>
<td>Using Q to develop a successful training course</td>
</tr>
<tr>
<td>7</td>
<td>Using methods from a Liberating Structures workshop to inform an improvement programme</td>
</tr>
<tr>
<td>8</td>
<td>Using the Q badge to spark new conversations</td>
</tr>
<tr>
<td>9</td>
<td>Hosting a Q visit to the Flow Coaching Academy</td>
</tr>
<tr>
<td>10</td>
<td>Using Q to develop a national ambulance network</td>
</tr>
<tr>
<td>11</td>
<td>Overhauling a GP practice’s appraisal process</td>
</tr>
<tr>
<td>12</td>
<td>Attending an Appreciative Enquiry workshop helped to increase staff engagement and motivation</td>
</tr>
<tr>
<td>13</td>
<td>Using social media to engage Q members with expertise in Key Performance Indicators</td>
</tr>
<tr>
<td>14</td>
<td>Contacts made during the Q co-design workshops led to learning from other organisations</td>
</tr>
</tbody>
</table>

In addition, four Q Exchange case studies were developed based on projects funded in 2018. These case studies explore how the idea for the project came about, why the team decided to apply for Q Exchange funding over other funding opportunities, the support the project received from the Q team at the Health Foundation and the wider Q community, any challenges faced during project implementation, the impact of the project to date and the future plans for the project. The case studies were selected in consultation with the Health Foundation to ensure variation in progress and geographical coverage. The project lead was invited to interview and two to three other project team members (or others involved in the project) were also invited to interview. The interviews were conducted by two researchers (JN and LH) and detailed notes taken by one researcher (LH). Each case study was sent to the corresponding interviewee for review to confirm accuracy and the level of anonymity provided. For consenting interviewees, we have provided the names of organisations relevant to the case study where possible.

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2 Case studies 1–3 were previously published in the interim evaluation report (Ling et al., 2018).
Table 4: List of Q Exchange case studies

<table>
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<tr>
<th>Case study no</th>
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<tbody>
<tr>
<td>1</td>
<td>Quality Improvement Partner Panels (QuiPPs)</td>
</tr>
<tr>
<td>2</td>
<td>A Paradigm Shift in the role of Hospitals through Community Organising</td>
</tr>
<tr>
<td>3</td>
<td>Repeat prescribing through co-design</td>
</tr>
<tr>
<td>4</td>
<td>Hexitime the Healthcare Skill Exchange Timebank</td>
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</tbody>
</table>

The researchers conducted 17 focus groups with a variety of Q members, and two with non-members. The approach to selecting individuals for participation in the focus group varied. For some focus groups, members were selected randomly, subject to certain criteria to meet the aims of the focus groups. Other focus group participants were identified with support from the Q team who put out an open call for members to volunteer to participate. The names of the members who volunteered were then passed onto the evaluation team. The focus groups were facilitated by one member of the research team (TL, JN, JE, LH) and notes were taken by another member of the research team (JE, BG, JE, KS, TD, LH).

Q project team
From May 2016 to November 2019, 14 interviews were conducted with the Q project team. These were conducted by six members of the evaluation team (EH, BG, JE, KS, TL or JN) and the protocols were tailored to the individual’s role in each case. The interviews conducted in 2016 and 2017 aimed to explore the governance and management of Q in more detail, whereas the later interviews across 2018 to 2020 focused more on the future of Q and reflections on the governance and development of Q since 2016.

Four focus groups with the Q project team were conducted from November 2016 to October 2017. These were facilitated by one member of the evaluation team (EH, TL or BG), with a second team member taking notes. Two of these focus groups were held with members of the Q Lab team, one focused on the regional roll-out of Q and the final focus group focused on the governance, management and impact of Q.

Other stakeholders
A number of interviews and focus groups were held with key stakeholders other than Q members and the Q team. Interviews were conducted by five researchers (JE, BG, EH, JN, TL):

- Two interviews were conducted with the steering group (JE, EH or JN) to explore perception of the governance, design and management of Q.
- Two interviews were conducted with a governance stakeholder (BG and TL) to understand how the governance model of Q 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, and what governance may look like in the future.
Seven interviews were conducted with external Quality Improvement experts (TL and JN) to understand their perspective of what Q is, how it fits into the wider QI landscape, what their expectations are and what they believe the impact is, at an individual, organisational and system level.

Six interviews were conducted with key Q stakeholders, such as Q Connectors, Q Conveners and SIG leads. The aim of these was to explore how Q has evolved over time, how Q fits into the wider health and care landscape, the impact of Q (on members and the system) and what Q needs to do to become self-sustaining.

Citizen ethnography with Q members

Citizen ethnography was conducted at three points throughout the evaluation: two at Q events and one diary-based ethnography collection over a ten-week period. Citizen ethnography offers a unique opportunity to identify additional perspectives and experiences from Q members that may not have been identified by the evaluation team in the more structured approaches to data collection, such as interviews and focus groups.

The citizen ethnography conducted at events was held at the Birmingham West Midlands Welcome Event in July 2017 (seven participants) and the Liverpool National Q Event in November 2017 (five participants). Q members volunteered to be ethnographers for these events and a call was held ahead of the event to ensure the ethnographers understood the requirements and to align expectations, as well as to answer any questions they may have. At the start of the event, the attending members of the evaluation team (TL, JN, LH, BG, TD) held a drop-in session at the start of the event for volunteers to ask any remaining questions and at the end of the event for ethnographers to hand in their notes and reflect on the process. At both events, volunteers were asked to note down observations that related to the following themes:

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

Ethnographers were also asked to record which theme their observation came under, the context and the actual observation (without reporting individual names).

The final citizen ethnography process was held in a different format. For this, the Q team put out a call for Q members to volunteer to be ethnographers and five participants agreed to take part. Citizen ethnographers were briefed on the exercise through an initial email and introductory call explaining the exercise, emphasising that even if the participant had not engaged with Q at all during a given week, this was of interest to the evaluation team. These individuals were asked to complete a weekly diary on how they (or their colleagues) had used Q over a ten-week period. Specifically, ethnographers were asked to comment on:

- What aspects of Q did you engage with this week?
- In what ways did you think of or talk about Q this week?
- Did you encounter any challenges in your improvement work this week?
- Could Q have helped you overcome these? If no, why not? If yes, in what way?
Data collection took place from August to December 2018. Although all citizen ethnographers completed ten journals, these weeks were not necessarily consecutive, as the exercise was ‘paused’ if ethnographers were on annual leave or holidays. The aim of this more embedded, longer-term approach to ethnography was to identify evidence of members connecting, developing, supporting and collaborating as well as asking members how it feels to be engaged in continuous and sustainable improvement in health and care, how members use the membership of Q to help them in this process, and how they experience and measure the benefits of their efforts.

The content of the journals was then read in full by the research team and data extracted using Excel to categorise the different ways in which participants had engaged with Q. This included the challenges that they had faced in their improvement work, how Q helped them overcome challenges and other information such as challenges engaging with Q, suggestions on how Q can improve, and frustrations that were expressed about being a member of Q.

After the journals had been analysed, a phone call was organised with members of the evaluation team and the citizen ethnographers that had participated in the exercise. In this call, held in December 2019, a summary of the findings from the ethnography was provided to participants, after which ethnographers had the chance to discuss whether the findings surprised them, and to discuss as a group some of the common challenges that they faced in their improvement work and in engaging with Q. During this call, participants were also asked to reflect on their experience of completing the citizen ethnography exercise, including how the act of completing a weekly journal may have changed the way they thought about or engaged with Q.

Some limitations of this method include the likelihood that through the way in which participants were recruited, we received a sample of Q members that were more engaged than the typical Q member. This was a reflection that was shared with the citizen ethnographers, which was discussed during the group phone call. This likelihood was considered when thinking about how the findings from the citizen ethnography fit in with the rest of the evaluation findings, although the same limitation likely applies to the interviews conducted with members of Q and to some extent the findings from the annual surveys. Another limitation is that through being asked to complete a weekly journal, participants in the citizen ethnography may have altered their behaviour by engaging with Q or thinking about Q more than they otherwise would have without the weekly journals. This was also acknowledged during the call in which citizen ethnographers were asked to reflect on the methodology, and one participant felt that completing the weekly diary had prompted them to think about and engage with Q more than perhaps they would usually. Lastly, during the call it was noted that for a few participants, if it were not for the citizen ethnography exercise coincidentally occurring at the same time as parts of the Q Exchange process, they would have had very little to report. Due to these limitations, it may be that the engaging with Q described below overstates the engaging of a typical Q member during a typical time period.

B.4. Surveys and social network analysis

The evaluation team undertook 13 online surveys, as shown in Table 5. Seven researchers implemented and analysed the surveys and social network analysis (SNA) (BG, CG, KS, LH, AH, SP, NP, CS).
Table 5: Online surveys

<table>
<thead>
<tr>
<th>Survey</th>
<th>Date</th>
<th>Participants</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application survey</td>
<td>Aug 16</td>
<td>• Phase 2 members • Phase 2 unsuccessful applicants</td>
<td>59% (135/227)</td>
</tr>
<tr>
<td>Annual survey</td>
<td>March 17</td>
<td>• Founding members • Phase 2 members</td>
<td>39% (175/447)</td>
</tr>
<tr>
<td>New member survey</td>
<td>March 17</td>
<td>• Phase 3 Wave 1 members</td>
<td>87% (307/352)</td>
</tr>
<tr>
<td>Unsuccessful applicant survey</td>
<td>March 17</td>
<td>• Phase 3 Wave 1 unsuccessful applicants</td>
<td>27% (17/62)</td>
</tr>
<tr>
<td>New member survey</td>
<td>June 17</td>
<td>• Phase 3 Wave 2 members</td>
<td>82% (455/554)</td>
</tr>
<tr>
<td>Unsuccessful applicant survey</td>
<td>June 17</td>
<td>• Phase 3 Wave 2 members</td>
<td>43% (27/62)</td>
</tr>
<tr>
<td>New member survey</td>
<td>Sept 17</td>
<td>• Phase 3 Wave 3 members</td>
<td>75% (327/436)</td>
</tr>
<tr>
<td>Unsuccessful applicant survey</td>
<td>Sept 17</td>
<td>• Phase 3 Wave 3 unsuccessful applicants</td>
<td>52% (12/23)</td>
</tr>
<tr>
<td>New member survey</td>
<td>Dec 17</td>
<td>• Phase 3 Wave 4 members</td>
<td>72% (261/363)</td>
</tr>
<tr>
<td>Unsuccessful applicant survey</td>
<td>Dec 17</td>
<td>• Phase 3 Wave 4 unsuccessful applicants</td>
<td>18% (2/11)</td>
</tr>
<tr>
<td>Annual survey</td>
<td>Dec 18</td>
<td>• Founding members • Phase 2 members</td>
<td>37% (1015/273)</td>
</tr>
<tr>
<td>Annual survey</td>
<td>Nov 19</td>
<td>• Founding members • Phase 2 members</td>
<td>24% (791/3362)</td>
</tr>
</tbody>
</table>

New applicant surveys were conducted with new Phase 2 and Phase 3 members to collect baseline data on respondent’s ability to conduct improvement work, their expectations of Q and reflections on the application process. The unsuccessful applicant surveys covered similar topics but focused more on collecting thoughts and experiences of the application process. The annual surveys, conducted in 2017, 2018 and 2019, aimed to collect views of Q members’ experiences of Q and the impact it has had on their professional lives. The 2018 and 2019 annual surveys also explored thoughts on the uniqueness and value of Q Exchange.

Social network analysis

The 2016 and 2017 surveys also included a question about respondents’ connections to other Q members to allow the evaluation team to conduct a social network analysis (SNA). To do this, respondents were asked to provide the names of Q members they had connected with to identify relationships between members (network ‘nodes’). If a single member reported a connection, this was treated as a reciprocal connection (it

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3 216 members and 11 unsuccessful applicants.

4 231 founding cohort members and 216 Phase 2 members.
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 SNA was carried out using Gephi.5

There are a number of limitations that should be considered when interpreting the findings of the SNA. While the SNA provides an overview of the number of connections, it does not provide any detail on the depth of quality of these networks. The way participants responded to this question may have varied, with some providing a long list of individuals they have met and others only providing the names of those they are well connected with.

In addition, for the Phase 2 application survey, rather than selecting names, members were asked to provide names but this did not work successfully as it was too burdensome for participants, many of whom skipped the question. As the number of Q members continued to increase, providing a list of names for participants to select was infeasible and the evaluation team received many reports of participants’ browsers crashing due to this question, which may have prevented members from completing this question.

In light of these challenges with collecting and analysing the SNA data, further data collection of this type was not conducted.

### B.5. Deep dives

In the second phase of the evaluation, four deep dives were developed: one in 2018 focusing on Scotland and three in 2019 focusing on Northern Ireland, Wales and the South West of England. Each region was selected in consultation with the Q team to provide perspectives from each of the four UK nations. To create these deep dives, 29 interviews and 2 focus groups (both for Scotland) were conducted by the researchers (TL, LH).

The deep dive interviews and focus groups covered a range of different topics to explore the context of Q at a regional level and the way in which Q has established itself different across geographies. These interviewed covered the current improvement landscape within the region (outside of Q), what the local Q community looked like and the enablers and barriers to engagement with Q at the regional level. The individuals selected for interview were identified in two ways. First, key Q stakeholders, such as Q Connectors, in the regions were approached. Secondly, random Q members were identified from the region. This ensured we collected perspectives from those more engaged with Q and a greater understanding of what the Q community looks like regionally, but also engaged ‘regular’ Q members to understand how Q is establishing itself on the ground in the region.

### B.6. Synthesis of findings

The findings from each data collection method were analysed individually, many of which are presented as independent annexes in this report with a subsequent narrative synthesised for the main body of this report.

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5 See www.gephi.org.
and cross-analysed across the data collection methods. These findings are presented in the main body of the report thematically, guided by the evaluation questions and the themes that emerged from the analysis.

B.7. Limitations

Table 6 summarises our assessment of the caveats to our approach.

Table 6: Overview of caveats to the data collection

<table>
<thead>
<tr>
<th>Caveat</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>Citizen ethnography</th>
<th>Synthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was limited opportunity to interrogate data further</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Not all individuals interpret all questions in the same way</td>
<td></td>
<td>●</td>
<td>●</td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Recall bias</td>
<td></td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Thematic analysis was performed and therefore it is not possible to represent all points</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Sampling bias related to those who were willing or able to participate in the evaluation</td>
<td></td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Semi-structured protocol meant not all questions were asked on all occasions</td>
<td></td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<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>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>The sample size was small relative to the entire pool</td>
<td></td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Potential non-response bias, where those who respond are not typical</td>
<td></td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>There may have been reluctance to air unpopular or minority views (social desirability bias)</td>
<td></td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Views are restricted to those of the project team</td>
<td></td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
<td></td>
<td>●</td>
</tr>
</tbody>
</table>
C.1. The Scottish context

After its establishment in 1948, the NHS developed in similar ways throughout the UK. However, following devolution in 1999, Scotland followed a more distinctive path. There were 14 geographically based NHS boards and a variety of special NHS boards. There has been more integration between health and social care and a rejection of the ‘English’ model of separating the commissioning and providing functions and encouraging competition. In place of competition, Scotland saw a variety of approaches to improvement and innovation, including the Scottish Audit of Surgical Mortality, a variety of improvement collaboratives, the Scottish Intercollegiate Guidelines Network (SIGN) to develop agreed guidelines and standards, and, importantly, the Scottish Patient Safety Programme (SPSP) that launched in January 2008. According to Donald Berwick, President Emeritus and Senior Fellow of the Institute for Healthcare Improvement (IHI), the Scottish government restated its ambition:

NHS Scotland has undertaken a bold, comprehensive, and scientifically grounded programme to improve patient safety…. In its scale and ambition, the Scottish Patient Safety Programme marks Scotland as leader – second to no nation on earth – in its commitment to reducing harm to patients dramatically and continually.

[Scottish government, 2010: 17]

The SPSP was preceded by the Safer Patient Initiative, commissioned by the Health Foundation in collaboration with the IHI, with 24 hospital sites participating from 2004 to 2008. It was one of the first initiatives organised around improving patient safety in the UK. It had certain features in common with Q: it was underpinned by a road map showing how the programme should work, aimed to build an QI infrastructure with training for clinicians in improvement science, established a learning system, and adopted the Model for Improvement (ihub, 2018). The setup and delivery of the SPSP involved bringing together leaders from Quality Improvement Scotland, the Scottish government and the IHI. As early as 2011 it was claimed, ‘The Scottish Patient Safety Programme continues to prove that a national strategic approach can lead to unprecedented improvement in patient safety. A mandated collaborative using a systems approach has not, to our knowledge, been tried in any other publicly funded health care system in the world’ (Haraden & Leitch, 2011). The approach was data rich and measurement was crucial, with target setting and timescales a feature of its operation. In May 2010, emerging from the SPSP, NHS Scotland’s Quality Strategy was launched (Scottish government, 2011).
Meanwhile, Healthcare Improvement Scotland (HIS) at that time aimed to provide a leadership role for these initiatives through helping to improve risk management, raising awareness of patient safety and promoting incident reporting. HIS no longer describes its role in this way but according to Philippa Whitford, a general and breast cancer surgeon before being elected as an SNP MP in 2015:

Healthcare Improvement Scotland has previously been criticised for encompassing both regulatory and improvement roles, but the Nuffield Trust found this approach to be more successful in improving the quality and safety of care for patients. The fact that such changes were brought about in the routine behaviour of clinicians, rather than just remaining in a protocol folder, is one of the biggest advances in NHS Scotland over the past 15 years. Quality improvement has made its way into the DNA of frontline staff – where it belongs. [Whitford, 2017]

Whitford mentions that HIS encompasses both regulatory and improvement roles (for clarity, HIS regulates independent healthcare but not the NHS). McDermott and colleagues describe this as ‘hybrid’ healthcare governance for improvement, combining bottom-up and top-down approaches (McDermott et al., 2015). They describe the emergence of this approach as comprising four phases: compiling evidence to provide advice and guidance (starting with the Griffiths Report (Griffiths, 1983) but including the creation of SIGN in 1993); quality assurance (including corporate accountability for clinical performance and establishing the Health Technology Board in 2000); implementation and improvement support (including the formation of Quality Improvement Scotland in 2003); and the emergence of scrutiny and inspection culminating in the establishment of HIS in 2011. McDermott and colleagues go on to comment:

Respondents noted that HIS utilizes a number of strategies to build implementation and improvement capacity, helping health service employees to address their own local, as well as national, improvement agendas. Interventions include: educational resources; training in data management and quality improvement methods; providing ‘bundles’ of tested interventions to implement locally; and the facilitation of networks to enhance peer learning and provide peer support. [McDermott et al., 2015]

Improvers in Scotland have organised around certain themes such as patient safety and within collaboratives. There has been a rhythm of events (large and small) bringing groups together to share experiences, practice and draw upon the views of people from outside the local community. In addition, improvers have had the opportunity to test and try things out and to let each other know about what has worked and what has not. Notwithstanding the risk of presenting an overly rosy picture, Scotland shows that there are organisational and practical ways of linking different parts of a QI community to create a shared sense of purpose and momentum. At the time of writing, HIS’s Improvement Hub (ihub) is key not only to supporting the delivery of the Health and Social Care Delivery Plan⁶ but also to building the capacity of the system to deliver improvement work. Therefore, it is both highly relevant to the Q community but also suggests a

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⁶ The Health and Social Care Delivery Plan for Scotland sets out the framework and actions for all health and social care services to meet set requirements. For further information, see: [https://www.gov.scot/publications/health-social-care-delivery-plan/]
more purposive and consistent national approach in Scotland than is the case for the NHS in England (ihub, 2017).

The literature reviewed at no point implies that the support for QI is perfect. However, key points are apparent. First the diversity of support and ‘bundles’ of tested interventions that are available at the local level leads to an embedding of QI approaches in everyday work that may not be uniformly available but does appear to be widespread. The implication is that there should be a requisite variety or approaches. In possible tension with this is the claim that consistency has been an important theme in supporting healthcare improvement in general and QI in particular in Scotland. However, a more accurate view would be that there has been a relatively consistent repertoire of approaches that may be refreshed over time, but which is given the time to become established and understood. Associated with this has been relatively stable leadership not only from health and care organisations but also politically. The background literature, then, suggests that the context of Q in Scotland includes:

- A variety of QI approaches are available at the ‘frontline’.
- There has been a degree of consistency around QI practices.
- There has been a degree of stability and consistency in support for QI from both health and care organisations and politically.

Therefore, Q was entering a sector that already had a significant and distinctive history of improvement that, following devolution, had seen Scotland progress in some respects differently to the rest of the UK. We explore the role of Q and its impacts in this context in the following sections.

**C.2. Benefits of Q and the use of Q resources**

Members often spoke of how they benefited from being a Q member and spoke positively of the activities, resources and events. The anticipated benefits for Scotland members were not markedly different from those of their counterparts elsewhere in the UK. Almost all members said they joined Q with the intention of making new connections and networks with new individuals involved with healthcare improvement, which has largely been successful for them (FG1 2018, FG3 2019, FG4, INT1, INT6, INT7). This was seen as particularly beneficial to Scottish members who could connect with members from across the UK (FG1 2018, FG3 2019, INT6). They emphasised that they would not have been able to make such UK-wide connections without Q due to isolation and distance.

Some members commented on continuing difficulty connecting with members who have similar interests to themselves, including those based in Scotland, although this may improve as more Q members join from Scotland (FG2 2018, FG3 2019). It was noted that it may be useful to set up a filter on the Q website to identify members involved in a similar area of work. There was an appetite for more digitally enabled interactions across the UK (along with recognition of the barriers created by the high cost of travelling to events in England) (FG1 2018, FG3 2019, FG4, INT2, INT4). It was said that members often only attend events in Scotland, which (according to one member) may slow Scotland’s shift away from an insular and inward-looking approach to improvement (although it should be noted that the idea that Scotland was inward-looking was refuted by other participants) (INT3, INT5).
C.2.1. Q within Scotland; the view of Q members

Throughout the focus groups and interviews, it was clear that many Q members and other improvement leaders believe that Scotland’s improvement landscape is different to the rest of the UK. An important stage in this, often referred to, was the SPSP introduced in 2008. This programme is as a pivotal point in Scotland’s healthcare QI journey and embedding the culture of improvement (although we note above its deeper historical roots) (FG2 2018, FG3 2019, INT1, INT3, INT5, INT6, INT7). The Scottish Quality and Safety Fellowship7 was also referred to multiple times as many Scottish Q members were often involved in this fellowship scheme (INT3). It was widely felt that these initiatives, and others, supported the QI community in Scotland to progress. This progress was also said to be aided in Scotland as healthcare improvement programmes have survived political cycles, allowing them to be embedded and stable.

In addition to formal initiatives and programmes, participants often spoke about how there were already well-established networks of healthcare improvers in Scotland, which they felt was made by the smaller population in comparison to England (FG1 2018, INT1, INT2, INT3, INT4, INT5, INT6, INT7). Rather than prior networks necessarily being a barrier to Q, it was felt by many interviewees that they should make it easier for Q to gather momentum and spread (INT2). However, this raised the question for some participants as to whether Q is a sufficiently distinct, and therefore visible, entity in the Scottish improvement landscape. It prompted one interviewee to wonder whether there needed to be a ‘Tartan Q’ that reflected this distinct landscape (INT5).

These formal and informal networks appear to have led to a different QI culture in Scotland compared to the rest of the UK. Amplifying these differences, it was said, was a more integrated health and care system that members said is more about collaborative models of care and more patient-focused than elsewhere in the UK (FG2 2018, INT4, INT6). A part of this cultural difference is said to be a greater ability to take risks with improvement within safer spaces to test ideas (INT2). This opportunity for testing and sometimes failing was felt to be absent in England. This culture is also reflected in the differences in employers’ attitudes to Q, it was said (FG1 2018, FG2 2018, FG3 2019). In Scotland, most members we asked said they did not feel the need to ask permission to join Q and would likely be given time off work to attend (local) events (FG1 2018, FG3 2019). Although members’ viewed Scotland as more advanced in terms of QI, there was still discussion about the need to further embed improvement in everyday work so it is not viewed as an ‘add on’ (FG2 2018, FG3 2019). However, it was also fully recognised that while there might be a different, and indeed better, QI landscape in Scotland, there remained massive challenges in the health and care system, often linked to deep-rooted and long-lasting inequalities (INT1).

C.2.2. Future of Q in Scotland

Members commented on how Q helped them to make improvements in their day-to-day activities. There were concerns raised that the involvement of Founding members could be lessening, possibly because some

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7 The Scottish Quality and Safety Fellowship programme is a course on quality improvement and clinical leadership, managed by NHS Education for Scotland alongside HIS and NHS Scotland. For further information, see: https://learn.nes.nhs.scot/814/quality-improvement-zone/learning-programmes/scottish-quality-and-safety-sqs-fellowship-programme
of the content at events is repeated, or because Q has not developed as some Founding members hoped (INT3). None of these concerns is unique to members in Scotland.

The need to widen recruitment to Q, including individuals earlier on in their careers and from a wider range of backgrounds, was frequently mentioned (FG1 2018, FG2 2018, FG3 2019, FG4, INT2, INT4, INT6). This includes younger and less experienced individuals, as well as people from other sectoral backgrounds, such as the voluntary sector and care support staff (FG1 2018, FG4, INT2, INT6). This was felt to be important in preventing Q becoming an ‘exclusive club’, and ensuring it remains a dynamic community (INT3, INT4, INT5). Interviewees noted that it would be helpful to recruit new members more widely from outside of health care (housing and education, for example) to enrich the mixture of ideas with Q (INT2, INT6).

The possibility of integrating Q with other QI initiatives in Scotland was frequently discussed. Q is already involved with QI Connect through WebEx webinars and Q could also get involved with other initiatives, the Scottish Improvement faculty, the Royal Colleges, and Healthcare Improvement Scotland (FG4, INT1). One member commented how Q could integrate with local initiatives to overcome the issue of implementing the same programme across differing regions (FG4).

While there was broad agreement about ensuring good integration with existing programmes in Scotland, there was less agreement about what this might mean for branding Q in Scotland. One person (as noted) was very strongly in favour of developing a ‘Tartan Q’ with a strong Scottish identity (INT5). However at least two others strongly disagreed, arguing that it was the UK identity that was especially attractive (INT4, INT6). The majority were spread along this continuum. A variation on this theme expressed by one interviewee was that Q in Scotland should in effect become a part of HIS.

In the future, some interviewees emphasised, it will be important for Q to harness the use of technology to support the relationships made as a result of Q, especially as in parts of rural Scotland, when these are over large distances (FG1 2018, FG3 2019, INT3). Members could be encouraged to upload documents and webinars etc. to allow members to look at these in their own time, rather than having to take time out of their work day.

C.3. Implications of, and reflections on, the Scotland case study for conceptualising Q

C.3.1. Niches that protect QI

Improvement is a creative, incremental and improvisational journey. How this happens and with what consequence varies from one context to another. Indeed, no two of our case study participants had the same story about their ‘improvement journey’ and the role of Q within this. We found human ecology and place-based thinking helpful in understanding this and believe it has wider implications for the final stages of our evaluation of Q. Improvement places – the local contexts where QI work is done – can be seen as niches. The notion of ‘niches’ comes from evolutionary biology, particularly allopatric speciation theory (Mayr, 1963), which suggests that otherwise identical species left to develop separately in different ‘niches’ will over time come to exhibit different characteristics. In technological evolution, by extension, niches and speciation are also important (Schot & Geels, 2007). We can think of local settings (niches) as providing
protection (or not) for different kinds of QI practices. Over time, these become entrenched in the particular history of each niche. Characteristics such as access to reliable data, the support of data analysts, the presence of individuals trained in improvement methods, a non-chaotic environment, strong networks, senior leadership buy-in and so forth are all likely to be relevant.

Our case study participants identified what for them were some of the important characteristics of these protective niches in Scotland. These echo many of the findings from our Q member surveys (time, leadership, travel costs, relationships, etc.) but had other distinctive characteristics. These distinctive features included a longer experience of improvement practices dating back to the SPSP and earlier, as reported by our interviewees, a more persistent rhythm of learning, a more collaborative working environment, a wider range of disciplines and services involved in QI providing a richer mix of ideas, and a leadership that was not only supportive of improvement but also was experienced and trained in it. The niches already in place in Scotland are therefore not unrecognisably different from elsewhere in the UK, but they are distinctive enough to suggest that they may require a different approach if they are to be nurtured and grown.

Understanding how QI niches become structured and aligned over time

While niches identify where the improvement work delivers benefit to patients and to the health system, Scotland case study participants talked about how local places were shaped and supported, and given direction over time, by a set of meso- and macro-level factors. Generically these might include:

- Enablers, structures and facilitators
- Activities and processes
- Organisations as interactive practices
- Spatial and temporal settings.

In Scotland, according to respondents, these included the supportive role of (at least some) Health Boards, the role of HIS, a balance of mandates and rewards (what we described as a ‘hybrid’ regulatory regime above), helpful data systems and supportive networks reaching beyond healthcare. We describe this in Figure 1 below.

Based on the responses of respondents, the implications for Q (in Scotland but presumably also across the UK) are clear and involve:

- Ensuring a multi-level approach to help coordinate and align QI practice.
- Nurturing a consistent approach to learning.
- Avoiding unnecessary and unsystematic frequent reinvention and repetition.
- Creating supportive local places.
- Maintaining a systematic approach to capacity building and QI practices.
- Supporting some form of hybrid governance that can combine national standard setting and mandates with reward.

In other words, delivering the theory of change of Q (with its central themes of connecting, developing, mobilising and supporting) requires not only ‘doing’ these things but also creating the preconditions for this by establishing a ‘platform for improvers’. Case study participants had different views about how stable and complete this platform is in Scotland. One view was that the current financial pressures might weaken
the platform. Also, one participant interestingly suggested that the platform was well designed to harvest ‘low hanging fruit’ (the early stages of the SPSP) but that achieving more complex aims would require further adaptation of the approach.

**Figure 1: The characteristics of the improvement system in Scotland**

Based loosely on Geels (2002, 1263)

C.3.2. A platform for improvers?

A ‘platform’ can be a generic term describing something that creates a stable element within a system, allowing other parts of the system to interact more efficiently and effectively than would otherwise be the case. More recently, the term has sometimes specifically applied to online matchmakers such as Uber. When case study participants talked about Q and what they hoped to get from it, they described both the value of the activities and events organised by Q (primarily direct benefits) and also the access to networks and information external to Q which were a result of the ‘matchmaking’ role (primarily indirect benefits). However, while the benefits from activities and events might be primarily direct, they may also have secondary indirect benefits, and the converse might be true for the ‘platform’ role. We therefore think that there is merit in applying ‘platform thinking’ to the evaluation of Q (not specifically for Q in Scotland) alongside looking for more direct benefits from events and activities. We also think, and the interviews reinforce this, that the strength of the platform is enhanced by being organised alongside events and activities that have their own direct benefits (although this complicates still further the task of identifying the value created by Q as an initiative).
However, we do not believe that Q is only a platform, a view reinforced by the Scotland case study. Participants emphasised the importance of events and activities for building QI capacity in general and for the role of Q in particular. Indeed, we suspect that the ‘platform’ function of Q is enhanced by the activities and events function and vice versa. In this sense, a better metaphor for Q might be a medieval fair where multiple opportunities for matchmaking sit alongside activities which deliver benefits in their own right. These benefits might be direct or indirect.

C.3.3. Direct and indirect benefits

Reflecting on discussions in Scotland prompted us to think that Q might therefore be seen both as a delivery mechanism (comparable to a ‘club’) with (mainly) direct benefits and as a platform with (mainly) indirect benefits. Q both does things with direct benefits and enables other things to happen with indirect benefits. Hypothetically we might describe this in Table 7 below.

<table>
<thead>
<tr>
<th>Table 7: Hypothetical direct and indirect benefits of Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q as a club supporting new skills, improved techniques, enhanced resilience and mutual support</td>
</tr>
<tr>
<td>Developing new knowledge and skills that can be directly applied in niche settings</td>
</tr>
<tr>
<td>Q as a platform connecting people and facilitating them to do valuable things that would not otherwise have been possible</td>
</tr>
</tbody>
</table>

C.3.4. Linearity, discontinuities and timescales

None of the case study participants suggested that improvement in Scotland was at a tipping point. However, there was a consensus view that it took many years of effort in Scotland to arrive at a point where improvement practices were stabilised and socialised. There were differing interpretations around whether or not this narrative was linear. For many of those who had been directly involved, the process may have seemed more like the process of change described by Schumpeter (1939, 102) who proposed that ‘evolution is lopsided, discontinuous, disharmonious by nature’. If we consider the timescales and discontinuous evolution of improvement in Scotland with Q, we might conclude that it is too early to tell whether Q is a success. We might also consider whether Q is prepared for engaging with ‘lopsided, discontinuous, disharmonious’ development. However, if progress is lumpy, and if it takes time for a covert critical mass to be achieved before an overt step forward can be made, how would we know whether we were either at such a point or progressing towards it? From our small group of participants in Scotland, there was no shared answer to this. However, there was something about the extent to which a community of improvers makes sense of their community in a shared way.
C.3.5. Sense-making

Our respondents in the Scotland case study made sense of their improvement landscape in a variety of ways reflecting their separate QI journeys. However, despite differences, it was clear that sense-making is indeed a collective and social process. A shared mental map exists, at least among the case study participants, through which a story of the past has been established. It represents a story most often starting with the SPSP (but sometimes earlier) and includes the role of IHI and IHI Fellows in an environment shaped by organisations like HIS and leaders such as Jason Leitch. The point is not so much whether this is a ‘true’ story (whatever that may mean in this context) as the fact that it is a shared story. When Q is thought about and discussed in Scotland, it is most often in the context of a prepopulated story and sense-makers integrate the story of Q into this narrative. Therefore, the communications around Q may well mean one set of things in Scotland and another elsewhere. However, sense-making is continuous and already Q is being viewed differently; some respondents did not engage with Q as founding members because they were not sure it was relevant or they were put off by its name and communications but have since joined and revised their opinion. One other participant continues to question how Q will eventually fit into the Scotland environment, while hoping and expecting that it will.

Knowing that sense-making is continuous is important. Public policy was often referred to in discussions. However, this was most often not in terms of mandates or resources but in terms of providing a focus for, or legitimation of, a set of values. These values included fairness, equality and serving the public good. In particular, it included the sense that QI was important and legitimate (although obviously this was to an extent a self-selecting group).

C.4. Implications for Q

The Scotland case study suggests that it is possible to use the weight of an improvement community to shift the experience of doing QI. This is an assumption at the heart of the Q theory of change. The Scotland case study also suggests that having stability about the methods used and persistence among those involved may be important (and that this sustained effort and rhythm of learning is preferable to multiple one-off actions, no matter how good these are). It also suggests that it is important to engage both bottom-up and top-down ways of working. Indeed, the simplistic view of improvement in Scotland as bottom-up and professionally led needs qualifying.

The Scotland case study might enrich the Q theory of change, but it does not fundamentally alter it. The centrality of connecting, mobilising, supporting and developing are all relevant. However, there are important implications for how these lead to an improvement community with a shared sense of identity and history, a confidence in their capacity to improve and the sense that they are empowered to act. The importance of Q working not only for bottom-up change but also top-down suggests that the membership and leadership of Q should focus on policy and governance as well. This suggests finding a balance between Q being a benign disruptor and being a support for the existing system. The belief that a consistency of approach and a steady rhythm of learning may also suggest that Q is more narrowly focused but more long-term in its approach. Q members in Scotland also argued for a more diverse Q in terms of sector, age and background (and this has also been a theme elsewhere in the UK). Finally, the balance of opinions solicited
through the case study suggests that there should continue to be balance between an approach that recognises the diversity of the UK and one that provides opportunities for trans-UK learning.

Evidence from the interviews and focus groups, and from the wider documentary review, suggest that the lesson for Q elsewhere in the UK is that system leadership, time, persistence and renewal are all important. These lessons reinforce what Q members and stakeholders already know. The value of face-to-face working is also apparent as is the opportunity to mix with people sharing similar problems in similar professional circumstances. One benefit for QI in Scotland has been sustained political support, even during a change of government. Q should consider the extent to which it targets political leadership, in addition to healthcare organisation leadership. The importance was also emphasised to us of identifying and quantifying progress (for example, on patient safety) for building both political and professional support for QI.

More specifically, there is the claim that QI in Scotland operates in a context where the tension between bottom-up and top-down approaches is better managed. We feel that more work is needed on this given that very informed observers arrive at rather different conclusions. There is certainly a view that it is not simply a ‘bottom-up’ approach as has been suggested. However, for one respondent, at the national level it was mainly about clarity from above about expectations combined with interpersonal leadership, and then allowing freedom within these boundaries. For others, particularly closer to the ‘front line’, it was about being delegated a high level of autonomy in relation to QI activities that then fosters a sense of responsibility. Very often, scale was identified as providing cohesion between top-down and bottom-up approaches (including the negative effects of working across sparsely populated large geographical areas).
D.1. The Quality Improvement and innovation landscape in South West of England

To understand how Q fits into the NHS in South West of England, we first explored the current QI and innovation landscape in the region. The key themes raised by the interviews, discussed in more detail in this annex, include the approach to QI, the role of different organisations, particularly the South West Academic Health Science Network (AHSN), how QI learning has been taken from elsewhere (and in particular Scotland), and the QI and healthcare priorities in the region. However, it is important to note here that our interviewees were based in similar regions of the South West (Devon) and so there may be differences in the landscape in other areas.

D.1.1. QI and innovation is varied in the South West and often follows a more ‘traditional’ approach

Our interviewees discussed what QI looks like across the South West, focusing on how implementation of QI differs across the large region. It was also highlighted that, in general, the region often prefers a more traditional approach to QI rather than adopting some of the more innovative and radical methods.

Two interviewees described how the QI landscape in the South West is ‘well regarded’ across the region. However, the way it has taken root in different parts of the region differs and some geographical areas are more involved in QI than others (INT2, INT5). This varied approach to QI is particularly evident when looking across counties in the South West. For example, it was mentioned that Devon may struggle to implement effective QI activities due to the small number of Q members in this region (INT2), whereas Somerset was highlighted by two interviewees as an area more involved in driving QI, with some key pieces of work being published in journals and magazines (INT2, INT4).

When discussing the QI approach taken in the South West, one interviewee highlighted that a more ‘traditional’ view is often taken rather than more innovative approaches, although apparently this is not the case for the whole of the area (INT5). Traditional approaches were discussed by this interviewee in the context of those that have been well established and used for a long period of time, and often have easy to measure outcomes. This could include approaches such as training for healthcare providers, which is a common method used for QI and allows those implementing it to measure impacts pre- and post-training (INT5). This interviewee reflected that QI may only be seen as ‘right’, ‘proper’ and effective when these more traditional approaches are implemented. This may, in part, be driven by the need for NHS Trusts in England to meet specific goals and targets and so aligning with more traditional centrally supported
approaches makes it easier for policymakers and others to clearly see the impact of central funding on newly introduced initiatives (INT1, INT5).

D.1.2. Various organisations are involved in QI and innovation in the South West but interviewees stressed the role of the AHSN in particular

Our interviewees discussed the role of different organisations in QI and innovation in the South West with a particular focus on the role of the local AHSN. One interviewee discussed the role and activities of the South West AHSN in detail (INT1). They discussed how the AHSN, alongside a small number of others in England, had actively and voluntarily taken on a leadership role in improving quality in recent years. In particular, we were told that the South West AHSN has put a lot of resources into supporting improvement capability and infrastructure both in the region and nationally, as well as supporting other organisations such as Sustainability and transformation partnerships (STPs), to embed QI into their planning and day-to-day work (INT1). The South West AHSN in particular has been able to provide resources and drive improvement activities due to the early AHSN team members who were passionate about QI and had previous experience in implementing QI. They also identified the need for QI in the South West. This early work by the AHSN team led to some of the first QI work in the region and, as a result, to a base and legacy for others to continue to build on (INT1). It was said that it is unlikely that there is another organisation in the South West who would be able to take on this kind of work (INT1), although this poses a problem due to the recent funding and structural changes in the AHSN, which our interviewees reported have meant it is less able to provide this support for QI than it has in the past (INT1, discussed more in Section D.2.4).

Our interviewees discussed the role of other organisations in QI in addition to the AHSN. Collaborations for Leadership in Applied Health Research and Care (CLAHRCs) were described as being innovative, clinical research networks aiming to innovate and improve care (INT1). However, this interviewee noted that CLAHRCs’ funding is often restricted to certain activities that don’t relate directly to QI (INT1). Two of our interviewees discussed the collaboration between individuals and organisations in the South West with the Billions Institute\(^8\) in the US (INT1, INT5). For example, the early South West AHSN team worked with this institute to spread QI training across the region using a similar approach to spreading QI to IHI (INT1).

D.1.3. Implementing learning from Scotland in the South West of England

Our interviewees discussed the importance of the South West adopting QI methods and learning from Scotland. This was reported to have helped set up the infrastructure and develop capabilities to support QI in the region.

Two interviewees discussed how organisations in the South West have taken learning about QI from Scotland and implemented it the local area (INT1, INT2). In early 2018, we conducted a case study exploring Q in Scotland and this highlighted the positive progress that has been made there in implementing QI, in part, we were told, because the NHS in Scotland started focusing on creating an infrastructure to support QI earlier than was the case in England. As a result of this, the NHS culture in Scotland is more open to QI and has made more progress in embedding it into day-to-day activity and providing support for

\(^8\) For more information, see [https://www.billionsinstitute.com/](https://www.billionsinstitute.com/)
An evaluation of the Q Initiative 2016–2020

this. One interviewee also highlighted this point, describing how the culture of QI is more open to ‘testing and failing’ and how dedicated time is provided for these activities (INT1). This interviewee commented on how that is different from the culture in England, which is more focused on demonstrating positive outcomes (INT1).

We were told that one example of the learning taken from Scotland was the first South West patient care collaborative, which was based on the Scottish model, helping to develop a QI legacy for others in the South West (INT2). In addition, the South West AHSN has recently commissioned four people in the South West to attend the Scottish Leadership Programme to further the learning gained from Scotland (INT1).

D.1.4. Current improvement and healthcare service needs and priorities in the South West

We discussed with interviewees the current QI and healthcare service priorities in the South West. In general, these were seen to be similar to the priorities seen across the NHS. It was suggested that this may be because the South West has the same gaps seen elsewhere in the UK (INT1). The priorities the interviewees referred to generally focused either on implementing QI activities and innovation, or on priorities for particular healthcare services. By implication, priorities for healthcare services should be aligned with priorities for QI and respondents did not easily separate out the priorities of QI from other healthcare priorities.

For one interviewee in particular, there was a connection between innovation and improvement, linking a perceived need for additional support in developing innovations to improving support and capacity for QI implementation. Firstly, it was argued by one interviewee that supporting innovations early in their development should be a priority going forward. Specifically, it was believed that there needs to be clearer information and guidance on how much evidence is needed to scale up an innovation (INT1). In addition, there is a need to use QI methods to monitor uptake and spread of innovation, which is not yet a mature process in the healthcare system (INT1).

Secondly, there is a need to improve the support and capacity provided for implementing QI on a practical level. Those working in healthcare need to have a certain set of skills to implement QI and to have an understanding of what improvement looks like in the real world (INT1). For example, the South West has plans to introduce a QI Hub. However, there is a lack of clarity about who is responsible for this and who will be providing support in setting it up; the South West AHSN provided implementation support but it is unclear if this really fits into their developing role (INT1).

The healthcare services’ needs and priorities identified by interviewees relate to the need for collaboration across public services and a move towards focusing on patient care. To support a more holistic approach among healthcare services, there needs to be greater collaboration and networking across public services (INT1). It was thought that relevant knowledge and learning could be taken from Scotland (which our previous case study suggested has been moving towards a cross-public sector approach). Another interviewee raised the need for healthcare services to be reoriented to have a greater focus on patient and community-centred care (INT6). Using improvement science was thought to be one way of changing attitudes so that they are more open and receptive to this shift in care (INT6).
D.2. How Q fits into the South West improvement landscape

- Networks existed in the health and social care system across the South West before Q was established; however, Q has helped to enrich and further developed these networks.
- The improvement work undertaken by Q members may be seen by some stakeholders to sit outside of most NHS work, which may make it difficult to share the good work from members in the region. However, Q is able to provide a safe space and supportive network for these members so they feel less isolated in their work.
- The model behind the Q Commons Stewardship Group was thought to resonate with members and the ethos of Q, although implementation of the group has faced difficulties due to limited time and resources.
- The South West AHSN was supportive in the early implementation of Q in the region, helping to generate a cohesive community; however, recent funding and resource changes have meant it is less able to provide this support now.
- Having the Q and Health Foundation banner on members’ QI work supports and adds validity to this work.

D.2.1. Although networks existed before in the South West, Q has supported these to widen and develop further

A strong network of healthcare providers existed in the South West before Q was set up and Q has enriched this network further by allowing a broader range, in terms of both experience and location, of people to get involved.

Two interviewees discussed how a network of healthcare providers existed across the South West before Q was set up (INT3, INT6). This network was originally established as the South West was relatively early (compared to other areas in the UK) to work with the IHI and the chief executive of the then Strategic Health Authority (SHA) that funded the acute community and mental health QI programmes in the region. These actions helped to connect individuals interested in QI across the South West and allowed connections to be made with those in other fields of work (INT3).

Q has helped to enrich and widen these networks and many of the individuals in the original networks are now Q members (INT3). For example, Q has contributed to connections developing across geographical boundaries and has allowed new people to join these networks, including from across hierarchies and outside of larger NHS Trusts, e.g. from social enterprises, charities and private companies as well as allowing patients to join (INT1, INT5, INT6). There are now Q members in nearly all NHS Trusts in the South West and these members have been involved in large QI projects across the region (INT2). One interviewee noted how the Q funding for regional support to develop these connections further, such as the Q Convenor, ‘fits in really nicely’ with the existing South West networks (INT1), although a key theme discussed in Section D.4.1 outlines how the interviewees think this type of support needs to be developed further. However, one interviewee felt that, because of the pre-existing networks in the South West, it isn’t clear how prominent the Q community is in the region (INT3).
D.2.2. Q may be seen by some stakeholders to sit outside of the main QI work in the NHS, however this may be beneficial to some members

Two interviewees discussed how Q activities may be seen to sit on the edge work in the NHS. One interviewee spoke about this issue in a more negative light, in that QI work in general sits on the periphery of the rest of the work in the NHS, which makes it difficult to share the important work done by Q members more widely in the system (INT3). If the work conducted under Q was made more overtly ‘mainstream’, it was said, and the Q members in the South West were made more visible across health and social care so they could be contacted to share ideas and contribute to problem solving, this may help to make it easier to share the Q work widely (INT3).

From an alternative perspective, another interviewee focused on how Q sits on the outside of improvement work specifically in the NHS. This interviewee described how Q attracts people working on the ‘edge of improvement’ and should provide support to this group that they might not be able to get elsewhere (INT5). For example, Q members working on the front line of healthcare may be more likely to take ‘radical’ approaches to QI. That is, they are ‘practising on the edge’ (INT5). Because of this, the interviewee felt that these individuals were more likely to feel isolated, disconnected and stressed and could ‘fall off the edge’ if they are not supported, and Q is a good mechanism to provide support to this group (INT5); for example, Q can help connect people doing this kind of work so they can provide support to each other and share ideas and experiences to input into others’ work (INT5).

D.2.3. The idea behind the Q Commons Stewardship Group was said to be interesting but difficult to implement

A recurrent theme across our interviewees focused on the establishment of the Q Commons Stewardship Group and how the idea and model behind this was interesting and well considered in principle. However, the implementation of the approach proved challenging and, it was said, little progress has been made in the past year.

The Q Commons Stewardship Group was established in the South West to pilot the model and this has now come to an end after one year (INT2). Multiple interviewees thought the Commons model was based on a ‘good idea’ and resonated well with those involved in its development as it was non-hierarchical and only required a small number of people to run it (INT2, INT3, INT4). One interviewee highlighted how the model ‘completely fits within the values of the Q community’ in that it encouraged the sharing of experiences and ideas across all Q members (INT3).

Despite this positive view of the Q Commons Stewardship model, most of our interviewees discussed how the group has faced difficulties in being implemented in practice, primarily due to difficulty finding time to set up the group (INT2). This lack of time meant regular meetings between group members did not happen and so the group struggled to gather momentum (INT2). Related to this, the majority of group members’ roles in the Commons Stewardship Group were voluntary, which made it difficult to find time on top of their main jobs to work on establishing the group (INT3).

Recent structural changes to funding and staff in the AHSN also presented a barrier to setting the group up as the AHSN was less able to provide support in the early stages (INT3, INT4). This meant the AHSN were unable to hold large events to bring together members from across the South West and promote the
idea and message of the Commons Stewardship Group (INT3). This led to the group losing momentum early in its development and it ‘never really caught back up’ (INT4).

Finally, our interviewees reported that the Commons Stewardship Group found it difficult to connect with the Q members in the region, particularly those members less engaged with Q, and to link Q with the regional STPs to encourage local organisations to reach out to Q members for support in solving problems (INT2, INT3). This may in part be due to the lack of momentum and events to promote the group discussed previously, but also the difficulty in connecting members across county boundaries (INT2).

These challenges were reflected in the lack of awareness of the Commons Stewardship Group; our interviewees were made up of key Q stakeholders in the South West, yet those who didn’t have direct involvement had not heard much information on the group and its activities, and were not very aware of the group in general (INT4, INT5).

D.2.4. The South West AHSN provided support in the early stages of Q but structural and financial changes have made this difficult to continue

Many of our interviewees discussed the relationship between the South West AHSN and Q. This was described as being a ‘symbiotic relationship’ as many of the same individuals both work with the AHSN and are a member of Q, both have similar goals and are focused on creating connections and bringing people together (INT2, INT4). This means that engaging the AHSN is important in engaging Q members and helps to motivate and encourage Q members at a local level, as well as holding the Q community together in the region (INT2, INT3). This support for Q provided by the AHSN was particularly evident during Q’s early development stages as the AHSN hosted events that brought together members from across the different counties in the South West and provided an opportunity to work with new members (INT3, INT5, INT6).

Despite these early, positive contributions from the AHSN, there was some concern from our interviewees that this support has diminished recently, in part due to the structural changes seen in the AHSN discussed previously and the increased pressure on the AHSN to meet targets (INT1, INT3, INT4, INT5, INT6). This has meant the AHSN does not have enough resources to provide the same level of support as it did when Q was first set up and it does not have explicit funding to spend on supporting Q (INT1, INT3). This has meant the Q community across the South West is less cohesive as there are fewer events and physical, face-to-face meetings bringing members together (INT3, INT5, INT6). These interviewees believe that additional resources should be provided for the AHSN to provide this support to bring together Q members across the region and to support QI more generally (discussed more in Section D.4.1) (INT1, INT3).

D.2.5. Q and the Health Foundation branding and resources support members’ improvement activities

Multiple interviewees discussed how having the Q and the Health Foundation ‘badge’ helps support their day-to-day QI work and the work they do through Q (INT3, INT5, INT6). For example, the Health Foundation and Q banners have been helpful in getting engagement for the reimagining health and social care special interest group (SIG) in the South West, as they have a recognised identity that brings validity to the work of the SIG and people have high expectations of activities with this badge (INT6). More
generally, it was highlighted that people value being a part of Q and it is seen as a ‘badge of honour’, particularly by frontline healthcare staff (INT3).

Relatedly, one interviewee outlined the importance of the support from the Health Foundation in providing resources and activities through Q (INT3). This interviewee felt that the Health Foundation ‘put resources together and displays them well’ and put on ‘fun events with the right people there’; they were seen as providing something that isn’t seen very often, particularly in the NHS environment (INT3).

D.2.6. Barriers to engaging with Q in the South West

Throughout the evaluation of Q, we have explored the barriers to engaging with Q at a national level and the barriers reported from the interviewees in the South West do not differ to a great extent from our previous results and are similar to those seen across the UK. Lack of time (INT1, INT3, INT4, INT6), and limited resources available to the AHSN to support Q (INT1, INT3, INT4, INT5, INT6) were the most frequently reported barriers to engaging with Q. We have found time to be a primary barrier to engagement across multiple data sources for this evaluation. Our interviewees discussed how it is difficult to fit Q activities into working life and manage to meet the expectations of the number of different roles within and outside Q (INT1, INT3, INT4). As discussed previously, the lack of time was a particular barrier in attempting to set up the Q Commons Stewardship Group. With regard to the limited AHSN resources, changes within the South West AHSN have made it difficult to provide the support in connecting Q members seen in the early stages of Q, which means the Q community in the region is not as cohesive as it once was (INT1, INT3, INT4, INT5, INT6).

There is no single barrier which, once removed, could open up access to engaging with Q but, rather, a range of different issues. In addition to lack of time (which in itself may represent a number of different barriers) and lack of AHSN resources to support Q, other barriers mentioned by interviewees include:

- **Q sitting at the periphery of the main NHS work**: Also discussed previously, as QI work in general tends to sit on the edge of NHS work, it can be difficult to spread the word about Q work going on in the NHS and getting members involved in this (INT3).

- **Lack of clarity on certain aspects of Q**: Two interviewees discussed how there is a lack of clarity in the role of Q Connectors (INT6) and on what the future of Q will look like (INT4). One Q Connector in the South West highlighted how they were unclear on what the role entailed. This interviewee also discussed how they have not had much information or support from the Health Foundation in starting the role of a Q Connector and, as a result, there has not been an opportunity to bring the Q Connectors from the South West together to discuss the role and the activities they would like to get involved with. The interviewee highlighted that the Q Connectors could have taken the responsibility among themselves to start working on new activities, but that this is difficult if the purpose of the role is unclear and there is no support from the Health Foundation to do so (INT6). Another interviewee was unsure about what new Q members might get out of Q in the future due to the level of ambiguity; members have an innate trust in the process but this ambiguity makes it hard to know what they need to contribute to the network (INT4).

- **Difficulty connecting members across the regions in the South West**: As the South West covers three large counties (Devon, Somerset and Cornwall), it can be difficult to get Q members together
and to create connections across this large geographical area, leading to more localised QI being seen compared to region-wide projects (INT2, INT3). One interviewee noted that it is also difficult to get Q members who work geographically close together to connect and work together (INT4). For example, two hospitals in the South West may be merging together organisationally and despite being physically close together, connections between staff in the two hospitals were poor before they ‘were forced to get to know each other’ (INT4).

- **The Q website can be difficult to use:** One interviewee highlighted how the Q website can be ‘clunky’ and difficult to use, albeit useful, in identifying Q members to contact (INT5).

- **There can sometimes be too much focus on communication rather than facilitating connections:** Two interviewees discussed how the Q team at the Health Foundation often provides good support on the communications side of engaging Q members, but less facilitation support in creating connections and bringing Q members together across the region (INT5, INT6). This, in part, links to there being fewer events in the South West for Q members; without an event to bring Q members together, engagement and networking is difficult (INT6).

### D.3. The impact of Q in the South West

The interviewees we spoke to discussed various impacts of Q that are starting to become evident in the South West, including: contributing to the development of new connections; accelerating QI across the region; the impact of the Reimagining Health and Social Care SIG and Q Exchange funding; and how the Q Labs process may have been more successful than the outcomes. Each of these points will be discussed in this section.

#### D.3.1. Contributing to the development of new connections between Q members across the South West, which is said to be leading to impacts on members’ organisations

Q has supported members across the South West to make new connections that may not have been made without Q (INT1, INT2, INT3, INT5, INT6). Our interviewees discussed how this impact is likely to be modest at least in the short run and recognised that the perceived impacts were based on anecdotal evidence. However, it is likely that these connections and the support provided by Q has ‘given people permission to grow in their improvement efforts, even if these aren’t recognised in their own organisations’ (INT1). Similarly, one interviewee highlighted how Q has allowed members to ‘cross-reference’ with each other to work on developing QI in their different organisations (INT1). In addition, two interviewees spoke about how the communication routes of Q, such as Twitter and newsletters, help members to feel more connected and that the importance of these routes of communication shouldn’t be underestimated (INT1, INT5).

> The kind of thing that Q is trying to do is networking, communicating, knowledge management. Just running a twitter feed, newsletter, making people feel connected and dedicating communications resources shouldn’t be underestimated. [INT1]

It is possible that these new connections in the South West are leading to impacts in Q members’ organisations (INT3, INT5). For example, one of our interviewees connected with a Q member from Plymouth to get their support in the Learning from Excellence work being set up in the South West (INT3).
In addition, Q members have been helping an NHS Trust in Cornwall to get out of special measures by sharing and implementing their QI skills (INT2).

*Royal Cornwall went into special measures and straight away a large number of Q members were pushed there to help with QI as they had the skills needed to make improvements.* [INT2]

This interviewee commented that ‘turning stuff around is as much as QI ideology as change management…it’s all valid and it’s all important’ (INT2). Another interviewee spoke about how Q members have changed the way their region views QI infrastructure, moving away from seeing it as something optional to something essential and being interested in how to enhance this infrastructure even further (INT1).

One interviewee highlighted that the Q team at the Health Foundation may not be aware of these anecdotal impacts resulting from new connections between members.

*Those [impacts] are probably things that Q doesn’t know about necessarily...but stuff is happening on the ground because of Q* (INT5). However, if these impacts needed to be registered somewhere so the Q team is made aware of them, this may risk reducing initiative and creativity across the Q network: ‘if you had to register that [impacts of Q], you would be squashing all the creativity.’ [INT5]

**D.3.2. Accelerating QI progression across the South West**

Multiple interviewees discussed how Q has contributed to accelerating QI in the region (INT2, INT3). Q has had an impact on the shape of QI change in the South West and this change has been faster because of Q.

*Q didn’t start the shift, but they put their shoulder to it so it could go faster and quicker.* [INT2]

*I probably won’t be able to remember all the little examples, and there are things that have probably been accelerated as a result of Q.* [INT3]

**D.3.3. The Reimagining Health and Social Care SIG progressed new ideas in health and social care as a result of Q support**

Two interviewees spoke about the local benefits of the special interest group (SIG)9 focused on reimagining health and social care, which builds on implementing new ways of working across the healthcare system in the South West (INT5). Although this is a national SIG, there are regional face-to-face meetings in pubs across the South West every month that are open to both Q and non-Q members (INT5, INT6). The SIG was described as being ‘vital’ in progressing new ideas and conversations in health and social care, and some of these ideas have started to come to maturity (INT5).

Without access to the Q network, the Q members leading on this SIG may not have been able to make as much sustained progress as they have. For example, Q provided a platform to hold an event for the SIG in which Q members and non-members were able to come together and have important discussions (INT5).

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9 Special interest groups (SIGs) are nationally organised groups with a shared interest in a particular issue relevant to improving quality.
D.3.4. Q Exchange funding is leading to changed perceptions of and improvements in patient involvement in QI

Q Exchange was seen by multiple interviewees to have worked well and been successful in the South West (INT1, INT2, INT3, INT4). Two of the winning bids came from Q members based in the South West, one of which is focusing on improving patient involvement in QI. One interviewee highlighted how they were ‘amazed’ at how well this particular project had come together in a short space of time and is starting to have a positive impact on the health service in educating healthcare staff on how to meaningfully involve patients in their QI projects and training patients to be better prepared to get involved (INT1, INT4). One interviewee commented that it is unlikely this project would have got off the ground without Q Exchange funding (INT2).

The other Q Exchange project in the South West, the Hexitime the Healthcare Skill Exchange Timebank, was believed by one interviewee to be slower at getting off the ground than the other project and they have not seen any information on its progress since the funding was announced (however, they noted that this may be due to them not having kept up to date on the project’s progress and it may actually have developed further than they knew) (INT4).

D.3.5. The approach to Q Labs may have been more successful than the impacts

The Q Labs were described by one interviewee as being ‘fantastic’, with another highlighting that the South West was particularly well represented in the first Lab (INT2, INT3). However, this interviewee also discussed how ‘the process of Q Labs has perhaps been more successful than the outcome’ as the South West has only seen one or two projects come out of the Labs (INT2). This may be due to the outcome relying on the drive and passion of individuals involved in Q Labs to push the work in their region (INT2), which may be limited by restricted time and capacity to do this on top of day-to-day job roles.

D.4. What is needed to increase the impact of Q in the South West?

- Support and investment at the regional level is needed from the Q team at the Health Foundation to aid the development of a cohesive Q community across the region. This includes funding and resources for the AHSN to provide the same supportive role in Q as it did when Q was first implemented.
- Introducing new resources, activities and events in the South West will also contribute to development of a more cohesive regional Q community, as it will support the development of relationships and sharing of knowledge.
- Relatedly, support mechanisms need to be put in place to encourage and facilitate the sharing of knowledge, experiences and ideas between Q members in the South West and the rest of the UK.
- Q members can be supported to develop relationships with organisations outside of the Q network, particularly policymakers and STPs, to widen the impact of Q.
- Mapping the Q community in the South West could help to identify locations with fewer members who may be struggling to be actively involved in QI and provide additional support to these areas.

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10 This project is the focus of the first Q Exchange case study. Interviews for this are currently underway and will provide more in-depth detail as to how this project has progressed and the early signs of impact.
D.4.1. Regional investment and support are needed from the Health Foundation and the South West AHSN to support Q members to connect across the region

Many of our interviewees discussed the need for support at the regional level to bring together Q members to create a more visible and solid Q community across the South West, as was seen with support from the AHSN earlier in Q’s life. Without this regional investment, interviewees believe that member engagement with Q in the region will suffer, particularly as the South West often felt disconnected from the rest of the UK and so may struggle to make connections outside of the region (INT1). Additionally, without regional infrastructure, clear and effective communication with local Q members, e.g. to raise awareness of events and Q resources, will be difficult (INT3).

It is important that the regional structure of Q is decided on quickly to prevent engagement with Q slipping (INT1, INT2). One way to do this is to create regional bodies for Q that can help members feel more connected (INT1). If these are to be introduced, they should be recognisable to encourage engagement from members (INT2).

Another mechanism for providing regional support for Q members is to create dedicated and potentially funded roles to hold the Q community together across the South West. This could be one or two individuals who have a dedicated role to know all the Q members in a county and can act as a signpost to connect members with relevant and similar needs (INT1, INT2, INT5, INT6). These individuals need to have in-depth understanding of how Q and QI work in the South West to ensure they identify solutions that can be implemented successfully in the region, rather than implementing something quickly that isn’t adapted to the local area and so struggles to gain traction (INT1, INT4). In addition, these individuals could help connect Q networks across different regions who are involved in similar work (INT5). This could also help to raise the profile of the Q community within local NHS Trusts (INT2). The role described by our interviewees here is similar to that of the Q Convenor and Connector roles already set up in the South West. This suggests that additional time and resources may need to be directed towards individuals in these roles to increase their visibility and the support they are able to provide to members in the region. It is worth considering how this suggestion fits with the insistence that a lack of time is a major barrier to engagement.

This regional infrastructure would require funding, either for Q to directly provide regional support or to provide funding to the AHSN to support Q (INT3). This funding could come directly from the Health Foundation, or other sources, such as innovator funding (INT1). If the AHSN is to provide the same support to Q as it did during the early stages, it would need additional funding and resources to be able to bring together Q members from across the region and to maintain the relationship between Q and the AHSN (INT2, INT3). This raises questions about how responsibilities for improvement should be shared and funded across the improvement landscape.

D.4.2. Additional Q resources, activities and events are needed to encourage and support Q members to reach out to one another and create a more cohesive Q community across the South West

The need for additional or improved Q resources, activities and events was highlighted by multiple interviewees. This may help to overcome the concern that there is more of an emphasis on communication with the Q community, rather than facilitating connections and supporting QI work (INT5).
Elements of the Q website could be improved to make processes more efficient. For example, speeding up the time between submitting a blog to be uploaded to the website and it being published, as well as disseminating more information on activities organised by Q members, such as online talks (INT2). Some Q members are disseminating their activities via channels other than the Q website, such as Facebook and LinkedIn, which has proved successful in increasing engagement and making activities accessible to a wider group of people (INT5). Including the Q or Health Foundation ‘badge’ when disseminating information through these alternative routes could encourage engagement, as discussed earlier in this report (INT5).

Multiple interviewees highlighted the importance of offering different methods of connecting with other members, including face-to-face and online (INT5). Face-to-face connections were seen as important, yet these physical connections are perhaps not as good in the South West as they could be (INT5). The face-to-face interactions are important in developing local connections, whereas online connections are important in reaching out to Q members outside of the South West (INT5). One interviewee suggested that the online connections to those outside of the region could be enhanced by the Q team purchasing a small number of Zoom accounts to make it available to members at a low cost (INT5). These could be used to support the convening of meetings, such as national SIG meetings (INT5). However, it is important that Q offers different ways to connect to other members so the best way of connecting can be chosen based on the needs of the members (INT5).

Putting on events to share ideas and celebrate achievements was seen as important by some of our interviewees (INT2, INT4). This would allow Q members with similar interests to come together and share information on what has been going on in the region, and such high-energy and enthusiastic events can lead to members encouraging each other in their QI work (INT2, INT4).

The sharing of information would be made easier if there were a list of Q members in the South West made available to those outside of the South West AHSN (who already have access to this information). This would make it easier and quicker for members to identify and contact other members with relevant skills and experience (INT2).

Two interviewees highlighted how it may not be necessary for Q to provide new resources, such as those outlined previously, but instead to slightly change the delivery of these resources to make them more efficient (INT2, INT5). For example, meetings of the Reimagining Health and Social Care SIG are held in pubs across the South West on weekday evenings, which doesn’t cost the convenors or attendees anything and is minimally resource intensive (INT5). This same interviewee suggests that Q should focus on ‘enabling members to do what they want to do with the resources they’ve got’ (INT5).

D.4.3. The need for greater support for sharing and disseminating knowledge and ideas between Q members across the country

Our interviewees highlighted the importance of sharing information and experiences outside of the South West to the rest of the UK which in part could be supported by hosting additional events discussed in the previous section (INT2, INT4).

11 Zoom is a company providing remote conferencing services through the use of cloud computing. More information can be found here: https://www.zoom.us
As the South West is well regarded in terms of QI, and Q has slightly above average performance in this region compared to others, sharing information more widely across the UK can support Q members in other regions with their QI work (INT2). On the other hand, the Q members in the South West can also learn from other UK regions (INT2). For example, members in the South West often adopt learning and knowledge of organisational work from Manchester and of patient engagement and mental health care from London and Kent (INT2).

One specific example raised by an interviewee of knowledge that would be helpful to share, is related to maintaining networks (INT3). The interviewee spoke about how they learnt about managing networks through Q and believe that this information would be helpful to other Q members. This is something the AHSN could provide support with and the knowledge could help improve the Q Commons Stewardship Group Model (INT3).

**D.4.4. The importance of supporting Q members to connect with stakeholders outside of the Q community was highlighted**

One interviewee discussed the possibility of Q supporting members to engage with stakeholders outside of the direct Q community, including policymakers and STPs (INT5).

As Q has the ability to ‘tap into passionate activists’, it could play an important role in connecting policymakers, or other individuals exploring the impact of QI activities, with Q members at the front line of QI work (INT5). This can benefit policymakers by providing insight into Q members’ QI work and can benefit Q members by new policies reflecting their views (INT5).

The same interviewee discussed the possibility of STPs working with the Q community to provide a neutral space for conversations between STPs and other organisations, patients and local communities that might not take place in settings, such as those convened by the STPs (INT5). This would support the development of a strength-based approach for the STP at the regional level (i.e. recognising and building upon what works well) (INT5).

**D.4.5. The importance of mapping and widening Q member demographics in the South West**

One interviewee discussed the possibility of conducting a mapping exercise to see which areas in the South West have fewer Q members (INT2). For example, it is already known that North Devon has recently seen a reduction in the number of Q members, which may lead to them becoming isolated from the rest of the Q community and struggling to be actively involved in Q (INT2). Once the weak spots in terms of numbers of Q members have been identified, other Q members nearby can help to mentor and support the struggling areas. Additionally, the reasons behind the lack of members can be explored, for example, if there is a lack of senior staff support for Q, to see if anything can be done to mitigate this (INT2). In addition, the same interviewee noted that many Q members in the South West have clinical backgrounds and there is a need for more patient representation (INT2).
D.5. Implications of, and reflections on, Q in the South West

Recognising that this short report is based on just six expert interviews, we should be cautious about making strong claims. However, we identify some emerging implications in this final section and these will then be triangulated against wider evidence from the evaluation and in particular with the other two deep dives (in Wales and Northern Ireland). Within this limitation, we draw out some conclusions.

D.5.1. Q ‘at the edge’ versus Q being at the core of the NHS

One interviewee noted that Q should be tapping into ‘passionate activists’ (INT5) and there was a sense that Q was able, and should continue, to work ‘at the edge’ by doing things differently and challenging existing ways of working. The view of this interviewee was widely shared by other interviewees that Q is unique and that Q should not become just another provider of quality improvement training. It was emphasised that Q needs to be more than just a transactional network (INT5). On the other hand, the same interviewee recognised that one consequence of this could be that Q ‘falls off the edge’ along with Q members, i.e. it ceases to be sufficiently relevant to merit the time needed to engage with it. According to another interviewee, Q needs to provide a platform for focused conversations to tackle the big issues facing the healthcare system. This interviewee emphasised that Q can helpfully provide a focus for conversations and should use its structured methods as tools to better focus conversations, for example, on whether social deprivation undermines improvement efforts. Such focused conversations would support frontline staff to implement QI improvements relevant to the needs of patients (INT4).

Q in the South West faces a tension between generating novel approaches that contribute to a transformational agenda on one hand, and focusing on incremental improvement that is relevant to the core business of the NHS on the other. Until now, we were told, the AHSN has played an important role in managing this tension but there were doubts about where the resources for this would come from in the future. The Commons model had proved conceptually attractive but in practice had struggled to fulfil such a coordinating role.

D.5.2. Q can both strengthen a community of improvers and support change in NHS organisations

Our interview findings from the South West region suggest that the tension identified in Section D.5.1 can in practice be managed by supporting a community of improvers meeting formally or informally, and helping them to focus on important issues such as engaging patients and the public in improvement work or more specifically helping a Trust requiring active change. One example we highlighted was how at the local level meetings in pubs it had been possible to engage with a national SIG to reimagine health and social care by identifying new ways of working in the South West (INT5, INT6).

In the South West, there was already a community of improvers prior to the arrival of Q but this community has been strengthened since then. However, to sustain this, we were told, it is important to create a shared purpose for Q. It was pointed out that people in the South West were not demanding a Q network and it had been established ‘from above;’ this meant there was no inherent sense of what the purpose would be at the local and regional level (South West INT6).
Five of the six interviewees specifically mentioned that as a direct result of Q new relationships have been formed that would most probably not have happened without Q (INT1, INT2, INT3, INT5, INT6). The national brand of Q was specifically mentioned as contributing very positively to this process and helping to support day-to-day improvement work (INT3, INT5, INT6). While improvements in specific aspects of the national platform were proposed, there was a clear and agreed benefit from the national offering (as well as from Q branding at the national level).

D.5.3. Building a profile for improvement (and QI in particular)
The view was expressed that a challenge for Q in the region is linked to the low priority attached to quality improvement work in general. This was linked to a sense that QI in general, and perhaps Q in particular, was not sufficiently focused on the issues that matter most to local and regional decision makers. This is associated with the idea that Q can be seen to be outside core NHS work and may be a consequence of not communicating the work of Q effectively to decision makers (INT3).

In addition, it was also argued that Q needs to be pushing forward innovation and new ways of working. One of the things that Q could offer local decision makers facing the need to transform is a means to manage change through the use of tried and tested improvement practices. This needs to be accompanied by a greater understanding that more innovative approaches to improvement and transformation may require a tolerance of failure.

D.5.4. Q Exchange is an important model for how national support and incentives can aid local action
There was a common view among interviewees that Q Exchange had supported rapid and relevant collaboration in the South West (INT1, INT2, INT3, INT4). The reaction of local Q members to Q Exchange was thought to have been a success in the region and helped to seed wider engagement with improvement (INT1, INT4).

The Q Exchange approach provides central funding and other support for local groups, who are then expected to engage with other groups proposing related work elsewhere in the country. As such, it is an interesting example of how relationships can be designed to link local groups and then connect these to other parts of the network. It may be that other aspects of Q could be re-engineered with this outcome in mind.

D.5.5. Barriers to Q are varied
A challenge arising for Q in the South West of England is that, in addition to the generic concern about a lack of time, there are seen to be specific and varied barriers to achieving change. The challenge this poses for the central Q team is that there are no simple levers that would remove the barriers. It also reinforces the importance of facilitating local groups to identify and attempt to overcome the barriers.

D.5.6. Bridging and bonding
The description of the work of Q provided by our interviewees is strongly reminiscent of social capital (Putnam, 2000). Bourdieu (1983) argued that durable networks brought with them the ability to mobilise resources that increase the resources available. Networks that support social capital are kept alive by diffused,
and often non-hierarchical, decision making. The social capital produced may be both bonding (in this case, bringing the Q community together and establishing what the members of the community share in common – the shared purpose of Q) and bridging (bringing the benefits of Q to a wider audience and linking Q members to non-members). Bonding and bridging are far from mutually incompatible; indeed, bonding may help a community to bridge. The example of Q Exchange is a good example of how bridging and bonding can be mutually reinforcing.

D.5.7. Boundaries and responsibilities

Our interviews reveal some uncertainty about the responsibilities of the Health Foundation, Q, AHSN, NHS Trusts and others, such that it is unclear where the boundaries of responsibility for leading improvement lie. Supporting improvement practitioners, promoting the value of improvement to decision makers, identifying improvement priorities and funding improvement should all be shared responsibilities. There may be a temptation, suggested by the interviewees, to regard Q as a free good and the Health Foundation as a ‘funder of last resort’, i.e. as a resource to draw upon when other funders are forced to retrench. For a variety of reasons, this is neither a sustainable nor desirable option.
E.1. The Quality Improvement landscape in Northern Ireland

To understand how Q has established itself in Northern Ireland, we first explored the current QI and innovation landscape in the region. The key themes raised by the interviewees, discussed in more detail in this chapter, include an overview of how the QI infrastructure has changed in Northern Ireland over the past decade and the implications this has had in shaping the QI landscape seen today. This section also covers interviewee’s views on the impact of not having a health minister for the country.

E.1.1. The QI infrastructure in Northern Ireland has seen a major overhaul in recent years

Our interviewees provided an in-depth narrative of how the QI landscape in Northern Ireland has seen major changes in recent years including, for example, the establishment of Health and Social Care Quality Improvement (HSCQI). This section will provide an overview of these new initiatives and approaches to QI.

QI in Northern Ireland has deep roots but could be described as starting to gain traction and visibility with the establishment of the Patient Safety Forum in 2007. This forum was set up to help improve quality of care in certain areas, for example, by developing care bundles and establishing quality and safety collaboratives and guidelines (INT6, INT7). It also provided the resources for a small number of people to attend the SPSP training (INT7). The forum has since evolved into HSCQI, which will be discussed later in this section.

Despite initiatives such as the Patient Safety Forum contributing to improvements in QI across Northern Ireland, and reports of pockets of good QI seen therein, one interviewee discussed the recommendations from two policy strategies that a more robust, collaborative QI infrastructure was needed to spread this improvement work across the country to make it more connected and aligned (INT1). The first of these was the Quality 2020 strategy for Northern Ireland, published in 2011 and due to be completed in 2020, which aims to improve the quality of health and social care services (INT5). Although this strategy has helped to improve QI in some aspects, for example, advocating for QI-specific training, one interviewee suggested that frontline staff never felt ‘ownership’ over this strategy as it was mandated by the Northern Ireland Department of Health (INT7).

We have had Quality 2020 for a long time and this has advocated for training but was probably never really owned by the system, it was developed by the Department and sent out to us. [INT7]
The second policy strategy involved the establishment of the Transformation and Implementation Group (TIG) in 2016 by the then minister of health and social care (INT7). This group was made up of key leaders in the system and focused on improving patient outcomes and improving co-production across the region, as well as highlighting the importance of QI and sharing across geographical boundaries, which was reported to be lacking across the region by one interviewee (INT7). This interviewee noted that the TIG was key in supporting the development of regional QI infrastructure and collaboration across Health and Social Care Trusts (INT7).

*The permanent secretary kept asking ‘why aren’t you learning from each other?’ and going round and visiting places and saying ‘I’ve seen an example of something brilliant in this place, why are you all not doing it?’. So there has been a socialisation and normalisation of collaboration and cooperation which I think is key to the changed environment.* [INT7]

As a result of the QI gaps highlighted by both of these strategies, each Health and Social Care Trust in Northern Ireland has developed its own local QI infrastructure. We were told that the South Eastern Trust’s Safety, Quality and Experience (SQE) programme provided an early example of how this might be addressed (INT1, INT2, INT6, INT7).12

*South Eastern Trust had forged ahead on their own and had a robust infrastructure for QI but others didn’t, others were still relying on regional support and learning.* [INT1]

The SQE programme allowed clinicians and others in the South East Trust, including those in administrative and support roles, to learn about QI and embed it into everyday practice (INT6). This has since developed into a nine-month programme covering many aspects of basic QI skills, such as collecting appropriate data, and participants are encouraged to undertake a QI project (INT6).

*I think probably one of the more impressive aspects of that [SQE programme] is that it tried to send the message out that quality was everybody’s business and so they encouraged portering staff, admin staff, all to join onto the SQE programme.* [INT6]

Since the SQE programme was introduced in the South East Trust, other Trusts in Northern Ireland have developed programmes based on this (INT1, INT6). The infrastructure differs slightly across each Trust, depending on the individual Trust’s size and needs, but is largely based on the following QI training initiatives (INT1, INT6) resulting in a three-level approach across Northern Ireland:

- **Level 1 programme**: A basic introduction to QI provided online. The same programme is offered across all Trusts.

- **Level 2 programme**: More advanced QI training offered to frontline staff involved in local QI projects. Each Trust offers a slightly different Level 2 training programme.

12 Health and social care provision in Northern Ireland is the responsibility of five geographical Health and Social Care Trusts: Belfast HSC Trust, South Eastern HSC Trust, Western HSC Trust, Southern HSC Trust and Northern HSC Trust. A sixth trust, the Northern Ireland Ambulance Service, offers ambulance services across the region.
Level 3 programme: More specialised QI training on directing and leading QI, based on the Scottish Quality and Safety Fellowship programme and the Scottish Improvement Skills programme, to help develop QI leaders.

It was suggested by interviewees that this improved infrastructure and training has enabled a more mature and structured QI landscape to develop which helps QI initiatives to scale up and spread across the region (INT1, INT2). One interviewee felt as though Northern Ireland is particularly able to act as a test bed for QI initiatives due to its small size, allowing initiatives to be tested on a small scale first.

_The challenges around that [scale and spread of QI initiatives] are not inconsiderable, even for somewhere with a population of 1.9 million but we are a nice test bed in terms of trying to take some of that work forward._ [INT1]

However, one interviewee felt as though although the greater collaboration and networking seen with these training programmes provided some benefit in terms of progressing QI, the mandatory nature meant that it was more of a tick-box exercise, rather than stimulating staff to drive innovation independently (INT7).

_We were obliged by the department to do the safety forum work, the bundles of care, and they were monitored by the department and our own Trust board. That happened in a formulaic way and people knew each other. There was a QI person that was responsible for QI in each Trust. This is not the kind of network that would spark improvement, but there were people who knew each other and probably did come together a couple of times a year._ [INT7]

In addition to contributing to changes in the QI training infrastructure, the two Northern Ireland policy strategies also recommended the establishment of an improvement institute, which led to the creation of HSCQI (previously the Patient Safety Forum) (INT1, INT6). HSCQI is run by a team of senior leaders in the health and social care sector, whose aim is to lead improvement, with a particular focus on increasing the scale of QI projects. HSCQI will also help to identify QI projects that could be scaled up across a wider area and provide support to achieve this (INT2).

_HSCQI will get into the meat of the operational delivery of quality of improvement hopefully across the region as a whole, largely through identifying projects that look feasible for delivery at scale across the region._ [INT2]

Within HSCQI, five Communities of Practice have been set up by bringing people with relevant experience together and supporting them to build these communities from the grassroots by developing relationships, rather than having a single leader mandating changes (INT7). These Communities of Practice cover ICT and communications, personal and public involvement, innovation, workforce, and evaluation and outcomes (HSCQI, 2018).

In addition to these Communities of Practices set up within HSCQI, one interviewee discussed the successful QI work undertaken by the Maternity Quality Improvement Collaborative, set up by the Patient Safety Forum (INT7). This interviewee commented how the collaborative has been around for a number of years and has been undertaking positive QI work without this being very well known. The interviewee highlighted improvements that the collaborative had contributed to in maternity care, for example, the development of improvement bundles (INT7).
In addition to the QI strategies and changes in QI infrastructure, Northern Ireland has seen more integrated approaches to health and social care compared to England. This, in part, was thought by one interviewee to have been supported by the development of the new QI training programmes rolled out within each Trust in Northern Ireland (INT1). The interviewee discussed how a social work strategy was launched a couple of years ago that included some funding to run a Level 2 programme specifically aimed at social work (INT1). This programme was seen as important because health and social care often work with different language and terminology, and this programme meant the QI language was understandable by those in social work (INT1).

*We had tried to link some of our social work people into these existing programmes and just the language and terminology didn’t always sit well with them as it was all quite acute [health care] focused and…they felt they needed a couple of programmes for themselves…so we have moved them out into their own programmes where they’ll be more comfortable and where the language will be more comfortable, where there is mutual understanding of the context in which they work.* [INT1]

This interviewee also highlighted that each of the five Health and Social Care Trusts in Northern Ireland has a lead for social work who has taken part in an improvement advisors programme that allowed these individuals to reach Level 3 QI training (INT1).

Although QI projects do not always cross both health and social care in Northern Ireland, one interviewee described how social care was being increasingly incorporated into projects over time (INT2). Examples included projects aiming to improve antimicrobial stewardship in nursing homes, to reduce suicide, and to identify and reduce diabetes in the community (INT2).

*The towards zero suicide one is you can see both actually health and social care bringing something to the party and, fingers crossed, we might get some sense as to whether our system facilitates the integrated working of health and social care better.* [INT2]

E.1.2. Factors that have supported and challenged these changes

Our interviewees discussed the factors that had helped introduce these changes to QI infrastructure, including the small population of Northern Ireland and having senior leadership buy-in, as well as the factors that acted as barriers.

The small population of Northern Ireland was seen by two interviewees as helping to introduce and develop QI infrastructure (INT1, INT5), although another interviewee expressed surprise that, with the small population (and small number of health and social care Trusts), there had not been greater connectivity before these initiatives were introduced (INT8). One interviewee felt that the small population meant many people working in improvement already know each other, which has contributed to the development of the non-Q networks in the region and makes it easier to set up networks (INT1), such as the maternity collaborative and HSCQI’s Communities of Practice. Another interviewee commented on the small number of Trusts and arm’s-length bodies (six Trusts and eight main arm’s-length bodies) and how this makes it easier for representatives from all Trusts and relevant organisations to meet and connect at a single

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13 Arm’s-length bodies are a specific category of non-departmental public body.
event (INT5). Northern Ireland events are frequently held in which representatives of each of these organisations attends, which helps to share learning and to embed QI in practice (INT5).

We’re really privileged in Northern Ireland that we have six Trusts and we’ve got probably about 8 arm’s length bodies and it is easier to get all six health and social care Trusts together and represented at a regional event. We’re very privileged to be able to try and improve at a regional scale. [INT5]

In addition to small population size, another factor that was thought to have supported the changes in QI infrastructure was senior leadership support in the health and social care sector (INT2, INT3, INT6, INT7). In particular, chief executives of Trusts were thought to have often been on board with QI in the past and to have continued to drive QI forward (INT2, INT6, INT7).

So I think we’ve had a few evangelists in the last 10 years. We’ve had notable chief executives who have really driven the QI message. [INT6]

One interviewee mentioned a previous chief executive who was described as being an early leader with QI, who introduced QI training across the Trust and was willing to collaborate with other Trusts (INT7).

He did an awful lot in letting a thousand poppies bloom, he introduced a training programme in his organisation. [INT7]

Another example of chief executive buy-in with QI was with a project linked to the Sheffield Flow Coaching Academy on orthopaedics (INT2). The chief executive involved was an IHI fellow and Q member and this interviewee felt that the successful progress of the project was due to this individual’s drive to push it forward (INT2).

Interviewees also discussed some factors that acted as barriers to progressing QI in Northern Ireland. Two interviewees reported that financial constraints within the health and social care sector made introducing and supporting QI initiatives difficult (INT7, INT8). These interviewees also considered that the time lag between changes in practice that arise after QI practices are implemented and political cycles contribute to this difficulty (INT7, INT8).

Our budget cycle here is a year, our political cycle, if we had one, might be 3 years. It is this mismatch that means we really need to change the psyche of the organisation but that is going to take 10 years. [INT7]

Similarly, one of these interviewees thought that the level of investment for QI, although it has increased recently, is not enough to reach the high standard of QI seen elsewhere, such as in Scotland. It was reported that this has led to a lack of QI leadership in the region, yet they are still expected to reach the same standards as Scotland.

What we don’t have is a level of investment in infrastructure that someone like Scotland has had…you cannot get results like Scotland have got if you don’t invest seriously in QI. There is almost an over-reliance on a small number of us to do a lot. While we have done a lot through a small infrastructure, a lot of it has been through goodwill, which is unsustainable going forward. [INT8]
One interviewee mentioned that there are difficulties that can arise in making connections to groups outside of Northern Ireland, partially due to negative press coverage over providing funding to some individuals to attend IHI training in the US (INT7). This was considered to contribute to the health minister at the time making it more difficult to make international connections and made individuals more cautious in reaching out to relevant people and organisations in other countries (INT7).

Finally, one interviewee reported that frontline healthcare professionals lack an understanding of how the health and social care system works in Northern Ireland (INT2). This was felt to limit the ability of frontline staff to use and interact with the health system better to drive QI (INT2).

E.1.3. The improved QI infrastructure has made healthcare improvement a priority and has allowed for improved collaboration across Trusts

Our interviewees outlined what the QI landscape now looks like since these changes to the infrastructure have been implemented, primarily in relation to greater importance and focus on QI and greater collaboration across Trusts for QI projects.

QI was described by interviewees as being a high priority in Northern Ireland (INT3, INT6).

> I would say as a system, we are very focused on QI…. As a system, I believe we have really stretched ourselves over the last 10 years to grow a system that is very focused on QI. [INT6]

An example provided by one interviewee of the priority placed on QI was the inclusion of QI in medical training (INT1). This interviewee outlined how year seven of medical and dental training includes a programme in which clinicians take a year out of practice to develop their leadership skills, including taking part in a QI project (INT1). In addition, Queen’s University Belfast offers QI modules within the medical training for student doctors and nurses. The University of Ulster was also reported to offer QI training for student nurses (INT1).

The importance of QI was felt by one interviewee to be reflected in the change in QI language (INT7). This interviewee noted that QI was spoken about more openly as it has become part of day-to-day practice, rather than only being discussed by those specialising in QI.

> The language has changed. People talk about improvement in a more considered fashion. In the past, it was a specialist sport for some small people. There is much more openness and willingness. We are much more open to it. [INT7]

It was felt by one interviewee that the priority placed on QI had led Northern Ireland so have a more mature QI landscape compared to the rest of the UK (INT2). This interviewee suggested that this was due to the large number of professionals in Northern Ireland with at least a basic understanding of QI methodology, as well as a large number that have a higher level of QI training (INT2). However, despite the high level of training reported across Northern Ireland, the interviewee considered that this didn’t necessarily translate into action due to time constraints in practice (INT2).

> I think it’s about thirty thousand that are what we call attribute level one, which is sort of a basic awareness of QI methodology and we then have I think about 500 who have a more intensive level of QI training… but we still actually have a very limited number of people who have some time within their job plan devoted to QI. [INT2]
In addition to QI becoming a higher priority in Northern Ireland, interviewees reported that there is now greater collaboration across Health and Social Care Trusts since the new QI infrastructure was developed (INT2, INT4, INT8). One interviewee suggested that this shift away from individual Trusts working in silos was due to the policies discussed in the previous section highlighting the importance of sharing and working across geographical boundaries, as well as to the establishment of HSCQI (INT4, INT8). Despite greater collaboration, QI was still thought to vary across Trusts by one interviewee, with pockets of activity seen across Northern Ireland (INT2).

Over the past few years there has been much more of a drive to create that cohesion. We now have much more of a well-functioning QI network across NI and I meet with my colleagues on a regular basis which is a good place for sharing and learning and collaborating. At the moment, this network is serviced by the HSCQI hub that is coordinated by a small number of people. That has certainly helped promote a lot of sharing across the system. [INT8]

E.1.4. The lack of a health minister in Northern Ireland was felt to be both a help and a hindrance

Northern Ireland has been without a health minister since 2017 and two interviewees felt that this was both a help and a hindrance (INT1, INT5). It was seen as positive for frontline QI work as it has been easier to progress new ways of working without the bureaucracy of politics slowing it down (INT1). Another interviewee discussed how they hadn’t noticed much change in day-to-day work and they continued progressing with QI as normal (INT5).

I think that not having a minister lends itself sometimes to just being able to move things along as it’s the right thing to do and we get on with it and there is no political interference. [INT1]

Two interviewees felt it had some negative aspects in that there can be a reluctance by senior leadership to take forward major QI strategies until a minister is appointed, particularly for the big picture strategies (INT1, INT8). In addition, the same interviewees reported that a lack of a minister has led to budgets being published late which can make planning for future work difficult, particularly for QI work, which needs long-term investment (INT1, INT8).

E.2. Q in Northern Ireland

The main purpose of our interviews was to explore how Q fits into Northern Ireland’s QI landscape, outlined in the previous chapter. This section will cover how Q has established itself in Northern Ireland, the barriers to engaging with Q in the country, the impacts of Q and what is needed to increase these impacts across Northern Ireland.

This section will provide an overview of our interviewees’ thoughts on the landscape of the Q network in Northern Ireland. Specifically, it will cover how interviewees considered that Northern Ireland has a strong, active Q community, that Q provides added value to the region and how Q is used as a platform for QI work.
E.2.1. There is an active Q community in Northern Ireland

Multiple interviewees discussed how there is a strong and active network of Q members in Northern Ireland, possibly more so than in other areas of the UK, in part due to the greater focus in Northern Ireland on QI in recent years, as discussed in the previous chapter.

I am aware we have a thriving Q community and my suspicion is it’s putting out around maybe one hundred individuals in that sort of order which possibly pro-rata is as good if not better than most regions across the UK. I get that sort of sense. [INT2]

Our interviewees often reported that Q is frequently attached to wider events happening across Northern Ireland and how this is also open to non-Q members (INT1, INT6, INT8). For example, HSCQI incorporates the work of Q members and the HSCQI website has a dedicated section for Q. This was reported by interviewees to prevent these initiatives working in isolation to each other and to encourage individuals to apply to Q (INT1, INT6). There are also regular meetings with the HSCQI leads from each Trust in Northern Ireland which includes a standing agenda item on Q, allowing these leads to have regular updates on Q and QI work across the region (INT1). In addition, there are often recruitment drives within Trusts to encourage staff to join up to Q (INT8).

One interviewee discussed the informal Q community group in their organisation that meet every three months for a curry night in the evening (INT8). This has a standard agenda that encourages sharing, e.g. a member will share a particular QI tool they have learnt about recently (INT8).

More widely, one interviewee highlighted how Q is attached to all QI-related events that are hosted in Northern Ireland (INT1). Although often open to both Q and non-Q members, some of these events are run specifically for Q members. For example, the annual QI awards event in Northern Ireland is attached to the national Q event for the country (INT1). The aim of this approach was reported to be to encourage people to apply to Q and share information on the opportunities and resources provided within it (INT1).

Every time I go to an event I bring Q material to encourage people to sign up and engage in the community. [INT1]

Relatedly, one interviewee outlined the role Q was felt to play in implementing the Quality 2020 strategy by attaching the Q badge to events (INT5). The majority of task leaders within the governance group for the strategy are made up of Q members and, as a result, any event or meeting held as part of Quality 2020 has Q associated with it (INT5).

The majority of the task leads [for Quality 2020] are members of Q. Anything held as part of Quality 2020, the Health and Social Care Safety Forum are there with the Q information. We’ve tried to bring Q into as many opportunities as we can. [INT5]

Attaching the ‘Q badge’ to events and meetings such as those described here was felt by some interviewees to add credibility to QI work, particularly when trying to engage frontline staff (INT4, INT7).

[The Q badge] gives credibility to it which is important when you’re trying to sell new ideas to frontline staff, it helps to have a credible organisation behind you. [INT4]
E.2.2. Q provides added value in Northern Ireland

It was felt by our interviewees that Q provides added value across the region, specifically in reference to the activities and resources offered by Q, and that it was introduced at the right time for the region. Two interviewees felt this added value due to connecting people working in similar areas and allowing those working in QI in Northern Ireland to see what others in the UK are working on (INT3, INT8).

*I think it’s giving people the opportunity to be involved and to network with other colleagues here who are like-minded and in similar job roles, so I think it is a very welcome addition to what we are currently doing and would enable us to apply for funding or to see what’s going on in England in relation to the NHS Long Term Plan.* [INT3]

One interviewee discussed how Q had been introduced to Northern Ireland at the right time, when it was really needed (INT7). This interviewee highlighted how there was little to compete with Q as there were not many QI networks or initiatives in the region at the time, which this individual contrasted with Scotland where it was felt that Q was introduced into an already crowded QI landscape (INT7).

*Scotland probably wouldn’t have needed Q like we need Q. Q is competing with other things in Scotland because they have already come through that journey, whereas for Northern Ireland, Q came at the right moment, it gave a great platform to bring people together and there wasn’t a huge amount to compete with but there was enough to build on.* [INT7]

Many interviewees discussed how the added value provided by Q came from the activities and resources it provides. Q events and site visits were described as being useful touchpoints with other members to see how QI is moving forward in the region and allows members to share experiences of their QI work that others can learn from (INT1, INT3, INT8). One interviewee felt these regular points of contact through events were important, particularly with local events, which this interviewee felt allowed more connections to be made as they are on a smaller scale than the national events (INT1). However, one interviewee felt as though greater diversity is needed at the events as they thought that the same Q members attend all events, often those with improvement roles or clinicians/managers with a vested interested in QI (INT4). Other interviewees considered the regular Q newsletters to be helpful in keeping in touch with what is happening in the wider Q community (INT3, INT8). The training opportunities offered through Q were also thought to be valuable and some of these training schemes have been scaled up across single or multiple Trusts in Northern Ireland (INT4). Other resources offered through Q, such as the QI toolkits and booklets, were highlighted by one interviewee as being useful (INT8). Finally, one interviewee felt that having the ability to opt in and out of these activities was an additional added value from Q, which was thought to encourage members to get involved in areas they are passionate about without feeling they have to get involved in other areas.

*Having the ability to opt into and out of activities is what people really value about Q. There is no huge expectation that they have to do anything but if people are really interested in the subject area they will contribute and they’ll take a lot out of it as well.* [INT1]
E.3. Barriers to engaging with Q in the Northern Ireland

As with previous findings from the wider Q evaluation, and the previous deep dive in the South West, insufficient time was considered to be one of the main barriers to engaging with Q in Northern Ireland (we have found similar views across the UK so this barrier is not specific to Northern Ireland). There were also a small number of other barriers discussed by interviewees, which will be discussed in the following paragraphs.

E.3.1. It is difficult to find time to spend on Q in busy work environments

The majority of our interviewees felt that lack of time was a barrier to engaging with Q (INT1, INT3, INT4, INT6, INT7, INT8). This was primarily thought to be due to difficulty finding time within busy day jobs and being unable to find the headspace and time to reflect on QI and engage with Q resources (INT1, INT3, INT6, INT7).

*It is difficult as Q is an additional thing to do on top of everything else so sometimes it can be difficult to do alongside day job.* [INT1]

It was felt by one interviewee that, although there may be time to attend a Q training or study day, that reflecting on what has been learnt and introducing changes in practice as a result is very difficult due to day-to-day workload preventing this (INT3).

*Sometimes if you go out on a learning day or study day – that’s the only time you ever get to really reflect on anything and then you come back into work and before you know it you are bogged down in the workload. It’s hard at times to be able to find the time to reflect and get that time to truly engage in service improvement.* [INT3]

E.3.2. Other barriers to engaging with Q

Our interviewees provided details on other barriers they felt prevented them engaging with Q (again, it is likely that these barriers are not specific to Northern Ireland):

- **Involvement in Q is not mandated:** Although we discussed earlier that not being mandated to take part in Q activities was seen as a positive attribute, another interviewee felt that the lack of demands from Q for member involvement made it too easy to not engage (INT7).

- **The lack of a welcome event for Northern Ireland:** One interviewee highlighted how the lack of a welcome event for new members, now that recruitment for Q is on a rolling basis, may mean that new Q members in Northern Ireland struggle to connect with other members, particularly those in their local area (INT1).

- **Frontline staff may struggle to take time off for Q:** Similar to the time barrier discussed previously, one interviewee felt that Q members who are frontline staff may be less able to take time off to attend Q events compared to those whose role is specific to improvement (INT4).

- **Connections may only be made by those with improvement roles:** One interviewee considered that Q members with improvement roles are more likely to be engaged with Q and active in the network, which will increase the number of connections they make. It was felt that those working
on the fringe of improvement, or not in specifically improvement roles, may struggle to engage with Q and so not experience the same networking benefits (INT6).

- **Distance can make it difficult for members in Northern Ireland to connect with the wider community:** It was felt by two interviewees that Q members can feel slightly distant from the rest of the UK Q community due to physical distance (INT7, INT8). For example, one interviewee reported the difficulty in engaging with the Healthcare Skill Exchange and Timebank (Hexitime) due to not being on mainland UK (INT8). Even though many Q events for Northern Ireland are held in Belfast, those who do not live close to the city might struggle to get the full day off that would be needed to attend (INT7).

**E.4. The impact of Q in Northern Ireland**

Our interviewees felt that Q has had various impacts across Northern Ireland, including offering training opportunities, creating opportunities for sharing, connecting and learning, maintaining wider momentum around QI in the region and creating a platform for QI. However, one interviewee felt that these impacts were only affecting those whose role focuses exclusively on improvement and who are more active within the Q community (INT6). This interviewee also highlighted the difficulty of distinguishing impacts of Q from the impacts of general QI work in Northern Ireland.

> Am I seeing any significant difference as a result of Q? Probably not. Certainly not where I sit strategically, but I’m not in a Trust organisation and if you speak with someone in the Trust where you have an active Q member, you might get a different story. Because there is so much QI going on in Northern Ireland, I would find it difficult to determine whether Q membership was the lever behind all of that or whether it would have happened anyway because of all the quality activity going on in Northern Ireland. [INT6]

In addition, another interviewee discussed how it is difficult to separate the impacts of Q from the impacts of other QI initiatives in the region, for example, the government’s Delivering Together plan, which included some requirements for better cohesion (INT8).

**E.4.1. Q has allowed and encouraged more individuals to take part in QI training**

Two interviewees discussed the benefit of training opportunities offered by Q and the impact these have had in the region (INT1, INT4).

One interviewee provided the example of the Making Best Use of Data Masterclass training offered through Q which was reported to be popular among the Q community in the Belfast region, including with those in senior leadership positions (INT1). Since this training was offered, a Q member in the local area has taken what they have learnt from the session and has created their own training based on this that they offer within their local organisation to Q and non-Q members (INT1).

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14 Hexitime is a Q initiative founded on the principle that a member can give an hour of his/her time and claim one back from another registered member of the community who has a skill that is needed.
Another interviewee outlined how Q has been supportive in improving a training session that the interviewee offers on measuring improvement (INT4). This training session used to have low uptake but support from Q provided suggestions for improvements to the training that led to around 160 staff members taking part (INT4).

E.4.2. Q promotes connections, sharing and learning across Northern Ireland

Almost all of our interviewees discussed the impact Q has had in encouraging and supporting sharing and learning between members, and the development of new connections and relationships.

Many of our interviewees commented on how Q has encouraged the creation of new networks and connections across the region, although there was some disagreement as to whether Q had led to the creation of new networks (INT7) or whether it primarily supports existing ones (INT4).

When discussing these new connections made through Q, many interviewees focused on the relationships established across Northern Ireland. For example, one interviewee felt that Q has helped promote greater collaboration across the Health and Social Care Trusts in Northern Ireland, such as training offered through Q that has been spread across multiple Trusts (INT4). More generally, the connections and networking opportunities provided through Q are seen as the main benefit of being a part of the community (INT1, INT3). This was thought to be particularly useful when starting a new QI project or finding ways to overcome certain challenges in which Q members with relevant knowledge and experience can be reached out to (INT4).

For me, it’s all about relationships, networking and learning from each other. Any activity that helps this to happen if people are willing to put their time into and invest their time, because time is very limited…then I see that as value. [INT1]

In addition to Northern Ireland networks and connections, two interviewees discussed how Q enables relationships to develop outside of Northern Ireland (INT3, INT7). These interviewees felt that this allowed Q members in Northern Ireland to engage with the UK-wide QI agenda and a pan-UK Q community, which had not been seen before in Northern Ireland (INT3, INT7).

The ability Q brings to network nationally and internationally is very important and very valuable… Q is a connection to the national improvement agenda…I think that is something that has never been done before. [INT7]

As a result of greater networking and connections, Q was felt by some interviewees to support the sharing of QI learning within the community. One interviewee provided the specific example of Q members involved in the design of Q bringing back learning to the region, for example, by helping to set up the HSCQI Communities of Practice, as well as helping to support the other changes to the QI infrastructure happening in Northern Ireland at the time (INT7).

About 15 people from Northern Ireland were involved in designing Q. That was a great learning experience for the people involved in the design and they brought that back to us. Some of those people were involved in the communities of practice…. The people involved in the design were the same people doing the work around developing our own improvement system. That was very valuable. [INT7]
More widely within the Q community, one interviewee felt that bringing the Q community together in Northern Ireland has the benefit of allowing new conversations to develop around QI and some of the key areas of improvement work that the community could help to progress (INT5). This interviewee provided the specific example of the Quality 2020 strategy, in which, although Q didn’t have an impact on the outcome of the strategy, it has enabled the right connections and discussions to happen to inform the future direction of the strategy (INT5).

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

E.4.3. Q helps to keep momentum and support for QI in Northern Ireland

Some of our interviewees discussed the impacts of Q on a wider scale than just the impact on individuals, highlighting how Q helps to keep momentum for QI in Northern Ireland. For example, one interviewee highlighted how the Q community is able to explore QI methods and projects in other countries and feed learning from these back to Northern Ireland, which helps to keep a focus on QI. Another interviewee described how Q provides a credible platform for QI and keeps people thinking QI is ‘a good idea’ (INT4).

I think the challenge will always be maintaining the momentum and keeping the spotlight on QI. Keeping that focus and that momentum and keeping your finger on the pulse of changes internationally as well as nationally so we can learn and share together. That’s where Q has the really useful element to contribute is keeping that international eye in terms of what is happening with development and improvement and to feed this back to us locally as a nation. [INT1]

In addition, it was felt by one interviewee that Q helps to overcome some of the financial challenges faced by Trusts when attempting to implement QI projects, for example, by providing support and resources for Q members to attend QI training (INT7).

E.4.4. Q is used to create a better platform for QI

Many of our interviewees discussed how Q creates a platform for implementing QI across Northern Ireland (INT1, INT2, INT3, INT4, INT5). Interviewees often referred to Q as acting as a central hub, or ‘home’, for QI in the region, providing ongoing support and engagement for those leading QI at a local level, as well as for service users interested in knowing more about QI (INT1). This interviewee also highlighted how Q can be used to get additional support to develop and implement improvement ideas (INT1).

Q was also described as being a platform for providing additional support to QI activities. One interviewee felt Q helps improvement work get additional support from Q members at a peer-to-peer level and to get advice from experienced individuals in a safe environment (INT1). This interviewee provided the example of how the ambulance trust in Northern Ireland has a small group interested in QI who have reached out to a local special interest group for additional support (INT1).

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

As well as providing support to those already involved in QI, one interviewee felt as though Q acts as a platform to help introduce those with little experience to QI and create connections with those more experienced with QI (INT1).

It’s a starting point to get you from not having done much and building it up or building a platform for those who have done quite a bit but you want to be more supported and facilitated links. [INT1]

E.5. What is needed to increase the impact of Q in Northern Ireland?

The overall view of our interviewees was that Q could and should have a growing impact in Northern Ireland and they provided a range of suggestions for ways that the Q network in Northern Ireland could become more self-sustaining, relying less on the small number of QI ‘evangelists’, and ways to support Q members in their day-to-day QI work. This included the possibility of extending Q to the Republic of Ireland, supporting connections to be made across professional interests and with members locally, and hosting more events specific to Northern Ireland.

E.5.1. If possible, Q should be extended to the Republic of Ireland

The majority of our interviewees, when asked whether Q should be extended to the Republic of Ireland, considered that this would be a very positive addition to the Q community. Interviewees discussed how having Q members in the Republic of Ireland would help support the QI work already taking place in Northern Ireland and would support existing cross-border working (as the two nations share some healthcare services), with colleagues in Northern Ireland able to contribute their ideas and share valuable experiences (INT1, INT3, INT5, INT6, INT7, INT8).

We do a lot of cross border work with our colleagues in the Republic of Ireland so I would see nothing but benefit coming from that. It would help some of the stuff we are doing collectively as part of the cross border work on human factors, and capacity and capability building. [INT5]

It was felt that Northern Ireland and the Republic already have much in common in terms of QI work, for example, the Republic uses a similar QI Levels 1–3 training scheme, and Q would offer more opportunities to collaborate and the badge of Q would provide more traction for QI work (INT1, INT5).

There is a lot of common ground that we have with them already and with them joining Q it would just open up even further opportunities for us to be able to share and connect. [INT5]

Two interviewees also discussed the benefit of being geographically closer, which, if the Republic were to join Q, would make collaborations easier than might be seen with the rest of the UK (INT1, INT3).

It is easier to put someone on the train to Dublin than it is to put them on a flight to London. [INT1]
Since the writing of this deep dive, the Q team has announced that Q will be extended into the Republic of Ireland in 2020.

E.5.2. To encourage the Q network in Northern Ireland, greater coordination of members and professional interests is needed

Our interviewees discussed how the Q network in Northern Ireland could benefit from greater coordination and connections across professional interests and local areas which could help the Q network to become more self-sustaining in the region.

Greater connections across professional groups and interests was thought to be an area that could contribute to more collaboration and relationship building across Northern Ireland (INT3, INT5, INT6). For example, more proactively linking together individuals from similar professional backgrounds could help to integrate the QI work being done across local areas (INT3). This particular interviewee provided the example of setting up a cancer group, which was felt to be missing in Northern Ireland, to connect those working on improving cancer services across Northern Ireland. Another interviewee felt that setting up Communities of Practice for specific areas of interest could be used as go-to hubs if individuals with a particular set of knowledge were needed (INT6).

I know that there isn’t a cancer group per se that is available…and for linking in as I said with people who, I suppose from a general point of view in service improvement but also from a site specific or a cancer specific group. [INT3]

I think communities of practice around particular aspects. So for example, a passion of mine is digital practice and so there are pockets of things that could be grown as a community of practice and people might tap into that more than necessarily one big movement around quality. [INT6]

It was felt by one interviewee that linking Q more closely with professional interests and ongoing work could help overcome the barrier of time and encourage engagement in Q resources and activities (INT6). Relatedly, another interviewee felt that if they were asked to actively engage in activities that link to their day-to-day work, such as presenting during a webinar, then that may encourage more active engagement from Q members (INT7).

If you can link into people’s passions they are more likely to access information or participate. If as part of being a member of Q I can link in my work that I’m already doing and share it with other Q members or profile it in some way with Q, then I’m more likely to do that than do something separate or to have to read something online or participate in a webinar. [INT6]

Although there is a potential role for the Q team to play in helping to set up these professional interest groups, one interviewee took the view that some of this responsibility lays with Q members themselves, particularly those in senior leadership roles (INT5). Senior leaders could play a role in identifying Q members within their local area and identifying their professional interests. These could then be made more visible to the Q community (and non-Q members) in the area so individuals are able to connect with those who have relevant experience and knowledge (INT5).
As well as connecting Q members across Northern Ireland based on professional interests, it was felt by some interviewees that more support is needed to connect Q members locally to encourage the network to become self-sustaining.

*I think where we could do with more support at a local Trust level, they probably could do more at a local level to highlight Q on an ongoing basis.* [INT1]

For example, one interviewee discussed the possibility of introducing a ‘Q hub’ in each region of Northern Ireland, including providing funding for someone to lead and manage this hub (perhaps on a part-time basis) (INT1). Another interviewee highlighted the importance of the Q community (or at least some leaders within the Q community) having an understanding of how to maintain and sustain networks, which could translate to a small group having ‘ownership’ over the Northern Ireland Q network (INT7). This interviewee also discussed the importance of this group being dynamic and responding to changes in the Q community, such as promoting the resources and activities if engagement starts to drop or changing strategy/direction if a new need arises in the region (INT7). However, it is important that this isn’t just one or two leaders who take responsibility for this work and are the only individuals driving it forward as this creates a risk of the network becoming ‘cold overnight’ (INT6, INT7).

*There might be something about understanding how to maintain a network. It’s all very well when there a few key people and some enthusiasts but the system could become cold overnight. Being clear about having people with the skill to nurture the network. So not doing the work, but paying attention to the network.* [INT7]

**E.5.3. More Q events for Northern Ireland would help support engagement with Q and members to engage with the network**

Some of our interviewees discussed additional resources and events that could be delivered through Q to further support members in their day-to-day work and to create new relationships and networks.

Two interviewees discussed the possibility of holding more events in Northern Ireland, rather than in England (particularly London), on both a UK-wide and Northern Ireland level (INT1, INT3, INT6, INT8). One of these interviewees particularly mentioned that these events offer an opportunity for members to celebrate successes and to provide support to each other in their work (INT6). An example provided by one interviewee was the possibility of holding a Q roadshow across Northern Ireland, specifically to reach out to frontline staff not yet heavily involved in QI and encourage them to apply to Q (INT1).

*I would like to do a roadshow of Q across Northern Ireland to reach out to frontline staff that might not be involved in QI on a day to day basis and encourage them to apply to Q and hearing the message of Q.* [INT1]

It was felt that Q members are likely to engage with national events such as these as it provides members with an opportunity to raise the profile of their work, as we discussed earlier with the importance of members having an active role in events (INT6).

Another interviewee highlighted how having more advanced training in QI offered through Q would be helpful, for example, in providing QI leadership which this interviewee considered a gap in expertise in their organisation (INT4).
E.6. Implications of, and reflections on, Q in Northern Ireland

Recognising that this short report is based on just eight expert interviews we should be cautious about making strong claims. However, we can identify some overall implications from the interviews taken as a whole in this final section and these will then be triangulated against wider evidence from the evaluation and in particular with the other two deep dives (in South West of England and in Wales, respectively). Within this limitation, we draw the following conclusions.

Q has made a visible and, by the accounts we have seen here, positive contribution to the community of healthcare quality improvers in Northern Ireland. It may be that this was enhanced by fortunate timing (QI was already building momentum in Northern Ireland when Q began) and by a relatively clear improvement landscape (compared with Scotland, for example). Even so, the design, branding and practical offering of Q was well attuned to the needs of improvers.

As such, it has added value by bringing visibility, credibility and positive branding to QI. It has helped connect quality improvers within Northern Ireland and exposed them to the wider pool of improvement thinking from across the UK. The materials produced are seen to be relevant and useful. This has contributed to a situation in Northern Ireland where there are active safety collaboratives in paediatrics, pressure ulcer prevention, maternity, and nursing homes; where the Safety Forum Awards appear to be successful; where QI training is developing and becoming routinised; and where at least two universities are engaged in supporting QI skills. Engagement with the Scottish Quality and Safety Fellowship also plays into this landscape.

In contributing to this situation, Q is seen to be a supportive partner as much as a driver of change, sometimes taking the lead but also prepared to play a supportive rather than leading role, sustaining the spirit of co-production. The Q membership is diverse and well connected. It is worth noting that this contribution has been achieved without an AHSN (which elsewhere is thought to be important to the success of Q).

As elsewhere in the UK, finding time for non-QI specialists to engage with improvement activities is perceived to be a barrier to that happening. That said, it was noted that if Q could be more closely aligned with organisational and professional priorities it would then be easier to secure and justify such a time commitment. There are some tensions around this in that the Q Initiative is a community of improvers and provides a platform for strengthening awareness of, knowledge about, and sharing experiences regarding improvement; this landscape strengthening role is not the same as delivering improvement on the ground. However, the purpose of strengthening the landscape is that ultimately there will be practical benefits for service users and health and care systems that reflect local, regional and national priorities. It is also worth noting a different tension, which is that as well as believing that securing time to attend any Q events was a major constraint on engagement with Q, there was also a strong view that holding events in Northern Ireland was an important way to mobilise engagement.

The interviews suggest that how this tension between strengthening the QI landscape and directly meeting the patient and service user needs is managed in Northern Ireland (in the absence of an AHSN) may be different from how it is managed in (for example) the South West of England or in Wales. We will address this cross-cutting question when we complete all three of our case studies (and will also consider how this
may differ in Scotland). However, based on our interviews, we note that there appears to be a close relationship between Q and other aspects of the improvement landscape and that this is collaborative in style, involves mutual support, and is co-producing system strengthening. As elsewhere, demonstrating tangible benefits for service users and their families is difficult. To work more closely with improvers in the Republic of Ireland was met with approval and, indeed, was regarded as a natural development of existing relationships. It is unclear whether this would change how Q currently works in Northern Ireland.
F.1. The Quality Improvement landscape in Wales

To understand how Q fits into the NHS in Wales, we first explored the current Quality Improvement (QI) landscape in the region. The key themes raised by the interviews, discussed in more detail in this chapter, include the other improvement initiatives ongoing in Wales, how the geography and the size of the population of Wales influence capacity for improvement, and how QI is often driven by a small number of senior leaders.

F.1.1. There are multiple improvement initiatives in Wales alongside Q

Our interviewees discussed the other improvement initiatives that are working in parallel with Q, many of which were established before Q (INT1, INT2, INT3, INT5, INT6, INT8). These initiatives include:

- Improvement Cymru (Public Health Wales, previously 1000 Lives Improvement)
- Academi Wales
- All Wales Continuous Improvement Community
- Bevan Commission.

These are discussed in more detail here, where additional information was provided by interviewees on these initiatives.

Improvement Cymru, the national improvement programme for Wales, was established by NHS Wales in 2008 and is delivered by Public Health Wales (INT1, INT8).15 The programme now has eight sub-programmes of work covering a range of different services, such as cancer, maternity, sepsis and medicine safety. Much of the improvement work across Wales was said to occur through Improvement Cymru Improvement programme (INT1, INT2, INT3). It was felt by one interviewee that the Improvement Cymru programme has brought improvement to the forefront for clinical teams and has shifted attitudes away from viewing improvement as a methodology to a way of improving patient safety (INT8). This interviewee highlighted how this shift in perceptions of improvement has led to NHS Wales developing an effective grounding of improvement capability, spreading knowledge about QI and implementing it in practice, offering training and increasing QI networking across Wales (INT8).

15 Improvement Cymru. Homepage. Accessible at: http://www.1000livesplus.wales.nhs.uk/home
The main training offered through Improvement Cymru is the Improving Quality Together (IQT) programme, the national QI training programme for NHS staff in Wales. When the IQT was first established in 2013, it was compulsory for all NHS Wales staff to attend (INT5). One interviewee felt this training was an opportunity to network and contributed to the shift away from perceiving QI as a theory and encouraging more NHS staff to view it as something that can be implemented in day to day work, as well as encouraging the view that QI should be acknowledged as a specialty in its own right (INT5).

We are empowering the workforce to come forward with ideas and also supporting them with people who can really pull the idea apart and turn it into something that can be introduced in practice. The fact people are talking about it and even know what QI stands for is actually really nice. [INT5]

Academi Wales, set up in 2012, is a centre for excellence in leadership and management of Welsh public services. It offers training in QI and promotes QI across Wales (INT3).

The All Wales Continuous Improvement Community is an online portal that acts as a single source of good practice across public service in Wales. One interviewee described how they won an award scheme offered through the community and how it supports awareness of improvement projects across Wales (INT6).

The Bevan Commission is hosted by Swansea University and aims to provide independent advice to the Welsh government and leaders in NHS Wales on health and care (INT6). The commissioners are based in various NHS organisations across Wales and have a long history of working in health and care in the country (INT6). The commission runs its own improvement projects, such as one supporting ideas for improvement in industry, and publishes policy documents, such as a recent guide on Prudent Healthcare, which has been rolled out across the country (INT6).

These improvement initiatives often focus on healthcare rather than social care. However, one interviewee highlighted how social care is becoming a higher priority in Wales (INT1). For example, there is a network across Wales with engagement from 26 organisations, which includes social care representation.

F.1.2. The geography and size of Wales influences its ability to improve, both for the better and the worse

A small number of interviewees discussed how the geography (i.e. many rural regions) and relatively small population of Wales could both support and hinder the capacity for improvement.

As a benefit, the small number of people working in healthcare improvement in Wales means that these individuals tend to know each other and networking was thought to be easier than in England, where many more people work in healthcare improvement (INT3). However, another interviewee discussed how they felt improvement is well established across Wales, but it is only seen in pockets and the people working in them need to be better connected across the country (INT8).

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16 Academi Wales. Who we are. Accessible at: https://academiwales.gov.wales/pages/who-we-are-pwy-ydyn-ni
17 Good Practice Wales. About Good Practice Wales. Accessible at: https://www.goodpractice.wales/about
On the other hand, much of Wales is rural and travel between areas can be difficult, which one interviewee felt made connecting and communicating face-to-face more difficult (INT3). Another interviewee discussed how there is a north–south divide in the country (with the south, primarily Swansea and Cardiff, being the main urban areas in Wales) (INT8). For example, although there is a Public Health Wales office in North Wales, one interviewee felt this wasn’t enough for the organisation to have a presence across the region (INT8).

This fragmentation between North and South Wales may contribute to the perceived lack of communication across the healthcare sector in Wales (INT7, INT8). This was particularly felt by one interviewee working in the area of mental health who is often merely one staff member of many involved in a patient’s care, but reported not knowing what was happening with other aspects of the patient’s care and that this perception was also held by other clinicians (INT7). This interviewee felt the lack of communication extended to the improvement community as well (INT7).

F.1.3. A small number of senior leaders are driving QI

Multiple interviewees discussed the importance of senior leaders in Wales driving the QI agenda forward. For example, one interviewee discussed how a senior executive in North Wales has been heavily involved with the Health Foundation to support improvement in the area and has been the driving force in progressing QI, such as by hosting a patient safety symposium (INT4). Similarly, a chief executive in South Wales has also been supportive of QI, for example, through the creation of QI hubs, and is an active Q member (INT2). This has translated to greater investment in QI, such as that described by one interviewee whose organisation has invested heavily in the QI department by hiring additional staff (INT5). This interviewee felt that having QI experts in healthcare provider organisations meant frontline staff could come up with ideas for improvement and then hand the idea over to the QI department to implement, which is more efficient and may increase the likelihood of success (INT5).

Despite senior leadership engagement with QI in Wales, in many places this appears to be dependent on a small number of individuals without whom QI would probably not be progressing as much as is seen today (INT2, INT4). Another interviewee discussed how, although senior buy-in for QI is important, Wales has seen high turnover in executive teams, which was felt to lead to confusion for frontline staff due to the consequent frequent changes in top-down initiatives (INT8). However, this has been recognised as a challenge by senior policymakers and has led to the development of a framework in which new ideas are only introduced once they have become mature and are able to be implemented in a more concise manner and with a greater likelihood of gaining frontline traction (INT8).

F.2. Q in Wales

The main purpose of our interviews was to explore perceptions about how Q fits into Wales’ improvement landscape as outlined in the previous chapter. This section will cover how Q fits into the improvement landscape in Wales, the barriers to the Welsh Q community engaging with Q, the impact of Q and what is needed to support Q in Wales.
F.2.1. How Q fits into Wales’ improvement landscape

Our interviewees discussed a range of factors to consider in how Q fits into the improvement landscape in Wales, particularly how it aligns with the other improvement initiatives discussed in the previous chapter. This section will focus on the perceived lack of presence of Q in Wales, the alignment of Q with other initiatives, the benefits of Q activities and resources, and organisational and senior leadership support.

There is a perceived low visibility and presence of Q in Wales

The majority of our interviewees felt that there is a lack of presence of Q across Wales, particularly for frontline staff (INT1, INT3, INT4, INT6, INT8). This reflects both a perceived lower density of Q members in Wales and the fact that pre-existing QI programmes enjoyed visibility and presence. (We would note – but interviewees did not – that Q was not intended to replace existing improvement work but, rather, was intended to reinforce and amplify it.)

One interviewee felt the traction of Q in Wales was much lower than has been seen with other improvement initiatives there (INT6). Relatedly, one interviewee highlighted how they felt that members join Q as individuals, rather than as representatives of their organisations, and so do not connect their membership of Q with their day job (INT8) in their routine organisational setting.

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

This lack of visibility in Wales may, in part, be due to the smaller number of Q members in the country, particularly in North Wales as most Q members are concentrated in Swansea and Cardiff (INT4, INT5, INT8). It was felt by one interviewee that the number of members in rural areas is not enough to reach a critical mass for improvement (INT8). This can leave some members isolated within the Q community as they struggle to find members in similar roles to themselves in Wales, with some members not having any Q members within travelling distance from where they live (INT5).

At the moment, I don’t see much of a Q community in Wales. If I look at the member maps, there aren’t very many people in Wales, particularly in North Wales. [INT4]

The lack of visibility may also be due to the difficulty discussed by one interviewee of integrating Q with Welsh universities and Health Boards (INT2). This interviewee outlined how they were continuing to work to integrate Q into the seven Health Boards in Wales despite having had limited success in recent years, which they suggested may be due to the differing priorities held by the two organisations. (INT2). In addition, the Health Board in North Wales is in special measures (INT2) and so may struggle to engage in wider improvement activities. They also discussed how integrating Q within Welsh universities has not progressed as well. Some connections have been made with Bangor University and there are a small number of Health Foundation Fellows in Swansea University, but there has not been any engagement from Cardiff University (INT2). This is despite the chief executive of each Health Board receiving a professorship from a Welsh university, which should have incentivised research and evaluation into improvement activities, but this interviewee felt that this has not been the case (INT2).
There are mixed opinions as to how aligned Q is with other improvement activities in Wales

As discussed previously, there are a number of improvement initiatives and activities ongoing in Wales alongside Q. Our interviewees discussed how, if at all, Q is aligned with these initiatives and wider healthcare priorities in Wales.

Two interviewees felt that Q aligns well with other initiatives and networks (INT6, INT8). It was felt that Q and other initiatives mutually support each other and often share members, particularly the Gold Network, for those who have achieved the highest level of IQT training (INT2, INT4, INT6). In fact, a key part of being an IQT Gold level is to be involved in Q to share learning among improvement champions and connect people with improvement expertise within and outside Wales (1000 Lives Improvement, n.d.).

Another interviewee felt that Q has built on the networks that existed before Q was established, particularly those linked to Improvement Cymru, but has also helped to expand networks to the rest of the UK (INT6).

We weren’t starting from scratch; there were some networks around. Q has built on what was there already but taken it outside of Wales. [INT6]

However, one interviewee felt that by only building on existing networks this limits the expansion of the network in Wales to those already engaged and connected, rather than recruiting a wider audience of Q members (INT2).

QI is expanding out of existing strongholds and is encouraging more people to become involved, but is predominantly using the same former networks. Therefore, we haven’t got much fluidity in the system. Sometimes greater fluidity allows you to spread out a bit further. It is quite a static system in some ways. Because we have been tactical in our communication, we have tried to get around this by emailing other non-traditional people. We have seen more bonding than bridging in Wales and we need more bridging. [INT2]

Other interviewees felt there is a disconnect between Q and other improvement initiatives and wider health priorities (INT2, INT8). One interviewee discussed the lack of connection between the Improvement Cymru programmes and Q (INT2). It was highlighted that the work of Q runs in parallel with the national programmes, but that often the staff working on the national programmes are not Q members, leading to some perceived disconnection between Q and the Health Boards.

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

Interviewees suggested that the disconnect may have arisen due to Improvement Cymru and Q having different agendas and priorities (INT2, INT8). While it was felt that Q was bringing a broader improvement perspective into Wales, it was not ‘plugged into the main changes’ in the priorities of the healthcare system in Wales and it is important going forward that the actions of Q members align with the wider improvement agenda (INT2, INT8).
Q activities and resources are well received
Our interviewees discussed a number of Q resources and activities they found useful in their improvement work, including:

- **Searching Q member profiles** online to connect with relevant individuals (INT1).

- **List of Q members offering to hold talks** on specific topics helps identify new individuals to invite to events, rather than repeatedly having the same presenters (INT3).

- **Bi-annual Q event in Wales** is an opportunity to welcome new Welsh Q members and share knowledge and best practice for improvement. This event is often well attended by members (INT2).

- **Q website improvement resources** are thought to be valuable sources of information and an opportunity to find new ideas and trends in improvement (INT5, INT7).

  > The Q website has lots of resources and people that know far more about the technical, research, methodologies and things like that than I ever will…. You can have a hunt around and disappear down a worm hole. You find ideas that people have had that you would never think of yourself. [INT5]

- **Randomised coffee trials** were thought to be relatively easy to participate in and provide moral support in that members are reassured that they are not alone as others are also doing the same type of improvement work (INT7).

- **Q resources were frequently mentioned by interviewees and most often in a positive light.**

There may be organisational support for involvement in Q, but few senior leaders are Q members
Two interviewees discussed organisational and senior leadership support and buy-in for Q (INT6, INT8). One interviewee felt that their organisation was very supportive of their involvement in Q, for example, by providing time off to travel to London for events. It was felt that this is because the organisation understands the benefits of Q and because of the good reputation of the Health Foundation in producing high-quality outputs (INT6).

Despite this, there are very few senior leaders in NHS Wales who are part of Q, particularly chief executives and operating officers, although the chief executive of NHS Wales is a Q member (INT8).

F.3. Barriers to engaging with Q in Wales

F.3.1. Time
As with our previous deep dives in Northern Ireland and the South West of England (as well as data collected as part of the wider evaluation), a lack of time was considered by the interviewees to be one of the main barriers to engaging with Q (INT2, INT4, INT5, INT7, INT8). It was felt that shortage of time was a particular barrier for those working as frontline healthcare professionals (INT2), but also that workloads
in general have increased in recent years and there is little organisational capacity to be involved in Q activities (INT5, INT7, INT8).

I have looked a few times [at being involved in Q Lab] and suggested to our previous director here...a project that would have been a nice fit for us. But it would have been one thing too many for us to do at the time. We are more or less there again at the moment. The ground is constantly shifting so a lot of the time we are reacting. [INT7]

F.3.2. Geography and rurality

As mentioned previously, the geography of Wales, in particular the difficulty faced by the large rural regions of Wales in connecting to the rest of the community, was considered to be a barrier to engaging with the rest of the Welsh (and wider UK) Q community (INT2, INT4, INT6, INT7, INT8).

It was felt that living in rural locations, although the opportunity for virtual connections is available, acts as a barrier to face-to-face meetings, which was thought to cause a drop in momentum in members’ involvement with Q (INT4, INT7). It also means that there is a lower likelihood of another Q member being within travelling distance (INT7). However, it was felt by one interviewee that virtual methods of connecting, such as Skype, help overcome some of these geographical barriers (INT6).

Relatedly, it is often difficult to travel to London for events, both because of the financial cost but also getting time off work to travel long distances (INT6). This interviewee felt that the lack of Q events in Wales increases this challenge and it would be preferable to have events in Wales, or the West of England, to make travelling easier (INT6).

Multiple interviewees discussed the difficulties in members from North Wales actively participating in Q (INT2, INT3, INT7, INT8). North Wales is made up of one large Health Board covering three major hospitals, effectively running as three separate organisations. It was felt that this made it difficult for Q members to connect to other members within this large organisation (INT8). The North Wales Health Board is also facing wider challenges as it has been in special measures since 2015, which comes with a travel ban, making it extremely difficult for any staff, including Q members, to travel outside of the region for meetings and events (INT2, INT3).

F.3.3. Demographic of Q membership

Two interviewees discussed how the demographic of Q membership may be too restrictive and may put off some potentially valuable individuals from joining.

Although it was reported that there had been a recruitment drive recently to increase the number of members having clinical roles (INT2, INT6), one interviewee felt that the Q community in Wales lacks members with primary care roles (INT8). This interviewee highlighted how Wales only has one GP member and only a small number of other primary care roles represented, which may act as a barrier to other primary care providers joining Q, as they may not see what benefit they can receive from Q and are more likely to engage with networks offered through Improvement Cymru (INT8).

Similarly, one interviewee (who doesn’t work within healthcare delivery) felt somewhat isolated from the rest of the Q community and discussed how it was likely that representatives from other non-healthcare delivery sectors would feel similarly (INT4).
F.4. The impact of Q in Wales

This section will cover the two main impacts our interviewees felt Q brought to Wales, specifically the connections to improvers across and outside Wales, and a greater focus on improvement work more generally in Wales.

F.4.1. Q promotes members in Wales to connect to improvers across Wales and the rest of the UK

Although our interviewees value the opportunity to connect to other members within Wales, many described one of the main benefits of being a Q member as being able to connect to improvement experts across the UK. This was thought to be important in broadening horizons and to explore how others conduct improvement work, which often isn’t with a characteristic of other improvement initiatives (INT2, INT3, INT5, INT6).

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

Similarly, although events frequently being held in London can act as a barrier for Welsh Q member attendance, it was felt by one interviewee that travelling outside of Wales provides opportunities to learn about what is happening in other areas with regards to improvement (INT6). This can help overcome the barrier faced by some Q members of being one of a very small number of Q members in Wales with their particular job role, as it allows these individuals to connect to members with similar roles outside of Wales (INT5).

Connecting to a wider group of Q members was thought by one interviewee to provide members with the confidence to have a voice in the improvement world (INT2). It was also felt to offer the opportunity to connect with members who may hold different opinions and thereby to hear different viewpoints and perspectives (INT2).

F.4.2. Q has led to a higher priority being placed on improvement work in Wales and to the creation of new improvement initiatives

One interviewee felt that the establishment of Q has contributed to a shift towards a greater focus on QI in Wales and has improved the quality and structure of the QI activities that take place (INT6). It was also suggested that Q has led to a reduction in duplication for groups working on similar projects as they are more likely to be aware of each other and so to join up their efforts (INT8).

It was also thought that Q has both influenced existing improvement programmes and led to the development of new ones. For example, some programmes in Wales have been influenced by connections made to Q, such as the medicines safety programme (INT8). In addition, after one of our interviewees attended and circulated information from a Q event to the Welsh government, a Health Service Investigation Branch is starting to be set up in Wales (although other factors also contributed to this) (INT3).
F.5. What is needed to increase the impact of Q in Wales?

Our interviewees discussed ways in which Q could continue to be supported and have impact in Wales, primarily focusing on the need for greater support in building high-quality connections and the need for continued member recruitment.

F.5.1. More support for building connections

It was felt by multiple interviewees that the community of Q members in Wales could benefit from receiving more support for building connections, both within and outside Wales. Although there is some connecting support already available, such as through Q Connectors, it was felt that the support should be more formalised and additional support provided to the Q Connectors in exploring what improvement activities are ongoing (INT1). There should also be more of an emphasis on the quality and strength of connections, rather than the number (INT1). One interviewee felt it would be particularly helpful to support connections across Wales, Scotland and Northern Ireland, as there is already a lot of investment in supporting members in England (particularly London) (INT3).

Two interviewees discussed how more support to build connections at a local level could also benefit members (INT6, INT8). For example, investments could be made in supporting regions in their improvement work, or new roles, similar to Q Connectors but on a more regional level, could be created (INT6). It would also be helpful for organisations to be more aware of the Q members working within it and the improvement skills they have (INT8). Linking this knowledge to the Health Boards in Wales and then on a UK-wide level could contribute to the system change and transformation Q aims to achieve (INT8).

F.5.2. Continual recruitment of members in Wales

Multiple interviewees felt that the membership number in Wales needs to continue to grow to reach a critical mass (INT2); however, there appears to have been less recruitment of members in recent months (INT3). More advertisement of Q, including that recruitment is now rolling, and other support for recruiting new members could be useful in achieving higher membership numbers (INT3).

It was felt by two interviewees that recruitment should be focused on expanding the demographic of membership in Wales, including encouraging applications from those in primary care roles and those with roles relating to the integration of health and social care (INT1, INT8). Recruitment of those from health and social integration roles would also help Q align with national priorities in Wales, of which this is one (INT8).

F.6. Implications of, and reflections on, Q in Wales

Recognising that this short report is based on just eight expert interviews, we should be cautious about making strong claims. However, we identify some emerging implications in this final section and within this limitation, we draw out some conclusions.

It is interesting to note that interviewees suggested that Q should raise its profile in Wales. At the same time, it was noted that there were a number of pre-existing programmes and initiatives that enjoyed a higher
profile. As originally conceived, Q is not intended to replace existing approaches but, rather, it is intended to both mobilise and galvanise existing approaches, strengthen networks and improve the flow of ideas and learning. Finding the optimal means for achieving this in Wales requires further work and further communication.

Closely related to this is the question of critical mass. Especially in North Wales it was felt that geographical distance and low concentration of members means that the role of Q in mobilising change either directly through the Q community or indirectly through existing initiatives is limited. The current aim of the Q team to triple the number of Q members over the next ten years appears to fit with what might be needed in Wales to achieve this.

However, more Q members is only one part of the answer. Q provides both a bonding function (strengthening existing links among improvers) and a bridging function (opening up new connections across organisations and groups) (Putnam, 2000). As Q grows and develops in Wales, it will become increasingly important to resolve how best to balance these two important functions. For example, linking with universities and researchers active in the area of improvement could help mobilise existing resources and align these with the needs of the improvement community. It was also suggested that the bonding functions of Q are good at linking Q members to each other but are less good in Wales at linking Q members to their own organisations.

While the resources provided nationally by Q were well regarded, and there was a good awareness of these apparent among our interviewees, the question of how Q was ‘plugged into’ the system priorities arose. The role of Q in addressing the wider determinants of health, reducing health inequalities, strengthening healthy communities and so forth is a question being asked in Wales (as elsewhere). Clearly, this view of ‘improvement’ is some distance from QI defined as a particular set of practices such as Plan, Do, Study, Act (PDSA) cycles. However, not only did interviewees seem reluctant to locate Q as supporting just one or the other of these definitions, they also felt that the practices of ‘improvement’ must embrace the big challenges facing the health and care systems. Achieving this would require greater engagement with senior health organisation leaders (i.e. board level) than was apparent from our interviews.
Annex G. Citizen ethnography data

In order to collect more detailed information on the experiences of Q members, a citizen ethnography exercise was undertaken from August to December 2019 as part of the wider Q evaluation. Ethnography is a qualitative methodology borrowed from anthropology, which is also used across the social sciences. Although the definition of ethnography is broad, ethnographic approaches generally capture methods in which data collection is undertaken over an extended amount of time, and in which the data collection is observational, reflexive and open (Hammersley, 2018; Reeves et al., 2008). In the approach we have termed ‘citizen ethnography’, participants are asked to observe their own behaviours and play the role of both a researcher and a subject of research (Hammersley, 2018). In this citizen ethnography exercise, participants were asked to reflect on their own experiences of engaging with Q over the course of ten weeks, and to complete weekly journals to record these observations.

G.1. Results

An overview of the findings from the citizen ethnography journals is provided below. These findings were also presented to participants during the December 2019 call.

- **Engagement with Q resources:**
  - **Networking:** All citizen ethnographers mentioned the value that Q provides in terms of the Q network and opportunities to work on improvement projects with other members of the Q community, which was one of the major ways that the group engaged with Q. However, some citizen ethnographers also expressed frustration at the lack of engagement on the part of other members of Q in terms of limiting the amount of knowledge sharing, feedback and opportunities that are provided through the Q network. The level of member engagement was reported to vary by topic area and geography, with some areas having considerably more engagement than others.
  - **Online forums, blogs and website:** Most engagement with Q was through online resources such as the Q website, blogs and social media. Some of the citizen ethnographers had participated in or read online forums, although there was also some frustration at the level of engagement on these forums, particularly around SIGs in which engagement was lacking or very low.
  - **Q Exchange:** All citizen ethnographers participated in Q Exchange activities in some way, whether that was through applying for funding, assessing proposals, commenting and voting online or getting involved with a Q Exchange project team. There were mixed feelings as to
whether Q Exchange was run effectively, and whether the process ended up funding the best projects with potential for impact.

**Challenges to improvement:**
- **Time and resources:** Time and resources were cited as the top reason for facing challenges in participants’ improvement work, and many journals also mentioned lack of time as a barrier to engaging with Q more.
- **Organisational challenges:** Many of the citizen ethnographers commented on organisational challenges that impacted on their improvement work, including the fact that others within the organisation lacked skills of knowledge needed to conduct improvement work, cultural opposition to change in health and social care and issues in management and leadership. There were some suggestions on how Q could address these issues in some journals, although others expressed that Q could not help solve challenges that occur at an organisational level.

**Impact of Q:**
- **Positive impacts of Q:** Some of the citizen ethnographers commented that Q has had a positive impact on their improvement work, either through the methods and knowledge that have been learned through Q or through connecting to other Q members to draw on their expertise or to collaborate. Journals contained examples of how Q methods or other Q members helped participants through challenges they faced in their improvement work, and many citizen ethnographers had a positive perception of Q overall.
- **Lack of impact of Q:** There was also some perception that Q has not led to practical changes in the health and social care system, and will struggle to improve the delivery of care and patient outcomes through the current methods used in Q. Related to this, some participants reflected the desire for more tangible or concrete resources to be provided through Q, beyond the resources that it currently provides which were sometimes seen as overly focused on ‘soft intelligence’. Some participants expressed the need for Q to engage more with organisations in the NHS that work on creating improvements in the health and social care system.

These findings were also supplemented with additional data collection during the December 2019 call, during which detailed notes were taken. Along with the themes above, participants in the call commented further on some of the findings from the journals. These discussions during the call included:

- **The tension between active contributors to the Q community and members that receive benefit from Q without contributing themselves.** Several participants commented on the frustration they felt that other members of Q are not as engaged with Q, and the related issues associated with SIG posts going unnoticed and requests for comments or feedback going unanswered by other members the Q network. However, other participants appreciated the ability to connect with Q when they had the time and space to do so, without the obligation of having to contribute regularly, and another described themselves as a member who viewed content but did not add to it. Participants discussed this tension, and reflected that there may be a ‘critical mass’ of more actively engaged Q members that allow others to benefit.

- **A suggestion to reduce the number of SIGs** to increase engagement in each group and avoid engaging with a SIG that has essentially no active members. One participant was a relatively new member of Q and had signed up to a number of SIGs only to find there was no activity in them.
• **A suggestion to have more themed events throughout the UK** to provide more opportunities to connect with Q. This came out of a reflection that some participants felt they wanted to engage more with Q, but there were not enough opportunities to engage. Participants mentioned that themed events could be organised by levels of experience, so that there are a variety of opportunities to engage regardless of prior experience or seniority.

• **Expanding the methodologies that Q promotes** to be able to better create change in the health and social care sector. For example, participants mentioned that it can be detrimental to focus on only one QI methodology, particularly when there are more applicable ways to change the way services are delivered and to produce patient-level impacts using other methodologies.

Reflecting on the findings as a whole, it seems that even for members of Q that may be more engaged than the average Q member, much of the engagement with Q comes through virtual engagement (e.g. online forums, browsing the website and looking at social media feeds) and through Q Exchange. Additionally, much of the benefit derived from Q comes from other Q members, including through knowledge exchange activities, collaborations and support when facing a challenge in improvement work. Related to the Q network, there is a significant tension to consider around the ability to dip in and out of Q with no obligation, and the frustration that some more engaged members may feel about not seeing other members contribute to the community.
H.1. Overview

Since the founding cohort began the co-design of Q in 2014–2015, membership has increased rapidly, as demonstrated in Figure 2.

**Figure 2: Growth of the Q Community from 2015–2019**

During this time, the Q team has developed Q’s infrastructure to enable it to attract and connect more people with improvement expertise. It has also developed a flexible and growing offering of activities and resources. The Q Exchange is particularly noteworthy and is discussed in Section H.13 of this report. Q Exchange focuses on encouraging members to initiate and develop improvement projects. Through these means, and the wider Q offer, it is hoped by the leadership of the Q team based in the Health Foundation that improvement efforts will be communicated and spread by making good practice more visible, helping improvers to feel better equipped and strengthening collaborative working.

At the same time, across the Q community, organisational capacity has been developed to support these activities, including: creating a greater online presence; recruiting new members (with a recent shift to rolling recruitment); developing further the communications strategy; organising events; and strengthening collaborations with other organisations in the improvement landscape. Members form opinions about Q
arising not only from their interactions with other members but also from how they engage with Q as an organisation and what Q chooses to prioritise. How members engage both with each other and with Q as an organisation is evolving, and we can see that founding members in some specific respects may feel differently towards Q than more recently joined members. The survey data reported here provide a good opportunity to reflect on members’ views and experiences at this important stage in the evolution of Q.

The following sections provide a summary of the survey results.

H.1.1. Engagement and participation

The amount of time members report spending on Q has remained fairly consistent over time, with the 42 per cent reporting spending 1–3 days on Q in the previous year. Members in clinical and non-clinical roles report spending similar amounts of time on Q, although those in clinical roles are proportionately slightly more likely to spend greater amounts of time on Q (i.e. 7 or more days).

The amount of time members report wanting to spend on Q is higher than the amount of time actually spent on Q. Nevertheless, the number of members indicating they want to spend higher number of days (i.e. between +) has reduced since 2015.

Most members report engaging and participating in Q resources but not helping to organise them. Older members are more likely to say they would help organise activities, but this may reflect an enthusiasm that may diminish over time as they continue to be members of Q, but may also reflect time constraints and other work priorities. These responses have been similar since 2018.

When asking members what they would like their involvement to be in the future, members report wanting to be more actively engaged and leading activities than is seen in practice. This has remained fairly consistent over time, although respondents from earlier (2015–2017) surveys reported wanting to lead activities more frequently than in 2018 and 2019.

Most members report feeling that quality is embedded in their organisation and this has largely stayed consistent since 2015. Relatedly, most members feel that their organisations are largely positive about their involvement in Q and many do provide practical support. Despite this, almost one-quarter of members in 2019 reported that their organisations do not provide this support.

H.1.2. Use of Q resources and activities

When asked about usefulness of resources, over 50% of members in Group A reported not using four of the resources: participating in Q Lab, attending a Q visit, submitting a bid for Q Exchange funding and participating in a special interest group. The majority of Group A respondents reported finding the other seven resources Q offers as ‘Very useful’ or ‘Somewhat useful’, with only a relatively small percentage of individuals indicating that they did not find the resources useful. The most useful resources reported in this cohort were: engaging with Q communications (80%), meeting and contacting other Q members (72%) and using online learning resources and publications (78%).

The question on resources was framed slightly differently for Group B members, insomuch as they were asked about how useful they expected the same 11 resources were going to be in supporting their improvement work. Here, a different picture is seen. The majority of Group B respondents reported that they expected all listed resources to be ‘Very useful’ or ‘Somewhat useful’, with the highest scoring ones
being the same as those in Group A: using online learning resources and publications (88%), engaging with Q communications (85%) and meeting and contacting other Q members (83%). Of all resources, Group B members were least confident about the usefulness of engaging with the Q community on Twitter with 16% ticking ‘Not useful’. Group B members were least sure about whether participating in Q Lab was going to be useful or not, with 38% ticking ‘Don’t know’.

H.1.3. Perception of Q’s value

While the majority of members feel they personally benefit from Q, one in ten reported that they do not, and the proportion of individuals agreeing that they personally benefit has risen since 2018. In addition, many members agree that Q benefits health and care across the UK and agreement with this statement is higher in 2019 compared to 2018.

In general, members feel they have access to more information and resources and ability to make new connections than they would without Q, and this has increased since 2018. Of all the statements touching on the value of Q, this was the one that the most number of respondents agreed with in 2019.

Over three-quarters of members agreed that Q has helped develop knowledge and skills, and the ability to share this knowledge. Fewer respondents (just under two-thirds) feel that Q supports their improvement activities, though this has still increased since 2018.

Two-thirds of members feel that they could get support from their organisation for improvement activities without Q, and a slightly higher proportion feel they could still undertake improvement activities without Q. Just under two-thirds of members feel they would have the same level of enthusiasm for improvement without Q, suggesting that the other third would not feel as energised to undertake improvement work without Q.

Many members used Q resources in organisational improvement activities in 2019, but newer members were more optimistic about wanting to use resources than was in practice evident from reported use by older members. Similar results were seen when asked if Q had increased the visibility of improvement activities within organisations, and if Q has positively impacted on the quality of care provided by their organisation.

Service user engagement could be improved by introducing better strategies to engage this group and by making Q more accessible. Q could also play a role in raising awareness of how healthcare professionals can use the skills and experiences of service users and supporting professionals to engage service users in their improvement work.

H.1.4. Impact of Q on members

The majority of Group A respondents were confident that Q had positively impacted all nine areas presented to them in the survey. Of these, members were most confident that Q has positively impacted their own skills and knowledge, followed by their ability to undertake improvement work and visibility of improvers in the healthcare system. They were least confident in Q’s ability to make improvers visible within organisations, with over a third of respondents ticking ‘Not very confident’ or ‘Not at all confident’ for this statement.
As with other questions, newer members (Group B) were more confident in the potential positive impacts of Q than older members reported in practice. Over 70% of this cohort reported being confident that Q would have a positive impact in the presented areas, with the two highest scoring areas being the same as for Group B (ability to undertake improvement work and impacting their own skills and knowledge). As with Group A, this cohort was least confident in Q’s ability to make improvers visible within organisations, albeit only 22% stated this.

Members shared a number of specific and general positive impacts that have resulted from Q. A small number of members reported negative impacts, mainly related to feeling isolated from the community.

To increase Q’s impact, members felt that Q could make itself more accessible, e.g. easier to find members with a particular set of expertise on the website. Thoughts differed on whether there is too much or too little communication from the Q team. There is also a need for more activity at a local level to help create more cohesive local Q communities, as well as raising the profile of Q within the health system.

**H.1.5. Q Exchange**

Responses to the question on Q Exchange were largely positive. Many respondents felt the application and voting process is collaborative and democratic, offering a chance for under-represented groups and ideas to receive funding. However, a small number felt the voting was a popularity contest and favoured those with larger networks.

For members supporting bidding teams, this was reported to help increase their knowledge of the types of improvement work and areas of priority on a national scale. It also enabled some people to make new connections and others enjoyed being altruistic and helping others in putting together their bids.

**H.2. Suggestions for the Q team to consider**

Members continue to report that they would like to spend more time on Q in the future than they do currently. This suggests a belief in the importance and relevance of Q but, since it is a consistently reported view, it is clear that there are constraints that prevent this aspiration translating into action. The main reason given for this is lack of time but this could be reinterpreted as a lack of priority. In turn, this may speak to organisations being positive about Q but not providing practical support for Q members to engage with the initiative. Identifying organisational benefits and communicating these to resource holders in the organisations should remain a priority to help address this.

Another consistently reported view is that Q is highly regarded for the relationships it facilitates and supports. Q Communications are well received and interactions are supported by a number of media. Perhaps counter-intuitively, newer members may be engaging less than longer established members through the medium of Twitter. In addition, Q is seen to provide members with access to resources that would not otherwise have been available and most members especially value the online resources. It also energises members and reinforces their enthusiasm for improvement work. Clearly much is perceived to be working well and Group B respondents were even more positive than Group A about whether they thought that Q would increase the visibility of improvement in their organisation, suggesting continuing confidence in the initiative (although this might suggest that with experience comes a degree of disenchantment).
One in ten respondent members report that they are not benefiting personally from Q and 17% disagreed that Q resources were being used in their organisations (even when some these found those resources useful). This suggests a group of members who may in time become disengaged. Refreshing their enthusiasm and demonstrating the relevance of Q in ways that are targeted on this group should be considered.

H.3. Introduction, method, overview and recommendations

H.3.1. Introduction

This report contains the results of the two 2019 Q member surveys, conducted from September to November 2019 as part of the larger 2016–2020 Evaluation of Q commissioned by the Health Foundation. They follow on from earlier member surveys conducted in 2016, 2017 and 2018.

The two surveys that were disseminated to Q members differed slightly in some response categories depending on the amount of time a member had been part of Q. Where appropriate, we use the following categories throughout the report:

- **Group A**: Members recruited from Q’s inception up to and inclusive of November 2018, i.e. been members for a year or more in Q (2,779 members).
- **Group B**: Members recruited between December 2018 and September 2019 inclusively, i.e. members with less than one years’ membership (583 members; those who have been in Q for less than one year at survey launch).

This report provides insights into the key trends arising from the survey data. It is intended to provide ongoing learning and data for the Health Foundation to inform the continuous development of the Q community, in addition to informing the independent evaluation of the Q Initiative by RAND Europe. These are the last of the member surveys to be conducted for the evaluation and will directly feed into the summative evaluation report to be delivered in spring 2020.

H.3.2. Methods and limitations

The surveys were carried out simultaneously between September and November 2019 during a seven-week period, using the Smart Survey platform. The surveys were developed using a mixture of adapting previous member entry surveys and annual surveys and adding new questions in light of new activities and areas of interest. All questions were developed by the evaluation team with input from the Q team on areas of priority and interest.

Data and findings set out below comprise results from both surveys combined, unless specified otherwise. Where question wording deviated between surveys (to reflect the different lengths of time members had been in Q), this is explained in footnotes.

The total number of responses to the Q 2019 annual survey was 852 (response rate of 25.3%), of which:

- **643** responses were from Group A (response rate of 23.1% from the total number of potential Group A respondents).
- **209** responses were from Group B (response rate of 35.8% from the total number of potential Group B respondents).
A total of 13 respondents did not consent to their responses to the survey being processed and were dropped from the data, leaving a total number of 839 responses.

To account for individuals who responded to the survey more than once (i.e. duplicates), these duplicate cases were dropped on the basis of email address. If two or more respondents had the same email address, then the entry with the most complete number of responses was kept. If individuals had exactly the same number of complete responses, then the record with the latest start date and time was kept.

Overall, a total of 40 individuals had responded to the survey two or more times, and 4 responded to the survey three times.

The total number of post-duplicated responses was 791 (response rate of 23.5 per cent). This is a difference of 48 observations not accounting for the 13 respondents who did not consent to take part in the survey. Figure 3 presents the number of responses graphically.

Figure 3: Number of survey responses

852 responses, of which:
- Group A: 643 responses
- Group B: 209 responses

839 responses

13 individuals did not consent

791 responses

Dropped duplicates:
- 40 observations to account for two duplicate rows
- 8 observations to account for three duplicate rows

The data were analysed using the statistical software Stata 15 (by AH). Qualitative free-text comments were analysed by developing thematic coding frameworks in Excel based on the identification of emerging themes, and the data coded accordingly (by SP and LH). Quotes from the free-text responses are presented throughout the report. These were selected as they best articulate the point being discussed in the narrative, provide in-depth responses and are the most clearly written.

It is important to note two key limitations with regard to the survey data, which should be considered when interpreting the results.

Firstly, not all Q members responded to the surveys (see response rates above) and so the views expressed below may not be representative of the full membership body. It is important to note that people who respond to the surveys may be more or less satisfied or engaged with Q membership than average. However, as is shown in the following chapter, the demographic representation in the survey is largely similar to that of the Q community as a whole. In addition, the responses shared in this survey are still valuable insights into the experiences and thoughts of the membership at this point in time.

Secondly, the format of the surveys means that free-text comments provided by respondents are necessarily brief, and there is limited scope to probe or further explore the context for comments, as is possible in other data collection methods such as interviews and focus groups. Where free-text comments have been
presented, these have been quoted ad verbatim where possible to avoid the risk of changing the respondents’ intent, although some content may have been removed for brevity (marked with parentheses, as is standard practice) and spelling/grammar mistakes corrected for clarity. In addition, to maintain anonymity, some parts of survey quotes have been redacted (shown by [redacted – ‘reason’]).

Where possible, we have compared the survey responses to the same/similar questions asked in the previous member surveys and have directly compared responses across the 2018 and 2019 annual surveys for relevant areas to explore further.

H.4. Profile of survey respondents

Figure 4 to Figure 9 below provide an overview of survey responses to questions about members’ profiles and characteristics. These provide an overview of the characteristics of survey respondents, with some comparisons to the overall Q community membership. As this demonstrates, our respondent cohort for the survey is largely similar in their demographics to the wider Q community.

To construct this demographic data, we had two questions in our survey (employment status, to filter the types of questions respondents viewed, and income, to represent seniority) and cross-analysed our responses with the demographic data held by the Q team, if respondents consented to this (775 out of the 791 respondents consented to this and an additional one individual could not be linked to the demographic data due to missing email address).

Figure 4: Respondent’s employment status

![Bar chart showing respondent’s employment status]

Number of total observations: 785
Number of observations from left to right: 726, 8, 20, 20, 11

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20 Question text: To help us understand how your engagement with Q relates to your job role, please select the option that reflects your employment status. (I am in full- or part-time employment, I am not currently in employment, I am self-employed, I am a patient/service user representative, Other (please specify).
Figure 5: Respondents’ organisation types

This was calculated using demographic data held by the Health Foundation. Only members with email addresses to link and those consenting to have their survey data cross-analysed with demographic data held by the Health Foundation are included in this graph (n=774).
Figure 6: Respondents' length of membership\textsuperscript{22}

![Graph showing the percentage of respondents by year joined, with data for 2015 to 2019.](image)

Figure 7: Respondents primary role (clinical or non-clinical)\textsuperscript{23}

![Graph showing the percentage of respondents in clinical and non-clinical roles.](image)

\textsuperscript{22} This was calculated using demographic data held by the Health Foundation. Only members with email addresses to link and those consenting to have their survey data cross-analysed with demographic data held by the Health Foundation are included in this graph (n=774).

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H.5. Engagement and participation with Q

The surveys contained a number of questions which asked about the way that members engage with Q and Q’s activities and/or resources.

H.5.1. Time spent engaging with Q

Respondents were asked how much time they had spent engaging with Q in the recent past and the nature of their involvement, and how much they would like to do so in the coming year. We analysed this separately for Group A and Group B, to illustrate any differences between the early phases of Q and the later phases.

Figure 10 depicts the amount of time Group A respondents spent engaging with Q over the past year for both the 2018 and 2019 surveys. For 2019, almost half of respondents (42%) spent 1–3 days on Q in the previous 12 months. One-quarter (25%) spent less than one day on Q, with another fifth (20%) spending 4–6 days. A smaller percentage spent 7–10 days (8%) or over 10 days (5%). Comparing the responses across the two years, Q members appear to be spending a similar amount of time on Q across 2018–2019 as they did previously in 2017–2018.

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25 Question text: What is your annual (FTE) income, before taxes but after any regular out of hours or overtime payments?
Figure 10: Amount of time Group A respondents spent engaging with Q in the past year for the 2018 and 2019 surveys

Figure 11 demonstrates the findings when results from both Group A and B are split by role, either clinical or non-clinical. Members in both types of role appear to spent a similar amount of time on Q. Non-clinical members appear more likely to spend between 1 and 6 days on Q, however when looking at the larger amounts of time spent on Q (i.e. 7 or more days), those in clinical roles are slightly more likely to spent this amount of time.

26 Question text: How much time have you spent engaging with Q over the last year? (e.g. participating in local events or other activities, visiting the website, attending a centrally run visit/event, participating in the Q Lab, writing a blog, participating in a webinar or twitter chat etc.). This question was not asked to Group B respondents as they had joined Q within the last 12 months.
Figure 11: Time spent during one year on Q by clinical and non-clinical roles (Group A only)\textsuperscript{27}

Figure 12 presents the overall time both groups report wanting to spend on Q over the next year for 2018 and 2019. For the 2019 responses, one-third (33\%) reported that they would like to spend 1–3 days on Q in the next 12 months and over one-quarter (28\%) would like to spend 4–6 days. Only 5\% report wanting to spend less than one day on Q over the next year. When compared to 2018, the results are fairly similar, suggesting that members desired level of commitment to Q has remained stable from 2018 to 2019.

\textsuperscript{27} 164 responses are from clinical roles and 383 from non-clinical roles.
The majority of individuals in Group A in 2019, who responded to both the amount of time they spent on Q in the previous year and the amount of time that they would like to spend on Q in the coming year, reported that they wanted to spend more time in Q in the coming year than they had spent in the past year (61%), the bulk of which made up one category increase (e.g. 1–3 days to 4–6 days, or 4–6 days to 7–10 days). Very few reported wanting to spend less time in Q in the future compared to what they had spent in the last year (3%). Just over a third (36%) had no difference in the amount they reported.

Figure 13 from the 2015–2017 surveys present the responses to this same question. While recognising there was variation among earlier recruitment cohorts, the distribution of answers has remained broadly consistent across surveys for wanting to spend less than one day and more than 10 days on Q in the next 12 months. Those wishing to spend 1–3 days on Q appears to have increased over time, from an average of roughly 18% in the 2015–2017 surveys (published in the 2018 interim report), to 30% in the 2018 survey and 33% in 2019. Respondents reporting wanting to spend 4–6 or 7–10 days on Q has dropped between 2015 and 2019, from 38% to 28% for 4–6 days, and 27% to 18% for 7–10 days.
Figure 13: 2015–2017 surveys’ responses to desired time commitment over next year (reproduced from the 2018 interim report)\textsuperscript{28}

\begin{itemize}
\item Less than 1 day: 2.3, 2.6, 2, 0.9, 0.8
\item 1-3 days: 23, 19, 18.3, 19, 18.4
\item 4-6 days: 18.4, 26.4, 29.2, 29.4, 29.4
\item 7-10 days: 31.6, 35.9, 31.7, 38.3, 41.8
\item More than 10 days: 21.4, 15, 15, 23.5, 27
\end{itemize}

\textsuperscript{28} Question text: Based on the information you have so far, and taking account how much time you have available, how much time would you like to spent over the next year?
Figure 14 breaks this question down further by analysing the time newer members from the 2019 survey want to spend on Q in the coming year by role (clinical or non-clinical). As with the previous question, the results for respondents with clinical and non-clinical roles are fairly similar. However, a greater proportion of respondents with non-clinical roles would like to spend 4–6 days on Q compared to those in clinical roles (33% compared to 19%).

Figure 14: How much time respondents want to spend on Q, by clinical and non-clinical role (Group A and B)

29 205 respondents answering this question are in clinical roles and 494 are non-clinical.
H.5.2. Type of engagement with Q

Members were also asked the nature of involvement with Q they had in the last 12 months (Group A) or since they joined Q (Group B) and wanted over the next 12 months (both groups). Figure 15 depicts responses from Group A about the nature of their involvement with Q in the past year for both 2018 and 2019, and Figure 16 demonstrates this for Group B since they joined (for 2019 only). As these graphs show, in 2019, both groups report similar types of participation in Q. The majority (64% for Group A and 66% for Group B) report occasionally making use of a small number of resources and activities. There is a slight difference in the number of respondents reporting that they significantly contribute to Q activities (7% for Group A and 2% for Group B), however this is most likely due to Group B members not having been involved in Q for long enough to contribute to such an extent. Comparing Group A with Group B, a similar percentage of respondents report actively participating in Q activities, but not helping to organise them (15% for Group A and 11% for Group B). A similar set of responses were seen for Group A in 2018. Similar to the 2019 responses, the majority (60%) of 2018 Group A respondents reported occasionally using a small number of resources. A comparable proportion of respondents to the 2019 survey reported actively contributing to Q (18%) and participating but not organising activities (7%).

For Group A, 15% (84 responses) selected ‘other’ for this question. The majority of these 84 responses (63%) are comments that the member has not engaged with Q at all, or very little, in the past year. A small number of other responses (10%) highlighted the specific types of activities that Q members have led and delivered relating to Q, or that they hold a specific leadership role within Q, such as a Q connector. The remaining ‘other’ responses are comments of specific resources members engaged with, such as Q Exchange or Randomised Coffee Trials (RCTs). For Group B, 21% of respondents selected the ‘other’ option (35 responses). Of these responses, most (69%) are comments that the member has not been a member long enough to be involved yet, with many commenting they had only been a member for a number of weeks before completing the survey. Other respondents (20%) commented that they had not engaged with Q, but did not specify if that is due to the short amount of time they have been a member.
Figure 15: How active Group A respondents reported being in the last year for both the 2018 and 2019 surveys

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

Figure 16: How active Group B respondents reported being since joining Q

2018: Number of total observations: 158
2018: Number of observations from left to right: 3, 18, 104, 33

Question text: How active have you been within Q since you joined? ‘Other’ responses offered an opportunity for respondents to provide a free-text response.
H.5.3. Type of engagement members would like in the future

Figure 17 depicts the nature of engagement with Q that respondents from both groups report wanting to have over the next year from both the 2018 and 2019 surveys. As this shows, nearly half of respondents (47%) in 2019 would like to actively participate in activities, but not contribute to their organisation. Almost one-third of respondents (32%) reported that they would like to only occasionally use Q resources and activities. A fairly small proportion of respondents (17%) in 2019 reported that they wanted to actively participate in activities and help organise them. When compared to the previous question, asking respondents what involvement they have had with Q in the past year, this suggests Q members responding to the 2019 survey would on average like to be more actively engaged in Q activities and resources, including in organising them, than they have been previously in practice. The respondents to the 2018 survey reported wanting to have a similar level of activity with Q over time to those in the 2019 survey.

In addition, in 2019, 4% of responses (32 responses) selected the ‘Other’ option. These outlined some of the factors that respondents felt would influence the type of engagement they have with Q over the next year, including a change in job role/employment status, whether they could obtain the time and/or resources to actively engage with Q, and whether what Q offers fits in with the priorities of their day job.

Figure 17: Desired level of activity in the coming year for Groups A and B in 2018 and 2019

However, in the 2015–2017 surveys (Figure 18) it appears that on the whole a greater number of participants reported wanting to contribute significantly and lead activities compared to both 2018 and

31 Question text: Taking into account how much time you have available, how active would you like to be within Q over the coming year?
2019. While the number of respondents reporting the desire to occasionally use Q activities dropped between 2017 and 2018, this appears to have increased slightly in 2019.
Figure 18: Desired level of activity in the coming year, as reported in the 2015–2017 surveys (reproduced from the 2018 interim report)\textsuperscript{32}

\textsuperscript{32} Question text: Taking into account how much time you have available, how active would you like to be within Q over the coming year?
H.6. Support from employers

Q members were asked about their agreement with the following statements concerning their ability to undertake quality improvement and Q-related activities in their current role:33

1. Improving quality is embedded in my organisation.

2. My organisation is positive about my involvement in Q.

3. My organisation provides the practical support I need (e.g. travel expenses, protected time) to participate effectively in Q.

Figure 19 depicts that the majority of respondents (85%) agreed to some extent that improving quality is embedded in their organisation, with only 10% disagreeing with this statement to any extent. This is similar to both the 2018 survey (Figure 20) and the 2015–2017 surveys (Figure 21).

Figure 19: Agreement with whether improving quality is embedded in member’s organisation34

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33 Question text: To what extent do you agree with the following statements about your organisation or professional network (outside of Q)? ‘Other’ responses offered an opportunity for respondents to provide a free-text response.

34 Question text: Improving quality is embedded in my organisation. 624 responses. 84.78% selected ‘Strongly agree’, ‘Agree’ or ‘Slightly agree’. 4.17% selected ‘Neither agree nor disagree’. 9.77% selected ‘Strongly disagree’, ‘Disagree’ or ‘Slightly disagree’.
Figure 20: 2018 survey responses exploring the agreement with whether quality is embedded in their organisation (716 responses)\textsuperscript{35}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure20}
\caption{2018 survey responses exploring the agreement with whether quality is embedded in their organisation (716 responses).}
\end{figure}

\textsuperscript{35} 716 responses. 79.47% selected ‘Strongly agree’, ‘Agree’ or ‘Slightly agree’. 7.82% selected ‘Neither agree nor disagree’. 12.71% selected ‘Strongly disagree’, ‘Disagree’ or ‘Slightly disagree’. 
Figure 21: 2015–2017 survey responses exploring whether improving quality is embedded in members organisations (reproduced from the 2018 interim report)
Figure 22 outlines the level of agreement when respondents were asked whether their organisation is positive about their involvement with Q. As with the previous question, the majority of respondents (65%) agreed to some extent that their organisation is positive about their involvement with Q, with only 5% disagreeing. Almost one-quarter (23%) neither agreed nor disagreed with this statement.

**Figure 22: Agreement with whether members’ organisations are positive about their involvement in Q**

![Bar chart showing percentage distribution of responses to the question: My organisation is positive about my involvement in Q.]

- **Strongly agree:** 24.32%
- **Agree:** 27.19%
- **Neither agree nor disagree:** 13.04%
- **Slightly agree:** 22.54%
- **Strongly disagree:** 2.25%
- **Disagree:** 2.25%
- **Don't know or not applicable to me:** 0.97%

Number of total observations: 621
Number of observations from left to right: 151, 172, 81, 140, 14, 14, 6, 43

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36 Question text: *My organisation is positive about my involvement in Q.*
Figure 23 outlines respondents’ agreement as to whether their organisation provides practical support for their engagement with Q, such as travel expenses or protected time. Again, the majority agreed to some extent with this statement (59%), but almost one-quarter disagreed (23%).

**Figure 23: Agreement with whether member’s organisations provide practical support for their involvement with Q**

H.7. Use of Q resources and activities

H.7.1. Usefulness of engaging with activities and resources

Members were asked to indicate how useful they found different Q resources and activities in improving quality. Figure 24 and Figure 25 show the reported usefulness of engaging with different resources and activities offered by Q. Figure 24 shows responses for Group A who were asked which resources they found useful in supporting improvement work, and Figure 25 shows responses for Group B who were asked which resources they expected to be useful in the future.

As Figure 24 demonstrates, over 70% of members in Group A reported not engaging with Q Lab (77%), attending a Q visit (72%) and submitting a bid for Q Exchange funding (72%). The majority of respondents reported not having used SIGs or other online groups (56%). The other resources were frequently thought to be very or somewhat useful, with only a small percentage of individuals reporting they did not find these resources useful. The most useful resources reported by Group A were engaging with Q communications (80%), meeting and contacting other Q members (72%) and using online learning resources and publications (78%).

---

37 Question text: *My organisation provides the practical support I need (e.g. travel expenses, protected time) to participate effectively in Q.*
Group B were asked whether they expected Q resources and activities to be useful in the future (Figure 25). Most Group B respondents expected all the resources to be useful to some extent, with the highest scoring ones being the same as those in Group A; using online learning resources and publications (88%), engaging with Q communications (85%) and meeting and contacting other Q members (83%). Of all resources, Group B members were least confident about the usefulness of engaging with the Q community on Twitter, with 16% selecting ‘Not useful’. Group B members were least sure about whether participating in Q Lab was going to be useful, with 38% selecting the ‘Don’t know’ option.

For each of the figures below, there is a corresponding table (Table 42 and Table 43) in H.14 that presents the numbers for each of the bars.
Figure 24: Usefulness of engaging with different resources and activities (Group A)\textsuperscript{38}

\begin{center}
\begin{tikzpicture}
\begin{axis}[
    ybar stacked, ymajorgrids=true, grid style=dashed, xtick=data, xticklabels={Participating in Q Lab, Attending a Q visit, Attending national event(s), Attending local event(s), Submitting a bid for Qx funding, Engaging with Qx in other ways, Using online learning resources and publications, Participating in a Special Interest Group or online group, Engaging with the Q community on Twitter, Engaging with Q communications, Meeting and contacting other Q members}, xticklabel style={align=center}, ylabel={Percentage (%)}, xlabel={Number of observations by question in descending order (top to bottom): 554, 552, 557, 553, 552, 547, 558, 550, 550, 551, and 551}
]
\addplot[fill=green!50!black] coordinates {
(1, 80) (2, 40) (3, 60) (4, 70) (5, 30) (6, 20) (7, 50) (8, 40) (9, 80) (10, 50) (11, 30)
};
\addplot[fill=green!25!black] coordinates {
(1, 40) (2, 60) (3, 40) (4, 30) (5, 20) (6, 40) (7, 50) (8, 20) (9, 40) (10, 40) (11, 30)
};
\addplot[fill=green!10!black] coordinates {
(1, 20) (2, 40) (3, 20) (4, 10) (5, 10) (6, 20) (7, 20) (8, 10) (9, 20) (10, 20) (11, 10)
};
\addplot[fill=green!5!black] coordinates {
(1, 0) (2, 0) (3, 0) (4, 0) (5, 0) (6, 0) (7, 0) (8, 0) (9, 0) (10, 0) (11, 0)
};
\end{axis}
\end{tikzpicture}
\end{center}

\textsuperscript{38} Question text: \textit{How useful have you found these elements of Q in supporting your improvement work?} The data table for this question can be found in Section H.14.
Figure 25: Expected usefulness of engaging with different resources and activities (Group B)\textsuperscript{39}

\textsuperscript{39} Question text: \textit{How useful do you expect these elements of Q to be in supporting your improvement work?} The data table for this question can be found in Section H.14.
H.8. Perceptions of Q’s value

H.8.1. Views on the benefit of Q

Members were asked whether they agreed or disagreed with a number of statements regarding the personal value of being a Q member. Figure 26 indicate the level of agreement that respondents reported with statements concerning the value of Q:40

1. I am confident I personally benefit from being part of Q.
2. I am confident that through being part of Q I contribute to something that ultimately benefits the quality of health and care in the UK.
3. As a result of my membership of Q, I have access to information and/or resources for improving quality that I would not have otherwise.
4. As a result of my membership of Q, I can make the connections I need to undertake quality improvement work.
5. Membership of Q has helped me to organise and/or undertake improvement activities.
6. Membership of Q has helped me to develop my knowledge and/or skills for improving quality.
7. As a result of my membership of Q, I am able to share my knowledge and skills for improving quality in health and care with others.
8. Without Q, I would still be able to get support for my improvement activities from other networks or organisations.
9. Without Q, I would still feel just as inspired/energised to undertake improvement activities.
10. Without Q, I would still be able to effectively undertake improvement activities within my organisation or professional network.

Figure 26 provides an overview of the extent to which respondents agreed with these statements. A breakdown for each statement in bar graph form can be found in H.15.

The vast majority (81%) agreed that they personally benefit from being a member of Q, and 10% of respondents disagreed with this statement to some extent. Figure 27 provides the responses to a similar

40 Group B received alternatives to items 1–2 and 5–7 (items 3–4 and 8–10 were identical):
I am confident I will personally benefit from being part of Q.
I am confident that through being part of Q I will contribute to something that ultimately benefits the quality of health and care in the UK.
Membership of Q will help me to organise and/or undertake improvement activities.
Membership of Q will help me to develop my knowledge and/or skills for improving quality.
As a result of my membership of Q, I will be able to share my knowledge and skills for improving quality in health and care with others.

The responses from Groups A and B have been merged in Figure 26–Figure 28.
question asked in the 2015–2017 surveys and Figure 28 provides responses to the same question asked in 2018 as to whether Q provides a personal benefit. This suggests that members were most confident that Q could personally benefit them in 2017, when the average agreement across all surveys was 91%; however, it should be noted that this question was phrased in a prospective way, asking members whether they thought Q could provide benefit, whereas the 2018 and 2019 surveys asked whether Q had benefited them personally. Between 2018 and 2019, members reporting agreement that Q has personally benefited them increased, from 63% to 81%.

When respondents were asked whether being a part of Q benefits the quality of health and care across the UK, over three-quarters of respondents (79%) agreed with this statement to some extent, 9% disagreed to some extent and another 10% neither agreed nor disagreed with the statement. When compared to the 2018 survey results (Figure 28), the number of respondents agreeing that being a part of Q benefits the quality of health and care nationally increased, from 63% in 2018 to 79% in 2019. Subsequently, the number disagreeing with this statement has reduced over time, from 26% in 2018 to 9% in 2019. The same percentage of respondents neither agreed nor disagreed with the statement in both years (10%).

Respondents were also asked if they have access to information and resources they would not have without Q. A large majority of respondents agreed with this statement to some extent (86%), with only a small proportion (7%) reporting that they would have access to the same information and resources if they were not a Q member. When compared to the same question asked in 2018 (Figure 28), the number of respondents agreeing with this statement has increased, from 73% in 2018 to 86% in 2019. Fewer respondents disagreed with this statement, falling from 20% in 2018 to the 7% in 2019.

Respondents were asked whether they feel they are able to make new connections to undertake quality improvement work as a result of being a Q member. Most respondents agreed to some extent that being a member supports their ability to make new connections (82%). Only a small proportion of respondents (7%) disagreed with this statement, while 9% neither agreed nor disagreed. When compared to results from the 2018 survey (Figure 28), the level of agreement with this statement has increased over time, from 64% in 2018 to the 82% seen in 2019, with a corresponding decrease in the proportion of respondents who disagreed with this statement, going from 27% in 2018 to 7% in 2019.

The degree of agreement from respondents when asked whether being a member of Q supports their improvement activities was also explored. The extent of agreement with this statement is slightly lower than seen with the previous statements in this section, with a little under two-thirds (62%) of respondents agreeing that Q supported their improvement activities. Compared to the other statements on members’ perception of Q’s value, a larger proportion of respondents disagreed with this statement to some extent (14%), or neither agreed or disagreed (18%). When comparing these results to the same question asked in 2018 (Figure 28), it suggests that respondents in 2019 agree to a greater extent than respondents in 2018 that Q supports them to undertake improvement activities. Agreement to some extent in 2018 was 44%, compared to the 62% seen in 2019. Although the proportion of respondents disagreeing with this statement to some degree in 2019 (14%) was higher than that of other statements, it was still lower than the 32% of disagreement seen in 2018.

Figure 26 also demonstrates the extent of agreement when asked whether Q has helped respondents to develop knowledge and skills for improvement. As this shows, over three-quarters of respondents (76%)
agreed with this statement to some extent, 11% disagreed with the statement and another 10% neither agreed nor disagreed. A comparison with the same question asked in 2018 (Figure 28) suggests that the extent of agreement from respondents as to whether Q has supported development of improvement skills and knowledge has increased over time, from 58% in 2018 to the 76% seen in 2019. Correspondingly, the level of disagreement with this statement has fallen, from 30% in 2018 to 11% in 2019.

We also explored whether respondents agreed that Q enabled them to share their improvement knowledge and skills. Again, around three quarters agreed with this to some extent (76%). A much smaller proportion (9%) disagreed, while a slightly higher proportion (12%) neither agreed nor disagreed. Compared to the results from the same question asked in 2018 (Figure 28), the level of agreement with this statement has increased over time, from 54% in 2018 to 76% in 2019. The level of disagreement has dropped for this statement, from 29% in 2018 to 9% in 2019.

Figure 26 also provides the results when respondents were asked if they could get support from their organisation for improvement work without Q. Compared to the results from the other questions in this section, agreement was slightly lower at 66%, particularly for the ‘Strongly agree’ category, which only 10% of respondents selected. Compared to the other questions in this section, more respondents disagreed with this statement to some extent (15%) and many were also unsure, with 16% neither agreeing nor disagreeing. This question was not asked in 2018 and so results cannot be compared to previous years.

We also looked at the extent of agreement when respondents were asked whether they would still feel as inspired and energised with improvement activities without Q. Over half of the respondents thought they would still be as inspired and energised even without Q (60%), and 21% of respondents reported that they would not feel as energised to undertake improvement work without Q. A similar proportion (18%) neither agreed nor disagreed with this statement. As previously, this question was a new addition to the 2019 survey and was not asked in 2018 and so data cannot be compared over time.

Finally, Figure 26 outlines the results when respondents were asked whether they thought they would be able to undertake improvement activities without Q. The extent of agreement with this counterfactual question is slightly higher than the previous two (72%), with some disagreement from respondents (12%). A total of 14% neither agreed or disagreed with this statement. This question was not asked in 2018 and so data cannot be compared over time.
Figure 26: Agreement with statements on the benefit of Q (N.B: the responses for ‘Don’t know’ or ‘Not applicable to me’ have been removed from this graph for visualisation purposes. The number of responses for this option can be found in Section H.15)
Figure 27: Responses to 2015–2017 surveys: Confidence that members would benefit from Q (reproduced from 2018 interim report)\textsuperscript{41}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure27}
\caption{Responses to 2015–2017 surveys: Confidence that members would benefit from Q (reproduced from 2018 interim report).}
\end{figure}

\textsuperscript{41} Question text: I am confident I will benefit from joining Q.
Figure 28: Level of agreement for the statements regarding the value of Q from the 2018 survey

- I am confident I personally benefit from Q
- I am confident I contribute to ultimately benefiting the quality of health and care
- I have access to info and/or resources I would not otherwise have
- I make connections I would not ordinarily be able to make
- It has helped me to organise and/or undertake improvement activities
- It has helped me to influence improvement activities locally
- It has helped me to develop my knowledge and/or skills for Q
- I am able to share my knowledge and skills for Q

Percentage (%)

- Strongly agree
- Agree
- Slightly agree
- Neither agree nor disagree
- Slightly disagree
- Disagree
- Strongly disagree

Number of observations by question in descending order (top to bottom): 927, 916, 925, 923, 924, 911, 923, and 922

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42 The data table for this graph can be found in Section H.14.
H.8.2. Sub-analysis: Time spent on Q compared to agreement on the benefit of Q

To understand whether there is an association between the perceived benefit of Q for members and time spent on Q, we compared the responses to these questions. The results of these sub-analyses are presented in Table 8 to Table 17 below. Note that these tables represent the data with the ‘Don’t know’ responses and missing data excluded.

As these tables show, in general members agreed to some extent that Q provides the range of benefits specified in the survey questions. However, there are a few interesting results to note. For Table 8 which outlines the cross-analysis for the time spent on Q and agreement with the statement 'I personally benefit from being a part of Q’, 31% of those members spending less than one day disagreed with this statement to some extent. Similarly, in Table 9, 30% of members spending less than 1 day on Q disagreed to some extent that as being part of Q they contribute to the quality of health and care across the UK. Similar results were seen in Table 12 and Table 13. In Table 12, 45% of members spending less than 1 day on Q disagreed to some extent that Q has helped them to organise and/or undertake improvement activities. In Table 13, 34% of members spending less than 1 day on Q disagreed to some extent that Q has helped them to develop their knowledge and/or skills for improving quality. These results indicate that members spending the smallest amount of time on Q perceive Q to offer less of a benefit, particularly with general benefits to themselves and the wider healthcare landscape and supporting them to undertake their own quality improvement work.

An additional result to note is in Table 16, in which 32% of members spending 4–6 days on Q disagreed to some extent that without Q, they would still feel just as inspired/energised to undertake improvement activities. It is unclear why this spike in disagreement occurs for this group, but if we were to make inferences from these results, it may be that members spending more time on Q are those in improvement-related roles and so have a greater interest in working on improvement outside of Q. However, the same level of disagreement was not seen in members spending seven or more days on Q.

Table 8: Time spent on Q compared to the agreement with the statement 'I personally benefit from being a part of Q.'

<table>
<thead>
<tr>
<th></th>
<th>Total agree</th>
<th>Neither</th>
<th>Total disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 day</td>
<td>65</td>
<td>25</td>
<td>41</td>
</tr>
<tr>
<td>1-3 days</td>
<td>190</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td>4-6 days</td>
<td>106</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>7-10 days</td>
<td>46</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>27</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 9: Time spent on Q compared to the agreement with the statement ‘I am confident that through being part of Q I contribute to something that ultimately benefits the quality of health and care in the UK.’

<table>
<thead>
<tr>
<th>Time spent</th>
<th>Total agree</th>
<th>Neither</th>
<th>Total disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 day</td>
<td>64</td>
<td>23</td>
<td>38</td>
</tr>
<tr>
<td>1-3 days</td>
<td>185</td>
<td>30</td>
<td>14</td>
</tr>
<tr>
<td>4-6 days</td>
<td>104</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>7-10 days</td>
<td>43</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>23</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 10: Time spent on Q compared to the agreement with the statement ‘As a result of my membership of Q, I have access to information and/or resources for improving quality that I would not have otherwise.’

<table>
<thead>
<tr>
<th>Time spent</th>
<th>Total agree</th>
<th>Neither</th>
<th>Total disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 day</td>
<td>97</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>1-3 days</td>
<td>205</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>4-6 days</td>
<td>105</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>7-10 days</td>
<td>44</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>24</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 11: Time spent on Q compared to the agreement with the statement ‘As a result of my membership of Q, I can make the connections I need to undertake quality improvement work.’

<table>
<thead>
<tr>
<th>Time spent</th>
<th>Total agree</th>
<th>Neither</th>
<th>Total disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 day</td>
<td>78</td>
<td>23</td>
<td>29</td>
</tr>
<tr>
<td>1-3 days</td>
<td>196</td>
<td>24</td>
<td>11</td>
</tr>
<tr>
<td>4-6 days</td>
<td>98</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7-10 days</td>
<td>43</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>25</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 12: Time spent on Q compared to the agreement with the statement ‘Membership of Q has helped me to organise and/or undertake improvement activities.’

<table>
<thead>
<tr>
<th>Time spent</th>
<th>Total agree</th>
<th>Neither</th>
<th>Total disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 day</td>
<td>30</td>
<td>36</td>
<td>53</td>
</tr>
<tr>
<td>1-3 days</td>
<td>126</td>
<td>56</td>
<td>35</td>
</tr>
<tr>
<td>4-6 days</td>
<td>90</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>7-10 days</td>
<td>41</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>22</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 13: Time spent on Q compared to the agreement with the statement ‘Membership of Q has helped me to develop my knowledge and/or skills for improving quality.’

<table>
<thead>
<tr>
<th>Time spent</th>
<th>Total agree</th>
<th>Neither</th>
<th>Total disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 day</td>
<td>56</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>1-3 days</td>
<td>177</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>4-6 days</td>
<td>100</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7-10 days</td>
<td>42</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>24</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 14: Time spent on Q compared to the agreement with the statement ‘As a result of my membership of Q, I am able to share my knowledge and skills for improving quality in health and care with others.’

<table>
<thead>
<tr>
<th>Time spent</th>
<th>Total agree</th>
<th>Neither</th>
<th>Total disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 day</td>
<td>51</td>
<td>40</td>
<td>35</td>
</tr>
<tr>
<td>1-3 days</td>
<td>178</td>
<td>30</td>
<td>19</td>
</tr>
<tr>
<td>4-6 days</td>
<td>99</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7-10 days</td>
<td>43</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>26</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 15: Time spent on Q compared to the agreement with the statement ‘Without Q, I would still be able to get support for my improvement activities from other networks or organisations.’

<table>
<thead>
<tr>
<th></th>
<th>Total agree</th>
<th>Neither</th>
<th>Total disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 day</td>
<td>86</td>
<td>28</td>
<td>18</td>
</tr>
<tr>
<td>1-3 days</td>
<td>144</td>
<td>42</td>
<td>41</td>
</tr>
<tr>
<td>4-6 days</td>
<td>75</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>7-10 days</td>
<td>34</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>19</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 16: Time spent on Q compared to the agreement with the statement ‘Without Q, I would still feel just as inspired/energised to undertake improvement activities.’

<table>
<thead>
<tr>
<th></th>
<th>Total agree</th>
<th>Neither</th>
<th>Total disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 day</td>
<td>85</td>
<td>31</td>
<td>20</td>
</tr>
<tr>
<td>1-3 days</td>
<td>143</td>
<td>40</td>
<td>48</td>
</tr>
<tr>
<td>4-6 days</td>
<td>57</td>
<td>17</td>
<td>35</td>
</tr>
<tr>
<td>7-10 days</td>
<td>27</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>18</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 17: Time spent on Q compared to the agreement with the statement ‘Without Q, I would still be able to effectively undertake improvement activities within my organisation or professional network.’

<table>
<thead>
<tr>
<th></th>
<th>Total agree</th>
<th>Neither</th>
<th>Total disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 day</td>
<td>98</td>
<td>22</td>
<td>13</td>
</tr>
<tr>
<td>1-3 days</td>
<td>171</td>
<td>33</td>
<td>26</td>
</tr>
<tr>
<td>4-6 days</td>
<td>76</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>7-10 days</td>
<td>33</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>More than 10 days</td>
<td>19</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

H.9. Organisational benefit of Q

Members were asked whether they felt their colleagues and their organisation could benefit as a result of Q.

Members were asked how strongly they agreed with the following statements:

1. *I have used Q resources, learning or activities to undertake improvement activities within my own organisation or professional network.*

2. *Membership of Q has helped me (or my colleagues) increase the visibility or profile of improvement activities within my organisation or professional network.*
3. My or my colleagues’ participation in Q has resulted in a positive impact on the quality of health and/or care that my organisation or professional network delivers.

Group B respondents were asked whether they expected Q to have these organisational impacts. Figure 29 to Figure 34 provide the results from Group A and B for these questions.

Figure 29 and Figure 30 outline the level of agreement of respondents when asked if Q resources, learning or activities had been used in their organisations improvement activities (Group A), or either have been used or are expected to be used in the future (Group B). For Group A, two-thirds (66%) agreed with this statement to some extent, with a further 17% disagreeing to some extent. When Group B were asked whether they expected Q resources, activities and learning to be used in organisational improvement work, the level of agreement was higher than for Group A at 82%. Only 6% disagreed with this statement, and a smaller proportion report neither agreeing nor disagreeing than in Group A (9% compared to 12%).

**Figure 29: Member has used Q resources, activities or learning in improvement activities in member organisations (Group A only)**

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43 Question text: I have used Q resources, learning or activities to undertake improvement activities within my own organisation or professional network.
Figure 30: Member expects to use Q resources, activities or learning in improvement activities in member organisations (Group B)

Figure 31 and Figure 32 outline the results when members were asked whether they felt Q had helped to increase the visibility of improvement work in their organisation for Group A, or if members expected Q to increase this visibility for Group B. Figure 31 provides the results for Group A that shows that over half of respondents agreed with this statement to some extent (57%), and compared to other questions in this section, a relatively large proportion of respondents disagreed (21%). An additional 19% neither agreed nor disagreed with the statement.

44 Question text: I have used (or expect to use) Q resources, learning or activities to undertake improvement activities within my own organisation or professional network.
As with the previous question, when Group B respondents were asked whether they expected Q to help increase the visibility of improvement work in their organisation, a larger number than Group A agreed with the statement to some extent (83%). Only 3% of respondents disagreed with the statement, with nobody choosing the ‘Strongly disagree’ option.

---

45 Question text: Membership of Q has helped me (or my colleagues) increase the visibility or profile of improvement activities within my organisation or professional network.
Figure 32: Increase in visibility/profile of improvement activities expected as a result of Q membership (Group B Only)\textsuperscript{46}

\textsuperscript{46} Question text: I expect that membership of Q will help me (or my colleagues) increase the visibility or profile of improvement activities within my organisation or professional network. No respondent selected 'Strongly disagree' and so it is not represented in this graph.
Figure 33 and Figure 34 outline the results when respondents were asked if Q has positively impacted the quality of health and care provided by their organisation (Group A), or if they expected it to going forward (Group B). For Group A, over half of respondents (56%) agreed to some extent that Q has positively impacted health and care in their organisation, with 18% disagreeing to some extent. A similar proportion (20%) neither agreed nor disagreed with the statement.

When Group B was asked whether they expected Q to positively impact health and care, a larger proportion agreed to some extent (87%). Correspondingly, fewer disagreed with the statement (4%) or did not agree or disagree (5%).

Figure 33: Membership of Q has positively impacted the quality of health and care provided by members’ organisations (Group A only)\textsuperscript{47}

\textsuperscript{47} Question text: My or my colleagues’ participation in Q has resulted in a positive impact on the quality of health and/or care that my organisation or professional network delivers.
H.10. Benefit of Q for patients

Members who reported being a patient/service user representative were asked whether they felt Q reflects the needs of patients in a free-text box. Of the 20 patient/service user representatives who responded to the survey, 18 (90%) provided a response to this question. Of those who provided a response, 4 (22%) indicated that Q does not represent the needs of patient and service users, 2 (11%) indicated that Q does represent the needs of patient and service users and 3 (17%) indicated that they were unsure of whether or not Q meets the needs of this population. The other nine valid answers did not express clearly positive or negative feelings about Q’s benefit for patients. Their views are not counted here, but are included in the analysis below. However, it is important to note here than 20 is a very small sample size and results should be interpreted with this in mind. These results may not reflect all service users within Q.

Of the 18 respondents to this question, 4 (22%) provided a view on **what Q already does well** in terms of serving the needs of patient/service user representatives. Responses in this category brought up comments on how Q:

- Provides opportunities for patients and service users to build up their network and discuss issues with like-minded individuals (1)

---

48 Question text: *I expect that my or my colleagues’ participation in Q will result in a positive impact on the quality of health and/or care that my organisation or professional network delivers.*

49 Question text: *To what extent do you feel Q reflects the needs of patients? In that regard, what does Q do well and what could it do better?*
• Helps patients understand their own needs, which helps them to improve services for themselves and other patients (1)

• Engages patients at a deeper level than just ‘lip service’ (1)

• Effectively supports projects that are co-produced by patients and service users (1).

Of the 18 respondents to this question, 13 (72%) provided a view on where Q can do better in terms of supporting the needs of patient/service user representatives. This included six respondents discussing the need for Q to develop better strategies to engage patients and service users more deeply and to become more accessible to this population. Similarly, two respondents identified that having more patient and service users within the Q community would make Q more valuable for this population. Respondents also identified that Q can better support patients and service users through Q’s work with healthcare professionals (4), including by providing more resources on co-production to people in the health and social care sector and by focusing on culture change in healthcare settings.

Most health care professionals have no idea what coproduction is. Q can help develop some resources so that people understand how to do coproduction. These need to avoid the simplistic stuff that everyone already knows — “why you do coproduction”, “what benefits you get from coproduction”. It needs to give hard and crunchy information about how to find patients, how to ask them to be involved, what reasonable adjustments need to be made, where to get information about DWP benefits. We really need something that talks about the nuts and bolts… Some patients struggle to establish credibility. They may be well known by one local trust, but not by the CCG or STP or other local trusts. Q could develop bits of work to help patients put something in a portfolio / on a CV to help establish credibility.

One respondent felt Q has a role to play in speaking up more for patient needs within the health and social care system.

H.11. Impact of Q on health and care

Members were asked how confident they felt in personally benefiting (or their colleagues benefiting) or in their expectations of benefiting, from being a part of Q in the following areas:50

1. Your ability to undertake activities relating to improving quality
2. Your own skills and knowledge
3. The skills and/or knowledge of those you work with
4. The strength or size of your own professional network
5. The strength or size of the network of quality improvers in your region/local area
6. The visibility of improvers in your organisation/professional network

50 Group A respondents were asked whether Q has already had impacts in these areas, whereas Group B were asked whether they thought Q could have an impact in these areas in the future.
7. *The visibility of improvers in the UK health and care system*

8. *The quality of health and/or care that you or those you work with deliver*

9. *The quality of health and/or care delivered by the UK health and care system.*

Group A and Group B were analysed separately to assess whether there were any major differences between the expectations of newer members of the potential positive impact of Q and the level of agreement for perceived existing impact from those who had been involved in Q for over a year. These results are presented in Figure 35 and Figure 36.

Figure 35 outlines the confidence Group A respondents reported when asked about different possible impacts of Q to date. As this shows, respondents were most confident that Q has a positive impact on their own skills and/or knowledge (72% selected ‘Very confident’ or ‘Moderately confident’). Members were also confident that Q positively benefits their ability to undertake activities relating to improving quality (68% selected ‘Very confident’ or ‘Moderately confident’), as well as the visibility of improvers in the UK health and care system (66% selected ‘Very confident’ or ‘Moderately confident’). Interestingly, of all statements, respondents reported least confidence in Q’s ability to positively impact the visibility of improvers in their organisation/professional network (54% selected ‘Very confident’ or ‘Moderately confident’), though this still made up the majority (over 50%) of overall Group A responses. The second lowest proportion of confidence was attributed to Q’s ability to positively impact the quality of health and/or care that they or their colleagues deliver (54% selected ‘Very confident’ or ‘Moderately confident’).
Figure 35: Members’ confidence that Q has a positive impact (Group A only)  

Question text: To date, how confident are you that Q has had a positive impact on the following areas? The data table for this question can be found in Section H.15.
Figure 36 outlines the results of asking Group B their confidence that Q will have an impact in the future. Compared to Group A, Group B are generally more confident that Q will have a positive impact in all of the outlined areas than the confidence Group A felt about whether Q was positively impacting already. Group B respondents were most confident that Q would have positive impacts on their own skills/knowledge (88% selected ‘Very confident’ or ‘Moderately confident’) the strength or size of their own professional network (87% selected ‘Very confident’ or ‘Moderately confident’) and their ability to undertake activities relating to improving quality (86% selected ‘Very confident’ or ‘Moderately confident’). On the whole, confidence that Q could impact positively in the other areas did not fall below 71% for any of the options, with the lowest proportion of these (71%) attributed confidence that Q will positive impact the skills and/or knowledge of those they work with, followed by confidence that Q would positively impact the visibility of improvers in their organisation/professional network (72%).
Figure 36: Confidence in expected impacts of Q (Group B only)\textsuperscript{52}

Number of observations by question in descending order (top to bottom):
139, 140, 139, 140, 137, 140, 138, 140, and 140

\textsuperscript{52} Question text: How confident are you that Q will have a positive impact on the following areas? The data table for this question can be found in Section H.15H.15.
Sub-analysis: Type of engagement compared to the agreement with statements on the impact of Q

To understand whether there is an association between the type of engagement with Q and the perceived impact of Q for members, we compared the responses to these questions. The results of these sub-analyses are presented in Table 18 to Table 26 below. Note that these tables represent the data with the ‘Don’t know’ responses and missing data excluded.

As these tables show, in general members agreed to some extent that Q provides the range of positive impacts specified in the survey questions. However, it is interesting to note that members reporting occasional use of Q resources (rather than actively participating or leading activities) seem to generally be less confident that Q positively impacts them and their colleagues. This is particularly evident for Table 20 to Table 26, in which 30% or more of members who occasionally used Q resources did not feel confident that that the positive impacts of Q in the survey questions were occurring. These relate to: the skills and knowledge of individuals members work (41% of members who occasionally use resources were not confident that this was positively impacted); the strength and size of their own network (36%); the strength and size of improvers networks in their region (36%); the visibility of improvers in their organisation/professional network (44%); the visibility of improvers in the UK health and care system (32%); the quality of health and/or care that they or those they work with deliver (4 %); and the quality of health and/or care delivered by the UK health and care system (37%).

Table 18: Time spent on Q compared to the confidence members have in their ability to undertake activities relating to improving quality as a result of being a part of Q

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I contributed significantly to help shape and lead activities</td>
<td>32</td>
</tr>
<tr>
<td>I actively participated in a range of activities, but did not help to organise</td>
<td>70</td>
</tr>
<tr>
<td>I occasionally made use of a small number of resources and activities</td>
<td>205</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
</tr>
</tbody>
</table>

Table 19: Time spent on Q compared to the confidence members have in their own skills and knowledge as a result of being a part of Q

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I contributed significantly to help shape and lead activities</td>
<td>30</td>
</tr>
<tr>
<td>I actively participated in a range of activities, but did not help to organise</td>
<td>70</td>
</tr>
<tr>
<td>I occasionally made use of a small number of resources and activities</td>
<td>223</td>
</tr>
<tr>
<td>Other</td>
<td>34</td>
</tr>
</tbody>
</table>
Table 20: Time spent on Q compared to the confidence members have in the skills and knowledge of those they work with as a result of being a part of Q

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Confident</th>
<th>Not confident</th>
<th>% Confident</th>
<th>% Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I contributed significantly to help shape and lead activities</td>
<td>27</td>
<td>7</td>
<td>79.41%</td>
<td>20.59%</td>
</tr>
<tr>
<td>I actively participated in a range of activities, but did not help to organise</td>
<td>63</td>
<td>14</td>
<td>81.82%</td>
<td>18.18%</td>
</tr>
<tr>
<td>I occasionally made use of a small number of resources and activities</td>
<td>161</td>
<td>110</td>
<td>59.41%</td>
<td>40.59%</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
<td>31</td>
<td>43.64%</td>
<td>56.36%</td>
</tr>
</tbody>
</table>

Table 21: Time spent on Q compared to the confidence members have in the strength or size of their own professional network as a result of being a part of Q

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Confident</th>
<th>Not confident</th>
<th>% Confident</th>
<th>% Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I contributed significantly to help shape and lead activities</td>
<td>32</td>
<td>4</td>
<td>88.89%</td>
<td>11.11%</td>
</tr>
<tr>
<td>I actively participated in a range of activities, but did not help to organise</td>
<td>71</td>
<td>7</td>
<td>91.03%</td>
<td>8.97%</td>
</tr>
<tr>
<td>I occasionally made use of a small number of resources and activities</td>
<td>182</td>
<td>101</td>
<td>64.31%</td>
<td>35.69%</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>30</td>
<td>50.82%</td>
<td>49.18%</td>
</tr>
</tbody>
</table>

Table 22: Time spent on Q compared to the confidence members have in the strength or size of the network of quality improvers in their region/local area as a result of being a part of Q

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Confident</th>
<th>Not confident</th>
<th>% Confident</th>
<th>% Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I contributed significantly to help shape and lead activities</td>
<td>31</td>
<td>3</td>
<td>91.18%</td>
<td>8.82%</td>
</tr>
<tr>
<td>I actively participated in a range of activities, but did not help to organise</td>
<td>60</td>
<td>15</td>
<td>80.00%</td>
<td>20.00%</td>
</tr>
<tr>
<td>I occasionally made use of a small number of resources and activities</td>
<td>175</td>
<td>99</td>
<td>63.87%</td>
<td>36.13%</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
<td>33</td>
<td>46.77%</td>
<td>53.23%</td>
</tr>
</tbody>
</table>

Table 23: Time spent on Q compared to the confidence members have in the visibility of improvers in their organisation/professional network as a result of being a part of Q

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Confident</th>
<th>Not confident</th>
<th>% Confident</th>
<th>% Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I contributed significantly to help shape and lead activities</td>
<td>31</td>
<td>4</td>
<td>88.57%</td>
<td>11.43%</td>
</tr>
<tr>
<td>I actively participated in a range of activities, but did not help to organise</td>
<td>53</td>
<td>21</td>
<td>71.62%</td>
<td>28.38%</td>
</tr>
<tr>
<td>I occasionally made use of a small number of resources and activities</td>
<td>155</td>
<td>123</td>
<td>55.76%</td>
<td>44.24%</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>34</td>
<td>42.37%</td>
<td>57.63%</td>
</tr>
</tbody>
</table>
Table 24: Time spent on Q compared to the confidence members have in the visibility of improvers in the UK health and care system as a result of being a part of Q

<table>
<thead>
<tr>
<th></th>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I contributed significantly</td>
<td>32</td>
<td>4</td>
</tr>
<tr>
<td>to help shape and lead</td>
<td>88.89%</td>
<td>11.11%</td>
</tr>
<tr>
<td>activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I actively participated in</td>
<td>68</td>
<td>8</td>
</tr>
<tr>
<td>a range of activities, but</td>
<td>89.47%</td>
<td>10.53%</td>
</tr>
<tr>
<td>did not help to organise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I occasionally made use of</td>
<td>194</td>
<td>90</td>
</tr>
<tr>
<td>a small number of resources</td>
<td>68.31%</td>
<td>31.69%</td>
</tr>
<tr>
<td>and activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>35</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>57.38%</td>
<td>42.62%</td>
</tr>
</tbody>
</table>

Table 25: Time spent on Q compared to the confidence members have in the quality of health and/or care that they or those they work with deliver as a result of being a part of Q

<table>
<thead>
<tr>
<th></th>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I contributed significantly</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>to help shape and lead</td>
<td>75.00%</td>
<td>25.00%</td>
</tr>
<tr>
<td>activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I actively participated in</td>
<td>58</td>
<td>13</td>
</tr>
<tr>
<td>a range of activities, but</td>
<td>81.69%</td>
<td>18.31%</td>
</tr>
<tr>
<td>did not help to organise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I occasionally made use of</td>
<td>158</td>
<td>113</td>
</tr>
<tr>
<td>a small number of resources</td>
<td>58.30%</td>
<td>41.70%</td>
</tr>
<tr>
<td>and activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>41.67%</td>
<td>58.33%</td>
</tr>
</tbody>
</table>

Table 26: Time spent on Q compared to the confidence members have in the quality of health and/or care delivered by the UK health and care system as a result of being a part of Q

<table>
<thead>
<tr>
<th></th>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>I contributed significantly</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td>to help shape and lead</td>
<td>76.47%</td>
<td>23.53%</td>
</tr>
<tr>
<td>activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I actively participated in</td>
<td>57</td>
<td>17</td>
</tr>
<tr>
<td>a range of activities, but</td>
<td>77.03%</td>
<td>22.97%</td>
</tr>
<tr>
<td>did not help to organise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I occasionally made use of</td>
<td>172</td>
<td>101</td>
</tr>
<tr>
<td>a small number of resources</td>
<td>63.00%</td>
<td>37.00%</td>
</tr>
<tr>
<td>and activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>45.90%</td>
<td>54.10%</td>
</tr>
</tbody>
</table>

H.11.2. Sub-analysis: Use of Q resources compared to perceived personal impacts of Q

To understand whether there is an association between the use of certain Q resources and the perceived personal impact of Q for members, we compared the responses to these questions. Due to the large number of comparisons that could be analysed for these questions, we focused on five types of Q resources (Q Lab, Q visits, submitting a Q Exchange bid, SIGs/online groups and meeting other Q members). We also focused the analysis on the personal impacts for Q members, i.e. members ability to undertake improvement activities, their own skills/knowledge and the strength/size of their own professional network. The results of these sub-analyses are presented in Table 27 to Table 41 below. Note that these tables represent the data with the ‘Don’t know’ responses and missing data excluded.
Table 27 to Table 29 show the analysis when comparing the perceived personal impacts with engagement with Q Lab. As this shows, the percentage of members with confidence that Q has personal positive impacts on members is fairly equal for those involved in Q Lab and those not. There is a slightly bigger difference in members confidence that Q positively impacts their own skills and knowledge, with 83% of members that used Q Lab agreeing with this statement and 75% of members who haven’t used Q Lab agreeing with this statement.

Table 27: Use of Q Lab compared to confidence that Q positively impacts members ability to undertake improvement activities

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>83</td>
<td>26</td>
</tr>
<tr>
<td>Have not used</td>
<td>247</td>
<td>96</td>
</tr>
</tbody>
</table>

Table 28: Use of Q Lab compared to confidence that Q positively impacts members own skills and knowledge

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>91</td>
<td>19</td>
</tr>
<tr>
<td>Have not used</td>
<td>260</td>
<td>85</td>
</tr>
</tbody>
</table>

Table 29: Use of Q Lab compared to confidence that Q positively impacts the strength/size of members professional network

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>76</td>
<td>31</td>
</tr>
<tr>
<td>Have not used</td>
<td>234</td>
<td>111</td>
</tr>
</tbody>
</table>

Table 30 to Table 32 show the analysis when comparing the perceived personal impacts with engagement with Q visits. Compared to the comparisons for Q Lab, the confidence in the personal impacts of Q slightly different depending on whether members had engaged with Q visits or not, with those attending Q visits having slightly higher confidence that Q impacts members positively. This is particularly evident for whether Q supports members’ ability to undertake improvement activities, in which 83% of members who had participated in a Q visit agreed with, whereas this dropped to 69% for members who had not been on a Q visit.

Table 30: Use of Q visits compared to confidence that Q positively impacts members ability to undertake improvement activities

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>112</td>
<td>23</td>
</tr>
<tr>
<td>Have not used</td>
<td>219</td>
<td>98</td>
</tr>
</tbody>
</table>
Table 31: Use of Q visits compared to confidence that Q positively impacts members own skills and knowledge

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>120</td>
<td>17</td>
<td>87.59%</td>
</tr>
<tr>
<td>Have not used</td>
<td>231</td>
<td>87</td>
<td>72.64%</td>
</tr>
</tbody>
</table>

Table 32: Use of Q visits compared to confidence that Q positively impacts the strength/size of members professional network

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>103</td>
<td>32</td>
<td>76.30%</td>
</tr>
<tr>
<td>Have not used</td>
<td>208</td>
<td>109</td>
<td>65.62%</td>
</tr>
</tbody>
</table>

Table 33 to Table 35 show the analysis when comparing the perceived personal impacts with submitting a bid for Q Exchange. For those members submitting Q Exchange bids and those not, the agreement that Q positively impacts themselves is fairly similar across these sub-analyses. There is a slight difference in members confidence that Q helps to strengthen/widen their professional networks, in which 79% of members who had submitted a Q Exchange bid agreed with this statement, whereas 64% of members who did not submit a bid agreed with this statement.

Table 33: Bidding for Q Exchange compared to confidence that Q positively impacts members ability to undertake improvement activities

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>105</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td>Have not used</td>
<td>225</td>
<td>93</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 34: Bidding for Q Exchange compared to confidence that Q positively impacts members own skills and knowledge

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>108</td>
<td>28</td>
<td>79.41%</td>
</tr>
<tr>
<td>Have not used</td>
<td>242</td>
<td>76</td>
<td>76.10%</td>
</tr>
</tbody>
</table>

Table 35: Bidding for Q Exchange compared to confidence that Q positively impacts the strength/size of members professional network

<table>
<thead>
<tr>
<th>Confident</th>
<th>Not confident</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>107</td>
<td>28</td>
<td>79.26%</td>
</tr>
<tr>
<td>Have not used</td>
<td>202</td>
<td>114</td>
<td>63.92%</td>
</tr>
</tbody>
</table>
Table 36 to Table 38 show the analysis when comparing the perceived personal impacts with engaging with SIGs/other online groups. Compared to analysis of the other Q resources, there are slightly bigger differences between those members that use SIGs/online groups (except for connecting with Q members) and those who do not. For members using SIGs/online groups, there was greater confidence that Q positively impacts their ability to undertake improvement work (80%) compared to members who did not use SIGs/online groups (67%). In addition, 85% of members who had used SIGs/online groups felt that Q positively impacts their skills and knowledge; however, this dropped to 70% for members who had not used these resources. The difference was slightly lower when exploring the impact on the size/strength of members networks, with 75% of members who has used SIGs/online groups feeling confidence that Q supports development of members networks, whereas 63% of members who had not used this resource felt this way.

Table 36: Using SIGs/other online groups compared to confidence that Q positively impacts members ability to undertake improvement activities

<table>
<thead>
<tr>
<th></th>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>172</td>
<td>42</td>
</tr>
<tr>
<td>Have not used</td>
<td>159</td>
<td>79</td>
</tr>
</tbody>
</table>

Table 37: Using SIGs/other online groups compared to confidence that Q positively impacts members own skills and knowledge

<table>
<thead>
<tr>
<th></th>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>183</td>
<td>32</td>
</tr>
<tr>
<td>Have not used</td>
<td>167</td>
<td>72</td>
</tr>
</tbody>
</table>

Table 38: Using SIGs/other online groups compared to confidence that Q positively impacts the strength/size of members professional network

<table>
<thead>
<tr>
<th></th>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>159</td>
<td>53</td>
</tr>
<tr>
<td>Have not used</td>
<td>151</td>
<td>88</td>
</tr>
</tbody>
</table>

Table 39 to Table 41 show the analysis when comparing the perceived personal impacts with meeting and contacting other Q members. As with the use of SIGs/online groups, there are larger differences between those members who have used Q to connect with other members and the perceived personal impact of Q. For members that had used Q to connect to other members, 79% felt that Q positively impacts their ability to undertake improvement activities; however, this dropped to 51% of members who had not used Q for this purpose. Similar results were seen when members were asked whether Q has supported the strengthening/widening of their professional network, in which 77% of respondents that had used Q to connect to other members agreed that Q has had this impact, but only 39% of respondents who had not used Q for this purpose felt this way. There was also a difference, albeit smaller, when members were asked
whether Q had supported their own skills/knowledge, in which 82% of respondents that had used Q to connect to other members agreed with this statement, whereas 62% of respondents that had not used Q in this way agreed with the statement. However, it should be noted when interpreting these results that only a small number of respondents reported not having used Q to connect with other members.

Table 39: Meeting and contacting Q members compared to confidence that Q positively impacts members ability to undertake improvement activities

<table>
<thead>
<tr>
<th></th>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>283</td>
<td>73</td>
</tr>
<tr>
<td>Have not used</td>
<td>48</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 40: Meeting and contacting Q members compared to confidence that Q positively impacts members own skills and knowledge

<table>
<thead>
<tr>
<th></th>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>292</td>
<td>65</td>
</tr>
<tr>
<td>Have not used</td>
<td>60</td>
<td>37</td>
</tr>
</tbody>
</table>

Table 41: Meeting and contacting Q members compared to confidence that Q positively impacts the strength/size of members professional network

<table>
<thead>
<tr>
<th></th>
<th>Confident</th>
<th>Not confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have used</td>
<td>278</td>
<td>82</td>
</tr>
<tr>
<td>Have not used</td>
<td>36</td>
<td>57</td>
</tr>
</tbody>
</table>

H.11.3. Examples of impact

Members in Groups A and B were provided with a free-text response box to provide specific examples of how Q had impacted themselves or their colleagues.53

Of the 286 members (from Groups A and B) who provided a valid answer to this question,54 40 members (14%) either specified that Q had not impacted them or their colleagues, or reported negative impacts of Q, and 13 members (5%) reported that Q has not yet impacted them as they have not been a member for a long enough time period. The majority of respondents, 233 (81%), provided some indication of the impact Q has had on themselves or their colleagues. Of these 233 individuals, 31 members (13%) provided specific examples of how Q has impacted their work, such as how they have used Q resources for a particular project or in their work, whereas the other 202 (87%) members provided examples of more generalised

53 Question text: Can you provide any specific examples of the impact Q has had on you, your colleagues or your organisation?
54 527 members did not provide a response to this question. Responses were categorised as invalid if they did not clearly provide an answer to the question or were irrelevant (n=27 across both groups).
impacts, such as a widening of their professional network, increased knowledge and sharing of learning among organisation. The types of more generalised impacts of Q are:55

- Opportunities for improving knowledge and learning (107, 53%)
- Widening of professional network (80, 40%)
- Opportunities to share learning within and outside of organisation (44, 22%)
- Support wider organisational QI work and projects (29, 14%)
- Increased confidence in ability to take part and lead QI work (10, 5%)
- Raise the profile of QI work within the organisation (8, 4%)
- Encouraging and promoting clinical staff involvement in QI (6, 3%)
- Support QI to become an organisational priority (6, 3%)
- Contribute to career progression (3, 1%)
- Support for funding opportunities (outside of Q Exchange) (2, 1%)
- Increase capacity for QI work in the organisation (2, 1%)
- Support to publish academic papers (2, 1%)
- Support development of a new organisational QI strategy (2, 1%)
- Encourage service user involvement in QI (1, 0%)
- Increase credibility of QI work (1, 0%).

Respondents often referred to specific Q activities and resources when outlining the impact Q has on their work, including:

- Q Exchange (38, 19%)
- Liberating Structures workshops (20, 10%)
- Site visits (18, 9%)
- SIGs (9, 4%)
- Events (9, 4%)
- RCTs (7, 3%)
- Webinars (4, 2%)
- Journal access (3, 1%)
- Q Labs (2, 1%)

55 These percentages do not add up to 100% as some responses covered more than one category.
Box 1 and Box 2 provide some examples of impact reported by members (some highly specific examples cannot be provided to protect anonymity).56

Box 1: Examples of specific impacts attributed to Q

- I was interviewing for a role for someone to lead some scaling of improvement work and I was wearing my Q badge – during the interviews one candidate noticed it and started up a really useful conversation about improvement that gave me confidence that she understood the nature of the work and could hit the ground running. The badge was a handy short-cut that enabled the identification of shared values and approaches to improving care.
- Development of a QI academy at local foundation trust.
- I attended the national meeting last year and the Liberating Structures workshop. Then the training day at the Health Foundation. I have since spread through the Trust and will be running taster workshops on our QI day this autumn.
- Q helped me set up a platform for excellence reporting on my unit, which is now being rolled out trustwide. It has had a measurable impact on staff morale.
- Local Q member set up a QI Delivery group which shares learning resources and approaches with other members in the group.
- Q membership has enabled me to demonstrate wider linkages to QI networks and resources. It has also enabled a charitable care provider to be linked to NHS resources and expertise which has been good. It has enabled an outward looking organisation to develop.
- I have found the resources very useful to teach patient safety and human factors in my organisation and for medical students.
- Through Q I was exposed to Liberating Structures. I now utilise these regularly in my leadership practice, and I have found they spread virally! With two fellow Q members I am developing a Midlands-based user group.
- Psychology of organisational change improved through my direction connection with a Q colleague in England, we provide data masterclasses through the Q platform in Northern Ireland, we help promote Q as the preferred ‘boundariless’ network for improvers.
- So I went to a master class on appreciative inquiry which I then used in various workshops – I would not have felt confident to try the skills otherwise.
- Through some of the webinars [redacted – named individual] and Q visits/events such as Liberating Structures and behavioural insights, I have applied new knowledge to QI workshops and other sessions I facilitate/teach.
- Telephone conversation with a doctor in Scotland who shared the same QI interest as me but is much more experienced was wonderful. I hope to meet him someday and show him the value of that call.
- My team is an improvement team traditionally working with a key group of hospital colleagues, Q has enabled us to identify, target and engage with other key players we can work with to achieve joint improvement goals and in time hopefully evolve some more focused groups and working in our speciality.
- Support to access online resources, and connections through the Q community have helped at the planning and evaluation stage of QI projects in the organisation. The sharing of ideas has also helped commence programmes of work.

56 The responses in the box are verbatim responses from survey participants; however, spelling and grammatical errors have been corrected.
Box 2: Examples of generalised impacts attributed to Q

- The national meetings are good for networking. The Random Coffee Trials are a good way of connecting with individuals.
- Is integrated into our regional improvement network. I’ve got to know colleagues in the same organisation which I wouldn’t otherwise have had the opportunity to do.
- Used QI methodology to engage clinicians to aid in improving health and seeking to be innovative.
- Being part of the co-production and joy in work forums. Gaining knowledge and sharing ideas when scoping for these projects to introduce into my organisation.
- Q has helped me with a number of projects that I have been working on to find resources and pull on other people’s experiences.
- I am new to Q and so far the benefits has been to have instant access to all types of improvement initiatives taking place across the country and being able to learn and discuss these with colleagues in the organisation.
- Helped us make connections to colleagues in different parts of the country who were working on a related project.
- Q has had a big impact on raising the profile of QI in my organisation as we now gave several Q members who not only support each other but have broadened the QI support network locally with other Q members we each know.
- Being part of Q has allowed our team to access resources that would otherwise be difficult or costly to access - such as insight visits, liberating structures workshops, Institute for Healthcare Improvement (IHI) and BMJ resources, and also a wide network of people working on things that we are interested in.
- Q Exchange opens opportunity for cross disciplines cross boundaries conversation and its first and important step to system thinking, building relationships for long term good.
- Yes, more and more colleagues in my organisation are becoming aware of QI or undertaking small projects to improve services within my organisation. I am now more conscious of QI and constantly thinking of what needs to be done to improve the service for the service users and colleagues.
- Increased access to training. Data training and Liberating Structures this year were excellent and skills learnt have been embedded in my day to day work.
- I can see that Q has given individuals in my organisation the pride, confidence, and energy to pursue improvement work at a different level to what I had seen previously. I now see a difference in depts. who have a Q compared to those without.
- Provided funds for open access – work would not have been published otherwise. Helped me connect with others in the area working in QI. Led to joint bid applications. Learning and sharing from webinars.

18 members (6%) felt that Q has a negative impact. This often relates to feeling isolated from the community, for example feeling excluded due to job role, lack of other Q members in their organisation or having difficulties covering the financial costs to attend events and workshops. Others have difficulties in dedicating time to use Q resources, activities or attend events, or report challenges in engaging colleagues with Q.
Members were provided with a free-text response box to provide suggestions for how Q could change or improve to increase its likelihood of having a positive impact. 293 respondents (from Groups A and B) provided a valid answer to this question. Of them, 258 (88%) provided at least one change that they felt Q could make to improve or achieve greater impact. The most common improvement identified by respondents was to make Q easier to navigate or more accessible, which was identified by 45 respondents (15%). This category included views that Q should make their website easier to navigate, that there should be a clearer communication around Q resources, that it should be easier to identify other Q members and their areas of expertise, and that Q should be more accessible in terms of the time and location of events. While many respondents commented on the need to make Q more accessible and easier to navigate, respondents varied in how they thought this should be done. For example, some respondents commented that there were too many communications from Q, resulting in a cluttered inbox, while other respondents mentioned that there was no communication from Q about resources and events, which resulted in them missing out on potentially useful opportunities. Examples provided by respondents of how Q can improve its accessibility are provided in Box 3 below.

Box 3: Examples of how Q can be more accessible

- Needs to be easier to navigate the things on offer! It’s very confusing to use and then leads to it being a bit ‘cliquey’ at times as only those with a decent chunk of time to invest really get to understand how to benefit from it. I’ve been a member for over a year and still don’t really understand what’s on offer, what’s relevant to me, what I can gain from each offer; or how then to access them. Your website needs to be clearer from the high level welcome pages! If I have half an hour free I spend it wondering what to engage in!! Feels a bit to me like a great opportunity that’s missing the mark.
- Signpost different initiatives through Twitter using Q-specific handles.
- Easier to access forum please. Password protocol is tricky and puts me off using the site. Also suggest making explicit what is required and desired to help encourage postings.
- There is too much ‘noise’. Make communications succinct and tailored, clean up the emails so the messages are clearer.
- Diversify the language and therefore members of the community.
- I do not use Twitter and do not want to use it as a means of communication, which means I miss out on a great deal of activity.
- When I try to join in discussion groups no one responds. Events are few and far between and geographically far away/fall when I am at work. I was so excited to join Q but hear very little from them and see very little online participation.
- I find it impossible to find out who Qs are in my organisation other than asking around. Is there a better way for us to have an up to date record of Qs? I would like more local events. I’m not sure I see very many so haven’t been to more than a couple.

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57 Question text: How could Q change or improve to make it more likely to have a positive impact in these areas?
58 An additional 48 responses were classified as ineligible or not relevant to the question.
Another common improvement that respondents identified was the need for Q to have more of a local focus in order to achieve impact, which was identified by 41 respondents (14%). Suggestions to increase the local focus of Q included holding more local events, networks and activities, as well as more connection with local trusts, integrated care systems and hospitals. Some of these respondents reflected that more local events and an increasingly local focus would lead to more action on a local level by bringing Q members within a region together and by allowing more ‘doing’ to take place between large national events.

The third most commonly identified improvement identified by respondents is for Q to improve its communication to increase its visibility and profile within the health and social care system, which was mentioned by 40 respondents (14%). Many of these respondents reflected that Q lacks visibility to senior leaders in the NHS, or that Q has limited reach in the wider system. Along with general promotion of Q, respondents commented that sharing success stories of what is happening in Q may help with communication efforts. Examples provided by respondents on how Q can improve external communications are provided in Box 4 below.

**Box 4: Examples of how Q can improve communications**

- Needs to raise the profile, maybe by making controversial statements?
- I think Q still has a limited reach, with lots of people on the front line being unaware of Q’s existence.
- Q could deliver more events that have a strong branding associated, and then make sure that the outputs of these events are widely shared.
- Feels like Q is doing a lot of excellent work, so much that I find it difficult to keep up with everything. This is due to lack of time and to other commitments on my own part, however. My main role is not improvement based, therefore I find that fewer people are familiar with Q. Perhaps this is different in the improvement sector, but perhaps more could be done to raise profile of Q to other healthcare professionals?
- Get out there, it’s in a silo like a secret society.
- It would be great to see more opportunities for building skills and capability. Perhaps the successful Exchange projects could do more to publicise how they are getting on and the sustainability of their work beyond Q Exchange.
- I often forget about Q. I think it would be useful to send a message to Q members to alert them to work that is underway in a similar field/geographical area.

Respondents also commented on other ways that Q can improve or better achieve impact. Members suggested that Q should (in decreasing order of how many respondents mentioned an improvement):

- Connect more with the NHS (including connecting with system leaders, frontline staff and trusts) (27, 9%).
- Offer new resources to members (including podcasts, thematic reports, project management courses and other training, troubleshooting sessions, accreditation frameworks) (25, 9%).
- Recruit new and more diverse members into Q (24, 8%).
Achieve more tangible outcomes/impacts from Q (including clearer impacts on patient outcomes and service delivery) (23, 8%).

Expand its geographic focus outside of London and the South of England (22, 8%).

Create more links with external organisations also working on improvement (18, 6%).

Better engage members (including by targeting members outside of medical professions, members in senior management positions, members in patient and public involvement and more diverse membership) (18, 6%).

Organise more events or allow more places on events such as site visits (17, 6%).

Create more opportunities or projects in specific areas (e.g. paediatrics, improvement science, secondary care, education, primary care, health inequalities) (16, 5%).

Foster less elitism or less of a feeling of cliques within Q membership (14, 5%).

Establish a clearer vision and strategic purpose for what Q is and what it is trying to accomplish (11, 4%).

Incorporate more evidence into Q strategy (including evidence from the current evaluation of Q and from improvement science) (10, 3%).

Foster deeper engagement with patients (10, 3%).

Expand the QI skills of Q members (8, 3%).

Provide members funding to allow them to attend events (6, 2%).

Improve the management and organisation of the central Q team (5, 2%).

Although not directly relevant to the question, 53 of the 293 respondents to this question (18%) also identified a number of changes external to Q that are needed in order for Q to achieve more impact. These external changes identified by respondents include: the need for the respondent to have more time/capacity to get more involved with Q (mentioned by 37, or 13% of respondents), the need for more organisational support to get involved with Q (mentioned by 11, or 4% of respondents), and the fact that Q has not had an impact for the respondent because their primary work is not relevant to improvement (mentioned by 7, or 2% of respondents).

H.13. Q Exchange

Respondents were asked whether and how they had engaged with Q Exchange in 2018 and/or 2019 and whether Q Exchange offers a unique funding opportunity and what value it provided to those supporting bidding teams.
H.13.1. Participation in Q Exchange

Members were asked how, if at all, they had been involved in Q Exchange for 2018 or 2019. The options were:

1. Yes, I was part of a team who bid for funding
2. I submitted an idea, but ultimately did not submit a full application
3. I provided comments to bidding teams
4. I signed up as a supporter for one or more projects
5. No.

The responses to this question are outlined in Figure 37. As this graph shows, the majority of respondents did not have any involvement in Q Exchange (54%). Out of those that were involved in Q Exchange in some capacity, most were involved in submitting a bid (18%). The same proportion of respondents provided comments to teams as to those supporting projects (12% for both). The smallest proportion of respondents submitted an idea but not a full bid (4%).

Figure 37: Involvement in Q Exchange

59 Question text: Have you participated in the Q Exchange programme in 2018 or 2019? Please select all that apply.
H.13.2. Value of Q Exchange

For all members who reported being involved in Q Exchange in any capacity, a free-text response box was provided to explore whether members felt Q Exchange is a unique funding opportunity in the area of health and social care. 186 respondents provided 208 free-text responses to this question and their responses can be broadly categorised as:

- 167 positive
- 41 negative.

These are analysed below. It should be noted that although participants were asked to comment specifically on the uniqueness of Q Exchange, many provided broader comments on their overall thoughts and experiences of Q Exchange. These have been included and discussed here.

Positive responses

The positive views expressed about the uniqueness of Q Exchange focused on a range of areas. Nearly half of respondents (n=48, 29% of the positive responses) stated that Q Exchange is a more collaborative means of applying for funding compared to other funding opportunities. This included the ability to collaborate within project teams, but also to gather feedback and support from the wider Q community on the project web pages. Five respondents specifically commented on the ability to refine ideas contributes to development of well thought out and planned projects (3% of the positive comments), and three felt that providing feedback is also beneficial to the individual providing the support, not just the bidding teams (2% of positive comments).

I think the emphasis on input from the Community, the opportunity to access the wide range of expertise available in the Q Community, is really helpful. It really supports that ethos of all being in it together so that, while everyone is in competition with each other for that funding, it still feels supportive. Very different to applying for, for example, HEE [Health Education England] funding, where it does not feel remotely supportive and as though it is being made difficult to apply for funding.

A number of respondents commented on the nature of the ideas submitted to Q Exchange (n=29). It was felt that new, untested ideas can be submitted, without the need to demonstrate success in practice before requesting funding (17% of positive responses). In addition, 22 respondents (13% of positive responses) felt that Q Exchange offers funding to projects that are not the ‘usual suspects’ and that this is one of very few funding opportunities explicitly for improvement work. Relatedly, six respondents commented that accessing non-NHS funding for improvement work is highly beneficial in the current financial constraints of the NHS (4% of positive responses).

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60 Question text: Do you feel that the Q Exchange model of funding offers something unique in the health and social care landscape? If yes, in what way? If no, why not?

61 An additional four responses were classified as ineligible or not relevant to the question. The number of responses do not add up to 186 as some free-text responses included both positive and negative comments.
I think it supports those with good ideas that haven’t been able to access funding in the conventional way, to try and get their idea/innovation up and running as a test to see if it works/or not.

An aspect of Q Exchange respondents often commented on as a positive aspect is the democratic, equal process of submitting an application and voting for projects, highlighted by 47 respondents (28% of positive responses). Multiple respondents commented on the transparency and democracy in that Q members vote for projects, rather than an unknown assessment panel. The openness to a wide audience was also noted by respondents, such as patients/carers/service users being able to submit a bid. Four respondents felt that the approach and format of Q Exchange contributes to creating enthusiasm for designing improvement projects (2% of positive responses).

It’s a unique way to obtain funding whilst receiving a full peer review from Q colleagues across the UK.

A small number of respondents commented on the simple application process (n=9, 5% of positive responses), indicating that the process is straightforward and not overly burdensome to complete within existing high workloads, and sufficient guidance is provided to provide support to bidders with little experience in applying for funding. One respondent commented on how they found the follow-up support after their bid was unsuccessful was beneficial (1% of positive responses).

Enough funding to try something without a huge document to fill in.

Finally, four respondents commented that they felt Q Exchange funding would contribute to QI work having a greater impact nationally (2% of responses).

It enables innovative QI ideas to have more of a national impact/network.

Negative responses

Some respondents shared negative or mixed views about the uniqueness and value of Q Exchange. These mainly related to the application and voting processes, and the uncertainty of the impact of the funded projects.

Despite many respondents feeling that Q Exchange is a democratic and equal process, 18 respondents did not feel this way (44% of negative responses), expressing concerns that the process is unfair and favours certain groups. For example, some felt that projects in the South of England had more of an advantage compared to projects from other locations, particularly the North of England and Northern Ireland. In addition, others commented that the voting felt like a ‘popularity contest’, with project teams with more connections or those in more ‘mainstream’ areas of healthcare receiving an advantage. There were also some concerns that funding was being allocated to projects that could have progressed without Q Exchange funding.

I think it’s a popularity contest, the more people you know, the more likely you will get funding.

While the majority of respondents reported that Q Exchange is a unique funding opportunity, 11 did not feel the same (27% of negative responses). These respondents commented that other funding opportunities for improvement projects are available, both within and outside of the NHS. However,
these comments appear to suggest merely that other types of funding for improvement projects are available, rather than suggesting that the process and format of Q Exchange is not unique.

There are other organisations i.e. non-NHS/philanthropic which sometimes offer funding opportunities.

Although a number of respondents reported that the application process for Q Exchange was simple, seven felt this was not the case (17% of negative responses), commenting that the process is laborious and time consuming, including the time that needs to be spent on engaging with online feedback. This was particularly felt to be the case if the respondent’s project was unsuccessful.

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

Related to the application process, three respondents felt that there were too many projects to meaningfully engage with via the online web pages (7% of negative responses).

Some respondents expressed concern over the funding and governance of the projects. Four respondents felt that the amount of funding on offer is not sufficient to sustainably support improvement projects over a long-term period (10% of negative responses). Of these respondents, two commented that the governance processes for the funded projects are unclear (5% of negative responses) and one respondent commented on the lack of traditional peer review making it difficult to confirm the bidding team’s experience in being able to deliver the project (2% of negative responses). Similarly, three respondents felt that some of the funded projects were not well planned or innovative (7% of negative responses).

Some respondents were unsure on the impacts of the funded projects (n=8, 20% of negative responses). This included a lack of communication about the impacts of the projects funded in 2018, as well as the need to include impact evaluations for all funded projects. This also related to uncertainties about the governance of the projects, with some respondents expressing the need to evaluate the impact of projects to ensure the project teams are held accountable for the funding.

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

Other respondents commented on specific negative aspects relating to Q Exchange. These included one comment that the large number of bidding teams may intimidate some members into not applying (2% of negative responses), that the link between Q and Q Exchange is not always clear (2% of negative responses), that ideas that did not fit the pre-defined themes in 2019 could not be submitted (2% of negative responses) and that unsuccessful teams could benefit from more feedback (2% of negative responses).
H.13.3. Value of offering support

For members who offered support to other project teams for Q Exchange, a free-text response box was provided to explore the personal value members felt they got from this process. In total, 70 free-text responses were received for this question and can be broadly categorised as:

- 49 positive
- 21 negative.

These are analysed below.

Positive responses

From the positive free-text responses, 30 were related to gaining learning and knowledge from supporting bidding teams (61% of positive responses). These included learning about new ideas (including work ongoing locally and in other regions and sectors), knowledge about the methodologies used and where some priorities/needs are in the system for improvement. Some respondents also reported an increased knowledge of how to write and assess funding bids.

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

A number of respondents commented that providing support to bidding teams had allowed them to make new connections and interact with new people (n=11; 22% of positive responses), including those outside of their normal networks.

*Made me think about different aspects if the project and interact with a different network of people.*

In addition, 16 respondents felt that being altruistic and offering support to others made them ‘feel good’ and feel more involved with the bidding projects (33% of positive responses). Others reported the positive feelings felt when being asked to support a project by a bidding team and the appreciation expressed by the teams. Some also expressed how they hoped their feedback helped to improve the project and provided confidence to the bidding team in putting together a successful idea. A small number of respondents (n=2, 4% of responses) provided support specifically to projects related to their area of work or that they thought would provide a benefit to patient care.

*We need to be available to colleagues. QI resources and funding is tight now, so not all projects have access to QI people. Q can bridge this gap.*

Finally, one respondent felt that providing support to a project made them more committed to following the outcome of the project (2%).

Negative responses

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62 Question text: *If you offered support to other members’ Q Exchange bids, do you feel this provided any value to you as an individual? If yes, in what way? If no, why not?*

63 An additional 18 responses were categorised as ineligible or not relevant to the question.
The 21 negative responses were often short comments, making them difficult to interpret. However, some respondents felt that the bidding team got the value out of the respondent’s feedback, rather than the supporter receiving any value or benefit. Others expressed feeling disconnected from the projects they supported, for example, through a lack of communication on how the project was progressing.

Didn’t feel connected to the bids – as often too vague. Long lag to hear if successful.

A small number of respondents commented on how they had expressed a willingness to support certain projects but the project team had not followed up with this offer.

*Offered to help with funded project with my local AHSN but offer never taken up. Would have loved to be involved. It was a great idea.*
H.14. Data tables relating to usefulness of resources

Table 42: Percentages for Figure 24 (Usefulness of engaging with different resources and activities for Group A)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Very useful</th>
<th>Somewhat useful</th>
<th>Not useful</th>
<th>Have not used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating in Q Lab</td>
<td>7.94%</td>
<td>11.91%</td>
<td>3.07%</td>
<td>77.08%</td>
</tr>
<tr>
<td>Attending a Q visit</td>
<td>17.75%</td>
<td>9.42%</td>
<td>0.36%</td>
<td>72.46%</td>
</tr>
<tr>
<td>Attending national event(s)</td>
<td>33.03%</td>
<td>20.83%</td>
<td>1.26%</td>
<td>44.88%</td>
</tr>
<tr>
<td>Attending local event(s)</td>
<td>39.78%</td>
<td>24.23%</td>
<td>1.81%</td>
<td>34.18%</td>
</tr>
<tr>
<td>Submitting a bid for Q Exchange funding</td>
<td>12.32%</td>
<td>11.96%</td>
<td>3.26%</td>
<td>72.46%</td>
</tr>
<tr>
<td>Engaging with Q Exchange in other ways</td>
<td>16.45%</td>
<td>33.64%</td>
<td>3.11%</td>
<td>46.80%</td>
</tr>
<tr>
<td>Using online learning resources and publications (e.g. masterclasses, webinars, IHI open school)</td>
<td>34.41%</td>
<td>33.15%</td>
<td>2.33%</td>
<td>30.11%</td>
</tr>
<tr>
<td>Participating in a special interest group (SIG) or online group</td>
<td>12.73%</td>
<td>24.55%</td>
<td>6.73%</td>
<td>56.00%</td>
</tr>
<tr>
<td>Engaging with the Q community on Twitter</td>
<td>24.55%</td>
<td>33.27%</td>
<td>6.00%</td>
<td>36.18%</td>
</tr>
<tr>
<td>Engaging with Q communications (e.g. Q-municate newsletter, Q website and blogs)</td>
<td>27.77%</td>
<td>52.45%</td>
<td>5.44%</td>
<td>14.34%</td>
</tr>
<tr>
<td>Meeting and contacting other Q members</td>
<td>34.48%</td>
<td>37.21%</td>
<td>3.45%</td>
<td>24.86%</td>
</tr>
<tr>
<td>Activity</td>
<td>Very useful</td>
<td>Somewhat useful</td>
<td>Not useful</td>
<td>Don’t know</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------</td>
<td>----------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Participating in Q Lab</td>
<td>28.21%</td>
<td>30.77%</td>
<td>2.56%</td>
<td>38.46%</td>
</tr>
<tr>
<td>Attending a Q visit</td>
<td>41.14%</td>
<td>24.68%</td>
<td>3.16%</td>
<td>31.01%</td>
</tr>
<tr>
<td>Attending national event(s)</td>
<td>37.97%</td>
<td>32.91%</td>
<td>1.90%</td>
<td>27.22%</td>
</tr>
<tr>
<td>Attending local event(s)</td>
<td>53.85%</td>
<td>23.72%</td>
<td>1.28%</td>
<td>21.15%</td>
</tr>
<tr>
<td>Submitting a bid for Q Exchange funding</td>
<td>37.34%</td>
<td>23.42%</td>
<td>5.70%</td>
<td>33.54%</td>
</tr>
<tr>
<td>Engaging with Q Exchange in other ways</td>
<td>29.49%</td>
<td>43.59%</td>
<td>2.56%</td>
<td>24.36%</td>
</tr>
<tr>
<td>Using online learning resources and publications (e.g. masterclasses,</td>
<td>61.01%</td>
<td>27.04%</td>
<td>0.63%</td>
<td>11.32%</td>
</tr>
<tr>
<td>webinars, IHI open school)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating in a special interest group (SIG) or online group</td>
<td>40.51%</td>
<td>32.28%</td>
<td>4.43%</td>
<td>22.78%</td>
</tr>
<tr>
<td>Engaging with the Q community on Twitter</td>
<td>33.12%</td>
<td>32.48%</td>
<td>15.92%</td>
<td>18.47%</td>
</tr>
<tr>
<td>Engaging with Q communications (e.g. Q-municate newsletter, Q website</td>
<td>40.51%</td>
<td>44.30%</td>
<td>4.43%</td>
<td>10.76%</td>
</tr>
<tr>
<td>and blogs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meeting and contacting other Q members</td>
<td>49.37%</td>
<td>33.54%</td>
<td>1.27%</td>
<td>15.82%</td>
</tr>
</tbody>
</table>
Table 44: Percentages for Figure 26 (Agreement of statements on the perceived value of Q, both groups combined)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Slightly agree</th>
<th>Neither agree nor disagree</th>
<th>Slightly disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don't know or not applicable to me</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident I personally benefit from being part of Q</td>
<td>27.44%</td>
<td>36.07%</td>
<td>17.83%</td>
<td>7.52%</td>
<td>3.48%</td>
<td>4.74%</td>
<td>1.39%</td>
<td>1.53%</td>
</tr>
<tr>
<td>I am confident that through being part of Q I contribute to something that ultimately benefits the quality of health and care in the UK</td>
<td>25.84%</td>
<td>36.59%</td>
<td>16.20%</td>
<td>9.92%</td>
<td>3.21%</td>
<td>3.91%</td>
<td>1.40%</td>
<td>2.93%</td>
</tr>
<tr>
<td>As a result of my membership of Q, I have access to information and/or resources for improving quality that I would not have otherwise</td>
<td>34.40%</td>
<td>36.77%</td>
<td>15.32%</td>
<td>5.01%</td>
<td>2.92%</td>
<td>3.06%</td>
<td>0.84%</td>
<td>1.67%</td>
</tr>
<tr>
<td>As a result of my membership of Q, I can make the connections I need to undertake quality improvement work</td>
<td>26.96%</td>
<td>34.64%</td>
<td>20.39%</td>
<td>8.52%</td>
<td>2.65%</td>
<td>3.35%</td>
<td>1.12%</td>
<td>2.37%</td>
</tr>
<tr>
<td>Membership of Q has helped me to organise and/or undertake improvement activities</td>
<td>15.10%</td>
<td>26.71%</td>
<td>20.28%</td>
<td>17.62%</td>
<td>3.78%</td>
<td>7.55%</td>
<td>3.08%</td>
<td>5.87%</td>
</tr>
<tr>
<td>Membership of Q has helped me to develop my knowledge and/or skills for improving quality</td>
<td>22.55%</td>
<td>33.61%</td>
<td>20.17%</td>
<td>9.80%</td>
<td>3.22%</td>
<td>5.60%</td>
<td>2.66%</td>
<td>2.38%</td>
</tr>
<tr>
<td>As a result of my membership of Q, I am able to share my knowledge and skills for improving quality in health and care with others</td>
<td>21.85%</td>
<td>30.81%</td>
<td>23.81%</td>
<td>11.76%</td>
<td>3.22%</td>
<td>3.92%</td>
<td>1.68%</td>
<td>2.94%</td>
</tr>
<tr>
<td>Without Q, I would still be able to get support for my improvement activities from other networks or organisations</td>
<td>10.38%</td>
<td>28.05%</td>
<td>27.63%</td>
<td>16.41%</td>
<td>7.29%</td>
<td>6.59%</td>
<td>1.54%</td>
<td>2.10%</td>
</tr>
<tr>
<td>Without Q, I would still feel just as inspired/energised to undertake improvement activities</td>
<td>12.61%</td>
<td>28.29%</td>
<td>19.47%</td>
<td>17.51%</td>
<td>9.24%</td>
<td>8.68%</td>
<td>2.66%</td>
<td>1.54%</td>
</tr>
<tr>
<td>Without Q, I would still be able to effectively undertake improvement activities within my organisation or professional network</td>
<td>13.99%</td>
<td>35.52%</td>
<td>22.52%</td>
<td>14.13%</td>
<td>4.48%</td>
<td>5.73%</td>
<td>1.68%</td>
<td>1.96%</td>
</tr>
</tbody>
</table>
Table 45: Percentages for Figure 28 (Level of agreement for the statements regarding the value of Q from the 2018 survey)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Total agree n (%)</th>
<th>Neither agree nor disagree n (%)</th>
<th>Total disagree n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident I personally benefit from being part of Q</td>
<td>584 (63.00%)</td>
<td>105 (11.33%)</td>
<td>238 (25.67%)</td>
</tr>
<tr>
<td>I am confident that through being part of Q I contribute to something that ultimately benefits the quality of health and care in the UK</td>
<td>579 (63.21%)</td>
<td>96 (10.48%)</td>
<td>241 (26.31%)</td>
</tr>
<tr>
<td>As a result of my membership of Q, I have access to information and/or resources for improving quality that I would not have otherwise</td>
<td>677 (73.19%)</td>
<td>61 (6.59%)</td>
<td>187 (20.22%)</td>
</tr>
<tr>
<td>As a result of my membership of Q, I can make the connections I need to undertake quality improvement work that I would not have otherwise</td>
<td>593 (64.25%)</td>
<td>83 (8.99%)</td>
<td>247 (26.76%)</td>
</tr>
<tr>
<td>Membership of Q has helped me to organise and/or undertake improvement activities</td>
<td>404 (43.72%)</td>
<td>222 (24.03%)</td>
<td>298 (32.25%)</td>
</tr>
<tr>
<td>Membership of Q has helped me to influence improvement activities in my organisation or local area</td>
<td>380 (41.71%)</td>
<td>223 (24.48%)</td>
<td>308 (33.81%)</td>
</tr>
<tr>
<td>Membership of Q has helped me to develop my knowledge and/or skills for improving quality</td>
<td>536 (58.07%)</td>
<td>114 (12.35%)</td>
<td>273 (29.58%)</td>
</tr>
<tr>
<td>As a result of my membership of Q, I am able to share my knowledge and skills for improving quality in health and care with others</td>
<td>500 (54.23%)</td>
<td>154 (16.70%)</td>
<td>268 (29.07%)</td>
</tr>
</tbody>
</table>
H.15. Data tables relating to the impact of Q

Table 46: Percentages for Figure 35 (Members’ confidence that Q has a positive impact for Group A only)

<table>
<thead>
<tr>
<th></th>
<th>Very confident</th>
<th>Moderately confident</th>
<th>Not very confident</th>
<th>Not at all confident</th>
<th>Don’t know or not applicable to me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your ability to undertake activities relating to improving quality</td>
<td>17.76%</td>
<td>49.90%</td>
<td>15.97%</td>
<td>8.38%</td>
<td>7.98%</td>
</tr>
<tr>
<td>Your own skills and/or knowledge</td>
<td>23.90%</td>
<td>48.39%</td>
<td>12.65%</td>
<td>8.23%</td>
<td>6.83%</td>
</tr>
<tr>
<td>The skills and/or knowledge of those you work with</td>
<td>12.70%</td>
<td>43.15%</td>
<td>22.58%</td>
<td>10.28%</td>
<td>11.29%</td>
</tr>
<tr>
<td>The strength or size of your own professional network</td>
<td>21.04%</td>
<td>42.69%</td>
<td>19.64%</td>
<td>9.02%</td>
<td>7.62%</td>
</tr>
<tr>
<td>The strength or size of the network of quality improvers in your region/local area</td>
<td>18.40%</td>
<td>41.00%</td>
<td>20.40%</td>
<td>9.80%</td>
<td>10.40%</td>
</tr>
<tr>
<td>The visibility of improvers in your organisation/professional network</td>
<td>14.84%</td>
<td>39.02%</td>
<td>24.59%</td>
<td>12.80%</td>
<td>8.74%</td>
</tr>
<tr>
<td>The visibility of improvers in the UK health and care system</td>
<td>21.29%</td>
<td>44.98%</td>
<td>18.88%</td>
<td>7.23%</td>
<td>7.63%</td>
</tr>
<tr>
<td>The quality of health and/or care that you or those you work with deliver</td>
<td>9.92%</td>
<td>43.52%</td>
<td>20.85%</td>
<td>13.36%</td>
<td>12.35%</td>
</tr>
<tr>
<td>The quality of health and/or care delivered by the UK health and care system</td>
<td>12.22%</td>
<td>44.69%</td>
<td>23.25%</td>
<td>9.02%</td>
<td>10.82%</td>
</tr>
</tbody>
</table>
Table 47: Percentages for Figure 36 (Confidence in expected impacts of Q for Group B only)

<table>
<thead>
<tr>
<th></th>
<th>Very confident</th>
<th>Moderately confident</th>
<th>Not very confident</th>
<th>Not at all confident</th>
<th>Don't know or not applicable to me</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your ability to undertake activities relating to improving quality</td>
<td>28.78%</td>
<td>56.83%</td>
<td>8.63%</td>
<td>0.72%</td>
<td>5.04%</td>
</tr>
<tr>
<td>Your own skills and/or knowledge</td>
<td>35.00%</td>
<td>52.86%</td>
<td>7.86%</td>
<td>0.71%</td>
<td>3.57%</td>
</tr>
<tr>
<td>The skills and/or knowledge of those you work with</td>
<td>15.11%</td>
<td>55.40%</td>
<td>19.42%</td>
<td>2.16%</td>
<td>7.91%</td>
</tr>
<tr>
<td>The strength or size of your own professional network</td>
<td>28.57%</td>
<td>58.57%</td>
<td>9.29%</td>
<td>1.43%</td>
<td>2.14%</td>
</tr>
<tr>
<td>The strength or size of the network of quality improvers in your region/local area</td>
<td>28.47%</td>
<td>48.91%</td>
<td>13.14%</td>
<td>4.38%</td>
<td>5.11%</td>
</tr>
<tr>
<td>The visibility of improvers in your organisation/professional network</td>
<td>27.14%</td>
<td>44.29%</td>
<td>20.00%</td>
<td>2.14%</td>
<td>6.43%</td>
</tr>
<tr>
<td>The visibility of improvers in the UK health and care system</td>
<td>34.78%</td>
<td>44.20%</td>
<td>13.77%</td>
<td>1.45%</td>
<td>5.80%</td>
</tr>
<tr>
<td>The quality of health and/or care that you or those you work with deliver</td>
<td>22.86%</td>
<td>53.57%</td>
<td>14.29%</td>
<td>2.14%</td>
<td>7.14%</td>
</tr>
<tr>
<td>The quality of health and/or care delivered by the UK health and care system</td>
<td>24.29%</td>
<td>52.86%</td>
<td>15.00%</td>
<td>2.14%</td>
<td>5.71%</td>
</tr>
</tbody>
</table>
I. Introduction

This report contains the results of the three 2018 Q member surveys, conducted from November to December 2018 as part of the 2016–2020 Evaluation of Q commissioned for the Health Foundation. This follows on from earlier member surveys conducted in 2015, 2016 and 2017.

This report provides insights into the key trends arising from the data. It is intended to provide ongoing learning and data for the Health Foundation to inform the ongoing development of the Q community, in addition to informing the independent evaluation of the Q Initiative by RAND Europe. A follow-up survey will be conducted in November–December 2019 to assess change among the membership, and inform the final summative evaluation assessment to be delivered in February 2020.

Three separate surveys were implemented, with shared questions across each of these. They differed slightly in some response categories depending on the amount of time a member had been part of Q. Where appropriate, we use the following categories throughout the report:

- **Group A**: Members recruited from Q’s inception up to October 2017 (1,786 members).
- **Group B**: Members recruited from November 2017 to July 2018 (683 members; those who have been in Q for less than one year but more than three months at survey launch).
- **Group C**: Members recruited from August 2018 to November 2018 (262 members; those who have been in Q for three months or less at survey launch).

I.2. Methods and limitations

The surveys were conducted from November to December 2018 during a four-week period using the Smart Survey platform. The surveys were adapted from the previous member entry surveys and annual surveys, with some question adaptations and new questions inserted in light of new activities and areas of interest (such as the Q Exchange). The questions were developed by the evaluation team with input from the Q team on areas of priority and interest.

The data and findings set out in this annex comprise results from all three surveys combined, unless specified otherwise. Where question wording deviated between surveys (to reflect the different lengths of time members had been in Q), this is explained in footnotes.
Response rates are included in Table 498.

Table 48: Response rates for all surveys\textsuperscript{64}

<table>
<thead>
<tr>
<th>Survey</th>
<th>Full responses</th>
<th>Partial responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group A survey</strong></td>
<td>423 (23.7%)</td>
<td>161 (9.2%)</td>
</tr>
<tr>
<td><strong>Group B survey</strong></td>
<td>203 (29.7%)</td>
<td>85 (12.6%)</td>
</tr>
<tr>
<td><strong>Group C survey</strong></td>
<td>122 (46.6%)</td>
<td>21 (8%)</td>
</tr>
</tbody>
</table>

Upon review, 38 respondents were found to have submitted more than one response (i.e. beginning a survey then restarting a second version). For these, the completed version or the partial response completed at the latest time was retained and the duplicate entry deleted.

The data were analysed using STATA\textsuperscript{65} (by AH). Qualitative free-text comments were analysed by developing thematic coding frameworks in Excel based on the identification of emerging themes, and the data coded accordingly (by KS, NP).

It is important to note two key limitations with regard to the survey data, which should be considered when interpreting the results.

Firstly, not all members responded to the surveys (see response rates above) and so the views expressed below may not be representative of the full membership body. It is important to note that people who respond to the surveys may be more or less satisfied or engaged with Q membership than average. In this regard, the views expressed below should not be taken as necessarily representative of the Q membership body, but rather an indication of views held by different parts of the membership. We recognise that response rates are lower in comparison to previous surveys. It is possible that this is a result of survey fatigue or, as previous surveys were mostly delivered shortly after members joined Q, reflective of the initial excitement of joining having faded somewhat.

Secondly, the format of the surveys means that free-text comments provided by respondents are necessarily brief, and there is limited scope to probe or further explore the context for comments, as is possible in other data collection methods such as interviews and focus groups. Where free-text comments have been quoted, these have been quoted ad verbatim where possible to avoid the risk of changing the respondents’ intent, although some content may have been removed for brevity (marked with parentheses, as is standard practice) and spelling/grammar mistakes corrected for clarity.

\textsuperscript{64} Partial response figures do not include duplicates, where a respondent began a survey and submitted a version at a later date. Where multiple responses were recorded, the completed responses have been included.

\textsuperscript{65} For more information on Stata, please see https://www.stata.com/
I.3. Overview

Since the founding cohort began the co-design of Q in 2014–2015, membership has increased rapidly, particularly since 2016, as can be seen in Figure 38.

**Figure 38: Growth of the Q Community from 2015 to 2018**

During this time, the Q team has developed Q’s infrastructure to enable it to attract and connect more people with improvement expertise. It has also developed a flexible and growing offering of activities and resources. Through the many different types of activities and resources, it is hoped by the leadership of the Q team based in the Health Foundation that improvement efforts will be communicated and spread by making good practice more visible, helping improvers to feel better equipped and strengthening collaborative working.

At the same time, across the Q community, organisational capacity has been developed to support these activities, including: creating a greater online presence; recruiting new members; developing further the communications strategy; organising events; and strengthening collaborations with other organisations in the improvement landscape. Members form opinions about Q arising from not only their interactions with other members but also from how they engage with Q as an organisation and what Q chooses to prioritise. How members engage both with each other and with Q as an organisation is evolving, and we can see that founding members in some specific respects may feel differently towards Q than more recently joined members. The survey data reported here is a good opportunity to reflect on members’ views and experiences at this important stage in the evolution of Q.

**Activities and resources**

Q remains a highly valued resource. There are multiple perspectives on what Q should do and be, and the continuing commitment from many members should be seen as a success. As a repository of information and a platform for learning/skill development, it is in general greatly appreciated but with some lack of engagement with Randomised Coffee Trials (RCTs) and special interest groups (SIGs). However, balancing
the lack of engagement from some members with RCTs and SIGs is the fact that members also still appreciate the flexibility that Q offers and many see this as especially useful. Therefore, there should not be an expectation that all members engage equally with every resource on offer. However, there are a few offerings that are said to lack visibility for some members (for example, access to BMJ Open Quality), which may be a matter of concern.

**Value of Q**
As noted, Q continues to be valued by most members. However, there are important nuances within this. While very new members continue to be very enthusiastic about what they believe to be the potential of Q, more longstanding members have indicated some more negative sentiments than in past surveys and when compared with newer members. A perennial reported problem is lack of time; this may be especially where they lack employer support and there are also cases of lack of support from senior managers and other colleagues. However, members also reported that they were less involved in the previous year than they want to be next year, suggesting that they are not disenchanted with Q.

Newer members also seem on average to want less in-depth engagement and perhaps have more of a transactional relationship, but this is not a decisive difference between newer and older members. Across the board, there is a sense that flexibility (how to engage and how often) is a valued feature of Q in its present form.

**Q may look different depending on your professional role, income level and where you work**
As Mannion and Davies note, ‘Healthcare organisations are best viewed as comprising multiple subcultures, which may be driving forces for change or may undermine quality improvement initiatives’ (2018). They go on to point out that culture has often been identified as a barrier to improving quality (Francis, 2013; Kennedy, 2001) but also warn against an overly simplistic understanding of what culture is. A simple survey will not allow us to explore deeply ‘multiple subcultures’ but responses suggest that Q may be understood and, most likely, acted upon differently by different ‘tribes’ within the NHS. This speaks against adopting an overly homogenised view of how Q ‘lands’ in the health and care system.

Recognising that some groups had small sample sizes, respondents to our survey who identified themselves as pharmacists and doctors were generally less likely to agree with statements that Q had helped them develop their knowledge and skills, or that Q had given them access to resources or information they would not otherwise have had. Pharmacists and doctors were the least likely to agree that as a result of being part of Q they would contribute something of benefit to the quality of healthcare in the UK. Meanwhile nurses were much more likely to agree that Q had helped them develop their skills and that Q had given them access to resources they would otherwise have missed. Nurses and people in allied health roles were much more likely to agree that being part of Q would help them contribute to improving the quality of healthcare in the UK. There was also a small difference between how people from different ethnic groups responded to this question with more positive responses from respondents from a minority ethnic background. Finally, there were only slight differences between income levels (with members with lower incomes below £50,000 responding slightly more positively).

Qualitatively, respondents also reported differing experiences of being in Q based on where they work. For example, individuals who felt isolated within their workplace see a particular benefit in Q helping make connections to improvers elsewhere.
Although my Q Membership supports existing improvement work, being the only member in my organisation has limitation and leaves me with little opportunity to discuss developments or contribute to the network on more than an individual member. Creating and developing connections with other members outside of my organisation has helped me to evolve my knowledge and discuss the developments presented by Q.

Equally, where there are a number of fellow Q members in the workplace the experience might be very different:

I think it has helped that there are a number of us (10) in the organisation that are Qs – collectively we have a loud voice and make ourselves heard!

I.4. Suggestions for the Q team to consider

There is clearly some basis for considering a smorgasbord approach to Q, given that many members like the flexibility this offers. This might be helped by stronger signposting (e.g. ‘if you are a social worker you might like these options; if you are a nurse you might consider those; if you are a lone rural QI worker, here is how we can help’). Equally, it might also help by following up participation with ‘if you enjoyed this activity, we can recommend that one’.

Responding to the finding that Q may look different depending on your circumstances also raises questions in relation especially to some clinicians, academics and pharmacists who may not feel that Q offers them anything new. However, understanding what lies behind this would be important; is it that they are simply not very curious about what more Q might have to offer, or is it that they are curious but unsatisfied with what they find?

However, there may also be risks in going too far down this road. A community is defined not only by the choices on offer but also the values and relationships it promotes and espouses. The strength of affection and commitment to Q outstrips the consumerist use of its services. A small group of respondents reported that they want to be involved in helping to organise activities and events. Helping this group to engage with Q as a whole, and in particular with the senior management of Q, might help mobilise both good ideas and energy.

However, it remains the case that for the other members who are less open to participating in Q, it is important to understand how to segment the audience, target messages and make distinct offers. The surveys show that some members want to influence improvement locally and some would like to influence national approaches. Experiences and preferences are likely to vary by region, by professional background and between individuals. These may not coalesce into distinct ‘Q tribes’ but there might be enough separation to support more targeted messaging.

As we have seen reflected in qualitative data, members are often keen to spend more time on Q than they have done to date. In these surveys, members across both Group A and B reported the intention to spend more time on Q in the following year. Making it easier to turn an aspiration to engage into real activity must be an important aim. This is not about making the case for engaging (this has already been accepted) but it is about influencing behaviour in a way that makes participation more likely (this is a topic widely
covered in behavioural science, emphasising the importance of social influence, prompts, deadlines, personalisation, ease and reminders).66

When looking at organisational support, the results show variable levels of support for Q members. The Health Foundation is well placed to influence employers both directly and indirectly. This might also be targeted to address members’ concerns that often their colleagues are unsupportive or felt the attending events is something of a ‘day off’. Equipping members with good responses to such concerns would also be helpful in respect of enhancing the legitimacy and value given to Q by employers and colleagues.

1.5. Profile of survey respondents

The following figures provide an overview of survey responses to questions about members’ profiles and characteristics. These provide an overview of the characteristics of survey respondents and an updated look at member profiles since the earlier Q member entry surveys (although, as response rates to this survey were lower than in previous years, caution should be taken in extrapolating to the full membership).

Figure 39 sets out the number of hours respondents were contracted to work per week.

**Figure 39: Number of hours per week contracted to work**67

![Bar chart showing the distribution of contracted hours per week.](https://example.com/figure39.png)

Responses are similar to previous surveys.

Figure 40 sets out participants’ reports of the amount of paid time they spend on improving health and care quality. Responses are similar to previous surveys.

66 See, for example: [https://www.mdrc.org/sites/default/files/BIAS_Capstone_Case_Study-MDRC_Version.pdf](https://www.mdrc.org/sites/default/files/BIAS_Capstone_Case_Study-MDRC_Version.pdf)

67 Question text: How many hours a week are you contracted to work? If you are self-employed, please choose the equivalent time that you spend on your primary role?
Figure 40: Number of paid hours spent on improving health and care quality each week\textsuperscript{68}

Figure 41 sets out participants’ reports of the amount of unpaid time respondents reported spending on improving health and care quality.

\textsuperscript{68} Question text: Approximately how much of your time in paid employment is currently spent in work directly related to improving health and care quality?
Figure 41: Number of unpaid hours spent improving health and care quality each week\textsuperscript{69}

![Bar chart showing the percentage of unpaid hours spent improving health and care quality each week]

Number of total observations: 741
Number of observations from left to right: 181, 303, 176, 59, 12, 6, 4

Figure 42 sets out the age profile of respondents. The proportion of ages as reported by respondents are similar to those reported in previous surveys.

Figure 42: Age of respondents

![Bar chart showing the age distribution of respondents]

Number of total observations: 745
Number of observations from left to right: 68, 224, 304, 149

\textsuperscript{69} Question text: Approximately how much of your time that is not paid is currently spent in work directly related to improving health and care quality? This could include voluntary work, unpaid overtime or work in the evenings or weekend, for example.
Figure 43 sets out the self-reported gender of respondents. The total proportion of females (68 per cent) is higher than reported in previous surveys, although as the response rates are lower for this survey, this may reflect a bias rather than any change in the overall Q membership profile.

**Figure 43: Gender of respondents**

![Gender Distribution Chart](image)

- **Female**: 68.17%
- **Male**: 31.83%

Number of total observations: 732
Number of observations from left to right: 499, 233

Figure 44 sets out the proportion of respondents who reported a disability.

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70 Question text: *Which of the following best describes your gender? ('Female', 'Male', 'Prefer not to say', ' Prefer to self-describe')*
Figure 44: Percentage of respondents reporting a disability which limits day-to-day activities\textsuperscript{71}

Figure 45 sets out the self-reported ethnic background of respondents.

Figure 45: Ethnic background of respondents\textsuperscript{72}

\textsuperscript{71} Question text: Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

\textsuperscript{72} Question text: What is your ethnic group?
Figure 46 sets out the income (full-time equivalent) of respondents.

**Figure 46: Respondents’ income (full-time equivalent)**

![Chart showing respondents' income distribution.](image)

Number of total observations: 739
Number of observations from left to right: 38, 245, 194, 114, 77, 71

Figure 47 sets out whether respondents reported having a clinical or a non-clinical professional background.

**Figure 47: Respondents’ professional background**

![Chart showing respondents' professional background distribution.](image)

Number of total observations: 750
Number of observations from left to right: 419, 296, 35

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73 Question text: What is your annual (FTE) income, before taxes but after any regular out of hours or overtime payments?

74 Question text: How would you describe your professional background (i.e. the profession you originally trained in)?
Figure 48 sets out the level of contact with patients that respondents have in their daily role. The proportion of respondents that reported ‘Occasional’ contact is lower than in previous surveys (in which this was closer to 40 per cent) and those that reported ‘No’ is higher than in previous surveys (where it was usually between 10 and 20 per cent). This may reflect the differing roles of newer Q members or may reflect an element of response bias.

**Figure 48: Percentage of respondents who have direct contact with patients in their daily work**

75 Question text: Do you have face-to-face contact with patients / service users as part of your job or current role?
1.6. Engagement and participation with Q

The surveys contained a number of questions that asked about the way that members engage with Q and the Q activities/resources.

1.6.1. Support from employers

Respondents were asked to indicate what kind of support they had from their employer to participate in Q activities. As displayed in Figure 49 (all groups), Figure 50 (Group A) and Figure 51 (Groups B and C), 60 per cent of responses indicate some form of support, and support is broadly consistent across all group respondents.

Figure 49: All groups: Support from employer to participate in Q activities

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76 Question text: What support do you have from your employer, or elsewhere if not employed, to participate in Q events and activities? Please select all that apply.

77 These figures display each option as a percentage of total ticked responses. As the total number of observations includes non-completed surveys, this figure should be interpreted as displaying the popularity of responses relative to the other options. Repeating the analysis with complete responses did not change the distribution of responses.
Figure 50: Group A: Support from employer to participate in Q activities

![Graph showing support from employer to participate in Q activities for Group A.](image1)

Figure 51: Groups B and C: Support from employer to participate in Q activities

![Graph showing support from employer to participate in Q activities for Groups B and C.](image2)

Figure 52, reproduced from the 2018 interim evaluation report, displays the answers to this question from previous Q member surveys. While there is a slight reduction in respondents that reported protected time compared to previous surveys (which we think may be related to the ‘newness’ of Q at the point of previous surveys), the distribution has remained broadly consistent across surveys.
Members were also asked about their agreement with the following statements concerning their ability to undertake quality improvement activities in their current role:

1. *In my current role(s) I am able to make changes that could improve quality in my local setting and/or organisation.*

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

3. *I get the support I need from my organisation for the improvement work I do.*

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

5. *Improving quality is embedded in my organisation.*

As depicted in . For each of the statements, we have combined the total agree and total disagree responses and present these along with their corresponding percentages in Error! Reference source not found. (see Section I.11).

Figure 53, a strong majority of respondents agreed to some extent with all statements. For each of the statements, we have combined the total agree and total disagree responses and present these along with their corresponding percentages in Error! Reference source not found. (see Section I.11).
When comparing to the results of the 2016 and 2017 surveys, the level of support for these statements does not exhibit major change across surveys. Consistent with previous surveys, the level of agreement is highest for statement 1 and lowest for statement 4.

I.6.2. Time spent engaging with Q

Respondents were asked how much time they had spent engaging with Q in the recent past and the nature of their involvement, and how much they would like to do so in the coming year. We analysed this separately for Group A and Group B, to illustrate any differences between the early phases of Q and newer members. Group C were not asked this question as they had only very recently joined Q at the time of the survey launch.

Figure 54 depicts the amount of time Group A respondents spent engaging with Q over the past year. While the majority of respondents in Group A spent a few days over the course of a year, over 10 per cent spent more than a week engaging with Q. The median category for both clinical and non-clinical respondents

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78 Question text: To what extent do you agree with the following statements?
was 1–3 days,\textsuperscript{79} and this was the same regardless of whether respondents had frequent, occasional or no patient contact in their current role.\textsuperscript{80}

**Figure 54: Amount of time Group A respondents spent engaging with Q in the past year\textsuperscript{81}**

![Figure 54](image)

Figure 55 depicts the amount of time Group B respondents spent engaging over the past three months.\textsuperscript{82} Group B respondents showed an apparently more intensive engagement with Q, which may in part reflect initial excitement about Q and participation in induction activities. However, it should be noted that longer-standing members may be more prone to recall bias given the greater timeframe, so caution should be taken in making direct comparisons between these responses.

The median category for both clinical and non-clinical respondents was 1–2 days,\textsuperscript{83} and this was the same regardless of whether respondents had frequent, occasional or no patient contact in their current role.\textsuperscript{84}

\textsuperscript{79} 420 responses.

\textsuperscript{80} 400 responses.

\textsuperscript{81} Question text: *How much time have you spent engaging with Q over the last year? (e.g. participating in local events or other activities, visiting the website, attending a centrally run visit/event, participating in the Q Lab, writing a blog, participating in a webinar or twitter chat etc.)*

\textsuperscript{82} Some Group B respondents had been in Q for less than one year at the time of survey, hence differing response categories.

\textsuperscript{83} 205 responses.

\textsuperscript{84} 196 responses.
Figure 55: How much time Group B spent engaging with Q in the past three months

Figure 56 (all groups), Figure 57 (Group A) and Figure 58 (Groups B and C) present the overall time respondents report wanting to spend on Q over the next year. While it is more difficult to compare Group B’s answers with Group B’s past activity, given the different response categories, there is a small indication that respondents in Group A report spending less time over the past year than they hope to spend on Q. This is consistent with other comments from members throughout the surveys about the lack of time they have available to commit to Q activities.

When looking at all responses, there was no difference in the median category based on professional background or level of patient contact in their daily role (4–6 days).

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85 Question text: as above.
Figure 56: Time respondents want to spend over the next year (all groups)

Figure 57: Time respondents want to spend over the next year (Group A)

86 Question text: Taking into account how much time you have available, how much time would you like to spend on Q over the next year?
Figure 58: Time respondents want to spend on Q over the next year (Groups B and C)\textsuperscript{87}

Figure 59, reproduced from the 2018 interim evaluation report, presents the responses to this same survey question from the Phase 1–2 surveys and Phase 3 entry surveys. While recognising there was variation among earlier recruitment cohorts, the distribution of answers has remained broadly consistent across surveys, with the exception of a slight depreciation among Group A (the subject of earlier surveys) towards lower answer categories.

\textsuperscript{87} Question text: as above.
An evaluation of the Q Initiative 2016–2020

**Figure 59: Desired time commitment over next year**

Based on the information you have so far and taking into account how much time you have available, how much time would you like to spend on Q over the next year?

- Less than 1 day
- 1-3 days
- 4-6 days
- 7-10 days
- More than 10 days

<table>
<thead>
<tr>
<th>% of respondents</th>
<th>Annual survey March 2017 %</th>
<th>Phase 1 - end of year %</th>
<th>Phase 2 %</th>
<th>Phase 3 Wave 1 new members %</th>
<th>Phase 3 Wave 2 new members %</th>
<th>Phase 3 Wave 3 new members %</th>
<th>Phase 3 Wave 4 new members %</th>
</tr>
</thead>
</table>

88 Question text: Based on the information you have so far and taking into account how much time you have available, how much time would you like to spend on Q over the next year?
I.6.3. Type of engagement members want with Q

Members were also asked the nature of involvement with Q they had and wanted. Figure 60 depicts responses from Group A about the nature of their involvement with Q in the past year.

**Figure 60: How active Group A respondents reported being in the past year**

[Bar chart showing percentages of respondents' level of involvement.]

Figure 61 (all groups), Figure 62 (Group A) and Figure 63 (Groups B and C) depict the nature of engagement with Q that respondents report *wanting* to have over the next year. As with the number of days spent on Q, responses from Group A indicated that respondents were currently less involved with Q than they hope to be in the coming year.

While responses were similar across Groups A and B/C, there was a small difference in the number of respondents who reported wanting to 'contribute significantly and help lead' activities, with 15 per cent of respondents in Group A answering in this way compared to 11 per cent in Groups B/C.

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89 Question text: *How active have you been in Q since joining?*
Figure 61: What kind of involvement all groups want in the next year\textsuperscript{90}

![Bar chart showing involvement preferences for all groups over the next year.]

Number of total observations: 930
Number of observations from left to right: 121, 508, 273, 28

Figure 62: What kind of involvement Group A want in the next year\textsuperscript{91}

![Bar chart showing involvement preferences for Group A over the next year.]

Number of total observations: 536
Number of observations from left to right: 79, 278, 162, 17

\textsuperscript{90} Question text: Taking into account how much time you have available, how active would you like to be within Q over the coming year?

\textsuperscript{91} Question text: as above.
Notably, when compared to previous surveys, the proportion of respondents indicating that they want to ‘contribute significantly to help shape and lead activities’ has decreased while the proportion indicating they want ‘occasional use of a small number of resources and activities’ has increased. Figure 64, reproduced from the 2018 interim evaluation report, presents the responses to this same survey question from the Phase 1–2 surveys and Phase 3 entry surveys. As the majority of respondents in these previous surveys were answering having recently joined Q, this may reflect some adjustment to the realities of membership.
Figure 64: Desired level of activity in the coming year, as reported in Phase 3 entry surveys and Phase 1–2 surveys (reproduced from interim evaluation report)

Taking into account how much time you have available, how active would you like to be within Q over the coming year?
I.7. Use of Q resources and activities

I.7.1. Frequency of engaging with activities and resources

Members were asked to indicate how often they engaged with different Q resources and activities. To account for members’ different periods of time within Q, Group C (members for three months or less) were asked how useful they expected different resources to be, rather than an indication of the frequency of use.

As depicted in Figure 65 and Figure 66, all activities and resources are being used on an infrequent basis by Group A and Group B respondents with no strong differences between the groups. (It is important to note that these figures do not reflect the value that a member feels they are or are not receiving from a particular activity or resource, and some resources, such as attending UK-wide events and publishing in BMJ Open Quality, may be periodic by nature.)

As depicted in Figure 67, Group C respondents (members for three months or less) were very positive about the potential utility of the resources and activities available to them as members, with the vast majority indicating that they would be ‘Of some use’ or ‘Very useful’.

For each of the figures below, there is a corresponding table (Table 55, Table 56 and Table 57) in Section I.11, which presents the numbers for each of the bars along with their percentages.
Figure 65: Frequency of engaging with different resources and activities (Group A)\(^{93}\)

Number of observations by question in descending order (top to bottom): 478, 470, 474, 472, 473, 478, 476, 474, 471, 472, 473, 472, 469

\(^{93}\) Question text: How often have you accessed the following opportunities and benefits for members in the past year?
Figure 66: Frequency of engaging with different activities and resources (Group B)

Question text: Since joining Q, how often have you accessed the following opportunities and benefits for members?

Number of observations by question in descending order (top to bottom):
230, 229, 231, 229, 226, 229, 232, 228, 230, 226, 229, 230, 231, and 232
Figure 67: Expected utility of different resources and activities (Group C)\textsuperscript{95}

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publishing my work in BMJ Open Quality</td>
<td></td>
</tr>
<tr>
<td>Participating in a Randomised Coffee Trial (RCT)</td>
<td></td>
</tr>
<tr>
<td>Attending UK-wide events</td>
<td></td>
</tr>
<tr>
<td>Attending a Q visit</td>
<td></td>
</tr>
<tr>
<td>Engaging with local or regional Q activities</td>
<td></td>
</tr>
<tr>
<td>Finding/Contacting someone through the Q Member Directory</td>
<td></td>
</tr>
<tr>
<td>Collaborating with a new person</td>
<td></td>
</tr>
<tr>
<td>Participating in a Twitterchat</td>
<td></td>
</tr>
<tr>
<td>Participating in a webinar</td>
<td></td>
</tr>
<tr>
<td>Engaging with online groups or Special Interest Groups</td>
<td></td>
</tr>
<tr>
<td>Reading Communicate</td>
<td></td>
</tr>
<tr>
<td>Engaging with online learning resources</td>
<td></td>
</tr>
<tr>
<td>Engaging with Q Lab</td>
<td></td>
</tr>
<tr>
<td>Accessing resources on Q website</td>
<td></td>
</tr>
<tr>
<td>Applying for project funding through Q</td>
<td></td>
</tr>
</tbody>
</table>

Number of observations by question in descending order (top to bottom): 129, 128, 128, 129, 128, 125, 127, 129, 126, 127, 129, 125, 128, and 128

\textsuperscript{95} Question text: How useful do you expect the following opportunities and benefits for Q members to be in relation to your work in improving quality?
I.7.2. Respondents’ perceptions of the most useful resources

Group A and Group B respondents were asked which resources and activities offered by Q they found the most useful in supporting their work in improving quality, with respondents able to identify up to three options in a free-text box.\textsuperscript{96}

Of the 527 members who provided at least one response, the following resources and activities were cited by members.\textsuperscript{97} In addition to those below, 8 members reported that none were useful, 4 reported that they didn’t know yet, and 30 were ineligible (i.e. they did not specify an activity/resource).

Table 49: Perception of most useful activities/resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online learning resources on the Q website</td>
<td>209</td>
</tr>
<tr>
<td>Networking</td>
<td>106</td>
</tr>
<tr>
<td>Local or regional events and networks</td>
<td>91</td>
</tr>
<tr>
<td>Q-municate (blogs, articles)</td>
<td>84</td>
</tr>
<tr>
<td>Special interest groups (SIGs)</td>
<td>78</td>
</tr>
<tr>
<td>UK-wide events</td>
<td>75</td>
</tr>
<tr>
<td>Webinars</td>
<td>72</td>
</tr>
<tr>
<td>Q Visits</td>
<td>69</td>
</tr>
<tr>
<td>Events (general)</td>
<td>65</td>
</tr>
<tr>
<td>Q directory</td>
<td>41</td>
</tr>
<tr>
<td>Access to publications and journals (BMJ)</td>
<td>33</td>
</tr>
<tr>
<td>Collaboration and learning from others</td>
<td>29</td>
</tr>
<tr>
<td>RCTs</td>
<td>27</td>
</tr>
<tr>
<td>Q Exchange funding opportunities</td>
<td>26</td>
</tr>
<tr>
<td>Q Lab</td>
<td>25</td>
</tr>
<tr>
<td>Collaboration and learning from others (non-specific)</td>
<td>23</td>
</tr>
<tr>
<td>Twitter/social media</td>
<td>21</td>
</tr>
<tr>
<td>Masterclasses</td>
<td>21</td>
</tr>
<tr>
<td>Institute for Healthcare Improvement (IHI) Open School</td>
<td>20</td>
</tr>
<tr>
<td>Email updates/newsletters</td>
<td>17</td>
</tr>
<tr>
<td>The community or network of people in Q (non-specific)</td>
<td>11</td>
</tr>
<tr>
<td>Training</td>
<td>11</td>
</tr>
<tr>
<td>Workshop</td>
<td>10</td>
</tr>
<tr>
<td>Toolkit</td>
<td>9</td>
</tr>
<tr>
<td>Institute for Continuous Improvement in Public Services (ICIPS)</td>
<td>1</td>
</tr>
</tbody>
</table>

\textsuperscript{96} Question text: Which of the activities and resources offered by Q do you find or expect to be the most useful in supporting your work in improving quality? Please indicate up to three options you consider to be the most useful. Very new members (Group C) were not asked this question.

\textsuperscript{97} As respondents were asked to report up to three resources and activities they found most useful, there are more responses than there are respondents.
Both Group A and Group B new members cited online resources and the networking opportunities as the most useful resources that Q offered. Of the eight members who stated that no resources or activities had been useful, seven were from Group A (members recruited in the Phase 1–4 recruitment rounds).

Respondents were also asked to explain why they found these resources useful. Generally, the explanations suggested that respondents find Q resources useful because they facilitate meeting and networking with people and communities with similar interests and different experiences and expertise, which enables the sharing and challenging of knowledge and learning between these groups.

Those who found Q-municate and the general online resources useful cited several reasons why. Some stated that they appreciated that these resources are easy to use and access (13), fit into their limited time availability (9) and are free (4). Some respondents felt that the online resources allow them to access new knowledge, skills and learning (9) and help them stay in touch and keep up to date (5), particularly if they were not part of a large team of quality improvement people (1). Online resources were considered helpful for quality improvement work (5), especially if respondents aren’t already part of a quality improvement network in their work or elsewhere, and some used them as training materials (2). A small number of comments referred to the usefulness of the Institute for Healthcare Improvement (IHI) Open School Resources in understanding improvement work to a greater degree (2) and also referred to respondents’ enjoyment of the free publications given out at Q events (1).

It is the one place where I can find what and who is out there, without me having to trail the internet. I can lift the phone to people and mention we met at Q or I saw their profile on Q.

Reasons that were given as to why Q events were useful include: the opportunity for networking (15), to learn new skills and gain new knowledge (7), to access new ideas (2) and to reconnect with the wider community and more diverse audiences (1). Regional and local events are considered useful because they allow respondents to meet other local practitioners working in the same area, sometimes facilitating further collaboration (4). Some respondents reported that events (national and regional) offer a rare opportunity to meet other quality improvement practitioners face to face, which, due to the respondents’ roles being in primary care and as a patient representative and self-employed, were hard to find elsewhere (3).

Respondents also reported that Q visits are helpful because they offered opportunities to see learning and improvement in practice (4). Some found these visits useful because they are directly relevant to their own work (2).

Respondents reported that webinars were beneficial because they facilitated learning (6), particularly for those who were new to QI (2). Respondents credited webinars with helping them to keep their minds open, expand their knowledge and learn about new concepts. Other respondents appreciated their accessibility, particularly the lack of travel required (3) and their ability to fit into limited time (3). However, some considered that these could be more useful still if it were possible to watch webinars later rather than live (2).

Those who indicated that the SIGs and Q directory were most useful, explained that these resources were accessible and convenient (5), allowing them to be useful even when they had limited time or limited support in their job to access Q resources. These resources facilitate networking and collaborating with
others, including those who have similar interests and areas of expertise (2) and those who are working locally to each other (3). Respondents also cited how they had learnt and benefited as a result of taking part in SIGs (3) and specifically from interacting with other Q members.

Those who considered RCTs to be most useful found them accessible, as they don’t involve travelling, are quick and easy to engage with, and allow them to learn new things, engage with new ideas and meet new people.

Access to funding and the BMJ and other publications were felt to be useful by those who could not access these in their current jobs (2).

I.7.3. Respondents’ perceptions of the least useful resources and activities

Group A and Group B members were also asked which three resources and activities offered by Q they found the least useful in supporting their work in improving quality and provided a range of responses.98 As detailed below, there was no clear pattern in responses, with respondents commonly citing reasons that were highly specific to their specific context (e.g. not using Twitter), although a few respondents raised concerns about a lack of engagement by other members. It is also notable that the question about most useful resources (Section I.7) received many more responses than that relating to least useful resources.

Of the 314 members who provided at least one response, the following resources and activities were cited.99

In addition to those below, 27 respondents reported that all resources were useful and 53 were classed as ineligible by the researcher.

Table 50: Perception of least useful activities/resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twitter and social media</td>
<td>82</td>
</tr>
<tr>
<td>RCTs</td>
<td>73</td>
</tr>
<tr>
<td>Q Lab</td>
<td>35</td>
</tr>
<tr>
<td>BMJ publications</td>
<td>33</td>
</tr>
<tr>
<td>Q visits</td>
<td>31</td>
</tr>
<tr>
<td>SIGs</td>
<td>29</td>
</tr>
<tr>
<td>Webinars</td>
<td>21</td>
</tr>
<tr>
<td>Events (non-specific)</td>
<td>19</td>
</tr>
<tr>
<td>Local/regional events</td>
<td>16</td>
</tr>
<tr>
<td>Online resources</td>
<td>16</td>
</tr>
<tr>
<td>UK wide events</td>
<td>13</td>
</tr>
<tr>
<td>Q-municate</td>
<td>9</td>
</tr>
<tr>
<td>Q directory</td>
<td>6</td>
</tr>
<tr>
<td>Networking</td>
<td>4</td>
</tr>
</tbody>
</table>

98 Question text: Which of the activities and resources offered by Q do you find or expect to be the least useful in supporting your work in improving quality? Please indicate up to three options you consider to be the least useful. Very new members (Group C) were not asked this question.

99 As respondents were asked to report up to 3 resources and activities they found most useful, there are more responses than there are respondents.
Both Group A and B respondents cited social media, specifically Twitter and RCTs as the least useful resources on offer from Q.

Respondents were also asked why they considered these resources to be less useful. Many responses to this question mentioned a general lack of time to take part and engage (39). Two respondents felt that there was generally little engagement when they had tried to interact with other Q members. A small number of other respondents felt that Twitter and RCTs were irrelevant to their field of work (4). Occasionally these were accompanied with specific reasons, including a perceived focus on health rather than social work and on those working at the front line. A few respondents felt that they already have sufficient networks and resources outside of Q and so do not find it as useful as others (3).

The reasons why respondents thought RCTs were less useful varied. Several responses cited the time commitment involved (7). This may explain why others found that successfully arranging RCTs was ‘hit and miss’, as plans to meet up could often go nowhere (5). Some respondents thought that the RCT process is not sufficiently targeted in how it matches individuals to provide useful networking (4), meaning they were matched with someone who was, for example, too far away. A few reported that this isn’t their ideal way of meeting people (3) or that connections made are not deep-rooted and slightly artificial (2). Two did not know what RCTs were.

Those who found Twitter and other forms of social media to be least useful said that they do not generally use this medium of interacting (18) or do not personally find it useful (4). A small number were particularly unsure about the Twitter chat approach (3), and others considered it overwhelming or chaotic (2).

Some respondents who found that SIGs and the Q directory were less useful reported that they had tried to engage but found them to be inactive or with few people engaging (9). Others mentioned that while they appreciated having the contact list, they found making the time to make connections difficult (3). Others explained that they find these resources less useful because they prefer face-to-face networking and contact to virtual contact (5), with one respondent suggesting that they are less likely to dedicate time to a virtual connection than they would to an in-person interaction. Others reported finding the directory and SIGs confusing to use (2) and one person reported excessive bulk emails from SIGs.

When events and Q visits were considered less useful, reasons cited frequently included difficulty in travelling and the cost of travel (22). Three responses noted that this was a result of their position as self-employed, a patient or carer or working in a small organisation. A few found that time commitments were the biggest barrier to these events being useful (5), while others felt that they were arranged at too short
Some responses explained that the events or visits they had attended had not been relevant or sufficiently valuable in terms of learning or structure to be worth the effort of attending. A few comments addressed regional events in particular, with one respondent unaware of regional events taking place and another who thought that Q was more useful for national events than regional connections, which could be obtained by other means. Three members also specifically voiced dissatisfaction about events elsewhere in the survey: two mentioned the ‘nebulous’ or ‘organic’ character of events and asked for more structure, and one voiced disappointment that the events felt like ‘more of the same’ conferences and speakers as they had experienced in the past decade.

When online resources were considered least useful, respondents reported that the website was difficult to navigate to find relevant resources and that doing so was time-consuming. A couple of respondents felt that they already have access to similar resources elsewhere, that the IHI Open School resources were less helpful than expected, and that Q sent too many emails. One respondent reported that they had had little opportunity to network at webinars and another that the timing of webinars was not ideal.

Those who reported that access to the BMJ in terms of accessing articles and waiving publishing charges is less useful tended to report that this was irrelevant and that publishing their work was not something they were interested in doing. Others considered that they did not have time to use this resource or had simply not heard of the opportunity.

Some responses explained why they felt Q was less useful overall, rather than focusing on particular elements. A few respondents felt that Q members were too academically and technically focused and that those who were from other backgrounds or small organisations could not benefit fully. One respondent felt that Q was less useful because of how broad the membership was and that it lacked a particular focus or drive.

Some responses attributed their opinions on the limited usefulness of Q to the difficulty of embedding quality improvement work in the NHS and national agenda rather than internal factors.

I.7.4. Perceptions of Q’s value

Members were asked about their reasons for joining, or continuing to be a part of, Q. Respondents were able to select up to three answers. Access to resources to support improvement was the most frequently selected option, totalling 13.4 per cent of responses. This was followed by sharing learning with other improvers and access to experts and insightful advice, each comprising 12 per cent each.

Figure 68 shows the number of times that each option was selected as a percentage of the total responses (not percentage of total respondents). Access to resources to support improvement was the most frequently
selected option, totalling 13.4 per cent of responses. This was followed by sharing learning with other improvers and access to experts and insightful advice, each comprising 12 per cent each.

Figure 68: Reasons for joining/continuing to be a member of Q (% of total responses)

I.7.5. Views on benefit from Q

The surveys contained some questions that sought to explore the value that members felt they personally obtained through membership of Q.

Figure 69 indicates the level of agreement which respondents reported with statements concerning the value of Q.  

1. I am confident I personally benefit from being part of Q.
2. I am confident that through being part of Q I contribute to something that ultimately benefits the quality of health and care in the UK.

3. As a result of my membership of Q, I have access to information and/or resources for improving quality that I would not have otherwise.

4. As a result of my membership of Q, I can make the connections I need to undertake quality improvement work that I would not have otherwise.

5. I am confident that membership of Q will help me to organise and/or undertake improvement activities.

6. Membership of Q has helped me to influence improvement activities in my organisation or local area.

7. Membership of Q has helped me to develop my knowledge and/or skills for improving quality.

8. As a result of my membership of Q, I am able to share my knowledge and skills for improving quality in health and care with others.
Figure 69: Respondents’ agreement with statements about the value of Q

- I am confident I personally benefit from Q
- I am confident I contribute to ultimately benefiting the quality of health and care
- I have access to info and/or resources I would not otherwise have
- I make connections I would not ordinarily be able to make
- It has helped me to organise and/or undertake improvement activities
- It has helped me to influence improvement activities locally
- It has helped me to develop my knowledge and/or skills for QI
- I am able to share my knowledge and skills for QI

Percentage (%)

- Strongly agree
- Agree
- Slightly agree
- Neither agree nor disagree
- Slightly disagree
- Disagree
- Strongly disagree

Number of observations by question in descending order (top to bottom): 927, 916, 925, 923, 924, 911, 923, and 922
For each of the statements in Figure 69, we have combined the total agree and total disagree responses and present these along with their corresponding percentages in Table 58 (see Section I.11). Responses were broadly positive, with over 50 per cent of respondents indicating that they agreed to some extent with all statements but two (those relating to statements 5 and 6, which may be a consequence of individual members’ contexts and ability to initiate change in their work environment). Notably, a large proportion of respondents indicated that they ‘Agree’ or ‘Strongly agree’ with the statements that Q provided them with the opportunity to make connections and access resources that they would not otherwise have.

However, the number of respondents indicating that they disagreed with statements 1 and 2 – that they personally benefited from membership, and that they were confident on Q’s ability to have an impact of health and care – has increased since previous members surveys (Figure 70 and Figure 71 reproduce the equivalent figures from the 2018 interim evaluation report), with over 20 per cent indicating that they disagreed with some extent with these statements (with the vast majority indicating ‘slight’ disagreement).

**Figure 70: Confidence that members would benefit from Q (reproduced from 2018 interim report)**

I am confident I will benefit from joining Q.
1.7.6. Personal benefit derived from Q

Members were asked in a free-text question specifically how they personally benefited, or expected to benefit, from being part of Q.

The question text was: How do you personally benefit, or expect to benefit, from being part of Q, if at all? Please give specific examples if appropriate. These might include:

- development of skills and knowledge
- supporting your existing improvement work
- opportunities for career development
- creating opportunity for new improvement work or collaboration
- developing connections.

Upon analysis, it was clear that the inclusion of examples in this answer proved a leading question for some respondents. In analysing the answers, we excluded all respondents who copied the examples from the question text ad verbatim, although included those who had edited these in some way (thus providing evidence of reflection). In the 2019 iteration of the survey, we suggested that the specific examples were removed from the question text.

Group A and Group B/C were analysed separately to assess whether there were any major differences between the newer members of Q and those who had been involved for over a year. For both Group A and Group B/C, networking and the opportunity for learning and personal skills development were the most frequently cited by respondents. This is consistent with the answers relating to the most useful activities and resources in Section I.7, and other data collected over the course of the evaluation.
The responses from the 363 Group A members who answered this question are displayed in Table 51. In addition to these, 45 members (12 per cent) stated that they had not experienced or did not expect benefit, and 11 (3 per cent) were classed as ineligible (i.e. they simply repeated the examples in the question wholesale).

Table 51: Group A respondents’ expectation of benefit

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of valid responses citing this</th>
<th>% of valid responses which cited this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity for networking</td>
<td>164</td>
<td>45%</td>
</tr>
<tr>
<td>Learning or personal skills development</td>
<td>108</td>
<td>30%</td>
</tr>
<tr>
<td>Opportunity for ideas exchange and knowledge sharing</td>
<td>92</td>
<td>25%</td>
</tr>
<tr>
<td>Ability to get help or support for existing projects</td>
<td>45</td>
<td>12%</td>
</tr>
<tr>
<td>No benefit</td>
<td>45</td>
<td>12%</td>
</tr>
<tr>
<td>Access to resources</td>
<td>41</td>
<td>11%</td>
</tr>
<tr>
<td>Opportunity to collaborate on projects</td>
<td>30</td>
<td>8%</td>
</tr>
<tr>
<td>Prestige or benefits for career</td>
<td>13</td>
<td>4%</td>
</tr>
<tr>
<td>Benefits for organisation/place of work</td>
<td>11</td>
<td>3%</td>
</tr>
<tr>
<td>Motivation/validation about improvement work</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>Support for specific project</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Reasons categorised under ‘Other’ included:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘encouragement to remember to QI mindset’; Q being a great conversation starter between providers and regulators; being able to make a contribution as a patient/carer representative; and two members who cited specific resources (a specific masterclass and membership of the Institute for Continuous Improvement in Public Services (ICiPS).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Responses from the 279 Group B and C members who answered this question are set out in Table 52. In addition to these, 14 responses (5 per cent) were considered ineligible (i.e. they simply repeated the examples in the question wholesale).

Table 52: Group B and Group C respondents’ expectation of benefit

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of responses</th>
<th>% of valid responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning or personal skills development</td>
<td>133</td>
<td>48%</td>
</tr>
<tr>
<td>Opportunity for networking</td>
<td>117</td>
<td>42%</td>
</tr>
<tr>
<td>Opportunity for ideas exchange and knowledge sharing</td>
<td>62</td>
<td>22%</td>
</tr>
<tr>
<td>Opportunity to collaborate on projects</td>
<td>41</td>
<td>15%</td>
</tr>
</tbody>
</table>

\[103\] Answers were coded into more than one category if respondents flagged multiple benefits.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Number of responses</th>
<th>% of valid responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to resources</td>
<td>27</td>
<td>10%</td>
</tr>
<tr>
<td>Prestige or benefits for career</td>
<td>22</td>
<td>8%</td>
</tr>
<tr>
<td>Ability to get help or support for existing projects</td>
<td>21</td>
<td>8%</td>
</tr>
<tr>
<td>Benefits for organisation/place of work</td>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td>Support for specific project</td>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td>Motivation/validation about improvement work</td>
<td>1</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

I.7.7. Negative impacts of Q

Members were also asked whether they or their employer experienced any negative impacts as a result of Q membership.\(^{104}\) (The question for Group B and C members was whether they or their employer had experienced or expected to experience any negative impacts.)

Of 269 Group A members who provided an answer to this question, 234 (87 per cent) stated outright that they had not experienced any negative impacts.

Of the 35 who did report a negative impact, 22 directly cited the time/cost needed to participate in Q, including specifically a lack of perceived benefit for the time invested (7) and time wasted due to members not keeping RCT appointments (1). One member stated that they felt an expectation from their organisation to make more use of Q, although they didn’t have the time to fully participate.

> Q can be a bit of a time vampire overall if you try to respond to requests for input to events and development of ideas, commenting on the Q-exchange projects etc. I feel some obligation to do some of these things because I am a member but I have to be very measured with how much time I put into this. I am not personally getting any benefit for my work and it could be distracting.

Six members reported a lack of support from their employer, due to Q being seen as a ‘distraction’ or not relevant. Four other members reported some ‘push back’ or resentment from colleagues, including Q being viewed as a ‘clique’ (1), and a clash between Q approaches and other established approaches being used by senior members of staff at their organisation (1). One member cited Q being seen as ‘a tick-box exercise’ for employers. One member reported that their colleagues had had a less positive experience of Q, making it therefore harder to ‘sell’ to others.

Of 259 valid answers from newer members (Groups B and C), 215 (83 per cent) indicated that they had not experienced, or expected no, negative impacts. Of the 44 who reported negative impacts, 15 respondents indicated that time constraints are an issue, and three indicated that the cost of travelling to events is problematic.

> I have personally found that my employer is quite dismissive of Q as a whole and tolerates my membership rather than welcomes it. I and other colleagues have had to explain that going to a visit is part of professional development – which any other

\(^{104}\) Group A question text: Have you or your employer experienced any negative impacts or challenges as a result of your membership of Q? Group B and C question text: Have you or your employer experienced, or expect to experience, any negative impacts or challenges as a result of your membership of Q?
professional would be entitled to – yet I think there is a perception from non-QI colleagues it is a ‘day out’. This makes me sad and realise we still have a long way to go with some colleagues.

Seven respondents indicated other issues: one that people were using it for ‘shamelessly marketing’ themselves (1); that the lack of understanding of Q led to perceptions that it was not useful (2); that their employer has little interest in Q (2); and that Q had given rise to some occasional accusations of exclusivity (1). One member cited ‘fatigue’, and that Q was ‘too glamorous’ and so did not attract people who wanted ‘simple’.

I.8. Satisfaction and dissatisfaction with Q

This section contains some comments from respondents that indicated reasons why they were dissatisfied or not engaging with Q. These comments were often added to the ‘Any additional comments’ boxes or free-text boxes in different sections and are thus drawn from across the survey. As we consider that these comments may be of particular use to the Q team, we have included them in detail here. However, this should not be interpreted as indicative of the balance between positive/negative views held by the membership, particularly as dissatisfied members may have been more likely to fill out the surveys and provide detailed comments. For balance, we also include some spontaneous positive comments provided by respondents at the end of this section.

I.8.1. Ability to engage with Q resources

Some (primarily newer) members mentioned that they were unclear how to engage with Q. One member noted that they weren’t aware of any local events, and five members noted that they did not find it clear what was available to them as members. Three members stated that they did not receive useful information about things that are going on, and a different member thought that they would benefit more if they understood how Q communicates, as the newsletters were ‘confusing’.

But it all feels rather difficult to grab hold of. There are bits I hear about from others than I am interested in, but I don’t know how they know about them. I feel like I need a crash course in how to actually engage with Q. It’s not clear to me.

I was asked to join Q based on my achievements, the only thing I have received back in return is countless emails saying great things are happening and yet no examples have ever been shared. I feel that this whole exercise is pointless for me...as soon as I can leave the contact list then I will.

Since joining I have only received emails stating great work is being done somewhere and that I can attend workshops somewhere in the UK.

Not sure I benefit at all...study leave/professional leave is precious and I need to be able to target it to events where there is a structured aim or group of people working on the same projects in order to be able to collaborate efficiently and make good use of time.

Some members voiced dissatisfaction with the activities and resources on offer. Six members mentioned that the Q offer isn’t particularly relevant for their sector or role: one member reported that they felt the offer is not of particular use for primary care, and another reported that they didn’t feel the offer is useful
for acute clinical care; one member considered Q to be too focused on acute health care, and a fourth too focused on secondary care. Another member felt that not all specialties are represented in the support networks. Two members noted that activity seems to be focused on the regional level, while they wanted a wider UK focus.

Some members also felt that the Q community lacked central implementation support: one member noted, ‘it just feels like you’re given an email address and a name and left to fend for yourself’, and another member who had not noticed any events in or around London felt that central oversight of the planning of events would be beneficial.

1.8.2. Strategic direction of Q

Some members reported dissatisfaction with the strategic focus of Q. Three members felt that the diversity of Q activity was a drawback. One member felt that projects championed by Q were ‘all quite small scale and using ideas that are really quite old with little innovation’, and that Q could achieve more by concentrating efforts on the ‘big’ problems. While another member, who had hoped to connect with influential members, felt that the networking opportunities were with ‘junior’ people doing very diverse projects, which weren’t useful to that member’s role in practice, resulting in a ‘piecemeal’ approach rather than a strategic agenda. A third felt that the ‘overload of products and fragmentation’ made it difficult to show their employer the value and benefit of Q.

I tried to very actively contribute to Q in early years, was highly engaged. Became very frustrated at what seemed to be years spent planning, detached after the Aintree event which disappointed me in that we still seemed to be in planning mode, and shifting more from practical quality improvement to evangelical QI. The bit of Q that initially really appealed to me was about people with track record of improvement rather than in capital Q capital I roles, but that seemed to have gone.

I find it is very hard to grasp the Q offer and therefore to make best use of it. Q generates lots of excitement. Great badge. Good Twitter. Yet it still feels like there is a great party but quite where? I am finding it hard to penetrate through to the concrete from which I can benefit or through which I can contribute.

Two members also queried the way that Q fit into the other QI activities going on: one felt that to ‘make the most of Q’ members needed to treat it as the ‘go-to’ place for QI activities, and one noted that there was competition between Q and bodies such as IHI and Healthcare Improvement Scotland, noting that they had done more IHI activities recently than Q.

Linked to this were views from some members that Q, regardless of intrinsic value, was not able to work effectively within the reality of the health and social care landscape. As these comments were highly specific, we have included them in full below.

Q is a good movement but lacks focus and needs to get in touch with the real world barriers we are facing. Organisations are not supporting Q members and GPs have had very few opportunities in QI. I will leave Q if it continues as it is as it is unsustainable although I’m glad I joined the things I have done so far.

I think Q needs to develop a stronger voice for itself. Since the Darzi Report (High Quality Care for All), the quality agenda has not been pursued as hard as it should....Q and HF should be strong in advocating quality.
I think Q has had a good start, but it perhaps needs to focus on changing the culture of the NHS into improvement, rather than assurance.

I think Q’s ambitions will always be limited by the NHS’s determination to see improvement as something separate from the day job exemplified by structural splits such as NHS Improvement, NHS England, AHSNs operating largely separately from each other.

I am not convinced that the ‘bottom-up’ rationale behind Q is going to work. Unless NHS Trusts / Foundation Trust Boards and CCG leaders understand the importance of the right cultures and tools to improve quality it’s not going to happen at the scale the NHS needs. We also need to sort out the payment systems that encourage gaming and discourage real innovation and quality improvement. Q does neither of these things.

I.8.3. Membership profile of Q

Some respondents voiced dissatisfaction about the current people they were able to engage with in Q: for example, five members voiced respectively that Q was a ‘closed’ community, that ‘too many silos’ had formed, that developing connections was ‘harder as the network has grown’, and that membership was ‘more status driven’.

I do not believe Q is beneficial to the NHS as to me it is an echo chamber, which deliberately does not include those interested in Q but with no real experience. I have benefited much more greatly from local non-Q contacts.

One member felt that the early engagement between Q members had ‘dissipated’, affecting commitment meaning they aren’t sure where Q is ‘going’, and another felt that as it had grown, it had lost its ‘potency’. A different member voiced disappointment that they had made connections but received ‘no real practical help’, while another member reported feeling ‘excluded’ due to being on a low income.

I.8.4. Positive comments about Q

For balance it is important to note that a number of members also (without prompting) included comments about the value they received from Q in responses throughout the surveys and the final ‘Any additional comments’ box. While these were often less specific than the negative comments (possibly because members had been given the opportunity in the survey to discuss their thoughts about the way they benefit Q in more depth), some key themes, such as the community and sense of support, recur. Examples of these are included in Box 5.
Box 5: Positive comments offered about Q

Some statements related to the **activities and resources**:
- Fairly new to Q. I attended a Q visit which was excellent. I have not yet fully engaged with the site or resources.
- The information they send out is fantastic and I know I will access it much more in the coming year.
- I enjoy being involved in the activities I pursue and always try to be as helpful as possible in the pursuit of quality.
- I’m pleased I joined Q; fantastic network and access to great resources. I really need to better use it and dedicate more time to making it work for my role.

Some statements related to the **community**:
- I keep inviting other people to join and I think it is a refreshing environment that gave me great opportunities of talking honestly about QI work.
- Q is a fabulous easily accessible community that is making a difference to patient care and experience.
- Q brings great energy and encouragement to its members.
- I love being part of something national about QI with an outward focus.

Some statements related to the **value members felt they received from Q**:
- I am extremely thankful for the excellent teaching, exchange of ideas, collaboration and support that has resulted from joining Q.
- I really enjoy being a part of Q, I feel a real sense of community which is very helpful when at times you can feel that you are the lone worker trying to establish quality improvement within your team, service, or organisation. I feel that Q events are a safe space for real discussion, where other participants genuinely care and want to hear your stories and experience.
- The national team have been a real support to patient leaders and patients that have attended events, they have supported in ways others do not and I think this is shown in the way people talk about Q and the Health Foundation. Thank you for everything including the evaluation of each stage of the project.
- Q is committed to collaboration within and across organisations which is essential.

Some statements were **generally positive** without further elaboration:
- Q is excellent but not there yet ... keep developing.
- Q has been fantastic. Thank you so much for your support. Keep up the good work. This makes transformation possible.
- I think Q is a great resource. I am still exploring it and seeing how I can best use it and be of use to it in my new consultant role.
- Thank you. Member almost 1 year and reaping the benefits and positivity!
- Really glad to be part of Q, and would like to use it more but knowing it is there I have an excellent resource.
- Love Q. Please continue with your excellent work!
- I love Q. I wouldn’t be without it. I don’t get the opportunity to access the resources as much because my organisation doesn’t value improvement science.
1.9. Impact of Q on health and care

Groups A and B were asked whether their membership of Q had led to any impact on the quality of health and care that their team/organisation or collaborators delivered, with a request to provide specific examples. These were analysed separately to explore differences between newer- and longer-serving respondents.

Of 263 Group A respondents who provided a valid answer to this question, 127 (48%) reported no impact and 133 (50%) provided some indication of impact. Of those who reported some impact, 27 members (10%) provided a specific example of a project or instance of impact which they attributed to Q membership, 94 members (36%) provided an answer which indicated that they had experienced more general impact, such as skills development, increased awareness of QI or involvement in difference activities, and 12 further members (5%) indicated that they had a project in progress, which they hoped or expected to result in impact. Of this latter category, five of these related to Q Exchange funding, and one cited non-specified funding. One member reported hoping to set up a group through Q for professionals in their field; five cited engaging with Q resources for their own specific projects which were in early stages. In addition to these respondents, three other respondents reported that they were unsure as it was difficult to distinguish between the impact of Q and other QI activities with which they were involved (GenQ, KQuIP and their regular role in transformation).

For the 135 respondents in Group B who answered this question, 69 (51%) reported that they had not yet experienced any impact (although many acknowledged that they had recently joined), 31 members (23%) offered non-specific positive responses or general examples of impact (on aspects such as their skills, knowledge or networks), and a further 30 (22%) provided a specific example of impact. Five members (4%) reported expected impact: three from projects linked to Q Exchange, a fourth from working on a personal QI project, and a fifth who was integrating learning from the Q Behavioural Insights Day in their organisational work streams. Box 6 provides some examples of impact reported by members (although for reasons of anonymity some highly specific examples cannot be included here).

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105 Responses were categorised as invalid if they did not clearly provide an answer to the question or were irrelevant (n=24, Group A; n=5, Group B). Group C was not asked this question.
Box 6: Examples of specific and non-specific impact attributed to Q

<table>
<thead>
<tr>
<th>Examples of specific instances of impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A lot of learning especially from the [region] Q book club. I took ideas from [one discussion] to my health and safety coordinator, e.g. people having a code word if a mistake is taking place.</td>
</tr>
<tr>
<td>• Teamed up with other Q folk in the organisation, delivering an improvement methodology across the organisation.</td>
</tr>
<tr>
<td>• Q has helped me streamline a number of patient pathways and background processes which have impacted positively on patient experience and outcomes. I’m currently working on [redacted] prescription processes to reduce patient treatment deferrals, delays and drug waste.</td>
</tr>
<tr>
<td>• Developed one of my team through QI to gain a promotion to develop patient safety initiatives and engagement.</td>
</tr>
<tr>
<td>• The resources from Q helped me to build better resources tailored to the [redacted] profession.</td>
</tr>
<tr>
<td>• Changed, revised and improved our change management system. Changed and updated our Quality/Safety Dashboard.</td>
</tr>
<tr>
<td>• Improved our DNA [Did Not Attend] rate via use of some of the techniques referred to during the workshop.</td>
</tr>
<tr>
<td>• Implemented change to improve the timely delivery of medication within the [redacted] setting.</td>
</tr>
<tr>
<td>• Lean processes learning event at Nissan and Tees – AMAZING! Totally transferable to the programme of work in my organisation.</td>
</tr>
<tr>
<td>• Yes as ideas have been adopted and developed within this organisation. Such as the purple butterfly.</td>
</tr>
<tr>
<td>• Yes – example of data collection to prove and improvement has had an impact [sic] – moving away from RAG rating to statistical process charts for reports.</td>
</tr>
<tr>
<td>• Introduced the [region] team to liberating structures - recommended it highly. Used it in facilitating workshops. Others who attended the workshops have now utilised it as a method of working.</td>
</tr>
<tr>
<td>• We are doing Improvement via Lean.</td>
</tr>
<tr>
<td>• Yes, we are actively and purposefully listening to our patients and clients through our new continuous quality improvement system, this has been created and enabled due to our membership of Q.</td>
</tr>
<tr>
<td>• Working on patient flow. Starting to show improvements in A/E waits and hospital length of stay.</td>
</tr>
<tr>
<td>• Yes we have completed a Safety Culture Quality Improvement Project that explores how to promote bottom up sustainable transformation in front line teams.</td>
</tr>
<tr>
<td>• Yes, developing a regional innovation and improvement strategy.</td>
</tr>
<tr>
<td>• Local Q members are delivering QI training to Junior Doctors.</td>
</tr>
<tr>
<td>• I am currently undertaking a [redacted - multi-region] project…. I would have never had the confidence to attempt such a transformation without Q.</td>
</tr>
<tr>
<td>• It has been difficult to spread the Q initiatives throughout my organisation as the only member…. I have used some of the resources and discussions to commence discussion around areas such as the HSIB, training for quality improvement and use of audit in the CCG world. I have been using some of the Human Factors discussions within some of my project work around incident management and primary care.</td>
</tr>
</tbody>
</table>
**Dementia diagnosis rate success in [region], Sepsis improvement project as part of the deteriorating patient work stream with NEWS, impacted thinking around end of life in my [organisation]. Many other specific examples.**

**Examples of non-specific or general impact**

- Will assist in new creative ways of engagement with staff.
- In the NHS we are used to short term, often quick fix projects. The resources available through Q have helped me develop and communicate an ethos of ‘continuous improvement’.
- Increased knowledge and confidence in using ‘new’ tools like Liberating Structures.
- My membership has supported some of the teams I work with and my organisation as a whole in progressing our efforts to promote and embed an improvement culture in the organisation.
- More PPI.
- Given us a realistic standing in the trust. Made people see and realise that we are worthy of what we do and if Q/Health Foundation can see that then they trust have looked and value what we do too as a result.
- It's had an influence but not a direct impact. Influence because the Q website and resourced has informed some of our strategic thinking.
- Not directly, but the quality of conversations has much improved and the relationships have improved significantly.
- Credible and acceptable platform for flattening hierarchies and the benefits that gives.
- It has enabled us to support QI projects in the NHS by introducing us to teams who want our support.
- I think so, but hard to give details.

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**I.10. Q Exchange**

Respondents were asked whether they had engaged with Q Exchange. All respondents who did not submit a funding application were asked why they chose not to apply (detailed in Section I.10.1 below). Participants who applied but were unsuccessful were asked some questions about their intentions to seek funding elsewhere or reapply to Q and their perceptions of any wider value from the application process, which is detailed in Sections I.10.2 and I.10.3 below.

**I.10.1. Reasons why participants did not choose to apply**

Respondents who indicated that they had not applied for Q Exchange funding were asked to indicate why they chose not to do so. These responses are presented in Figure 72 and indicate no predominant reasons, although 18 per cent of respondents were not aware of Q Exchange.
Figure 72: Percentage of respondents who indicated particular reasons why they chose not to apply for Q Exchange funding\textsuperscript{106,107}

In addition, 76 respondents selected ‘Other’ and provided free-text comments to provide an alternative reason. As detailed in Error! Reference source not found.\textsuperscript{3} the majority of reasons given related to the individuals’ circumstances, rather than any dissatisfaction with the concept.

Table 53: ‘Other’ reasons provided for not applying for Q Exchange funding

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of responses citing this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable to role</td>
<td>15</td>
</tr>
<tr>
<td>Colleague or organisation submitted a proposal</td>
<td>10</td>
</tr>
<tr>
<td>Too busy</td>
<td>7</td>
</tr>
<tr>
<td>Didn’t need funding</td>
<td>6</td>
</tr>
<tr>
<td>Wasn’t in a position to submit a proposal</td>
<td>6</td>
</tr>
<tr>
<td>Joined Q too late to apply</td>
<td>6</td>
</tr>
<tr>
<td>Started application but unable to finish</td>
<td>5</td>
</tr>
<tr>
<td>Didn’t think they would be successful</td>
<td>4</td>
</tr>
<tr>
<td>Felt their project was unsuitable</td>
<td>4</td>
</tr>
<tr>
<td>Didn’t have the support of their employer</td>
<td>4</td>
</tr>
<tr>
<td>Already working on a QI project outside of Q</td>
<td>4</td>
</tr>
<tr>
<td>Would now like to submit a proposal</td>
<td>3</td>
</tr>
</tbody>
</table>

\textsuperscript{106} Question text: Why did you not apply for Q Exchange funding? Please select all that apply. Members could select more than one reason.

\textsuperscript{107} These figures display each option as a percentage of total ticked responses. This figure should be interpreted as displaying the popularity of responses relative to the other options.
Several responses reported that they did not apply for funding because doing so was not part of their role or job (15). In two cases, respondents indicated that others within their trust or team did submit proposals.

In total, ten respondents indicated that their organisations or colleagues had submitted a proposal: four of which indicated that they had supported this bid. Other respondents reported that they had started an application but been unable to complete this (5). In all but one case, this was because they ran out of time.

Other respondents considered that they were too busy to apply for funding (7) or were already working on QI projects outside of Q at the time (4). Some responses reported that they had not applied because they did not need the funding (6). In three cases, this was because project teams had other funding sources that were internal to their own organisation. Some respondents replied that they were not in a position to be part of a bid (6), often because they were starting a new role, on sabbatical or relocating at the time of application. Six respondents were new members and had joined Q only after the application deadline. A lack of support from employers was a reason why four other respondents did not submit a bid.

Other responses indicated that respondents did not apply for Q exchange funding because they did not think that their bid would be successful (4). Reasons given for this lack of confidence included previous failures to win funding (2) and concerns that their project would not gain enough support (2). Another respondent explained that they found the process too complex and one more that their project did not fit the Q exchange criteria. (On the other hand, one respondent who had been successful in securing funding noted elsewhere in the survey that winning funding was a ‘fun’ and ‘less intimidating’ experience due to the ‘community’ feeling.)

Of the four respondents who felt that their project was unsuitable, three believed that one factor in their decision not to apply for Q exchange funding was because their project was patient centred. One felt that the process of applying for the Health Foundation funding tended to ‘favour pre-defined target outcomes’, which they considered to be more challenging for projects focused on patient-centred activities. Another felt that their patient-led project was not the sort of project which would get funding, while another expressed frustration at the lack of support available for primary care generally.

Two respondents did not believe themselves to be eligible to apply and another two did not know about the Q exchange at the time. One member was based outside the UK and so unable to take part, while another decided not to apply because they felt the process was too complex. Three respondents who did not submit an application for funding reported that they would now consider submitting a bid for proposal.

### I.10.2. Questions for unsuccessful Q Exchange applicants

The surveys also contained a number of questions specifically for unsuccessful Q Exchange applicants (87 respondents). As depicted in Figure 73 and Figure 74, the majority of unsuccessful applicants would definitely or potentially apply again for Q Exchange and 70 per cent were also intending to seek alternative funding for their current project.
Figure 73: Percentage of unsuccessful applicant respondents who would apply again for Q Exchange funding

<table>
<thead>
<tr>
<th>Percentage (%)</th>
<th>Yes, I would apply again to Q Exchange</th>
<th>Maybe</th>
<th>No</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>59.96</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.72</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.81</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.49</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number of total observations: 86
Number of observations from left to right: 49, 29, 5, 3

Figure 74: Percentage of unsuccessful applicants who will seek alternative funding

<table>
<thead>
<tr>
<th>Percentage (%)</th>
<th>Yes, I am confident that our project can find funding elsewhere</th>
<th>Yes, but I am not sure whether our project can find funding elsewhere</th>
<th>No, we will not look for funding elsewhere</th>
<th>I do not know where to look for alternative funding</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.77</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.79</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.79</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number of total observations: 86
Number of observations from left to right: 17, 43, 11, 4, 11

---

108 Question text: Would you apply again for funding from Q Exchange?
109 Question text: Will you or your team look for funding for your project elsewhere?
I.10.3. Wider value of the Q Exchange application process

Unsuccessful applicants were also asked about their perceptions of the wider value of the application process. The 69 free-text responses received to this question can be broadly categorised as:

- 43 positive
- 18 negative
- 8 mixed or neutral.

These are analysed below.

Positive responses

More positive views about the wider value of the process of applying focused on a variety of factors. Several responses mentioned how the process had helped them to focus their ideas and plans into a project (13). This included helping to focus, clarify and ‘get down’ their ideas on paper, as well as in planning and fine-tuning projects that were already more developed.

*It concentrated our random thoughts and gave us the drive to come up with a plan on a way forward.*

Several respondents considered that they had learnt from the process, including in gaining new skills and more knowledge about their particular topic and others’ projects (10). In particular, some of these respondents reported that they had found the process useful in terms of developing skills and knowledge about bid writing and funding applications (4).

For several respondents, the feedback that Q members themselves provided was another reason why the process was valuable. Several responses focused on the useful insights, contributions and feedback from commentators that changed and developed their ideas (6), and others found the sense of peer support and community within Q most valuable (4). One member, in response to a different survey question, noted that the process of applying had ‘focused their mind’ on their project and helped them engage frontline staff, and they now had the ability to access funding from an unspecified different source.

Other responses focused on the opportunities for networking and connecting with others that the process had brought to them (6). One respondent mentioned that these connections were useful because they found people to learn from who had similar aims. Another reported that these connections had been ‘invaluable’ after Q Exchange, while a further response considered that they had found potential future collaborators from the process.

*Huge value in connecting Q members, opening my eyes to some really wonderful new and innovative ideas.*

Other respondents felt that the collaboration within the process had made it valuable, both within the project team and within the Q community who had supported their project (4).

The impact of the process on the project idea itself was considered by some respondents, who reported that it had raised awareness about their particular topic or project (6). Two respondents also thought that the process had been valuable for raising the profile of Q within the wider NHS and encouraging non-members of Q to get involved.
A few responses drew out other particularly useful aspects of the Q Exchange process, including the events (3), the public vote method (1) and the shortlisting procedure (1). Another reported that the forms involved in the process were easy to use and accessible.

Negative responses
Some respondents who reported negative or mixed views about the wider value of the Q Exchange application process offered a range of reasons, which mainly focused on the nature of the process itself.

Some respondents felt that the practice of allocating funding based on votes was unfair (6). One felt that this meant more nuanced approaches might be overlooked and another that it became political rather than based on merit. Three of these respondents suggested that this process favours organisations with more resources and disadvantages those from small organisations or with lived experience.

Other responses reported that they had found the process itself to take up a lot of time, effort and work (5). One felt that it was ‘quite convoluted and difficult to navigate’. Two other respondents also noted that they were unclear about how the process worked, particularly around how the final shortlist was drawn up and the evaluation criteria.

Two other respondents had found it difficult to get much interaction with or feedback from Q members in order to develop their bid, and one found that the difference between the Q Exchange process and other funding applications was unhelpful.

A couple of respondents suggested ways in which the process could be improved in future years (2). One respondent from a group with little experience of funding applications thought that it would be more useful for projects to receive expert feedback at the beginning of the process rather than the end. Another respondent suggested that some projects would have benefited from being linked to each other.

Beyond the process itself, two respondents indicated that their project’s failure to win funding had had a negative impact on their impetus to continue working on it. One mentioned that their motivation was lost when they were not successful and another that it was ‘ultimately disheartening’.

Personally I found the Q Exchange event very time consuming, and emotionally it was a bit of a rollercoaster. It was a very time-intensive process, that was exhausting, and for our team, ultimately unsuccessful. The fact that we did not get funding hit harder because of the time and emotional investment all our team put in.
1.11. Data tables for figures

Table 54: Number and corresponding percentages for Figure 53

<table>
<thead>
<tr>
<th></th>
<th>Total agree n (%)</th>
<th>Neither agree nor disagree n (%)</th>
<th>Total disagree n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my current role(s) I am able to make changes that could improve quality in my local setting and/or organisation</td>
<td>665 (92.88%)</td>
<td>21 (2.93%)</td>
<td>30 (4.19%)</td>
</tr>
<tr>
<td>In my current role(s) I am able to make changes that could improve quality regionally or nationally</td>
<td>607 (85.13%)</td>
<td>48 (6.73%)</td>
<td>58 (8.13%)</td>
</tr>
<tr>
<td>I get the support I need from my organisation for the improvement work I do</td>
<td>603 (84.69%)</td>
<td>41 (5.76%)</td>
<td>68 (9.55%)</td>
</tr>
<tr>
<td>I get the support I need from organisation(s) other than my own for the improvement work I want to do</td>
<td>526 (73.46%)</td>
<td>123 (17.18%)</td>
<td>67 (9.36%)</td>
</tr>
<tr>
<td>Improving quality is embedded in my organisation</td>
<td>569 (79.47%)</td>
<td>56 (7.82%)</td>
<td>91 (12.71%)</td>
</tr>
</tbody>
</table>
### Table 55: Number and corresponding percentages for Figure 65

<table>
<thead>
<tr>
<th>Activity</th>
<th>At least once a week n (%)</th>
<th>At least once a month n (%)</th>
<th>At least once every 2–3 months n (%)</th>
<th>At least once every 4–6 months n (%)</th>
<th>Less frequently n (%)</th>
<th>Never n (%)</th>
<th>Did not know about this n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Published my work in BMJ Open Quality (Q covered the Article Publishing Charge)</td>
<td>1 (0.21%)</td>
<td>6 (1.26%)</td>
<td>6 (1.26%)</td>
<td>8 (1.67%)</td>
<td>23 (4.81%)</td>
<td>291 (60.88%)</td>
<td>143 (29.92%)</td>
</tr>
<tr>
<td>Participated in a Randomised Coffee Trial (RCT)</td>
<td>–</td>
<td>8 (1.70%)</td>
<td>37 (7.87%)</td>
<td>19 (4.04%)</td>
<td>72 (15.32%)</td>
<td>295 (62.77%)</td>
<td>39 (8.30%)</td>
</tr>
<tr>
<td>Attended UK-wide events (e.g. masterclasses, annual Q community event)</td>
<td>–</td>
<td>–</td>
<td>17 (3.59%)</td>
<td>107 (22.57%)</td>
<td>195 (41.14%)</td>
<td>152 (32.07%)</td>
<td>3 (0.63%)</td>
</tr>
<tr>
<td>Attended a Q visit</td>
<td>–</td>
<td>2 (0.42%)</td>
<td>3 (0.64%)</td>
<td>29 (6.14%)</td>
<td>110 (23.31%)</td>
<td>309 (65.47%)</td>
<td>19 (4.03%)</td>
</tr>
<tr>
<td>Engaged with local or regional Q activities</td>
<td>3 (0.64%)</td>
<td>10 (2.12%)</td>
<td>40 (8.47%)</td>
<td>116 (24.58%)</td>
<td>188 (39.83%)</td>
<td>110 (23.31%)</td>
<td>5 (1.06%)</td>
</tr>
<tr>
<td>Found/contacted someone I did not know before through the Q Member Directory</td>
<td>–</td>
<td>9 (1.90%)</td>
<td>30 (6.34%)</td>
<td>62 (13.11%)</td>
<td>167 (35.31%)</td>
<td>199 (42.07%)</td>
<td>6 (1.27%)</td>
</tr>
<tr>
<td>Contacted/collaborated with a new person who I met through Q</td>
<td>3 (0.63%)</td>
<td>8 (1.67%)</td>
<td>33 (6.90%)</td>
<td>71 (14.85%)</td>
<td>173 (36.19%)</td>
<td>187 (39.12%)</td>
<td>3 (0.63%)</td>
</tr>
<tr>
<td>Participated in a Twitter chat</td>
<td>3 (0.63%)</td>
<td>8 (1.68%)</td>
<td>18 (3.78%)</td>
<td>38 (7.98%)</td>
<td>85 (17.86%)</td>
<td>307 (64.50%)</td>
<td>17 (3.57%)</td>
</tr>
<tr>
<td>Participated in a webinar</td>
<td>–</td>
<td>9 (1.90%)</td>
<td>23 (4.85%)</td>
<td>67 (14.14%)</td>
<td>130 (27.43%)</td>
<td>234 (49.37%)</td>
<td>11 (2.32%)</td>
</tr>
<tr>
<td>Activity</td>
<td>At least once a week n (%)</td>
<td>At least once a month n (%)</td>
<td>At least once every 2–3 months n (%)</td>
<td>At least once every 4–6 months n (%)</td>
<td>Less frequently n (%)</td>
<td>Never n (%)</td>
<td>Did not know about this n (%)</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------</td>
<td>-----------------------------</td>
<td>-------------------------------------</td>
<td>--------------------------------------</td>
<td>-----------------------</td>
<td>-------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Engaged with one or more online groups/special interest groups</td>
<td>3 (0.64%)</td>
<td>16 (3.40%)</td>
<td>48 (10.19%)</td>
<td>64 (13.59%)</td>
<td>119 (25.27%)</td>
<td>209 (44.37%)</td>
<td>12 (2.55%)</td>
</tr>
<tr>
<td>Read Q-municate articles and blogs</td>
<td>10 (2.11%)</td>
<td>88 (18.57%)</td>
<td>137 (28.90%)</td>
<td>99 (20.89%)</td>
<td>87 (18.35%)</td>
<td>44 (9.28%)</td>
<td>9 (1.90%)</td>
</tr>
<tr>
<td>Engaged with online learning resources (e.g. IHI Open School, BMJ Quality and Safety journal, Creative Approaches to Problem Solving toolkit)</td>
<td>6 (1.27%)</td>
<td>43 (9.09%)</td>
<td>65 (13.74%)</td>
<td>84 (17.76%)</td>
<td>98 (20.72%)</td>
<td>135 (28.54%)</td>
<td>42 (8.88%)</td>
</tr>
<tr>
<td>Engagement with Q Lab resources and activities</td>
<td>2 (0.42%)</td>
<td>13 (2.75%)</td>
<td>31 (6.57%)</td>
<td>55 (11.65%)</td>
<td>116 (24.58%)</td>
<td>239 (50.64%)</td>
<td>16 (3.39%)</td>
</tr>
<tr>
<td>Accessed resources on the Q website (e.g. directory, events listing)</td>
<td>8 (1.71%)</td>
<td>54 (11.51%)</td>
<td>104 (22.17%)</td>
<td>95 (20.26%)</td>
<td>133 (28.36%)</td>
<td>65 (13.86%)</td>
<td>10 (2.13%)</td>
</tr>
</tbody>
</table>
Table 56: Number and corresponding percentages for Figure 66

<table>
<thead>
<tr>
<th>Event</th>
<th>At least once a week n (%)</th>
<th>At least once a month n (%)</th>
<th>At least once every 2–3 months n (%)</th>
<th>At least once every 4–6 months n (%)</th>
<th>Less frequently n (%)</th>
<th>Never n (%)</th>
<th>Did not know about this n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Published my work in BMJ Open Quality (Q covered the Article Publishing Charge)</td>
<td>–</td>
<td>2 (0.87%)</td>
<td>2 (0.87%)</td>
<td>–</td>
<td>6 (2.61%)</td>
<td>130 (56.52%)</td>
<td>90 (39.13%)</td>
</tr>
<tr>
<td>Participated in a Randomised Coffee Trial (RCT)</td>
<td>–</td>
<td>8 (3.49%)</td>
<td>13 (5.68%)</td>
<td>4 (1.75%)</td>
<td>10 (4.37%)</td>
<td>163 (71.18%)</td>
<td>31 (13.54%)</td>
</tr>
<tr>
<td>Attended UK-wide events (e.g. masterclasses, annual Q community event)</td>
<td>–</td>
<td>4 (1.73%)</td>
<td>14 (6.06%)</td>
<td>50 (21.65%)</td>
<td>100 (43.29%)</td>
<td>–</td>
<td>63 (27.27%)</td>
</tr>
<tr>
<td>Attended a Q visit</td>
<td>1 (0.44%)</td>
<td>2 (0.87%)</td>
<td>–</td>
<td>20 (8.73%)</td>
<td>27 (11.79%)</td>
<td>164 (71.62%)</td>
<td>15 (6.55%)</td>
</tr>
<tr>
<td>Engaged with local or regional Q activities</td>
<td>–</td>
<td>7 (3.10%)</td>
<td>20 (8.85%)</td>
<td>48 (21.24%)</td>
<td>65 (28.76%)</td>
<td>78 (34.51%)</td>
<td>8 (3.54%)</td>
</tr>
<tr>
<td>Found/contacted someone I did not know before through Q Member Directory</td>
<td>–</td>
<td>10 (4.37%)</td>
<td>27 (11.79%)</td>
<td>30 (13.10%)</td>
<td>53 (23.14%)</td>
<td>101 (44.10%)</td>
<td>8 (3.49%)</td>
</tr>
<tr>
<td>Contacted/collaborated with a new person who I met through Q</td>
<td>–</td>
<td>12 (5.17%)</td>
<td>19 (8.19%)</td>
<td>26 (11.21%)</td>
<td>53 (22.84%)</td>
<td>116 (50.00%)</td>
<td>6 (2.59%)</td>
</tr>
<tr>
<td>Participated in a Twitter chat</td>
<td>1 (0.44%)</td>
<td>8 (3.51%)</td>
<td>13 (5.70%)</td>
<td>17 (7.46%)</td>
<td>27 (11.84%)</td>
<td>145 (63.60%)</td>
<td>17 (7.46%)</td>
</tr>
<tr>
<td>Participated in a webinar</td>
<td>–</td>
<td>7 (3.04%)</td>
<td>17 (7.39%)</td>
<td>25 (10.87%)</td>
<td>48 (20.87%)</td>
<td>121 (52.61%)</td>
<td>12 (5.22%)</td>
</tr>
<tr>
<td>Activity</td>
<td>At least once a week n (%)</td>
<td>At least once a month n (%)</td>
<td>At least once every 2–3 months n (%)</td>
<td>At least once every 4–6 months n (%)</td>
<td>Less frequently n (%)</td>
<td>Never n (%)</td>
<td>Did not know about this n (%)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>----------------------------</td>
<td>--------------------------------------</td>
<td>--------------------------------------</td>
<td>-----------------------</td>
<td>-------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Engaged with one or more online groups/special interest groups</td>
<td>2 (0.88%)</td>
<td>17 (7.52%)</td>
<td>27 (11.95%)</td>
<td>27 (11.95%)</td>
<td>34 (15.04%)</td>
<td>107 (47.35%)</td>
<td>12 (5.31%)</td>
</tr>
<tr>
<td>Read Q-municate articles and blogs</td>
<td>14 (6.11%)</td>
<td>55 (24.02%)</td>
<td>41 (17.90%)</td>
<td>43 (18.78%)</td>
<td>31 (13.54%)</td>
<td>36 (15.72%)</td>
<td>9 (3.93%)</td>
</tr>
<tr>
<td>Engaged with online learning resources (e.g. IHI Open School,</td>
<td>9 (3.91%)</td>
<td>27 (11.74%)</td>
<td>33 (14.35%)</td>
<td>21 (9.13%)</td>
<td>36 (15.65%)</td>
<td>74 (32.17%)</td>
<td>30 (13.04%)</td>
</tr>
<tr>
<td>BMJ Quality and Safety journal, Creative Approaches to Problem Solving</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>toolkit)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement with Q Lab resources and activities</td>
<td>1 (0.43%)</td>
<td>17 (7.36%)</td>
<td>19 (8.23%)</td>
<td>24 (10.39%)</td>
<td>55 (23.81%)</td>
<td>101 (43.72%)</td>
<td>14 (6.06%)</td>
</tr>
<tr>
<td>Accessed resources on the Q website (e.g. directory, events listing)</td>
<td>6 (2.59%)</td>
<td>42 (18.10%)</td>
<td>46 (19.83%)</td>
<td>36 (15.52%)</td>
<td>52 (22.41%)</td>
<td>43 (18.53%)</td>
<td>7 (3.02%)</td>
</tr>
</tbody>
</table>
Table 57: Number and corresponding percentages for Figure 67

<table>
<thead>
<tr>
<th>Activity</th>
<th>Very useful n (%)</th>
<th>Of some use n (%)</th>
<th>Of limited use n (%)</th>
<th>Not at all useful n (%)</th>
<th>Don’t know n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publishing my work in BMJ Open Quality (with Q covering the Article Publishing Charge)</td>
<td>17 (13.18%)</td>
<td>20 (15.50%)</td>
<td>47 (36.43%)</td>
<td>31 (24.03%)</td>
<td>14 (10.85%)</td>
</tr>
<tr>
<td>Participating in a Randomised Coffee Trial (RCT)</td>
<td>5 (3.91%)</td>
<td>24 (18.75%)</td>
<td>66 (51.56%)</td>
<td>15 (11.72%)</td>
<td>18 (14.06%)</td>
</tr>
<tr>
<td>Attending UK-wide events (e.g. masterclasses, annual Q community event)</td>
<td>–</td>
<td>10 (7.81%)</td>
<td>41 (32.03%)</td>
<td>77 (60.16%)</td>
<td>–</td>
</tr>
<tr>
<td>Attending a Q visit</td>
<td>–</td>
<td>9 (6.98%)</td>
<td>44 (34.11%)</td>
<td>66 (51.16%)</td>
<td>10 (7.75%)</td>
</tr>
<tr>
<td>Engaging with local or regional Q activities</td>
<td>–</td>
<td>9 (7.03%)</td>
<td>42 (32.81%)</td>
<td>74 (57.81%)</td>
<td>3 (2.34%)</td>
</tr>
<tr>
<td>Finding/contacting someone I do not know through the Q Member Directory</td>
<td>–</td>
<td>14 (11.20%)</td>
<td>56 (44.80%)</td>
<td>53 (42.40%)</td>
<td>2 (1.60%)</td>
</tr>
<tr>
<td>Contacting / collaborating with new people who I meet through Q</td>
<td>–</td>
<td>4 (3.15%)</td>
<td>65 (51.18%)</td>
<td>57 (44.88%)</td>
<td>1 (0.79%)</td>
</tr>
<tr>
<td>Participating in a webinar</td>
<td>–</td>
<td>17 (13.18%)</td>
<td>74 (57.36%)</td>
<td>35 (27.13%)</td>
<td>3 (2.33%)</td>
</tr>
<tr>
<td>Participating in a Twitter chat</td>
<td>11 (8.73%)</td>
<td>43 (34.13%)</td>
<td>39 (30.95%)</td>
<td>23 (18.25%)</td>
<td>10 (7.94%)</td>
</tr>
<tr>
<td>Engaging online groups/special interest groups</td>
<td>3 (2.36%)</td>
<td>21 (16.54%)</td>
<td>60 (47.24%)</td>
<td>35 (27.56%)</td>
<td>8 (6.30%)</td>
</tr>
<tr>
<td>Reading Q-municate articles and blogs</td>
<td>2 (1.57%)</td>
<td>12 (9.45%)</td>
<td>65 (51.18%)</td>
<td>43 (33.86%)</td>
<td>5 (3.94%)</td>
</tr>
<tr>
<td>Engaging with online learning resources (e.g. IHI Open School, BMJ Quality and Safety journal, Creative Approaches to Problem Solving toolkit)</td>
<td>1 (0.78%)</td>
<td>8 (6.20%)</td>
<td>61 (47.29%)</td>
<td>55 (42.64%)</td>
<td>4 (3.10%)</td>
</tr>
<tr>
<td>Engaging with Q Lab resources and activities</td>
<td>4 (3.20%)</td>
<td>12 (9.60%)</td>
<td>56 (44.80%)</td>
<td>44 (35.20%)</td>
<td>9 (7.20%)</td>
</tr>
<tr>
<td>Accessing resources on the Q website (e.g. directory, events listing)</td>
<td>1 (0.78%)</td>
<td>4 (3.13%)</td>
<td>71 (55.47%)</td>
<td>51 (39.84%)</td>
<td>1 (0.78%)</td>
</tr>
<tr>
<td>Applying for funding through Q Exchange</td>
<td>6 (4.69%)</td>
<td>20 (15.63%)</td>
<td>39 (30.47%)</td>
<td>48 (37.50%)</td>
<td>15 (11.72%)</td>
</tr>
</tbody>
</table>
Table 58: Number and corresponding percentages for Figure 69

<table>
<thead>
<tr>
<th>Statement</th>
<th>Total agree (n, %)</th>
<th>Neither agree nor disagree (n, %)</th>
<th>Total disagree (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am confident I personally benefit from being part of Q</td>
<td>584 (63.00%)</td>
<td>105 (11.33%)</td>
<td>238 (25.67%)</td>
</tr>
<tr>
<td>I am confident that through being part of Q I contribute to something that ultimately benefits the quality of health and care in the UK</td>
<td>579 (63.21%)</td>
<td>96 (10.48%)</td>
<td>241 (26.31%)</td>
</tr>
<tr>
<td>As a result of my membership of Q, I have access to information and/or resources for improving quality that I would not have otherwise</td>
<td>677 (73.19%)</td>
<td>61 (6.59%)</td>
<td>187 (20.22%)</td>
</tr>
<tr>
<td>As a result of my membership of Q, I can make the connections I need to undertake quality improvement work that I would not have otherwise</td>
<td>593 (64.25%)</td>
<td>83 (8.99%)</td>
<td>247 (26.76%)</td>
</tr>
<tr>
<td>Membership of Q has helped me to organise and/or undertake improvement activities</td>
<td>404 (43.72%)</td>
<td>222 (24.03%)</td>
<td>298 (32.25%)</td>
</tr>
<tr>
<td>Membership of Q has helped me to influence improvement activities in my organisation or local area</td>
<td>380 (41.71%)</td>
<td>223 (24.48%)</td>
<td>308 (33.81%)</td>
</tr>
<tr>
<td>Membership of Q has helped me to develop my knowledge and/or skills for improving quality</td>
<td>536 (58.07%)</td>
<td>114 (12.35%)</td>
<td>273 (29.58%)</td>
</tr>
<tr>
<td>As a result of my membership of Q, I am able to share my knowledge and skills for improving quality in health and care with others</td>
<td>500 (54.23%)</td>
<td>154 (16.70%)</td>
<td>268 (29.07%)</td>
</tr>
</tbody>
</table>
This appendix outlines further selected results of the five surveys undertaken over the course of the first two years of the evaluation and is reproduced from the interim evaluation report (Ling et al., 2018).

Figure 75 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 (with categories being the response options, e.g. ‘Strongly disagree’, ‘Strongly agree’. For an increase, responses moved towards the agree statements). For the 31 Phase 2 respondents, there was no statistically significant change.

**Figure 75. 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 76 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 76. 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 77 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 77. Ability to make non-local improvements**

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

- 100%           0%  
- Phase 3 Wave 3 new members  
- Phase 3 Wave 3 unsuccessful applicants  
- Phase 3 Wave 2 new members  
- Phase 3 Wave 2 unsuccessful applicants  
- Phase 3 Wave 1 unsuccessful applicants  
- Phase 3 Wave 1 new members  
- Phase 2  
- Phase 1 - end of year  
- Phase 1 - baseline  
- Annual survey March 2017  

- Strongly disagree  
- Disagree  
- Slightly disagree  
- Neither agree nor disagree  
- Slightly agree  
- Agree  
- Strongly agree
Figure 78 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 78. Skills and knowledge**

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

![Bar chart showing the percentage of respondents for each phase and wave, with categories from Strongly disagree to Strongly agree.](chart.png)
Figure 79 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 79. Support from own organisation**

I get the support I need from my organisation for the improvement work I want to do.
Figure 80 shows the support from other organisations reported by respondents. This question was not asked in Phase 1 or 2.

**Figure 80. 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.

- Strongly disagree
- Disagree
- Slightly disagree
- Neither agree nor disagree
- Slightly agree
- Agree
- Strongly agree
Figure 81 shows the extent to which respondents reported being part of strong, supportive networks. This question was not asked in Phase 1 or 2.

**Figure 81. Network membership**

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

- **Strongly disagree**
- **Disagree**
- **Neither agree nor disagree**
- **Slightly agree**
- **Agree**
- **Strongly agree**
Figure 82 shows the extent to which respondents reported collaborating with diverse people. This question was not asked in Phase 1 or 2.

**Figure 82. 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 83 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 83. Support from network**

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

![Graph showing support from network](image-url)

- **Strongly disagree**
- **Disagree**
- **Slightly disagree**
- **Neither agree nor disagree**
- **Slightly agree**
- **Agree**
- **Strongly agree**
Figure 84 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 84. 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.

Annual survey March 2017

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
Figure 85 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 85. Embedding of improvement**

Improving quality is embedded in my organisation.

- Annual survey March 2017
- 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 86 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 86: Member’s self-reported suitability for membership**

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

- **Strongly disagree**
- **Disagree**
- **Slightly disagree**
- **Neither agree nor disagree**
- **Slightly agree**
- **Agree**
- **Strongly agree**

<table>
<thead>
<tr>
<th>Phase/Group</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly disagree</th>
<th>Neither agree nor disagree</th>
<th>Slightly agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual survey March 2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase 3 Wave 1 new members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase 3 Wave 2 new members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase 3 Wave 3 new members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phase 3 Wave 4 new members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
K.1. Background to Q Exchange

Q Exchange is a funding programme offered through the Q Initiative. It was first piloted in 2018 and a second round ran in 2019. In 2018, funding for Q Exchange was provided by the Health Foundation only and totalled £450,000 (Brewster, 2019a). As the 2018 pilot allowed the Q team to demonstrate the feasibility and value of Q Exchange, NHS Improvement provided an additional £200,000 in 2019. This meant a greater number of projects were funded, rising from 15 in 2018 to 20 in 2019 (Brewster, 2019b).

Q Exchange has three main aims (Brewster, 2019b):

- Activate the knowledge of improvement experts across the UK.
- Create links between those leading work and those who can help champion, support and adopt these ideas.
- Boost ideas that have the best potential to generate value for the health and care system.

Q members were involved in the creation and design of Q Exchange. Two prototype workshops were held with Q members and an online reference group was set up with Q members to test possible formats and structures that Q Exchange could take (Pereira & Henderson, 2018).

Although Q Exchange has (at the time of writing) been run twice, in 2018 and 2019, the Q team consider both of these to be ‘test rounds’ (Pereira & Henderson, 2018). The second round saw refinements and changes to the bidding and voting format, which will be discussed in further detail below.

Engagement with Q Exchange from Q members, e.g. in providing feedback online and submitting bids, has been consistent over the two years it has been operating. The ability to vote remotely online in 2019 was associated with an increased number of votes received compared to the 2018 pilot. The engagement statistics are shown in Table 59.
Table 59: Engagement with Q Exchange over 2018 and 2019 (Brewster, 2019b)\textsuperscript{110}

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideas uploaded</td>
<td>181</td>
<td>180</td>
</tr>
<tr>
<td>Full proposals submitted</td>
<td>139</td>
<td>117</td>
</tr>
<tr>
<td>Number of votes</td>
<td>241 (10% of members eligible to vote)</td>
<td>608 (18% of members eligible to vote)</td>
</tr>
</tbody>
</table>

K.1.1. Changes to the format of Q Exchange from 2018 to 2019

As mentioned, a number of changes were introduced to the Q Exchange format from the 2018 to 2019 rounds. Through assessment of key documents from the Q Exchange team, we summarise these changes and the rationale in Table 60.

Table 60: Changes made to Q Exchange from 2018 to 2019

<table>
<thead>
<tr>
<th>Type of change</th>
<th>2018 format</th>
<th>2019 format</th>
<th>Reason for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voting format</td>
<td>Only members attending the 2018 national event could vote for projects.</td>
<td>All members could vote remotely over a three-week period.</td>
<td>Remote voting is more accessible for all member [Brewster, 2019b, 2019a].\textsuperscript{111}</td>
</tr>
<tr>
<td>Project themes</td>
<td>Projects ideas could be on any topic, although the Q team advertised particular interest in peer support-related projects.</td>
<td>Projects had to fall into one of two themes: ‘Understanding alternatives to traditional outpatient appointments’ or ‘Building improvement capability and insights across boundaries’.</td>
<td>Feedback indicated confusion at an open call with expressed interest in a certain area [Brewster, 2019a].</td>
</tr>
<tr>
<td>Application process</td>
<td>Full applications to Q Exchange uploaded via the Health Foundation’s grant system (AIMS) following initial engagement on the Q Exchange website.</td>
<td>Bidders could submit their applications through the Q website.</td>
<td>To make the application process simpler for bidders (and the Q Exchange team) and increase the transparency of applications and shortlisting [Brewster, 2019b, 2019a].</td>
</tr>
<tr>
<td>Bid assessors</td>
<td>A two-stage assessment process was in place. The first was a longlist generating stage, in which internal Health Foundation assessors evaluated the bids using AIMS and were asked to assign projects as approve, reject or borderline. The second</td>
<td>To create the longlist, a small number of external assessment panels were established, each made up of three to four volunteering Q members, that recommended which projects should be approved or rejected. The Health Foundation’s Q Exchange team, NHS</td>
<td>Having Q members on the assessment panels (and having a larger number of panels) was thought to make the assessment more democratic, engaging and rigorous [Brewster, 2019a].</td>
</tr>
</tbody>
</table>

\textsuperscript{110} Initial ideas are uploaded by potential bidding teams, who are then invited to submit a full application to Q Exchange at a later date. Not all teams submitting ideas make the decision to submit a full proposal.

\textsuperscript{111} This is also reflected in our data collection, discussed later in this annex.
Table 61: Documents reviewed for Q Exchange

<table>
<thead>
<tr>
<th>Document name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive rehearsal forms</td>
<td>These documents were completed the day before the 2018 national event (and the announcement of Q Exchange winners). It asked bidders to complete a form on how they will feel, what they will need and what they will do immediately after the winners are announced, one week later and one month later depending on whether they received funding or not.</td>
</tr>
<tr>
<td>Insights from AIMS and feedback calls</td>
<td>This document summarises the call with bidding teams in which teams were asked to comment on their experiences and reflections of the Q Exchange process, and for suggestions on how to improve Q Exchange going forward.</td>
</tr>
<tr>
<td>Q Exchange: update and request for second round</td>
<td>Letter from Penny Pereira and Sarah Henderson to the Health Foundation Directors Team to request the second Q Exchange round.</td>
</tr>
<tr>
<td>Q Exchange 2 update</td>
<td>Internal Health Foundation proposal for the suggested plan and changes for the second Q Exchange round in 2019.</td>
</tr>
<tr>
<td>Document name</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Q Exchange shortlisting decision database</td>
<td>A database tracking each submitted ideas in 2018 through the process of shortlisting, highlighting the strengths and weaknesses of each.</td>
</tr>
<tr>
<td>Building improvement capability across boundaries: analysing ideas</td>
<td>The analysis of the initial ideas submitted under the ‘Building improvement capability across boundaries’ Q Exchange theme in 2019.</td>
</tr>
<tr>
<td>Anna Burhouse: feedback on Q Exchange Support</td>
<td>Anna Burhouse’s, a Q Exchange moderator, review of Q Exchange support provided by members within the Building Improvement Capability Across Boundaries theme in 2019.</td>
</tr>
<tr>
<td>Understanding alternatives to traditional outpatient appointments: feedback from the moderation of the Q Exchange special interest group and ideas space</td>
<td>RCPQI moderated the Q Exchange theme ‘Understanding alternatives to traditional outpatient appointments’. This paper provides feedback on the role of the moderator and comment on the themes and quality of the ideas and projects submitted to the 2019 Q Exchange round.</td>
</tr>
<tr>
<td>Q Exchange 2019 online voting platform</td>
<td>Details of the voting requirements and specification for 2019.</td>
</tr>
<tr>
<td>Q Exchange 2019 feedback to unsuccessful teams</td>
<td>A revised plan of the feedback process for unsuccessful applicants for 2019. It provides context as to the feedback process in 2018 and the rationale for modifying it for 2019.</td>
</tr>
</tbody>
</table>

**K.2.2. Interviews with Q Exchange team and bidding teams**

From April to October 2019, 12 interviews were conducted, 1 with a member of Q Exchange team at the Health Foundation and 11 with individuals who applied for the 2018 Q Exchange funding round. Two of the interviews conducted with bidding teams were held with two members of the project team.

The aim of the interview with the member of the Q Exchange team, held in April 2019, was to frame and provide context for the interviews with the Q Exchange bidders, as well offering an opportunity for us to explore the design of Q Exchange in more detail and provide an update on the process of the 2019 round.

The interviews with members of the 2018 Q Exchange bidding teams allowed us to explore their thoughts and reflections of the application and voting process, the wider value of Q Exchange and the progress and any early impacts of their projects. Two interviews were conducted with members of project teams that had been shortlisted (with two additional individuals providing comments via email) but had not received funding, and six were conducted with project teams that received funding (with an additional interviewee providing comments via email). Interviewees were selected randomly to participate in an interview. After interviewing a member of a project team, other team members from the same project were excluded from the random sampling to ensure we spoke to individuals from a range of teams.

These interviews are referenced throughout this chapter. The shortlisted, but unsuccessful, interviewees are referenced as ‘shortlisted INTX’ and those successful in receiving the funding as ‘INTY’ (including those
individuals who sent comments via email). In addition, throughout this chapter we draw on data collected from wider interviews conducted throughout the Q Evaluation. To protect the anonymity of interviewees, we do not specify the project they work on.

K.2.3. Focus groups

We conducted three face-to-face focus groups, two with groups shortlisted for the 2018 Q Exchange funding round in September 2018, and one with individuals shortlisted for the 2019 Q Exchange funding round in November 2019. Both of these were held the day before the annual national Q event. All bidders were asked to join the focus groups by the Health Foundation, and the names of those who volunteered to take part were passed onto the research team.

Similarly to the interviews with bidding teams, the aim of these focus groups was to explore bidders thoughts and reflections of the application process and the voting process for the 2019 bidders (as voting took place during the national event in 2018). We also explored the wider value of Q Exchange and what plans were in place for the projects if they were not to receive the funding.

These are referenced throughout this chapter as ‘FG1 2018’ and ‘FG2 2018’ for the 2018 focus groups, and ‘FG3 2019’ for the 2019 focus group. To protect the anonymity of participants, we do not specify the project they work on.

K.2.4. Case studies

Four case studies of projects funded by Q Exchange in 2018 were developed between April and October 2019, and were selected in consultation with the Q Exchange team at the Health Foundation. These are:

1. Case study 1: Quality Improvement Partner Panels (QuIPPs)
2. Case study 2: A Paradigm Shift in the role of Hospitals through Community Organising
3. Case study 3: Repeat prescribing through co-design

The creation of these case studies allows a deeper exploration of the experiences and impacts of Q Exchange, including: how the funding supported development and implementation of the project; if additional Q resources were used in setting up and implementing the project; whether new connections were made when applying for funding and/or implementing the project; whether the project has been able to gain traction in their local area; how much support the wider Q community had provided the Q Exchange project teams; and whether the project had started having a positive impact and was reaching its aims.

The case studies were developed by conducting two to four interviews with members of the project teams. The project leader was initially invited to an interview and was asked to recommend other members of their team (or others) the research team could approach. We also reviewed the evaluation reports produced for two of the case studies at the end of 2019.

Each case study can be found in Sections K.11 to K.14, and these are referenced throughout this annex as ‘CSX’. Each case study has been reviewed by the interviewees to confirm accuracy and the level of anonymity provided.
K.2.5. Annual Q member survey (Q Exchange-related questions)

As part of the annual surveys in 2018 and 2019, we asked respondents questions specific to Q Exchange. The methods for the surveys can be found in Annex B.

In 2018, we asked respondents to share the reasons they did not apply for Q Exchange funding in 2018, whether, for those unsuccessful in receiving funding, they would apply again for Q Exchange funding and if they would seek other funding, and whether Q Exchange had a wider value than only funding projects. In 2019, respondents were asked if they felt Q Exchange was a unique funding opportunity and whether, for those who offered support and feedback to projects, there was a value in doing so.

The remainder of this annex will provide an overview of the results of this data collection.

K.3. Creation of Q Exchange bidding team

The majority of interviewees reported that their Q Exchange bidding team was made up of individuals who had worked together before bidding (INT1, INT4, CS1, CS2, CS3; unsuccessful INT2). These interviewees reported that the existing relationship means the team members know that they work well together, are interested in similar areas and have the required experience and knowledge (INT1, INT4, CS1). In our first case study, it was highlighted that the idea for the Q Exchange project was shared among their organisation and those interested in taking part volunteered to get involved in the bid (CS1).

Others we consulted set up project teams with individuals outside of their own organisation (INT2). This included reaching out to existing and new contacts to put together a bidding team (INT2, INT4, FG1 2018, FG2 2018, FG3 2019, Phase 3 INT12, shortlisted INT4). This was, for example, to bring new and different perspectives to the project team, such as patient voice, and to reach out to local Q members (to 'collaborate with neighbours'), as well as to take advantage of the opportunity to work on a project with existing contacts which may not have been possible before (FG2 2018, shortlisted INT4). A small number of project teams we consulted were made up of individuals who had connected with each other through Q activities, such as Q Labs and national Q events (shortlisted INT4, FG3 2019).

Potential interviewees were contacted based on the Q Exchange project websites, which outline the project team members. When reaching out to randomly selected team members based on this online information, many individuals reported that they were not close enough to the project for the evaluation team to interview them. This may suggest that whilst collaborators are involved at the bid stage, they may not all continue to be involved once the project begins.

K.4. Reasons for applying to Q Exchange

Our participants provided a range of reasons for applying to Q Exchange. These include the inability to get funding elsewhere, the unique format and collaborative approach of Q Exchange, familiarity with other opportunities offered within the Health Foundation and Q, and the opportunity to fund an existing idea. These rationales are discussed below. We also cover the responses from the 2018 survey of Q members where we asked respondents why they chose not to apply for Q Exchange, if that was the case. (In the 2018 annual survey, unsuccessful bidders were asked if they would apply for Q Exchange in the future; over half
(57 per cent of 86 responses) reported they would apply in the future and only 6 per cent reported that they would not apply again.)

K.4.1. Difficulty accessing alternative funding for improvement work

One of the main reasons for applying to Q Exchange was an inability to get funding elsewhere (INT1, INT3, INT4, INT5, CS1, CS2, CS4, shortlisted INT1, shortlisted INT2, FG2 2018, FG3 2019). This was thought to be due to the topic of the projects being outside the areas of traditional funding streams (INT1, CS1, CS2, CS4, shortlisted INT1), a lack of internal funding (INT4), a lack of funding specifically for improvement work (INT3, INT5, FG3 2019) and other funding opportunities restricting what types of activities funding can be used for (FG2 2018). For example, it was suggested that many other funding opportunities are not open to QI projects outside of acute care, whereas Q Exchange is open to a broader range of topics (INT5, FG1 2018). This was also expressed in the 2019 survey, with multiple respondents sharing that funding opportunities specific to improvement work are not common (2019 survey).

As long as the project was aimed at quality improvement, I think anything could fit, we didn’t have conversation after conversation trying to work out whether we fit the criteria for the grant, so that was quite appealing. [FG1 2018]

It was felt by some interviewees and survey respondents that Q Exchange allows novel and early ideas to be submitted for funding, rather than requiring a detailed evidence base to support the bid, which encourages the testing of new ideas (INT1, INT2, CS4, 2019 survey, FG3 2019). Related to this, one interviewee highlighted that the Q community is more likely to understand the importance of the projects put forward and how they address unmet needs compared to the decision makers in other funding models (INT1).

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

K.4.2. Q Exchange is a unique funding opportunity and encourages collaborations

Another reason for applying to Q Exchange is the unique format, particularly the ability to receive feedback from the Q community on project ideas and the collaborative nature of the application. Several interviewees discussed that they applied for Q Exchange as they are familiar with other Health Foundation and Q activities and funding, and already had connections within the Q community from whom to get support, and so felt comfortable in understanding how to apply to Q Exchange and liked the way of working (INT5, INT8, CS3, CS4).

Participants often referred to the ability to collaborate and collect feedback from the wider Q community during the application process (and later, during project implementation), as a main reason for applying to Q Exchange (FG1 2018, FG2 2018, INT1, INT4, INT5, INT6, INT8, CS4, 2019 survey, shortlisted INT1). Two interviewees highlighted how Q community support and resources provided alongside the financial resources set it apart from other funding opportunities, and it was felt that these additional resources were just as, if not more, important as the funding itself (INT4, INT8). Participants from one of the focus groups reported that applying to Q Exchange allowed the project team to engage with a community that they felt understood their projects and what they were trying to achieve (FG1 2018). The
perceived benefit and value in the collaborative nature of Q Exchange, and the impact on the design of projects, is discussed further in Section K.6.3.

I think the emphasis on input from the Community, the opportunity to access the wide range of expertise available in the Q Community, is really helpful. It really supports that ethos of all being in it together so that, while everyone is in competition with each other for that funding, it still feels supportive. Very different to applying for, for example [other forms of funding], where it does not feel remotely supportive and as though it is being made difficult to apply for funding. [2019 survey respondent]

In addition, the participatory nature and having the opportunity to refine projects throughout the application process based on peer feedback, which other funding opportunities do not offer is seen as a benefit (INT2, INT5, 2019 survey, shortlisted INT1). In particular, the peer review by the Q community in deciding which projects receive funding is thought to be a main benefit of applying to Q Exchange (INT6, CS4). It was said that other funding opportunities are reviewed by ‘faceless’ assessors and assessment by Q members felt safer. The involvement of Q members in assessing bids also contributed to the engagement with and visibility of Q Exchange (INT6, CS4).

Two participants provided further reasons for applying to Q Exchange. One applied as it was felt that service users were treated equally, with this interviewee reporting that they would not feel confident enough applying to other types of funding (phase 3 INT12). Another participant reported applying to Q Exchange in 2019 as they had heard positive experiences from colleagues who had applied and received funding in 2018 (FG3 2019).

K.4.3. Q Exchange is an opportunity to submit existing project ideas, as well as generate new ideas

Many respondents felt Q Exchange was a well-timed opportunity to submit existing project ideas that had not received funding elsewhere (shortlisted INT4, FG1 2018, FG3 2019). For example, participants at two of the focus groups described how they already had the idea for their project and felt Q Exchange was a good opportunity to apply for funding and to flesh out the idea into a more detailed plan (FG1 2018, FG3 2019). In addition, the project team for our second case study had been set up before Q Exchange as the project was already in its early stages and this team thought Q Exchange funding would be helpful in progressing this to the next stage (CS2). For the second Q Exchange round in 2019, participants particularly reported that their existing ideas fitted into one of the predefined themes, which provided even more of an impetus to apply (FG3 2019).

A similar number of participants that submitted existing ideas explained how the project teams created the idea for the project in response to Q Exchange, often in co-production with healthcare staff or patients, which allowed the project to focus on a particular priority or healthcare need in the member’s organisation (INT6, INT7, INT8, CS3, CS4). It was felt that this legitimised the project teams spending time on a project idea (INT6, INT8). As the projects are targeting an identified need, are co-produced, and are often based on cross-organisational collaborations, it was also felt that this is more likely to lead to successful impacts (INT6).
K.4.4. Reasons for not applying to Q Exchange

In the 2018 annual survey of members, we asked respondents who did not apply for Q Exchange why this was the case. Over one-quarter (26% of 695 responses) felt they did not have time to put together a bid. A smaller number of respondents reported that they were not aware of Q Exchange (18%), were not a Q member at the time Q Exchange applications were open (17%), did not have time to undertake the project (16%) and/or did not have an idea for a project (14%). A very small number of respondents said they did not apply because they could not find collaborators (2%) or because the funding was not sufficient for their idea (2%).

K.5. Where would the projects be without Q Exchange funding?

If the project had not received funding from Q Exchange, many participants thought that their project would still have gone ahead in some form, but would have faced additional challenges and would likely have required alternative funding. However, some project teams reported that their projects relied on Q Exchange funding to the extent that they would not have been able to progress without it.

K.5.1. Most projects could go ahead, but would need to be scaled back, happen over a longer time period or start after a delay

The majority of our participants thought that, without Q Exchange funding, their project would have run on a smaller scale and over a longer time period (INT1, INT3, INT5, CS1, CS2, CS3, FG1 2018, FG2 2018, FG3 2019, Phase 3 INT15).

The scaling back of projects would cause multiple challenges for the project teams. For example, some projects are based on existing work, such as online platforms and toolkits, and the progress of improving these would be slower and they may not be able to reach their full potential (INT1, CS2, CS4). In addition, one interviewee reported that patient recruitment would be difficult without the Q Exchange funding so that the number of patients involved would likely be lower (CS1). It was felt by one interviewee that without the funding, the project would not have been able to create resources that were tailored for different organisations, but rather would have been constrained to use a one-size-fits-all approach, which was thought to be much less impactful (INT7). Finally, without the funding, there may be fewer opportunities for evaluating the impacts of the projects (FG2 2018).

K.5.2. Some project teams would seek alternative funding

Multiple participants reported that without Q Exchange funding the teams would apply for other funding opportunities, including creating business cases for internal funding (FG1 2018, FG2 2018, FG3 2019, shortlisted INT1, shortlisted INT2, shortlisted INT4, Q Lab INT2, 2018 survey).

When asked in the 2018 survey whether unsuccessful bidders would seek funding elsewhere, 50 per cent of respondents to that question reported that other funding would be sought but were unsure whether this would come to fruition. A further 20 per cent reported that they would seek alternative funding and were confident that this would be successful. Only 13 per cent said that they would not seek alternative funding. In addition, only 5 per cent were unsure of where to find other funding sources (2018 survey).
Our participants provided additional detail on how and where they would seek other funding, where relevant. Some participants reported that they would apply for external funding elsewhere, particularly as the project idea and plan are well-thought-out since bidding for Q Exchange (FG1 2018, FG2 2018, FG3 2019, shortlisted INT2, shortlisted INT4, 2018 survey). External funders include charities, such as Arts Councils or the Big Lottery Fund (FG2 2018), or other public sources such as AHSNs (FG3 2019). Others reported the possibility of creating a business case to propose to local commissioners (FG1 2018, FG3 2019) or internally within their organisation (shortlisted INT2). One interviewee, unsuccessful in receiving funding in 2018, reported that the follow-up coaching was helpful in that it confirmed ideas about where else to seek this alternative funding (shortlisted INT4).

The perceived ease of obtaining other sources of funding varied between participants. Some considered that accessing other funding would be relatively easy as, for example, there are other organisations interested in the topic of the project (FG3 2019). Others felt that accessing other funding would be challenging and further slow the progress of implementing the project (shortlisted INT4, Q Lab INT2). Accessing alternative funding was thought to be difficult for a number of reasons, including lack of a deadline for that meaning it is not a priority (for the project team or potential funder), conversations with multiple funders not resulting in any support, and challenges in putting together a business case and receiving approval (shortlisted INT4, FG3 2019).

K.5.3. Some projects would not be able to go ahead at all without Q Exchange funding

Some participants felt their project could not have gone ahead without Q Exchange funding (INT4, INT6, INT7, CS4, FG2 2018).

For those projects that already had prototypes or small processes in place, it was felt that the project could not have scaled up past this point without Q Exchange, which would have had an impact on the progression and visibility of the project (INT4, CS4).

Other interviewees discussed how, without the funding, the project would not have been able to be implemented as the team would not have been able to dedicate the resources and staff time (INT6, INT7, FG2 2018) or would not have been seen as a priority internally and so would not be able to gain traction (INT6). Similarly, it was felt by one case study interviewee that receiving the Q Exchange funding gave the project the mandate to go ahead, and without the funding this would not have been the case, making it difficult to get the project off the ground (CS3).

K.6. Experiences and reflections on the application and voting process

Experiences of the application and voting process were largely positive with bidding teams seeing the value in getting feedback from the Q community throughout the application process., but some challenges arose. These experiences largely covered three main areas, which will be discussed in further detail here, namely the application process, the nature of peer voting and the collaborative nature of the process.

K.6.1. The application and feedback process

Participants discussed a number of experiences and reflections they had about the process of submitting an application and collecting feedback from the Q community (and more widely). These include the positive
aspects of the simple application process, but also the challenges of engaging with the large number of submitted projects and lack of clarity in the format of the application, particularly in the first Q Exchange round.

**Simple and straightforward application**

A majority of participants felt that the application process was clear and simple, unlike other funding models, and did not overburden project teams with existing workloads (INT1, INT2, INT3, INT4, INT5, INT6, CS1, CS3, CS4, FG1 2018, FG2 2018, FG3 2019, shortlisted INT2, shortlisted INT4, Phase 4 INT3, Phase 1 INT17, 2019 survey). Although there were some reports of the application being fairly time consuming, which was particularly difficult within the reported short timeframes to put together a bid (FG1 2018, Q Exchange Team, 2018), it was generally felt that the application required information that was helpful for the project team to collate and that the idea did not need to be fully fledged (FG2 2018, FG3 2019, shortlisted INT2, shortlisted INT4, Phase 4 INT3, Phase 1 INT17, 2018 survey). This was felt to be valuable, including for teams that did not receive funding (shortlisted INT4).

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

Some participants felt that the word limit was restrictive, including in the application and the project web pages, limiting the ability to provide details of the project and what impacts it would have (shortlisted INT2, INT4, Phase 3 INT15, FG3 2019, Q Exchange Team, 2018); but the word limit helped the project teams identify where more information was required and ensured the application was concise (shortlisted INT2, FG3 2019). Additional word count on the project web pages would have been helpful for some bidders as it would have allowed space to include information on how the project had been adapted in response to the feedback from the Q community (Q Exchange Team, 2018).

Related to the application process, one participant of a focus group felt that there were challenges in only the lead applicant being able to edit the application online, as it put a large amount of responsibility on ‘a single point of failure’ and made project team coordination difficult (FG3 2019).

**Difficulties engaging with the large number of bidding projects**

Multiple participants discussed the difficulties in engaging with the large number of shortlisted projects when looking for collaborations and deciding who to vote for (INT1, INT2, INT5, shortlisted INT2, Phase 3 INT12, Q Exchange Team, 2018, Burhouse, 2019b, Royal College of Physicians Quality Improvement, 2019, CS1).

Relatedly, some project teams reported that the large number of comments created difficulties in finding time to respond and in identifying individuals to collaborate with, particularly for small project teams (INT1, INT2, INT5, shortlisted INT2, Q Exchange Team, 2018). In addition, one interviewee felt that the format of the comments on the web pages made it difficult to see where new comments had been added (Phase 3 INT12).

This challenge was also reflected in feedback by Q Exchange moderators after the 2019 application round. Some moderators felt it was difficult to keep track of ideas they had already reviewed and engaged with as
there was no way of filtering these out (Burhouse, 2019b). In addition, the large number of submitted projects made it difficult for assessors to engage with each of them, although it was felt that feedback and support from the wider Q community did balance this out to some extent (Royal College of Physicians Quality Improvement, 2019).

**Unclear format for application and voting**

Some interviewees felt that the format of the application and voting was unclear and it was difficult to know what to expect (INT2, INT4, shortlisted INT4, FG3 2019, 2018 survey). This was particularly difficult for the first Q Exchange round in 2018, as bidding teams did not have a previous funding round to compare with (INT2, Q team INT1, shortlisted INT4). For example, one interviewee was not aware that additional resources could be brought to the national Q event, where the voting took place, to have on the project stand, which they felt left their project at a disadvantage (shortlisted INT4).

**K.6.2. The format of the voting is thought to be democratic and transparent**

Many participants, particularly the survey respondents, commented on the democratic, equal and transparent nature of the application and voting process (INT2, INT3, INT5, CS2, 2018 survey, 2019 survey, FG2 2018, FG3 2019).

The creation of ‘a level playing field’ for all bidding teams was seen to be important as it meant all teams, no matter how senior or well-known the project leader is, or where the project is based, have an equal chance of getting funding. This was in part due to the availability of five votes for each member (INT2, CS2, FG3 2019, 2019 survey).

> It’s a unique way to obtain funding whilst receiving a full peer review from Q colleagues across the UK. [2019 survey respondent]

Specifically, multiple participants from one focus group felt that the level playing field contributed to traditionally underrepresented groups submitting applications (FG2 2018). This included providing patients with the confidence and support to submit (and lead) applications (FG2 2018).

A large number of participants who submitted applications for the 2018 Q Exchange round felt that the requirement to attend the event to vote for projects put many teams at a disadvantage as most of the Q community were unable to cast a vote, including members of project teams who were unable to attend the event (INT2, INT4, INT8, shortlisted INT1, shortlisted INT2, shortlisted INT3, shortlisted INT4, Q Lab INT2, FG1 2018, FG3 2019, CS1). This was considered a particular disadvantage for projects from locations and organisations in which there were not many members attending the event, such as the South West of England, as well the likelihood of fewer clinical staff attending the event due to challenges in taking time off (FG1 2018, shortlisted INT1, shortlisted INT4). However, the voting process was changed for the 2019 funding round, which enabled all Q members to cast a vote online over a three-week period. This contributed to an increase in the number of votes, from 241 in 2018 to 608 in 2019 (Brewster, 2019b).

Although many participants thought that Q Exchange provided a level playing field for all bidding teams, others felt as though the voting process was a ‘popularity contest’ and very competitive (INT1, INT5, shortlisted INT1, shortlisted INT4, CS3, FG1 2018, Q Exchange Team, 2018, 2018 survey, 2019 survey), with one interviewee describing it as being like on ‘Dragon’s Den’ (CS3).
When discussing the 2018 funding round in particular (as 2019 did not involve pitching at the national event), it was felt that those project teams with wider existing networks, for example, within SIGs, or better at making connections and engaging with members and pitching, get more votes (INT1, INT2, INT5, FG1 2018, Q Exchange Team, 2018). This was thought to be a particular disadvantage for certain groups, including frontline healthcare workers, who may not have experience in networking and engaging with a group of people in such a way (INT5), as well as projects not perceived to be ‘popular topics’, such as social care or climate change (shortlisted INT1, shortlisted INT4), or those in certain locations, such as the North of England and Northern Ireland (Stakeholder INT3, 2019 survey). Similarly, one interviewee discussed how they felt it would have been difficult for those not accustomed to writing funding applications, particularly frontline healthcare workers, to put together a bid if they did not have support from those with more experience (INT7).

I found the funding process time consuming and I had little chance of being selected as I am from a [redacted – organisation] with no other Q members to support my application, I felt that the big trusts who have lots of Q members were going to get the votes and therefore the funding…but [I] feel it was not a ‘fair’ process for the novice.

[2018 survey respondent]

Related to this, some participants in one focus group felt that the reliance on getting votes using online pitching, particularly via social media, put those who do not regularly use this form of technology at a disadvantage and having the opportunity to pitch in person may have been helpful for these bidders, although this option was no longer offered in 2019 (FG3 2019).

K.6.3. The collaborative-based format of the application and voting is viewed as the unique aspect of Q Exchange and one of the most positive aspects of applying

Many respondents discussed how the opportunity for collaboration, particularly the online feedback through the project web pages, is one of the most positive aspects of bidding for Q Exchange funding (INT1, INT2, INT3, INT5, INT6, INT7, shortlisted INT1, shortlisted INT2, shortlisted INT3, shortlisted INT4, FG1 2018, FG2 2018, FG3 2019, CS1, CS3, CS4, stakeholder INT2, Q Exchange Team, 2018, Q Lab INT2, 2018 survey, 2019 survey). It was felt that Q Exchange is more focused on teamworking and developing a well-thought-out project that meets the needs of local organisations, rather than on competition, and that project teams support each other (FG1 2018, shortlisted INT3, 2019 survey). However, as mentioned earlier, a number of participants reported that Q Exchange is a ‘popularity contest’.

The feedback offered online was thought to be beneficial as individuals with a range of backgrounds provide feedback, including clinical and non-clinical perspectives, from other organisations, such as AHSNs and CCGs, as well as SIGs (INT7, CS3, FG1 2018, shortlisted INT1, shortlisted INT3, Q Exchange Team, 2018). The feedback also offers supportive challenge and critique of the project, which one interviewee felt was very valuable when refining their project idea and which is not offered through other funding mechanisms (shortlisted INT2). In addition, the feedback was thought to be particularly helpful for those working more in isolation, such as researchers and academics as it enables these teams to connect with others to collaborate (Q Exchange Team, 2018).
Many participants reported that the online feedback their team received did lead to changes and refinements in the project design (FG1 2018, FG2 2018, shortlisted INT4, FG3 2019, 2018 survey). For example, one project shifted away from a local focus to a national focus (shortlisted INT4), and another changed the language and tone used when describing the project to make it more understandable to a broader audience (FG3 2019). The feedback also highlights any information a project might be missing in the application (FG3 2019). Some project teams followed up with individuals who had provided feedback outside of the web page to receive more in-depth feedback on how their project idea could be improved. This follow-up was felt to be highly valuable, including with individuals from other countries with expertise in a particular topic (shortlisted INT1, FG2 2018). However, views collected from the Q team at the Health Foundation expressed concern that this feedback and collaboration provided outside the project web pages could not be reviewed by assessors, making it difficult for the teams to demonstrate their engagement with the community (Q Exchange Team, 2018).

Interviewees reported that the support and feedback has often extended into support during project implementation (INT5, INT8, CS4). For example, one project team that lacked evaluation experience were put into contact with an evaluation expert via a Q member on the project web page (INT7). In addition, one of our case studies involved a Q member putting the project team into contact with an experienced and trustworthy software designer. The interviewee felt that the project could not have gone ahead without this company’s involvement (CS4).

Other participants expressed uncertainty about why they were receiving the online feedback and felt that the feedback did not feed into their project design. This appeared to have been mainly for projects that were building on existing processes rather than setting up new ones (INT5, INT6, INT7, CS3, FG2 2018, FG3 2019, Phase 3 INT12). Although these participants felt that the feedback process allowed the creation of new connections relevant to the project, it did not change any aspect of the project idea (FG2 2018, FG3 2019, Phase 3 INT12).

In addition to feedback leading to project refinements, multiple participants from the third focus group expressed that receiving online feedback for their project encouraged them to read the other bidding project web pages and to provide their own feedback, which was felt to be valuable (FG3 2019).
go through other people’s projects and comment on them because they had spent time on my project and commenting on it. I got a lot out of that side of it. [FG3 2019]

Others, particularly in the third focus group, expressed uncertainty with the purpose of the feedback process and how it felt slightly clunky and ‘odd’ (FG3 2019). These participants felt that there was a need to be seen to responding to feedback in order to receive votes from the community, rather than engaging with feedback to improve the project (FG3 2019).

Feedback from a SIG moderator highlighted potential missed connection opportunities more generally, particularly considering the similar sub-themes that emerged across many of the bidding projects, such as focus on prisons and care homes, and there was little linking up of these projects (Burhouse, 2019a).

In addition to the online feedback, a bidding team at the 2019 focus group outlined how they used the feedback received during the debrief session after an unsuccessful bid the previous year to feed into their application for 2019, allowing them to improve their project design (FG3 2019).

Another opportunity for feedback was through the SIGs. However, feedback from the 2019 project SIG moderators was that there was a lack of engagement within these groups (Burhouse, 2019b; Royal College of Physicians Quality Improvement, 2019, FG2 2018). Although the SIGs grew in numbers quickly, suggesting there was interest among the community in engaging with projects, it was felt by the moderators that only a small number of these participants actually contributed to the group and it is not clear what these groups contributed to Q Exchange (Burhouse, 2019b; Royal College of Physicians Quality Improvement, 2019). One participant from a bidding team reported trying to contact a SIG to seek feedback on their project but did not get a response, which they found to be disappointing (FG2 2018). Similarly, one interviewee reported difficulties in getting member engagement on the project web page and via Twitter during the application and implementation of the project, despite actively disseminating information within the Q community, which they felt was disappointing (INT4).

K.6.4. The voting format

In addition to the feedback provided during the application phase, the voting event in the 2018 funding round was also thought to work well overall and many reported enjoying the experience (INT1, INT2, INT3, INT4, INT8, CS4, shortlisted INT4, Q Lab INT2, Phase 2 INT10). Interviewees highlighted how the event allowed for further debate and discussion on the shortlisted projects (INT1, shortlisted INT4) and for new connections to be made with people working on similar projects (INT2). One interviewee also felt as though they had learned new skills as a result of pitching their Q Exchange idea to Q members during the event (INT1).

Support from outside the Q community

Some participants discussed the support received from outside of Q (CS1, CS2, INT7, FG3 2019). The project forming the first of our case studies received matched funding from the local AHSN to support recruitment of patients to the programme (CS1). Two of our case studies received support from other organisations interested in the project. One project team was visited by the Royal College of Physicians who

112 Individuals external to the Health Foundation volunteered to moderate the SIGs for each Q Exchange theme in 2019.
had submitted a similar project to Q Exchange but did not receive funding, as well as by other interested organisations, and this interviewee felt that they would not have been able to connect with these individuals without Q (CS1). Another case study received support in testing the toolkit the team is developing from a maternity network that was interested in adopting the toolkit and wanted to be involved in its development (CS2). An interviewee discussed the support the team has received from the local CCG in providing advice to the team on engaging with similar projects in the areas to ensure the team do not ‘step on any toes’ (INT7).

Some of our interviewees reported receiving helpful support from the Health Foundation team during their application (INT1, INT2, INT3, CS1, CS2). The type of support varied, including technical support when problems with the website arose on the deadline day for submitting bids (INT2), social media support to raise awareness about the projects (INT3), and visits from members of the Health Foundation team to support implementation of the project (CS1). Two interviewees also reported they were planning on getting additional support from the Health Foundation in the future to help in scaling up the project (INT3) and in presenting information on the project to a wider audience (INT2). Three interviewees discussed the follow-up support calls with the Health Foundation (INT1, INT2, INT4). Two interviewees felt that these calls are not needed as they have the knowledge and expertise to implement the project themselves, and that there were too many people on the call for it to be useful (INT1, INT4). However, another interviewee felt these calls were very useful and would prefer more of them to help keep the project on track (INT2).

One of our case studies discussed how the involvement of an individual from the Health Foundation was vital in creating the project team (CS4). This individual was aware of two organisations that were working on building a similar platform for timebanking and connected these two groups together and suggested they bid for the Q Exchange funding (CS4). One of our interviewees for this case study felt the individual from the Health Foundation had gone above and beyond his role in supporting this project and connecting the project team to members of the Q community (CS4).

K.7. Challenges to implementing projects

Our participants who were successful in receiving funding in 2018 reported some challenges in implementing their Q Exchange projects, but were generally pleased with how their projects were progressing and were confident they could overcome these challenges. The challenges that have arisen are:

- Time constraints due to their day-to-day job roles can make it difficult to dedicate time to working on the Q Exchange project, particularly if the project team is small.
- There are some challenges with organising and hosting large events, although support from the Health Foundation was helpful.

113 For anonymity reasons, we have not attached the specific interview codes for these points. This section draws on: INT3, INT5, INT7, INT8, CS1, CS3.
The difficulty in governance and who directly receives the funding, particularly where a member of the team is self-employed and so the funding was used to pay their salary, whereas other project members are not paid for this.

Reaching sufficient engagement with the project, such as individuals to take part in training/workshops or patient involvement, etc.

Difficulty adapting resources produced as part of the project to local areas, rather than having one-size-fits-all approaches, which may not be as successful.

Challenges with collaborating with other organisations that are part of the project team.

Lack of a particular skill set, e.g. evaluation experience or software development skills.

K.8. Emerging project impacts

For many of the projects, particularly those we engaged with who had received funding in 2019, the impacts of the project had not yet had time to appear. For some projects, there were some emerging impacts we discussed with the teams.

Multiple interviewees discussed the impacts their projects were having at an individual level:114

- A teenage boy in a rural community with a mental health illness refused to leave home, preventing him from accessing healthcare services. Persuading him to use telemedicine has meant he is able to access healthcare without needing to leave his home. In addition, a patient from a rural community in Skye needed to see two clinicians in very far away locations. A three-way video call was set up between the patients and the clinicians, saving the patient two long journeys and a better conversation was had about the patients’ health as it was with multiple clinicians. For the same project, NHS England visited the Highlands to see the progress telemedicine has made in that location. As a result, NHS England has adopted a co-production viewpoint in developing telemedicine.

- After taking part in a training session, the Trusts involved are more aware about how to present and use data and have reported that better informed decisions are made as a result of interpreting the data differently.

- Increased empowerment and confidence for service users involved in the project (INT5, INT8, CS1). For one of our case studies that trained patients in QI, the service users involved increased their knowledge of QI theories and methods, which made them more confident in their abilities to be involved in improvement projects and gave them the knowledge to support improvement work in a non-tokenistic way.

- One of our case study examples, Quality Improvement Partner Panels (QuIPP), used the funding from Q Exchange to provide service users with training in QI and set up panels with the trained

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114 For anonymity reasons, we have not attached the specific interview codes for these points. This section draws on: INT4, INT8, CS1 and CS4.
patients to offer a service user perspective to healthcare professionals implementing improvement projects. Multiple projects have benefited from this service user input, such as changes to an NHS Trust’s sepsis programme to introduce questions for receptionists to ask patients walking into A&E to detect symptoms of sepsis, rather than only focusing on potential sepsis in patients coming into A&E by ambulance. Other examples of the impact of having trained service user panels can be found in Section K.11.

- Hexitime, our final case study, has many examples of how the exchanging of time has led to impacts. These can be found in Section K.14 and on the Hexitime website. One example provided by our interviewee was a doctor and midwife who visited a struggling maternity unit to share their story on how they improved maternity safety in their own Trust. This was thought to contribute to the struggling maternity unit subsequently coming out of special measures. In addition, nurses at a hospital in Birmingham needed process mapping to reduce length of stay. They received support from a local academic in mapping the unit to improve the length of stay.

Although many of our participants felt that Q Exchange offers direct impacts through the funded projects, as well as the indirect values of participating in Q Exchange discussed here, a small number expressed uncertainty as to the impacts of the projects (Royal College of Physicians Quality Improvement, 2019; 2019 survey). Feedback from one SIG moderator and a small number of survey respondents expressed concern that £30,000 is not enough funding to create substantial or sustainable impact from the projects, particularly in the area of outpatient departments, which is thought to be a highly complex system (Royal College of Physicians Quality Improvement, 2019; 2019 survey).

K.9. Wider impacts of Q Exchange

In addition to the direct impacts of the funded projects, participants reported a number of wider, indirect benefits of engaging with the Q Exchange process. We have covered some of these earlier in this annex, such as creation of connections/expanding networks; however, other benefits arose when engaging with Q Exchange. These include added value for those supporting bidding teams, increased confidence in requesting funding for improvement projects and the ability to demonstrate the importance of the project internally within their organisation.

K.9.1. Learning for those providing support to bidding teams

Participants, particularly from the 2019 survey, highlighted how individuals providing support to bidding projects, not just the bidding teams themselves, benefit from Q Exchange. Reading the project web pages and engaging with teams at the national events is reported to increase Q members’ learning and knowledge (both for bidders and supporters) of the types of health and social care improvement work ongoing outside of their organisation, and highlights what needs there are in the system (stakeholder INT5, 2018 survey, 2019 survey, FG2 2018). In addition, it is an opportunity to learn about improvement work happening outside of the healthcare sector (2019 survey). A small number of respondents also reported gaining additional knowledge on how to write proposals for funding by reading through the project bids (2018 survey, 2019 survey).
An evaluation of the Q Initiative 2016–2020

I did my reviews, I did my vote and I offered some support. Having that central point where you can go and see what is the current thinking, what people are working on, what’s the energy being exercised on from a QI perspective, what’s important to people working in health and social care. [Q stakeholder INT5]

Offering support to bidding teams was also thought by 2019 survey respondents to encourage the creation of new connections, particularly with those outside of their existing networks (2019 survey). Survey participants expressed the enjoyment felt in being altruistic and helping others to improve their projects (2019 survey).

We need to be available to colleagues. QI resources and funding is tight now so not all projects have access to QI people. Q can bridge this gap. [2019 survey respondent]

A small number of survey respondents reported offering support to bidding teams that was not then taken up by the project team, which they felt was a disappointment (2018 survey, 2019 survey).

K.9.2. Increasing bidding teams’ confidence with improvement

Multiple participants reported an increase in confidence as a result of bidding for Q Exchange funding (FG2 2018, 2019 survey, Q Exchange Team, 2018). It was felt that having a project idea shortlisted gives the team a ‘boost of confidence’ and the belief that the idea has value (FG2 2018, Q Exchange Team, 2018). In particular, this benefit was expressed by a service user involved in a bidding team who thought that their voice as a service user is now being heard in the improvement space (FG2 2018).

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

Despite this, participants involved in a feedback call with the Health Foundation felt that confidence may reduce in bidding teams, particularly those lacking in experience of writing funding proposals, due to the large number of applicants and competing with applicants from ‘big hitters’ (Q Exchange Team, 2018).

K.9.3. Demonstrate importance/priority of a particular topic

Multiple respondents, particularly in our focus groups, discussed how being shortlisted for Q Exchange has helped to demonstrate the importance of their project ideas and has helped to place greater priority on these topics in their organisations (INT2, INT6, CS1, FG1 2018, FG2 2018, FG3 2019, Q Exchange Team, 2018).

Multiple interviewees highlighted the validity and credibility applied to the projects that were shortlisted, in part by having the ‘Q badge’ attached, and the benefit winning Q Exchange funding has brought in getting wider interest and engagement in the project, including from within the project team and local organisations, to motivate them to progress with the project (INT2, INT6, CS1, FG3 2019). It is felt that this ‘legitimisation’ of projects has supported the development of buy-in from organisational leaders and executives who are recognising the value of, and need for, the projects, which they may not have done without the team bidding for Q Exchange (FG1 2018, FG3 2019).
Within our organisation…it has been really helpful to show a concrete action of the work we are doing and it has been well received outside of the organisation. Executives and non-executives have been receptive to this in developing profile of the teams work and visiting conversation from a different angle and to encourage engagement from leadership and demonstrate the importance. [FG3 2019]

This is also useful for the shortlisted projects that did not receive funding as it supported the project teams to know that there is interest in the topic, and to make further improvements on the design based on feedback from the community, as well as to create new connections through this feedback. It was felt by these teams that this gave the projects enough credibility to seek funding elsewhere (Q Exchange Team, 2018).

K.10. Possible improvements to Q Exchange

Based on their experience of applying for the first round of Q Exchange, our participants offered some ideas for possible improvements for future funding rounds. These suggested areas for improvement covered the application process and after funding has been allocated. Some areas for improvement were suggested for the voting and Q Exchange aspects of the national event; however, the majority of these no longer apply after the changes were made to the 2019 funding round, such as the suggestion for remote voting, and so have not been included here.

K.10.1. Improvements to the application phase

Some participants felt expectations for the application and voting process needed to be made clearer. Feedback received from the Q team at the Health Foundation also indicated this, with participants reporting that clearer expectations up front about the application and what was involved would have been helpful (Q Exchange Team, 2018). However, as discussed earlier in this annex, this was a challenge for the team in 2018 as Q Exchange was a pilot and there were no previous years for bidders to learn from (INT2, Q team INT1, shortlisted INT4).

Related to the 2019 Q Exchange round, one interviewee felt that having the two themes for projects restricted the ability to submit potentially impactful projects (INT5). While this interviewee did not suggest removing the themes, they suggested the Q team could publicise the themes earlier in the process to allow teams to coordinate and put together an idea that fits with the themes (INT5).

Multiple participants expressed the need for greater support for bidding teams during the application phase (shortlisted INT1, shortlisted INT3, Phase 2 INT10, Burhouse, 2019b; Q Exchange Team, 2018). There was an expressed need for more general support with the application, particularly for those with a lack of proposal writing experience, such as short guides on how to submit, examples for putting together applications and the creation of a SIG or meetings for those new to Q Exchange bidding (Burhouse, 2019b, shortlisted INT1). This was thought to be particularly important to encourage bids from service users (shortlisted INT1). More specifically, some participants felt that greater support was needed for smaller organisations, such as charities, which it was felt may struggle competing with larger organisations bids (shortlisted INT3). Similarly, one interviewee felt that Q Exchange needs to better support project ideas
that are more ‘out of the box’, such as through a special prize awarded outside of the community voting system (shortlisted INT1).

Some participants suggested that more support could be provided to make connections during the application (Burhouse, 2019b; Q Exchange Team, 2018), for example, advice on how to create connections and where to find potential collaborations. As with support for new bidders, it was thought a short guide could be produced to help with this aspect (Q Exchange Team, 2018). Feedback provided by a Q Exchange moderator in 2019 suggested that many of the connections made through the Q Exchange web pages were taken onto other platforms, such as direct messages, email and WhatsApp. The moderator felt a mechanism for making these connections more formalised could be introduced going forward (Burhouse, 2019b).

K.10.2. Greater support from the Health Foundation after announcement of the successful projects

Participants also offered ideas for improvements after the funding has been awarded. This included more catch-up calls with the Health Foundation team to help keep the project on track (INT2) as well as more connections to other Q Exchange winning teams who could help support each other during project implementation (CS1). In addition, one interviewee reported needing evaluation support as the project team had little experience in this area and evaluation was a requirement as part of receiving the funding (INT7).

Two shortlisted interviewees felt more support is needed for projects that do not receive funding (shortlisted INT2, shortlisted INT4). For example, unsuccessful teams could be permitted to engage with the catch-up calls offered to successful teams, so as to learn from these discussions and to try and keep momentum with their project without the funding (shortlisted INT4). In addition, it was felt that any feedback offered to unsuccessful teams should be circulated to the whole team rather than only those who could attend the calls (shortlisted INT2).

Two interviewees felt as though the speed at which the Health Foundation publishes information on the projects, such as blogs, could be increased to support project implementation (CS1, INT4). Similarly, one shortlisted interviewee felt that all the bidding project teams web pages, including the unsuccessful projects, should be kept live and updated so they can be followed and connections can continue to be made (shortlisted INT4).

K.11. Case study 1: Quality Improvement Partner Panels (QuIPPs)

This case study provides a summary of the Q Exchange funded project, Quality Improvement Partner Panels (QuIPPs), previously named Patients are Equal Partners in QI. The case study is based on four interviews with three members of the project team (INT1, INT2 and INT3) and one participant of the QI training offered as part of the project (INT4). In the following paragraphs, we provide an overview of the project itself, the interviewees’ experiences and perspectives of applying to Q Exchange, the impact of the project so far and future plans for the project.

QuIPPs aims to train patients in QI to support their active engagement and involvement in health and social care improvement projects. Once patients are trained, they become members of a QuIPP, which
advise healthcare professionals on how to make their improvement projects more patient centred (Broad et al., 2018).

The box below summarises the key points from this case study.

<table>
<thead>
<tr>
<th>Key Point</th>
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<tbody>
<tr>
<td>In the South West of England, there is a lack of patient and public involvement in health and social care improvement work. Therefore, this project provides QI training to patients to support their active engagement in improvement work. As of October 2019, around 40 patients have taken part in the training.</td>
</tr>
<tr>
<td>The Q Exchange bidding team was made up of individuals working at the South West AHSN who are also Q members. Alongside Q Exchange funding, the AHSN provided match funding and staff support for the project as they saw the value in including patient voice in improvement work. Without the Q Exchange funding, the project could have gone ahead with the AHSN funding alone; however, it would have been on a smaller scale and fewer patients would have been trained.</td>
</tr>
<tr>
<td>Existing connections to Q members were used to develop and refine the project idea during the application process, such as those made through Q Lab. New connections were also made through the project web page, particularly to teams with similar project ideas. The feedback provided by these Q members was found to be useful and positive, and fed into the refinement of the project plan.</td>
</tr>
<tr>
<td>The training has received positive feedback from participating patients who report an increase in knowledge on QI and designing improvement projects. Healthcare professionals who have received advice on their improvement project from the trained patients also reported positive feedback. As a result, these improvement projects have had positive implications for patients, such as supporting vulnerable patients discharged from hospital and implementing a sepsis awareness programme to a wider group of patients.</td>
</tr>
<tr>
<td>Going forward, the project team would like to extend the training to other AHSNs in England and potentially incorporating refresher training for those patients who have already taken part in the programme.</td>
</tr>
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K.11.1. About the project

Within the South West of England, there are perceived insufficiencies in patient and public involvement (PPI) in health and social care improvement work. Out of over 400 people taking part in QI training offered by the South West AHSN, only two of these were patients (Broad et al., 2018). It was felt by interviewees that training is needed to ensure patients are provided with adequate knowledge of QI to be able to meaningfully engage with QI projects and provide their perspective in a useful way (e.g. in the right QI language) for the project team (INT1, INT2).

As a result of this need, the project team used the funding offered through Q Exchange to develop QI training for patients. The training is based on that provided by the Institute for Healthcare Improvement (IHI) and was developed with input from the South West AHSN (INT1, INT2). It also included input from patient representatives to ensure that the training was tailored to patients, as well as involving experts in delivering QI training (INT2). The training was adapted throughout the first few sessions. For example, it was found that patients needed more time on some activities compared to healthcare professionals, who are usually the recipients of QI training. Also, the training had to be adapted to the range of patient ages and backgrounds (INT2).

Recruitment of patients to participate in the QI training was undertaken by the South West AHSN, which reached out to relevant organisational partners. To increase the diversity of patients involved, the training
was also promoted through social media and other websites to recruit patients who were not directly involved with the AHSN (INT2). One interviewee felt that recruitment was supported by having the Q badge attached to the project, which gave it credibility and encouraged participants to engage with it (INT1). Individuals who expressed interest in participating in the training were provided on a one-to-one basis with in-depth detail as to what the training entailed and the expectations of them. Although this led to some dropping out, one interviewee felt that this ensured those who remained were fully aware of the process and what was expected of them (INT2). The training takes place over four days, which was felt by one interviewee on the project team to be fairly intensive, particularly as many of the participants are starting without any background knowledge of QI, but felt as though those involved were able to follow and understand the content of the training (INT2).

As of October 2019, around 40 patients had been trained across the South West (INT1, INT2, Broad et al., n.d.). Once patients are trained, they then join an online panel of experts (QuIPPs) for at least one year, during which healthcare professionals developing an improvement project can get the patients’ feedback on how to make their project more patient centred (INT1, INT2, Broad et al., n.d.). In some cases, an individual QuIPP member may ask to be involved in designing an improvement project (Broad et al., 2018). There are currently four QuIPPs across the South West: in Somerset, Devon, Cornwall and the Isles of Scilly, and one focusing on peninsula-wide strategic items (INT1, South West Academic Health Science Network, 2018). Panel meetings are held monthly via Zoom, a video conferencing service, which means it is easier for patients to get involved as there is no travel involved (INT1).

In addition to training patients in QI and creating the QuIPPs, the project involves informing healthcare professionals who plan to use the QuIPPs on what knowledge the patients have and how the patients can provide input. This allows the healthcare professional teams to know where the panel can provide the most meaningful input. It is emphasised to the healthcare professional teams that the feedback from patients is advice only; it is not mandatory to follow (INT1). The discussions the panel have with the healthcare professional team follow a structured approach to keep them on topic and allow the patients to identify particular trends occurring across different improvement projects they are involved in (INT1). Healthcare professionals are asked to complete two short surveys after the panel meeting to identify if the design of the QI project had been changed in any way as a result of the feedback they were given (INT1).

K.11.2. Why did the team apply for Q Exchange funding?

For the application, a local team was put together, made up of individuals working at the South West AHSN Faculty for QI and who were also Q members and/or senior leaders (INT1). These individuals are presumed to have wanted to be part of the project team as they were interested in the project idea and saw value in it (INT1). The same interviewee felt that involving individuals from the South West AHSN in the project had encouraged a wider range of people to get involved in the project team due to the relationships and networks the AHSN has; this resulted in one of the bigger project teams (around 12 members) (INT1). One member of the project team thought it unlikely that the project, because of its topic, would have been accepted in funding streams available in the South West other than Q Exchange (INT2).

In addition to Q Exchange funding, the South West AHSN provided match funding as well as staff support. The project team felt that this was because the AHSN saw the value the training could provide and
understood that the funding from Q Exchange was not enough to deliver the programme effectively (INT1, Broad et al., n.d.). This meant that the project would have been able to go ahead without Q Exchange funding, but that Q Exchange funding has meant more patients have been trained than would have been possible otherwise: 50 per cent more patients have been trained as a result of receiving the Q Exchange funding (INT1).

K.11.3. Support from the Q team and Q community

One interviewee discussed the support from the Q central team at the Health Foundation during the application process. The project idea was discussed with the Q team at the Health Foundation before applying to Q Exchange and the interviewee felt that they were very encouraging and were open to a patient-led project (INT1). In addition, a Q team member travelled to Cornwall to deliver one of the training sessions for patients. One interviewee felt was very powerful and valued that they had provided the money and time to deliver the session (INT1).

Existing Q connections were used during the application process. One interviewee outlined how the project team had contacted individuals they met during Q Labs (including patients) to help to decide which NHS Trusts should be approached to be involved in the training (INT1). New connections were also made during the application process. These included connections made to other Q Exchange bidding teams who were putting in applications for similar projects and were interested in learning more about this project (INT1, INT2). For example, the Royal College of Physicians submitted a similar project idea to the same Q Exchange funding round but did not receive funding. They visited the project team in the South West to learn more about how the training was progressing (INT1). These connections have continued during project implementation (INT1).

The feedback received from the wider Q community on the project website during the application process was felt to be positive by the project team (INT1, INT2). Some of these connections have extended into face-to-face meetings, not just with people working on projects with similar topics but also with people with wider interests (INT2). It was felt by one interviewee that the input provided by the Q community was ‘brilliant’ and allowed people from a variety of backgrounds to provide advice and get involved in the patient training. However, the same interviewee felt that the hardest part of the application was changing and adapting the project based on this feedback (INT1).

It was reported by one interviewee that Q resources were not used during the application process, apart from the project web page and the feedback provided through this from Q members (INT1). In addition, one interviewee felt that engagement with some Q members was accidental: they were reaching out to individuals for advice during the application process based on their expertise and knowledge, and sometimes they happened to connect with Q members but that this was not the primarily reason for engaging with them (INT2).

K.11.4. Challenges during project implementation

One interviewee reported very few challenges faced during implementation of the project. However, the interviewee did feel that awareness of the project at the start was lower than anticipated and so the project team is working on disseminating the value of the project to a wider audience (INT1). It was felt that the
slow process of uploading blogs and other communications to the Q website contributed to this lack of engagement (INT1).

K.11.5. Impact of the project

The training has received positive feedback from the participating patients and the healthcare professionals who have received advice from the QuIPPs (INT2). The feedback includes that the process is innovative, interesting, allows for easy access to people with the required knowledge to meaningfully advise on a QI project, and that patients feel as though they have been provided with a voice (INT2). It was reported by one person who had taken part in the training that they are going through the process of applying to be a Q member as a result, as they now have an understanding of the importance of QI in day-to-day practice (INT4). The same interviewee discussed how the patients attending the training had made connections to, and formed working relationships with, others in the group (INT4).

One project team member shared specific examples of QI projects that have received input from the QuIPPs and of the impact this has had. One of these examples was a project providing telephone support calls to those with dementia after they had been discharged from hospital. The QuIPP felt as though this could be extended to less vulnerable discharged patients who don’t have an in-house carer but require a small amount of extra support, such as reminders to take medication. This change is now being implemented for discharged patients who are likely to recover and not merely those likely to enter long-term care (INT1). Another project focused on improving sepsis awareness in hospitals, specifically ensuring that clinical and non-clinical staff were more aware of sepsis. The original project plan put together by clinical staff only focused on the sepsis cases that arrive at hospital by ambulance, rather than the cases that walk into A&E. It was identified by the QuIPP that more cases arrive through A&E than by ambulance, so the QuIPP advised that the awareness programme be extended to staff that treat non-ambulance cases. As a result of this, the programme included training for A&E receptionists to recognise sepsis early (INT1).

Our interviewee who had taken part in the training was from an NHS organisation and outlined how they had implemented changes within their organisation as a result of engaging with the training. This interviewee engaged with a patient in the training who was hard of hearing and who shared ideas for methods of engagement for those with hearing difficulties at conferences. As a result of this, our interviewee contacted their organisation’s patient experience lead to discuss how they could better support and engage patients who are hard of hearing. This resulted in the organisation purchasing equipment to enable these individuals to actively engage with conferences (INT4). In addition, as a result of participating in the training, the interviewee has worked on encouraging sharing learning and best practice across the South West region. Teams from Cornwall visited a team and shadowed meetings in Gloucester to learn about the QI practices in place, such as how to have QI conversations and how to get the right people in the room. This interviewee felt that the Cornwall took ‘four to five golden nuggets’ from this visit that they have since implemented. For example, improvements to carrying out physical health checks for patients with severe mental illness have been introduced since August 2019. Early results of this suggest the process is working more efficiently than the one used previously and patients are more engaged in decisions made about their healthcare (INT4). The Gloucester team intend to visit Cornwall to see what they can learn from the other team (INT4).
In addition to these impacts outlined by our interviewees, an evaluation by Munro Research and Evaluation and Christina Dixon Consulting reported in September 2019. This outlined the successes of the project over its first year (Munro Research and Christina Dixon Consulting, 2019). This included that the patient recruitment process was effective in creating diverse panel groups, and that the format and structure of the panels were thought to work well, particularly the use of Zoom (despite some technical issues). In addition, members of the panel demonstrated increased knowledge of, and confidence with, QI including the more technical aspects and certain improvement approaches, such as PDSA cycles, as well as a more generalised understanding of how the NHS functions.

K.11.6. Future project plans
The project team plans to scale up the training to expand it to other AHSNs across England (INT1, Broad et al., n.d.). It was felt that this would be fairly straightforward as most of the process, other than the training, is done online (INT1). One interviewee felt that further funding could be obtained from the South West AHSN to provide support for the scale-up and spread of the project and to train more patients (although NHS England and NHS Improvement would need to endorse this first) (INT2). Any other funding was thought to rely on developing a compelling business case for the project (INT2).

Two interviewees discussed the importance of introducing refresher training for patients in future, to ensure there is retention of trained patients over time, as well as training new patients on a regular basis (INT1). The project team plans to conduct refresher training and recruit new patients every three years and will assess the number of trained patients on a more regular basis to recruit at other times if needed (ITN1). It was thought that patients who have already been trained are open to taking part in additional training (INT2).

K.12. Case study 2: A Paradigm Shift in the role of Hospitals through Community Organising
This case study provides a summary of the Q Exchange funded project, A Paradigm Shift in the role of Hospitals through Community Organising. The case study is based on two interviews, both with members of the project team. It provides an overview of the project itself, the experiences and perspectives of applying to Q Exchange, the impact of the project so far and future plans for the project.

A Paradigm Shift in the role of Hospitals through Community Organising aims to support the development of relationships between clinical teams and communities. The clinical teams then work with local communities to jointly identify healthcare issues and/or priorities faced by the community and co-produce solutions to these.

The box below provides a summary of this case study.

- This project involves individuals from Imperial College Healthcare NHS Trust and the charity Citizens UK. Staff from these organisations met two years before submitting the Q Exchange bid to discuss whether the principles of community organising could be applied to an NHS context.
- As a result of this relationship and discussions, a toolkit and a healthcare professional training package were developed to support healthcare staff to involve members of the community in their improvement work. The Q Exchange funding has been used to further test and refine the toolkit, piloting it across a single care pathway with a group of healthcare professionals at St Mary’s Hospital.
The team applied for Q Exchange as they found it difficult to find funding elsewhere because the idea often did not fit into existing funding streams.

The project team did not heavily engage with the Q community via the project web page as the toolkit had already been developed and so did not need much refinement. There were also difficulties in engaging with the community, which may have been because one of the project team member was not a Q member.

The project has faced a number of challenges in testing and piloting the toolkit. This includes challenges with staff turnover in the project team, difficulties in engaging healthcare professionals in the training and a lack of accountability (in the form of having to update the Q community and the Health Foundation) slowing progress.

At the time of writing, the toolkit was still being tested and refined. However, the team plans to disseminate the tool to more hospitals, some of which have already expressed interest in testing it.

K.12.1. About the project

The project involves individuals from Imperial College Healthcare NHS Trust and the charity Citizens UK. Citizens UK works with civil society groups to encourage citizens to get involved in public life by supporting them to identify what matters most to them at a local and national level (INT2). One of our interviewees felt that healthcare traditionally has been about the curative aspect of healthcare, but attitudes are shifting towards the belief that this is a minor part of healthcare services and there is much more to what people think about their health and well-being, which is where community organising may have a role to play (INT1). Community organising is a method that provides the community with a voice in how their local healthcare services are delivered and leads to the community being energised and mobilised to find solution to support their own health and well-being (INT1). For example, it was felt that many of the initiatives put in place to help overcome loneliness are created top-down by policymakers, whereas community organising methods could be used to make improvements at a local level (INT1). The aim of community organising is to be able to influence policy and legislation and set up a central programme using these community-based levels (INT1, INT2).

In 2017, staff from Imperial College Healthcare NHS Trust approached Citizens UK, which had been doing work in the area of community organising, to discuss whether the principles of community organising could be applied in an NHS Trust’s context, particularly in areas such as leadership skills and ‘deep listening’ (an approach to becoming a better listener), and connecting these to improvement (INT1, INT2). Staff members at Citizens UK have since been embedded within the QI team at Imperial College Healthcare NHS Trust (INT1).

The aim of A Paradigm Shift in the role of Hospitals through Community Organising is to bring community organising into a healthcare context, enabling effective relationships to be built between healthcare professionals and communities (INT2, Nacer-Laidi et al., 2018). The project team hopes this will lead to communities taking greater responsibility over the health of their community and lead to more co-production in health services (Nacer-Laidi et al., 2018).

The project involved the creation of a toolkit, which was first designed before applying to Q Exchange, alongside the training of healthcare professionals in community organising (INT1, INT2). While the approach and relationships needed to create the toolkit had been established before Q Exchange, the funding allowed the team to develop and test the toolkit (INT2). The aim of the toolkit is to support and
enable healthcare professionals to involve members of the community in their improvement work and for members of the public to understand where and how they can get involved in improvement activities (Nacer-Laidi et al., 2018). The toolkit involves five key stages (Nacer-Laidi et al., 2018):

1. Recruiting and training volunteers in community organising.
2. Identifying issues and health priorities among clinical leads and community champions.
3. The community teams work with health professionals to identify feasible solutions to the issues/priorities.
4. The community teams and the NHS trust decision makers co-produce services and community prevention interventions.
5. The community and clinical teams evaluate how the process went and can move onto a new set of issues to be solved.

The Q Exchange funding is being used to help further test and refine the toolkit across a single care pathway with a particular group of professionals to develop an evidence base before disseminating it to a wider number of hospitals (INT1). So far, the toolkit and training has been tested in St Mary’s Hospital within Imperial College Healthcare NHS Trust (INT2).

K.12.2. Why did the team apply for Q Exchange funding?

It was felt by both interviewees that the project idea was ‘wackier’ than other bidding ideas (INT1, INT2). This meant it was difficult to finding funding elsewhere as the idea did not fit into other types of funding stream, so both interviewees felt Q Exchange was crucial for this project as it is willing to fund more ‘radical’ ideas (INT1, INT2). In addition, it was felt that the knowledge and experience of the Q community was just as important as the financial funding and this type of support isn’t offered through other funding streams (INT1).

Thus, both of our interviewees thought the funding from Q Exchange was crucial in being able to test and refine the toolkit, distribute it on a wider scale and provide the time for the project team to dedicate to the toolkit development (INT1, INT2). Without the funding, it was suggested that the project could have continued (as it had already started before Q Exchange) but only on a much smaller scale and developing an evidence base for the rationale behind the approach would have been a challenge (INT1, INT2). The project team would have sought other funding options to support the project but it was felt this would have been difficult to obtain (INT1).

K.12.3. Support from the Q team and Q community during the application process

Our interviewees reported that they did not extensively use the online web page to interact with the wider Q community during the application process, although a small number of online discussions were had (INT1, INT2). This was because the project had already been set up before applying for the funding so the idea did not need as much refinement and feedback as others may have needed (INT1). However, one interviewee felt that the project team would try and harness the experience and knowledge of Q members going forward to demonstrate the impacts of the toolkit and to encourage members to test the toolkit in their local area (INT1). Our other interviewee discussed how they found engaging with the Q community
to be difficult, particularly building relationships and networks for the project, possibly because they are not a Q member (INT2).

One interviewee reported having informal discussions and support from the Q team at the Health Foundation during the bidding process (INT1). This interviewee also reported receiving support from participants in a maternity network who expressed interest in testing the emerging toolkit design (INT1).

K.12.4. Challenges during project implementation

Our interviewees discussed three main challenges the project has faced during its implementation: project team turnover, difficulty engaging healthcare professionals in training and a lack of accountability.

The project team members from Citizens UK faced high turnover soon after winning the funding, which left much of the implementation to two individuals at Imperial College Healthcare NHS Trust and Citizens UK (INT2). Although this was reported to be a challenge at the start of the project, it was felt by one interviewee that these two individuals have a similar attitude and approach to the project so have been able to ‘hit the ground running’ (INT2).

One interviewee discussed the difficulty in engaging healthcare professionals in the training that the project offers (INT2). Two training sessions for GPs were planned for this but both were subsequently cancelled due to too few participants signing up. Our interviewee speculated that this was likely due to other higher priorities, a lack of time and a lack of funding offered to participants to attend (INT2). This interviewee thought that it was particularly difficult to engage junior healthcare professionals in the training due to their particular time demands, whereas more senior staff was perceived to have greater flexibility in their time and a greater interest in the topic area (INT2).

Finally, a lack of accountability, although not seen as a major challenge or area that needs addressing, was felt to slow the implementation of the project (INT1, INT2). For example, one interviewee reported that because they were not forced to engage with the Q community via the website, this meant the project team did not feel the need to engage with members online and so may not have got as much out of them as possible (INT1). Similarly, our other interviewee felt that the lack of check-in points with the Health Foundation during the implementation of the project meant that progress sometimes lost momentum as there was no deadline to meet (INT2).

K.12.5. Impact of the project and future plans

As the toolkit is still being tested and refined, the impacts have not yet fully emerged; more progress is likely emerge in future (INT1).

Although the project impacts are still emerging, one interviewee felt as though the work so far has triggered wider conversations with healthcare providers in London around the role they could play in community organising (INT2).

The next steps for the project include planning for disseminating the toolkit to more hospitals and the best way to designing implementation support for the hospitals (INT1, INT2). Some hospitals have already expressed interest in adopting the toolkit, including South Warwickshire and Morecambe Bay, as well as health charities (INT2). One interviewee reported that the other priorities for the project include delivering the training to GPs (and finding the best way to engage them), producing a journal article to engage wider
K.13. Case study 3: Repeat prescribing through co-design

This case study provides a summary of the Q Exchange funded project, Repeat prescribing through co-design. The case study is based on two interviews, both members of the project team. It will provide an overview of the project itself, the experiences and perspectives of applying to Q Exchange, the impact of the project so far and future plans for the project.

Repeat prescribing through co-design aims to support GP practices to identify problems and blockages within their repeat prescribing system and identify solutions to overcome these by hosting workshops. The team is also developing a toolkit that GP practices can use to improve their repeat prescribing process.

The box below summarises this case study.

- This project focuses on improving repeat prescribing systems by helping GPs in Wales to identify the problems and blockages in their systems and ways of tackling these through hosting workshops. This project idea was developed in response to Q Exchange due to the variation in repeat prescribing systems across Wales; it was not a pre-existing project.
- As of September 2019, four workshops had been run with GPs in Wales, with one more planned. These workshops were well attended, with practices providing backfill so GPs could attend.
- The project team applied to Q Exchange as they felt it was a good opportunity to implement a new project in an area in need of improvement that often lacks funding. The team also felt that having the Q badge attached to the project would increase the project's reputation and a mandate to do the work.
- During the application phase, the project team actively engaged with the Q community on the project webpage and connected with people working in the area of repeat prescribing. Although this feedback was helpful, the team did not think it led to changes in the project design.
- Anecdotal evidence from the workshops suggests that the sessions have supported GPs to identify that their repeat prescribing system has a problem, what this problem is and what they could do to overcome this. However, at the time of writing it was too early to identify whether any changes had been made in practice by GPs.

K.13.1. About the project

The project team became aware of the funding provided through Q Exchange and wanted to take advantage of this opportunity to start a new improvement project (INT1). The team decided to focus on repeat prescribing after asking members of the All Wales Practice Pharmacy Community of Practice and primary care staff at conferences, events and meetings what they thought was a priority for them in terms of improvement. Repeat prescribing was identified as a priority as there is a large amount of variation in the repeat prescribing systems used across different general practices in Wales (INT1, INT2, Gimson & Ware, 2018). One interviewee highlighted how GPs felt this was ‘a problem that had never been cracked’ (INT2). In addition, repeat prescribing was seen as an area of priority by the chief pharmaceutical officer in Wales (INT2) as repeat prescriptions are increasing in Wales and were responsible for 80 per cent of the £593 million spent on prescriptions in Wales in 2015–2016 (Gimson & Ware, 2018).
The project team discussed a number of challenges in repeat prescribing systems that, through the workshops, staff at GP practices can be supported to start to address. The number of queries from GPs to pharmacists to confirm whether a patient is able to be prescribed a certain medication can be high (INT2). One of our interviewees reported findings that a small GP practice can generate 20,000 queries per year, totalling around 10 queries per patient (INT2). This then leads to blockages later in the system, due to the number of decisions that need to be made per patient, which can impact on patient care. For example, a scarcity of time for decision making in a system under pressure may mean patients are not offered follow-up tests in the optimal timeframe, i.e. a month’s worth of drugs are prescribed for a patient to ‘buy’ some time for the GP (INT2). There are also challenges with the amount of time GPs spend signing prescriptions and managing the ‘failure demand’ (i.e. demand caused by a failure to undertake a task at all or correctly), contributing to a loss of time, resources and also having impacts on safety (Gimson & Ware, 2018).

One member of the project team highlighted how there have been previous improvement projects aimed at the repeat prescribing system. However, they reported that these have often been unsuccessful as they take a ‘one-size-fits-all’ approach with programmes not being adapted to local contexts, which means they often are not focusing on the needs of the individual practice (INT1).

As a result of these challenges and identified needs for repeat prescribing, the team put together a project that aims to help GP practices in Wales to understand how they can redesign their repeat prescribing system, and the benefits the practice could see in doing so (INT1, INT2). To do this, the project team used the Q Exchange funding to host workshops aimed at all GP practice staff (INT1, INT2, Gimson & Ware, 2018). The aim of these workshops is to support GP practices to map their repeat prescribing system and identify where the problem may lie (INT1, INT2). The workshop also covers how to overcome some of the common challenges with repeat prescribing (INT1, INT2). One member of the project team discussed how they are aware that general practices are constantly firefighting in their job roles, so the improvements to repeat prescribing are more about ensuring a system is ticking along while still being monitored, rather than making major changes (INT2). Before the Q Exchange, the project team did offer one-to-one support for GP practices in improving their repeat prescribing systems; however, offering workshops was seen as a better option as it allowed multiple practices to share best practice and ideas at once (INT1).

As of January 2020, the project team had run all five workshops at a national level in Wales, (INT1, INT2). Our interviewees reported that the workshops had been very popular and valued by the GP staff who attended, demonstrated by the workshops being at full capacity and GP staff organising and funding backfill at the practice to allow staff to attend (INT1, INT2). It was discussed how each GP practice had a different reason for sending staff to the workshop as they all have their own challenges with repeat prescribing that need solving, but the desire to improve safety is often a driving force for attending (INT2). In addition, all participants were followed up after the workshop to complete an evaluation form to explore their thoughts on the content, facilitators and workshop venue. Overall, the responses to these evaluation forms were positive and areas for improvement have been acted on by the project team to further improve the sessions (INT2).

K.13.2. Why did the team apply for Q Exchange funding?

The project team felt Q Exchange was a good opportunity to identify an area that required improvement and obtain funding for a small project on the topic. Both interviewees are Q members and were familiar
with the Health Foundation and Q processes, so felt comfortable in applying for the funding (INT1). One interviewee felt that having the backing of the Health Foundation and Q’s reputation would help raise awareness of the project (INT1). One of our interviewees felt that the kudos that comes with Q Exchange funding was of equal importance to the funding itself (INT1).

In addition, one interviewee we spoke with felt that Q Exchange was a good opportunity to receive funding for improvement in the current environment of budget constraints (INT2). This interviewee felt that the workshops could have been held without the Q Exchange funding, but that they would not have started at this time but only after some delay. Receiving the Q Exchange funding has allowed GP practices to start improving their repeat prescribing systems sooner (INT2).

In this particular project, the interviewee felt that without winning the Q Exchange funding, the importance of the project would not have been made clear and the interviewee’s organisation may not have provided the support that in the event it has (INT1).

K.13.3. Support from the Q team and Q community during the application process

One of our interviewees discussed how the project team engaged with the Q community from the very start of the application process (INT1). This was through Q members providing feedback on the project web page as well as the project team actively engaging with other people who work in the area of repeat prescribing, which led to the creation of new connections (INT1). Although the interviewee found this feedback helpful, they felt it changed the project only slightly and on reflection thought that the team could have done more to mobilise the community’s involvement in designing (and later implementing) the project (INT1).

K.13.4. Challenges during project implementation

Our interviewees did not discuss many challenges they have faced in implementing their project. One challenge an interviewee mentioned, however, that is still ongoing is that the team have wanted to develop a practical tool that can be used by GP practices to support them improve their repeat prescribing system. However, it has proven difficult to find a balance between having a tool that can be used in any GP practice while at the same time being able to solve context-dependent problems (INT1).

K.13.5. Impact of the project and future plans

As the project has not yet finished, our interviewees reported that it is likely too early for impact to be seen (INT1). However, anecdotal evidence from the workshops for GP staff indicates that the sessions have allowed them to identify that their repeat prescribing system has a problem, what that problem is and where to make improvements (INT2). There is potential for time and cost savings, as well as improved patient safety, if the improvements are implemented (INT1). However, it is not yet clear whether changes have been implemented in all the practices, as only a few have later asked for further bespoke support (INT1).

The project team has completed five workshops and hopes to continue offering further workshops across Wales through other funding mechanisms, albeit possibly in a slightly different format as they will likely be hosted by a different organisation with different priorities as the current organisation delivering the workshops is unable to carry this on (INT2). In addition, the project team is working with an academic colleague to decide whether the work could be published in a journal (INT2).

This case study provides a summary of the Q Exchange funded project, Hexitime the Healthcare Skill Exchange Timebank (previously, the Q Community Time Bank). The case study is based on two interviews, both members of the project team. It provides an overview of the project itself, the experiences and perspectives of applying to Q Exchange, the impact of the project so far and future plans for the project.

Hexitime is an online platform that allows those in clinical and non-clinical roles to exchange time with others within the scheme for any improvement-related work, such as mentoring, presentations or data analysis, with the underlying concept of ‘giving one hour and getting one back’ (Abdalla et al., 2018). There is no financial charge for using the platform.

The box below provides a summary of this case study.

- Hexitime is an online timebanking platform that allows people to exchange time with others for healthcare improvement-related work. As of October 2019, Hexitime had been live for four months and had over 350 users, exchanging 100 hours of time.
- Before the Q Exchange funding was announced, our two interviewees were working on two separate healthcare timebanking projects until a member of the Q team at the Health Foundation put them into contact with each other. They decided to combine their projects and created a prototype platform in collaboration with TimeBank UK. This prototype highlighted the areas in need of further improvement, which is what the team applied to do with the Q Exchange funding. It was felt by the project team that they would have struggled to obtain funding from other types of funders as the idea of applying timebanking to healthcare was a new one and had little evidence behind it yet. Some of the funding was also used to hold a launch event and a number of Hexithon workshops to engage organisations with Hexitime.
- The project team collected feedback from the Q community through the project web page, which was felt to be useful and influenced the design of the platform. One of the most important connections the project team made (to a reliable software developer) was made through the project web page. As Hexitime developed, the project team have been collected impact stories from users which highlight a number of positive implications of the project, for example, increased safety on a maternity ward, process mapping the discharge process for a hospital and obtaining a better understanding of how to use mental health data.
- Hexitime is the only Q Exchange funded project that has long-term funding through a partnership model with Walsall Together and Kent, Surrey and Sussex AHSN. Going forward, the project team plan on increasing the number of organisations involved in this partnership.

K.14.1. About the project

Time banks have traditionally been used in local communities and the concept is that someone in the community offers an hour of their time, e.g. gardening, in exchange for an hour of another person’s time with a different skill, e.g. accounting (INT1). Timebanking is a proven method within the community and the project team wanted to apply this established model to the healthcare system, a particularly time poor area of the workforce in the UK (INT1, INT2). Introducing a time bank across healthcare would enable organisations to offer time and skills to each other while receiving credits to bring support back in return, and also gaining additional benefits around staff satisfaction, capability and boosted networks (INT2). This
was thought by the project team to be particularly useful when funding is a limiting factor for an organisation as funding isn’t needed to backfill a position when using timebanking (INT1).

Before putting together the application for Q Exchange, our two interviewees were working on separate timebanking projects and were not aware of each other’s work until an individual at the Health Foundation linked the two projects together (INT1, INT2). This individual facilitated a Skype call for our interviewees who discussed their work and found out they were both working on similar ideas but coming at it from slightly different angles (INT1, INT2). They decided to combine their ideas, which the individual from the Health Foundation suggested could be submitted to Q Exchange (INT1, INT2).

Before receiving the Q Exchange funding, the project had already started to get off the ground through development of a prototype of the online platform, funded personally by one of the project team members (INT2). This prototype was developed in collaboration with TimeBank UK, an organisation which supports the creation of time banks (INT2). The prototype was taken to Q members who provided helpful feedback on the functionality of the platform, how it would be used and what users expected of the system (INT2). This interviewee felt that the feedback received from this early prototype enabled the project to specify where funding from Q Exchange should be prioritised and areas for further improvements (INT2). The early development of the platform also involved a GP who had experience of timebanking within their community (INT2).

Much of the funding from Q Exchange was spent on improving the online platform (INT2). One interviewee highlighted the importance of selecting the right software developer for this project as they needed to fully understand the aim of the platform; also the project team wanted to maintain control rights over the platform (INT2). Online feedback through the project web page from a Q member suggested the software developers, Made Open. The project team felt that this company met their needs and the company Director has become an unofficial partner in the project (INT2).

Some of the funding has been used to host a launch event at the Health Foundation in April 2019 as well as a number of workshops over the year, called Hexithons, which aim to engage organisations across the country in timebanking (INT1). Most of the audience for these events are Q members but there is an increasing number of non-Q member involvement (INT1, INT2).

As of January 2020, the platform, called Hexitime, has been live for four months after eight months of development and testing, and has over 600 users. Anyone is able to join the platform, not just frontline clinicians, e.g. academics, patients, third sector, local council members and executives, and managers (INT2). Individuals wishing to join the platform register their email and complete a short application for review by the Hexitime team as a sense check. Once registered, users can exchange time by advertising what skills they have and identifying other users with skills they would like to request (INT2). A confidential messaging service enables users to discuss their needs and what they can offer the other person, which then leads to meetings either virtually or face to face. Once a time transaction has completed, online credits on the platform are allocated (if time has been offered) or removed (if someone else’s time has been used) (INT2). As of January 2020, the website also has campaigns in particular areas, such as reducing length of stay, and users can offer or request time within these specific areas. The website also has additional functionality for teams to have private chat rooms, project management boards and surveys (INT2).
K.14.2. Why did the team apply for Q Exchange funding?

The project team chose to apply for Q Exchange over other funding opportunities for multiple reasons. Firstly, as both were already Q members, the connections to Q members and other improvement projects already existed, and feedback from Q members on the early prototype was positive so that the team felt there would be support for the project (INT1). Secondly, one of our interviewees found that Q members reviewing the applications and voting on who should receive funding was a positive aspect of the process as the interviewer respects the thoughts of Q members. It was felt that external assessors would not have had the same level of engagement (INT1). Finally, it was felt by one interviewee that the project struggled to receive funding elsewhere as, although the concept of time banks is well established, applying this to the healthcare sector has not been tried before (INT1). This interviewee felt that other funding streams require developed ideas to be submitted that have a lot of evidence behind them, which this project idea was not in a position to do, but thought that Q Exchange was open to buying into a new concept (INT2).

Without Q Exchange funding, one interviewee felt that the team would have tried to get funding elsewhere (INT1), although this may have been difficult due to the lack of evidence for the project. Our other interviewee felt that without the funding, the platform would not have been able to improve beyond the prototype, which was not user-friendly or appealing to use and so it is unlikely it would have had the engagement seen so far (INT2).

K.14.3. Support from the Q team and Q community during the application process

The project team gathered feedback from Q members through the project web page. Our interviewees considered that the Hexitime project received useful feedback from members, which influenced the development of the project (INT1, INT2). For example, a Q member suggested the project team could reach out to the software developer Made Open to design the platform, which one interviewee felt was one of the most useful connections the team made (INT1). The project team has also engaged with Q members in testing the prototype of the platform, and also reached out to members through SIGs to promote the project and to collect ideas on further improvements (INT1).

Support from the Health Foundation was also felt to be very important during development of the project, both in joining the two projects before Q Exchange and then during the application process (INT1, INT2). For example, one individual from the Health Foundation connected the project team with individuals who could advocate for the design and use of the platform, which our interviewee felt went above and beyond their job role (INT1).

K.14.4. Challenges during project implementation

One of our interviewees discussed some of the challenges the team faced in implementing the project (INT2).

The first was a technical challenge in deciding which company should build the online platform, as the team required a software developer that they could trust to make coding decisions on behalf of the team and so needed to have a good understanding of the platform and what it was trying to achieve (INT2). This was thought to be difficult in finding the right developer, but this time spent in identifying the right company has paid off as the relationship has been working well since (INT2).
Secondly, the interviewee discussed some of the misconceptions people, particularly NHS staff, can hold in relation to Hexitime (INT2). For example, it is difficult to spread the message that there is no financial commitment needed to use the platform; the interviewee felt it can be difficult to persuade staff that there is no ‘catch’ in signing up (INT2). In addition, there are a small number of organisations that hold concerns that staff will leave if they find out about interesting improvement work happening in another organisation (INT2).

K.14.5. Impact of the project and future plans

One of our interviewees highlighted how the number of members of Hexitime was not for them an indicator of success. Rather the number of hours exchanged was seen as a more important indicator as it demonstrates the skills that have been brokered (INT2). In the first nine months, around 100 hours of time had been exchanged (INT2). However, this interviewee was aware that some time exchanges may be occurring outside of the platform and these cannot be measured (INT2).

The project team has been gathering evidence of Hexitime’s impact through interviews with its users. These are published on the Hexitime website and they demonstrate the varied reasons time is exchanged (INT1, INT2). Overall, it was felt that Hexitime helps bring together and connect users across hierarchies and geographical boundaries who would not normally have met, including staff within the same organisation (INT1). Our interviewees provided a few examples of where Hexitime has had an impact on its users. The first was support in improving safety on a maternity ward (INT1). NHS staff members working in a Trust that was in special measures invited a doctor and midwife from another Trust who had recently transformed their maternity unit to improve safety to share their experience on how they had approached this project. The staff visits were organised through Hexitime so the trust in need of support did not need to pay for these. It was felt by the struggling maternity unit that these visits helped to catalyse change within their organisation and has contributed to the trust coming out of special measures (INT1). Another example of impact was reducing length of stay in a Birmingham hospital. Three nurses from this hospital (who were not Q members) requested support through Hexitime for an expert in discharge process mapping to reduce the length of stay in their ward. A Q member with expertise in this area conducted the mapping without needing payment and the nurses did not have to add this task onto their existing job role (INT2). Finally, another example of impact was with a commissioning team who were struggling with how to best use the data they had on mental health. The commissioners sought statistical process control expertise through Hexitime, which helped the commissioning team to understand how to read the mental health data better and has changed decision making as a result (INT2).

It was recognised that a large amount of impact from the project is on the social value that Hexitime brokers, which is very difficult to measure. For example, by providing healthcare staff with services that release some time, the team believe these staff can spend time on other activities, such as skills building and networking, which is thought to benefit the wider healthcare community (INT1). The team have sourced a social value accountant to begin reviewing this and establish a system for measuring the social value over and above money saved or case studies created (INT2).

115 These can be found at: https://hexitime.com/impact-stories
Our interviewees also discussed the funding model for Hexitime and where they would like this to go in the future. As of January 2020, we understand that Hexitime is the only Q Exchange funded project that has sustainable, long-term funding through a partnership model (INT1, INT2). The project now has organisational partners, Walsall Together, part of Walsall CCG, and Kent, Surrey and Sussex AHSN, which have a role in decision making. In exchange they fund the project, which has allowed it to extend beyond the length of the Q Exchange funding (INT1, INT2). This funding model ensures the sustainability of the project but also ensures that Hexitime remains free to use for the end user (INT1). Going forward, the project team plans on expanding the number of organisations funding the platform, as well as asking these organisations to commit time from their staff to offer on Hexitime (INT1, INT2).
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