An evaluation of the first phase of Q

Engaging the founding cohort in a co-designed approach to healthcare improvement

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Preface

Q began as an initiative to recruit '5,000 Safety Fellows' in response to a recommendation put forward in the 2013 Berwick Report. The initiative is led by the Health Foundation and supported and co-funded by NHS England. It aims to connect people working in improving quality across the healthcare system throughout the UK, to make it easier to share ideas, enhance skills and thus bring about changes that benefit patients. During 2015 the Health Foundation recruited 231 members to become a founding cohort to help design, refine and test Q before the wider recruitment process commences in 2016.

RAND Europe was commissioned to undertake a real-time evaluation of the first phase of Q, to inform its future design. This report presents the key findings of that evaluation, detailing our assessment of events but also describing the role of the evaluation team as 'embedded evaluators', aiming to both participate in the process and maintain rigour and independence in data collection and analysis. The evaluation commenced in April 2015 and assesses the story of Q from its beginnings in spring 2014 up until the end of January 2016. We draw conclusions based on findings from multiple methods and present a future evaluation framework to inform the next phase of the evaluation of Q, which will run up to the end of 2019. A comprehensive overview of the findings that informed this report is presented in the accompanying appendix (RR-1518-THF).

The evaluation was intended to help guide Q throughout the first phase. As such, the primary audience is the Q project team, members of the founding cohort and the Q steering group. The work will also be of interest to stakeholders such as the organisations who nominated members for the design process, academics with interests in quality improvement, and those involved in designing and delivering improvement initiatives. It is also possible that the evaluation will be of relevance to those working in health and social care settings, as well as to the general public, including patients.

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Background

Q began as an initiative to recruit '5,000 Safety Fellows' in response to a recommendation put forward in the 2013 Berwick Report [1], following the Berwick group's review into patient safety. The initiative is led by the Health Foundation and supported and co-funded by NHS England. It aims to connect people working in improving quality across the healthcare system throughout the UK, to make it easier to share ideas, enhance skills and thus bring about changes that benefit patients. During 2015 the Health Foundation recruited 231 members to become a founding cohort to help design, refine and test Q before the wider recruitment process commences in 2016.

The co-design process for Q is underpinned by a Theory of Change (ToC), shown in Figure S1, and the Design Council's 'double-diamond' model [2, 3]. Both elements have been employed by the Q project team during internal meetings, presented during design events and used in external publications such as *A proposed model for Q* [4].

Evaluation of the first year of the Q initiative

As part of the first phase of the Q initiative, following a competitive tendering process, the Health Foundation appointed RAND Europe to undertake an independent, embedded, real-time evaluation. The aim was to inform the direction and strategy of the Q initiative by providing real-time feedback throughout the first year of Q. The evaluation was intended to be focused on identifying problems and practical solutions.

RAND Europe worked closely with the Q project team throughout the evaluation. This embedded approach brings many advantages: for example, it allowed emerging findings from the evaluation to feed into the development of Q in real time. However, it can present a threat to the independence of the evaluation. Consequently, from the outset, both RAND Europe and the Health Foundation have maintained awareness of potentially conflicting principles.

The evaluation comprised two complementary strands: (1) to observe the design process undertaken during the first year of Q and to examine how effective this is; and (2) to evaluate whether or not Q is well placed to meet its stated goals. As requested by the Health Foundation, this report finishes with reflections on how effective the embedded evaluation was, and offers suggestions for a future evaluation framework for Q.

Methods and data collection

To inform the direction and strategy of Q, the evaluation took a multi-method approach. In line with the two overarching objectives we collected various data on both the design process and on Q itself:

- **Document review** of paperwork submitted to the Health Foundation by nominating organisations and an **online survey of nominating organisations**.

- **Online survey of Q founding cohort members** before and after the design events, including **social network analysis**.

- **Semi-structured interviews** with Q founding cohort members held before and after the design events, and **focus group**

Figure S1. Theory of Change issued with participant material during the final design event on 18 November 2015

Q – what we aim to achieve and how

Theory of change
As the design of Q progresses, the theory of what we aim to achieve (and how) will evolve to include more tangible outcomes and a supporting measurement and monitoring framework, becoming a more 'traditional' theory of change.

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ACTIVITIES AND OUTPUTS ————————————————————————— **SCOPE OF IMPACT**

GREATER INFLUENCE OF INITIATIVE

GREATER INFLUENCE OF ENVIRONMENT

Nov 2015

discussions held across the three design events with Q founding cohort members.

- **Citizen ethnography** undertaken by Q founding cohort members during two design events.

- **Online survey of host organisations** held after the three design events.

- **Non-participant observation** at Q project team meetings and design events, **review** of 'after action reviews' completed by the Health Foundation, and **semi-structured interviews** held with members of the Q project team over the course of the first phase of Q.

The findings from the different data collection methods were **synthesised** into a single narrative, grouped by organising themes.

Findings

Context: Q members reported a range of views on what quality improvement is, what the barriers to its effectiveness are, and what they expect from Q

Members provided a range of definitions of quality improvement. In interviews and focus groups members conceptualised quality improvement as a spectrum of activities from a *'mind set'*, which forms part of a continuous process that underpins service delivery rather than being separate from it, to a discipline in its own right underpinned by a formal methodology and set of tools. Members universally reported in interviews and focus groups that they face significant barriers in implementing quality improvement, principally lack of time and financial constraints, and the danger that some regard quality improvement as *'a fad'*. A number of members suggested that to achieve culture change requires buy-in at board level in order to support and enable individuals to make a change. Although among members surveyed there was reported to be a high level of skills and knowledge needed for quality improvement work,

interviewees considered more formal training to be a means to embed quality improvement and increase efficiency more widely.

Interviewees were optimistic at the start of Q that there was benefit to be gained from the creation of a national initiative. It was apparent from interviewees' accounts before the first design event that Q had not been clearly defined at this stage and, as such, what Q was trying to achieve was still the subject of debate. The most commonly cited aim of Q was to create a network and to provide opportunities for wider collaborations.

Implementation of a co-design process: the size of the founding cohort made co-design challenging but catalysed member buy-in

Q involved a co-design process between the founding cohort members and Q project team. Recruitment was conducted via a nominating process carried out by 48 nominating organisations: 18 Academic Health Science Networks and national improvement organisations, 3 professional bodies and 27 government organisations and charities. The recruitment process was perceived in the survey of nominating organisations and by the Q project team at team meetings to have recruited relevant individuals to the cohort with the breadth of knowledge needed to inform Q and which allowed the Health Foundation to engage with existing organisations with an interest in quality improvement. However, the size of the cohort was considered by many member interviewees and focus group participants and project team interviewees to be too large, and this was reported to have limited the extent to which all members were able to engage in the co-design process, and made decisionmaking challenging. One area that remains particularly unclear is the future role for patients. The founding cohort included only nine patient representatives.

Findings from interviews and citizen ethnography demonstrated that members felt that the events

were well organised and that the products and brand developed by the Health Foundation were of high quality, but for many members it was not until the third event that they felt more comfortable with and valued the design events. In general members in interviews and focus groups were uncertain about the extent to which the process had met their expectations of co-design. The key challenge identified by both the members and the Q project team was the large size of the founding cohort. Despite reported concerns about the process, the levels of commitment and loyalty expressed by most Q members interviewed at the end of the process were high and arguably reflected the efforts to engage them.

Mechanisms of change: Q has connected founding cohort members

The Theory of Change (ToC) is a key statement of what the intended mechanisms and their associated changes are. The ToC itself was a subject of considerable discussion and, from our observations at the second design event, diverted attention from the mechanisms themselves onto the ToC as an artefact. We reported this to the Q project team in the interim report, and at the third event the project team appeared to have shifted the focus away from the ToC to the implementation of Q; unlike at the previous design event, no session was dedicated to the ToC, and we did not observe discussions of the nature encountered previously.

In interviews, members provided a multitude of positive examples of the beneficial impact that participating in the Q founding cohort had had on the 'connecting' and 'developing' strands of the central part of the ToC, and to a lesser extent on the 'mobilising' and 'supporting' strands.

Outcomes: Q is a promising but unproven initiative

We observed at the design events that the overall vision of Q was hotly debated, especially early on in the first design event, in plenary discussions and at a breakout session. By the end of the second design event, the output from one breakout session was that a vision of Q as aiming to 'contribute to continuous and sustainable improvement in the health and care of all people in the UK' had emerged. This aim was incorporated into the latest version of the ToC, presented at the third design event, and we did not witness it being the subject of further debate. From the citizen ethnography at third design event, and member interviews, it was evident that the aims of Q remained unclear to at least some members even after all three events, with one reporting that they did not know what the aims were; but for most others any uncertainty they reported was linked more to the shape of Q than its aims.

In interviews after the final design event, Q founding cohort members and project team members agreed that Q did not make as much progress during the first phase as might have been hoped, and the future shape of Q remained unclear for most of those interviewed after the three design events. Despite the lack of future clarity, in general interviewees remained optimistic that Q could add value and that it had the right aspirations. When asked in interviews about their overall feelings about the Q initiative, most members were very positive, saying they enjoyed their experience. They thought '*it was well organised and well thought through', 'very useful', 'valuable', 'helpful and interesting', 'invigorating'* and '*inspiring'*; they said they felt '*hopeful', 'excited moving forward', 'privileged',* and that it gave them '*a sense of ownership'* and '*a feeling that they have a contribution to make'.*

The vast majority of interviewees stated that they would like to remain involved with Q in some capacity, but displayed caution by highlighting that Q was a promising rather than proven initiative. Only one out of the 156 survey respondents reported planning to opt out in the future, with 50.6 per cent (79/156) expecting to participate actively.

Discussion and conclusions

Right time?

The fact that host organisations continued to support staff in attending events, and members continued to participate, even when there was a lack of specific detail about the benefits Q would bring, is testimony to a deeply held view that this was the right time for such an initiative. However, its future success faces wider challenges in the shape of fragmentation of the NHS, low staff morale, efficiency savings and the lack of a national improvement body. Thus while the timing may have been 'right' for Q as a response to some of the problems facing the NHS, wider challenges were also perceived.

Right approach to delivering aims?

There was a continuing, and possibly unavoidable, tension between emphasising the importance of the principles of co-design (with emergent aims) and providing a clear 'public narrative' about the origins and aims of Q. On balance, the aim of co-design was ambitious; while some founding cohort members were comfortable with emergence, many members were confused by the process, and the communications around this were not always understood. Nominating organisations similarly expressed anxieties about pace and progress, which may be related to misaligned expectations. Despite this, not only were all design events well attended, but by the final design event there was a growing sense that the aim of co-design was being achieved, with ideas about improvement labs, mentoring, online sharing of good practice, and regionally based learning groups all emerging to give practical expression to Q.

Right members?

While the project team members emphasised that the founding cohort was about ensuring that a range of views were included rather than being 'representative' per se, and nominating organisations reported that nominees fulfilled the selection criteria, some concerns were raised about the suitably of the founding cohort – in particular, about whether or not the patient perspective was well represented and whether all founding cohort members had the appropriate level of technical improvement expertise.

Right size?

On the one hand, the inclusion of 231 members in an effort to co-design Q has proved to be an ambitious undertaking and posed serious challenges to both managing the process and for enabling all founding cohort members to engage and contribute in a meaningful way, but on the other it was perceived by interviewees from the Q project team that the cohort needed to be sufficiently large to incorporate a diverse range of views and backgrounds. The specific nature of the problem to be solved by Q was neither well understood nor agreed amongst members at the early stages. However, the efforts to engage founding cohort members appear to have generated considerable goodwill among the cohort, based on interviews at the end of the process and citizen ethnography at the final event.

Right place to move forward?

We have described some challenges encountered at the first and second learning events but the project leadership learned and responded to these challenges. Based on interviews with the Q project team and our observations at project team meetings, the Q project team perceived the first stage of the initiative to have finished more-or-less where it hoped to be when the initiative was launched, which was supported by papers produced for the Health Foundation board by the project team at the time of the launch. Given the uncertainties and hazards described in this report, whose impacts we observed during project team meetings, this is a considerable achievement. However, there are also future risks to highlight. The first is that the success of the networking

among the founding cohort was linked very strongly to the learning events and opportunities to meet others face to face. This level of national face-to-face activities is not in the current plans for Q going forward. Second, the improvement labs are an important dimension of the current plans for Q and although promising these are as yet unproven. Third, the single biggest barrier to participation for the founding cohort is that of time and this, in turn, depends upon the willingness of employers to support members' participation. To date they have remained strongly on board but will need to be kept informed, motivated and committed for the initiative to step up to the next level.

Future evaluation framework

Having summarised our findings and conclusions from the first phase of Q, we now reflect on how effective the embedded evaluation was, and make suggestions for a future evaluation framework for Q.

Reflections on the experience of the first phase of evaluation

Both the Health Foundation and the evaluation team were keen to establish what exactly might be meant by an 'embedded but independent' evaluation, and this was the subject of significant discussion both within the evaluation team and with the Health Foundation. It was apparent to the evaluation team that the project team not only listened to the emerging evidence but also used that evidence in their decisionmaking.

Risks included those of a reputational nature and a professional concern for rigour. On reflection, the internal challenge within the evaluation team and RAND's own Quality Assurance approaches worked well as a check in this respect. The evaluation in practice also acted as part of the interface between the implementation team and the members and this added a potential level of complexity.

Overall, on the basis of feedback from the project team at meetings and informally, the evaluation team is confident that risks were well managed and that both independence and partnering were successfully balanced: while evaluative evidence has been explicitly requested and used on an ongoing basis, indicating that the evaluation team was not too distant, on occasions the reaction to some of that evidence has indicated that it went against working assumptions at the time, implying that the evaluation team maintained its independence. The need for checks and balances was considered from the outset but there was also room for adaptation and improvement as the evaluation developed.

The task ahead; scoping the evaluation framework

Our overarching evaluation question is: Is Q achieving a sustainable improvement in health and care across the UK and, if so, how?

Our core sub-questions are as follows:

- Is Q achieving a connected community leading to quality improvement becoming routine in health and care across the UK?

- Is the initiative being delivered efficiently?

- Has Q created a learning and improvement infrastructure?

- Has Q contributed to a health and care system devoted to learning and improvement?

- How well does Q fit with the wider changes taking place across the UK healthcare systems?

- What are the costs and impacts of Q?

Implementation of evaluation and associated risks

The next phase of the evaluation must make a judgement about the overall value or worth of Q. The evaluation team is aware of a wide range of expectations, ranging from the belief that it

can lead the 'next revolution in healthcare after evidence-based medicine' through to more limited expectations that it can contribute to modest but sustainable continuous improvements.

Members themselves will be a crucial source of data. The evaluation team will also have requirements for the members and it is important that members are clear about their responsibilities and that the Health Foundation will reinforce messages from the evaluation team.

An inevitable challenge will be to evaluate the success of Q in the light of wider changes to healthcare that are unrelated to the work of Q but which either dampen or multiply its effectiveness.

Recommendations

On the basis of our evaluation findings, we make the following recommendations to the Q project team for the next phase of Q:

- Focus early on bringing substance to Q's features

- Strengthen clarity and good will by making clear the relationship between leadership and membership

- Avoid confusion over the recruitment strategy for members

- Stick with the current ToC for now but schedule a future 'step-back' moment to review and if necessary improve

- Harness diversity through a shared core of values supporting a wide variety of activities

- Structure a staged approach in transitioning from a formative to a summative evaluation.

Furthermore, should the Health Foundation run an initiative similar to Q in the future, we make the following recommendations:

- When recruiting a founding cohort, be clear about its role and recruit accordingly

- Ensure that events and activities fit within an overall vision and tailor them to this

- Make sure that accountability and processes for decisionmaking are clear to everyone in the project team

- Maintain the strengths of Q in any similar future initiatives.

Acknowledgements

We are very grateful to the Q founding cohort members who participated in focus groups, interviews and citizen ethnography, and to the many others who have shared their views more informally during and outside design events.

We have greatly appreciated the Q project team's open and frank approach to a partnered evaluation, particularly those who were interviewed, and their invitation to attend project meetings has provided us with an invaluable source of data. We are also indebted to the teams at Uscreates and Cynergy for their assistance in organising research activities, and to the Health Foundation and NHS England for their support.

Thank you to our quality assurance reviewers, Emma Pitchforth and Chris van Stolk, for their helpful comments, which have improved this report substantially, to Jess Plumridge for the layout of this document and to Calum MacLure for helping to administer the first survey. We would also like to thank Shannon Provost (University of Texas at Austin) and Peter Gloor (Massachusetts Institute of Technology) for their helpful advice on the social network analysis.

Abbreviations

AHSN	Academic Health Science Network
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
IHI	Institute for Healthcare Improvement
QI	Quality Improvement
ToC	Theory of Change

Glossary of terms

Co-design	A design process where designers, users and other stakeholders work together to understand a problem and generate solutions.
Host or employing organisation	The place or organisation where the members of the Q founding cohort work or volunteer, or to which they are otherwise connected. For some but not all members these will be frontline NHS provider organisations.
Nominating organisation	An organisation responsible for nominating the founding cohort members to be selected by the Health Foundation: organisations responsible for the national safety and quality improvement programmes across all four countries of the UK (e.g. AHSNs), royal colleges actively engaged in quality improvement work, and various other national organisations such as government, policymakers and arm's length bodies.
Patient leader	People who combine commitment, understanding and experience of improvement with their perspective as a patient or carer, or as a leader within an organisation that represents patient and public perspectives.
Q founding cohort member	A member of a geographically, institutionally and professionally diverse cross-section of people with expertise in quality improvement, selected to help shape the long-term design and structure of Q during 2015.
Q project team member	The Q project team comprises: employees of the Health Foundation, most of whom work on Q part time, and two of whom work full time and were recruited for the initiative; a representative of NHS England; an independent healthcare improvement consultant; representatives from Uscreates, a design consultancy; and representatives from Cynergy, an events management company.

Chapter 1. Introduction

1.1. Background

Q (initially termed the 5,000 Safety Fellows) has been established against a backdrop of ongoing efforts to increase the quality and safety of healthcare, which is a key goal of government policy across the world. However, despite some 'unmistakable progress' [5], examples of avoidable harm and poor care remain [6-8]. In the UK, efforts to improve quality and patient safety have had 'patchy' outcomes [9], and for the Health Foundation, strengthening quality improvement capacity and capability has been a key part of addressing the issue [10]. More specifically, the origins of Q can be found in 'the serious failings at the Mid Staffordshire NHS Foundation Trust' described in the Francis Report [11].

Following the Berwick group's review into patient safety, the Q approach directly stemmed from a recommendation that 'NHS England should organise a national system of NHS Improvement Fellowships, to recognise the talent of staff with improvement capability and enable this to be available to other organisations' [1]. As a result of the government accepting this recommendation [12], NHS England approached the Health Foundation to develop and deliver a long-term initiative, which the Health Foundation would lead but which would be supported and co-funded by NHS England.[1]

The stated goal of Q is to 'radically expand and accelerate improvement to the quality of care' [13]. The Theory of Change (ToC), developed during the initial design phases of Q, envisaged that Q would achieve this goal through the creation of a sustainable community of learning and improvement across the healthcare system that connects, mobilises, develops and supports groups and individuals to strengthen learning and develop improvement expertise and skills to bring about change at scale. The original aim was to recruit, by 2020, a total of 5,000 participants who would lead quality improvement across all parts of the healthcare system throughout the UK, but this number is no longer seen as a specific target.

In order to ensure that the design of the initiative was applicable to those who are working on quality improvement, the Health Foundation recruited an initial cohort – 'the founding cohort members' – to work with the Q project team[2] during 2015 to refine and contribute to the long-term design and structure of the initiative (a process referred to as 'co-design' in this report) before the wider recruitment process gets underway in 2016. This process was perceived to give credibility to the initiative; in addition, a successful initial year would be likely to help attract future participants, with appropriate expectations. Details of how the founding cohort was selected and its role in the development of Q are briefly outlined in Box 1.

1.1.1. The theoretical approach to Q

The co-design process for Q is underpinned by a Theory of Change (ToC) and a 'double-diamond'

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1   The Health Foundation and NHS England each committed an initial £1m (£2m total) of funding for 2015. This was the first time that the Health Foundation accepted external funding.
2   The Q project team comprises: employees of the Health Foundation, most of whom work on Q part time, and two of whom work full time and were recruited for the initiative; a representative of NHS England; an independent healthcare improvement consultant; representatives from Uscreates, a design consultancy; and representatives from Cynergy, an events management company.

Box 1. Overview of the founding cohort (adapted from [13-16])

The Health Foundation intended to recruit a geographically, institutionally and professionally diverse cross-section of people who have expertise in quality improvement. By recruiting a range of participants from across the healthcare system – such as frontline clinicians, managers, patient leaders, researchers, policymakers and experts from other industries – and from all parts of the UK, it was hoped to maximise insights.

In order to build on existing networks and work being undertaken in the area of quality improvement, members of the founding cohort were nominated by organisations responsible for the national safety and quality improvement programmes in England, Scotland, Wales and Northern Ireland. In total, 48 nominating organisations participated. These organisations fell into one of three channels:

- Channel 1 (n=18): regional organisations with responsibility for quality improvement; for example, the Academic Health Science Networks (AHSNs) took a lead in nominating people, involving their local Collaborations for Leadership in Applied Health Research and Care (CLAHRCs).
- Channel 2 (n=3): people working with a professional body (generally Royal Colleges).
- Channel 3 (n=27): organisations such as government, policymakers, arm's length bodies, the Nuffield Trust and charities.

Individuals were selected to join the Q founding cohort through a process run by the nominating organisations. The selection process was determined by the individual organisations, although the Health Foundation provided guidance [17]. A core requirement for involvement was for participants to have organisational support. As such, employing organisations were expected to provide cover for staff, as well as travel and associated expenses for other aspects of the initiative including the networking and development activities. Recruitment ran from 31 March 2015 to 15 May 2015. In total 231 participants were recruited into the founding cohort.

Interaction with the first cohort of participants was anchored around three 'design events', which aimed to bring together all founding cohort members to co-design Q with the Q project team. Q founding members were required to attend at least two of the three two-day design events convened by the Health Foundation. At the conception of Q it was envisaged that each event would cover a particular aspect of the initiative: 'improvement laboratories', selection of future participants, networking events and development activities, development resources and strategic alignment with other initiatives across the UK. The aims of the design events were:

- Workshop 1 (July 2015, Birmingham): to launch Q; to explain what Q was; to explain the Theory of Change; and to explain the co-design approach.
- Workshop 2 (September 2015, Glasgow): to progress co-design; to gain knowledge and insight; and to connect.
- Workshop 3 (November 2015, London): to agree next steps for Q; to gain knowledge and insight; and to connect.

In order to support the founding cohort, members were provided with access to the Institute for Healthcare Improvement (IHI) Open School, BMJ Quality and NHS Leadership Academy.

model [2, 3]. Both elements have been used by the Q project team during internal meetings, presented during design events and featured in the external publications such as *A proposed model for Q* [4].

A ToC was perceived to be an important tool for conceptualising what Q aimed to achieve and how. Thus, the development of a ToC in collaboration with the founding cohort was a key aim for the Q project team throughout the

first year of the initiative. The ToC was always intended to evolve throughout the year: the evaluation team is aware of five iterations. The most recent model, presented at the final design event, is shown in Figure 1. Core to the model is the aim to create 'a connected community leading to make quality improvement routine', as outlined in the model provided to participants on 18 November [4]. This connected community is to be achieved through four strands of activity – connecting, mobilising, developing

Figure 1. Theory of Change issued with participant material during the final design event on 18 November 2015

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Figure 2. The double-diamond design process (taken from the first design event slides)
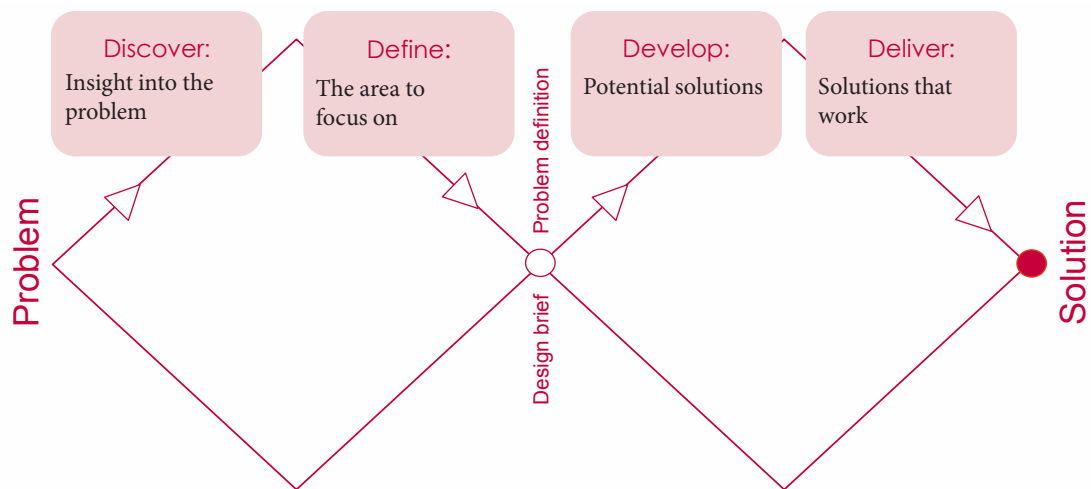
and supporting. It is anticipated that the ToC model will continue to evolve. For example, the Health Foundation has noted that later iterations will include 'more tangible outcomes and a supporting measurement and monitoring framework, resembling a more "traditional" ToC'.

Alongside the ToC, the Q project team used a double-diamond design process to structure its approach to co-designing Q [18]. This was developed by the UK Design Council as a way of mapping the common features between different approaches to the creative process [2]. The process involves four distinct phases – discover, define, develop and deliver – for capturing opinions, clarifying problems and finding solutions, shown in Figure 2. A problem is explored through emergent thinking and then defined through convergent thinking, and solutions are identified through emergent thinking and selected through convergent thinking (for information on convergent and divergent thinking, see Guilford et al. (1967) [19]).

1.1.2. The story so far

The Q initiative (initially the 5000 Safety Fellows), commenced in early 2014, with the nominating process for entry into the founding cohort starting in April 2015 (see Table 1). The evaluation was timed to coincide with the recruitment process and to report at the end of

the first year, following the final design event in November 2015.

1.2. Evaluation of the first year of the Q initiative

When the project team started to develop Q, there was some uncertainty about the mechanisms needed to deliver the intended changes and the context within which these mechanisms were being implemented. Prudently taking the initiative forward and ensuring a richer process required a formative and developmental evaluation that that could support structured 'learning by doing' and reduce some of the key uncertainties [20].

As part of the first phase of the Q initiative, following a competitive tendering process the Health Foundation appointed RAND Europe to undertake an independent, embedded, real-time evaluation. The aim was to inform the direction and strategy of the Q initiative by providing real-time feedback throughout the first year of Q. The evaluation was intended to be focused on identifying problems and practical solutions.

The evaluation team worked closely with the Q project team throughout the evaluation. This embedded approach brings many advantages: for example it allowed emerging findings from the evaluation to feed into the development of Q in

Table 1. Timeline of Q (based on a review of Q project team meeting minutes and weekly email updates, provided to the evaluation team by the Q project team)

2013	**February**	Francis Report published, following failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009.
	August	Berwick Review into patient safety published. Recommends a national system of NHS Improvement Fellowships.
2014	**January**	Government publishes response to Francis Report. In the response it accepts Berwick's recommendation for an Improvement Fellowship.
	March/April	'5000 Safety Fellows' project started, led by the Health Foundation, co-funded and supported by NHS England.
	July	Health Foundation board approves work to develop more detailed plans for initiative.
	September	Health Foundation director's team approves overall approach. Decision to introduce a 'co-design' structure (to work with a cohort of people currently working in quality improvement to help refine and test the design). Focus of the initiative is extended from safety to quality.
	October	Market research into strengths and weaknesses of the proposal with key stakeholders including potential participants and external experts. 'Big Room' and collaborative team design approach is adopted. First Theory of Change model drafted.
	November	Health Foundation directors' team approves more detailed proposals.
2015	**March**	Initiative rebranded as Q. Q information brochure released. Version 7.3 of the Theory of Change released with invitation to tender for evaluation.
	April	Nominating process for the founding cohort opened. Information phone calls with nominating organisations. RAND Europe commences evaluation of the Q initiative.
	May	Nominating process closes. In total 231 participants recruited into the founding cohort.
	June	Uscreates and Cynergy commissioned as technical providers, focusing on the design process and event management respectively.
	July	Simplified Theory of Change drafted for first design event. First design event held in Birmingham.
	September	Theory of Change refined for second design event. Second design event held in Glasgow.
	October	RAND Europe prepares interim findings.
	November	Theory of Change revised for third design event. Third design event held in London. 'A proposed model for Q: Shaped by the founding cohort and other experts and stakeholders' is released.
2016	**February**	RAND Europe prepares final findings.*
	Summer	Wider recruitment into the initiative planned to commence.

* This report

Table 2. Principles of an embedded independent evaluation

Embedded	Independent
• RAND Europe is embedded in the Q project team	• RAND Europe will maintain a critical distance from the Q initiative
• RAND Europe provides evaluation results in real time, so they can be used to maximum effect as Q evolves	• RAND Europe cannot be responsible for the design of Q as it would then be evaluating its own work
• RAND Europe attends project team meetings both for the purpose of data collection and to provide relevant evidence from work already completed	• RAND Europe is not part of the project team and will not make suggestions for the design of Q based on intuition or untested theory

real time. However, it can present a threat to the independence of the evaluation. Consequently, from the outset, both RAND Europe and the Health Foundation have maintained awareness of potentially conflicting principles (see Table 2).

1.2.1. Evaluation objectives

The evaluation comprises two complementary strands: (1) to observe the design process undertaken during the first year of Q and to examine how effective this is; and (2) to evaluate whether or not Q is well placed to meet its stated goals. The objectives are as follows, with references to where these can be found in the report.

Objective 1 – Design process:

1. Tell the story of the design process during the first year of Q, providing an independent account of how the initiative evolved (Section 1.1).

2. Provide continuous and final recommendations for how the Q design process could be improved, how design could operate subsequently, and if the Health Foundation were to take a similar role in future initiatives (Chapter 6).

Objective 2 – Potential for Q:

1. Provide an independent account of the first year of Q, identifying who was selected and how diverse they were (Section 3.1), what they learned, how the network of participants functioned to support learning and change (Section 3.3.2), how these are likely to change in future years of Q (if at all), unintended consequences (Sections 3.3 and 3.4), and how Q is meeting the needs and expectations of stakeholders (Sections 3.2, 3.3 and 3.4).

2. Assess how effective the recruitment process was, including the internal management of recruitment and the devolved nominations process; assess the strengths and weaknesses of the selection processes used by each nominating organisation, and the diversity and suitability of participants; and make recommendations for future recruitment strategies (Sections 3.1 and 3.2.1).

3. Work flexibly with the Q project team, sharing learning and engaging regularly in identifying emergent roles, barriers to progress and the inter-linking with other safety and improvement initiatives (through project meetings).

4. Carry out an end-of-year assessment of which parts of the Theory of Change are more and less valid, suggest amendments, and analyse whether Q is likely to be effective at executing it (Section 3.3).

5. Articulate specific options for the further design and implementation of Q during the first year and identify proposals for the initiative following the first year (Chapter 6).

6. Outline a monitoring, evaluation and quantitative and qualitative data collection strategy for the initiative to take forward following the first year (Sections 5.2 and 5.3).

The logistics and practicalities of the events are not covered by the scope of this evaluation, and in particular we do not consider Cynergy's role, as they were responsible for technical aspects of event delivery.

1.3. Structure of this report

The rest of this report is structured as follows. In Chapter 2, we outline the methods used to carry out the evaluation. In Chapter 3, we bring together the main findings from our research; these are presented under a number of key themes that were identified as being of most relevance to the Q project team and stakeholders with an interest in the success of Q. In Chapter 4, we draw conclusions from these findings. In Chapter 5, we outline a framework for the ongoing evaluation of Q beyond its design phase. Finally, in Chapter 6 we bring together our recommendations for the next phase of Q, based on our evaluation findings.

A comprehensive overview of the findings that informed this report is presented in the accompanying appendix (RR-1518-THF).

Chapter 2. Methods and data collection

2.1. Overview of methods

To inform the direction and strategy of Q the evaluation took a multi-method approach. In line with the two overarching objectives we collected data on both the design process and on Q itself, as outlined in Figure 3. A more detailed description of the methods is presented in the accompanying appendix (RR-1518-THF). The data collection methods comprised:

- **Document review** of paperwork submitted to the Health Foundation by nominating organisations to determine the rigour and appropriateness of the recruitment and nominating process.

- **Online survey of nominating organisations** (n=30) in August–September 2015 to gain further insight into the recruitment and selection process employed by nominating organisations for selecting nominated members. The survey comprised a series of closed and open-ended questions capturing the application process through to selection and nominating organisations' experience of the process. Quantitative survey responses were summarised using descriptive statistics (numbers and percentages), while qualitative (free text) responses were summarised in a narrative synthesis using a thematic analysis.

- **Online survey of Q founding cohort members** before the first design event in June–July 2015 (n=211; 91.3 per cent) to collect demographics of participants and their 'fit' with the proposed ToC strands – connecting, mobilising, developing and supporting. The survey was repeated after the final design event in January 2016 (n=165; 71.4 per cent) to understand what impact Q had had on members, if any. In total 154 members (66.6 per cent) responded to both the first and second survey, and 222 (96.1 per cent) to at least one of them. The survey comprised a series of closed and open-ended questions. Quantitative survey responses were summarised using descriptive statistics (numbers and percentages), while qualitative (free text) responses were summarised in a narrative synthesis using a thematic analysis. Data collected through the two surveys were used to conduct a social network analysis. This aimed to determine existing connections between founding members and to explore how connections had changed following the final design event.

- **Semi-structured interviews** held before the first design event in July 2015 (n=24) and after the last design event in December 2015 (n=21) and **focus group discussions** (n=11) held across the three design events with Q founding cohort members. Potential participants were randomly selected subject to conditions ensuring representation of a range of characteristics including geography, profession and ethnicity. Interviews and focus groups followed a semi-structured format, which allowed for reflexive questioning to explore members' opinions on the wider quality improvement landscape, their motivations for participating in Q, and their personal experiences and observations of being involved in the Q design process. Notes taken during interviews and focus groups were analysed thematically [21, 22].

Thematic categories were agreed between all members of the research team. Where appropriate we present anonymised quotes from participants to illustrate key themes.

- **Citizen ethnography**[3] undertaken by Q founding cohort members (n=17) during two design events (Glasgow and London) to capture members' insights into the design events and Q. All founding cohort members were offered the chance to participate. Those who volunteered were provided with a form at the start of the design event on which they could note any observations and/ or reflections that they had throughout the two-days of each design events. This was intended to be an informal data collection exercise and volunteers were requested not to formally ask other members for feedback on their experience, although they were encouraged to document insights from conversations they had [23].

- **Online survey of host organisations** (n=22) held at the end of the first year in January 2016 to explore whether the participation of their employees and/or associates in the Q initiative had any impact on host organisations' awareness of Q and their perceptions of and support for Q. The survey comprised a series of closed and open-ended questions. Quantitative survey responses were summarised using descriptive statistics (numbers and percentages), while qualitative (free text) responses were summarised in a narrative synthesis using a thematic analysis.

- **Non-participant observation** at Q project team meetings and design events. A member of the research team attended the fortnightly Q project team meetings (totalling roughly 40 hours) and members of the research team attended the three design events. The researchers took notes on proceedings but did not actively participate. Observations were intended to provide the research team with insight into the design process, to understand the context behind the initiative and to be able to link observations at design events or from members to actions behind observed phenomena.

- **Review of 'after action reviews'** completed by the Health Foundation after the recruitment process and each design event.

- **Semi-structured interviews** held with members of the Q project team and external consultants before the first design event in July 2015 (n=5) and after the final design event in November 2015 (n=5) to explore their experience of working on Q and their perceptions of the design events and the co-design process. Notes taken during the interviews were analysed thematically [21, 22], and we present quotes to illustrate key themes where appropriate.

The findings from the different data collection methods were **synthesised** into a single narrative, grouped by organising themes. Multiple data sources provide evidence for each theme, and in this way it is possible to compare and contrast the findings from the different methods and different stakeholders [24, 25].

2.2. Caveats and limitations

Table 3 summarises the limitations of each methodology. The methodologies were chosen to complement each other; although each had some limitations, none of these limitations was common to all methodologies and we were able to base our conclusions on multiple sources rather than relying on any one individual source.

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3   Ethnography is the study of social interactions, behaviours and perceptions that occur within groups, teams, organisations and communities.

Figure 3. Overview of the timing of data collection relating to the design process and to Q

Q

Document review of nominating organisation forms

'Before' survey of Q participants

24 'before' interviews with Q participants

4 focus groups with Q participants

4 focus groups with Q participants

Survey of nominating organisations

Survey of host organisations

'After' survey of Q participants

21 'after' interviews with Q participants

3 focus groups with Q participants

Start of evaluation

First design event

Second design event

Interim report

Third design event

Emerging findings workshop

Final report

Design process

Document review of Q project meeting minutes

4 interviews with Q project team members

1 interview with Q project team member

2 interviews with Q project team members

3 interviews with Q project team members
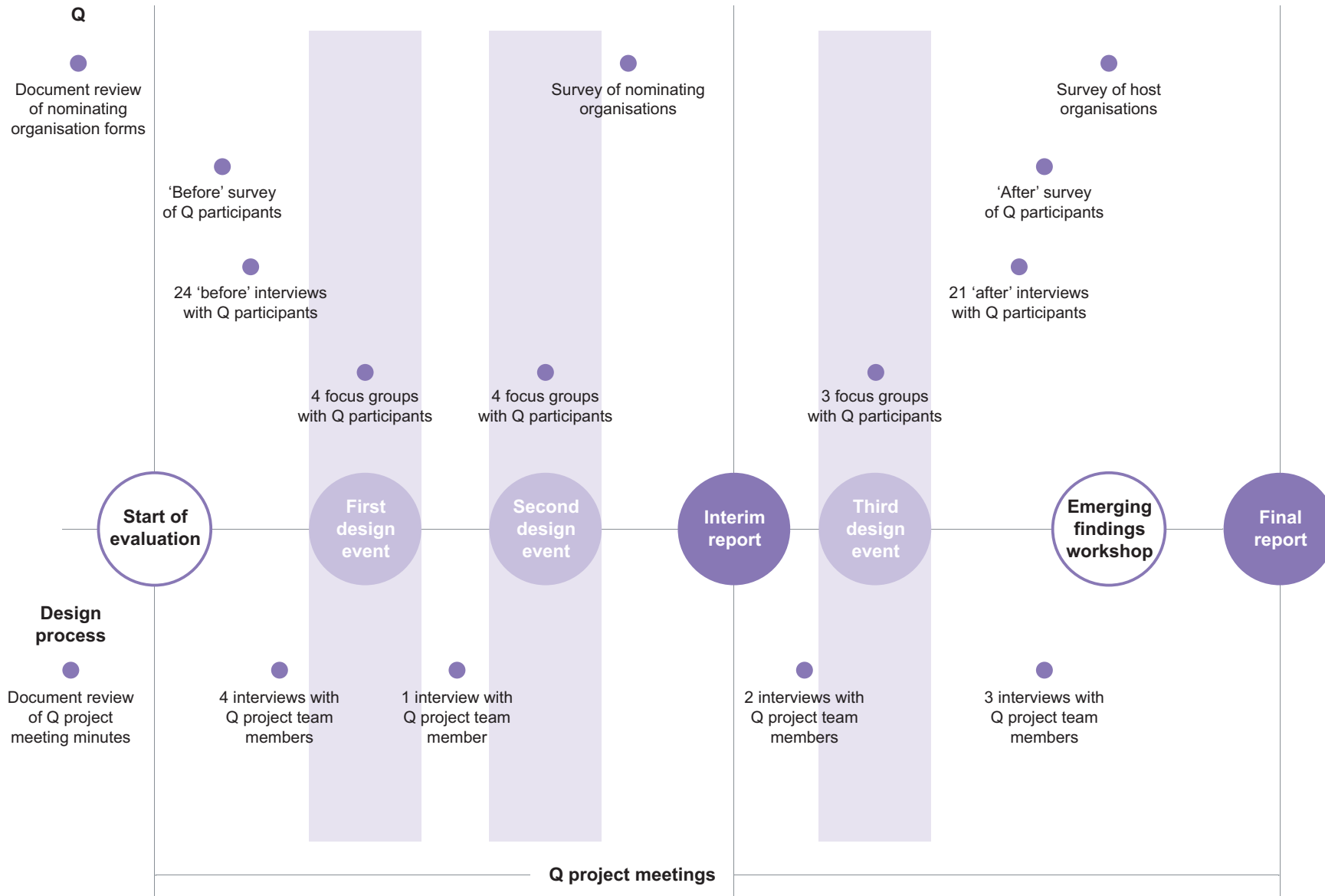
Q project meetings

Table 3. Overview of caveats and limitations of the study

	Document review	Surveys	Interviews	Focus groups	Citizen ethnography	Non-participant observation	Synthesis
There was limited opportunity to interrogate data further	●	●				●	
We had limited control over available data	●				●		
Not all individuals interpret all questions in the same way		●	●	●	●		
Recall bias		●	●	●			
Contradictory points could be raised and it was not always possible to give a consensus view		●	●	●	●	●	
Sampling bias			●	●	●		
Semi-structured protocol meant not all questions were asked on all occasions			●	●			
Time limitations meant that not raising a view was not the same as not holding a view			●	●			
Different members of the evaluation team had different coding styles			●	●	●	●	
The sample size was small relative to the entire pool			●	●	●		
There may have been reluctance to air unpopular or minority views				●	●	●	
Views are restricted to those of the project team							●

Chapter 3. Findings

In this chapter we present a high-level summary of the key findings emerging from the synthesis of all the different methods of data collection. The findings are presented thematically mapped against the Medical Research Council guidance for process evaluations [26]: context, implementation, mechanisms of impact and outcomes. We present each theme in turn. For a full overview of findings presented by method, see the accompanying appendix (RR-1518-THF).

3.1. Context

Q is operating within a wider environment of ongoing quality improvement initiatives and other efforts to improve the quality of healthcare in the UK. In order to understand this environment, and the potential for Q within it, interviewees and focus group participants were asked about their perceptions of the landscape and whether they perceived any value to be gained from Q. The themes emerging from the data highlighted differences in definitions of quality improvement, ambiguity around the individuals' roles in quality

improvement, and differences in the value quality improvement is given at the organisational level. Q was in part predicated upon a belief that the UK lacks both capacity and competence in quality improvement, so this is an important part of the context. Members revealed a lack of clarity over the aims of Q at the outset of the initiative, but even so the majority of interviewees were optimistic ahead of the first design event that it would add value to the quality improvement environment. These themes emerging from the qualitative data are discussed in more depth below. First we outline the demographics of the founding cohort, as these are likely to influence members' perceptions of the quality improvement landscape and Q's place in it.

3.1.1. Demographics of the founding cohort

In total 231 individuals from 192 organisations were recruited to participate in the founding cohort. An overview of members' demographics and occupational characteristics is provided in Figures 4–8. The figures demonstrate that the

Figure 4. Gender breakdown of the founding cohort, based on information provided by the Health Foundation from members' application forms
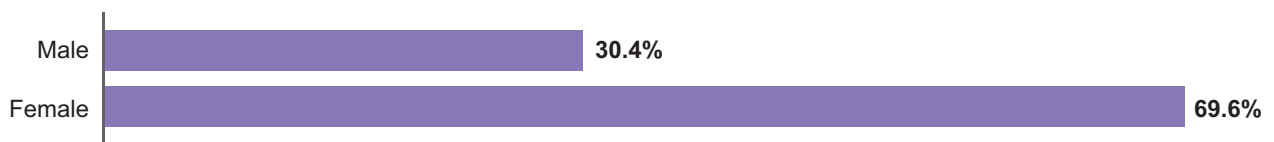

Male   30.4%
Female   69.6%

Figure 5. Age breakdown of the founding cohort, based on baseline survey of members

16 to 24   —
25 to 34   6.2%
35 to 44   27.3%
45 to 54   56.5%
55 to 64   7.2%
65+   1.4%

Age group
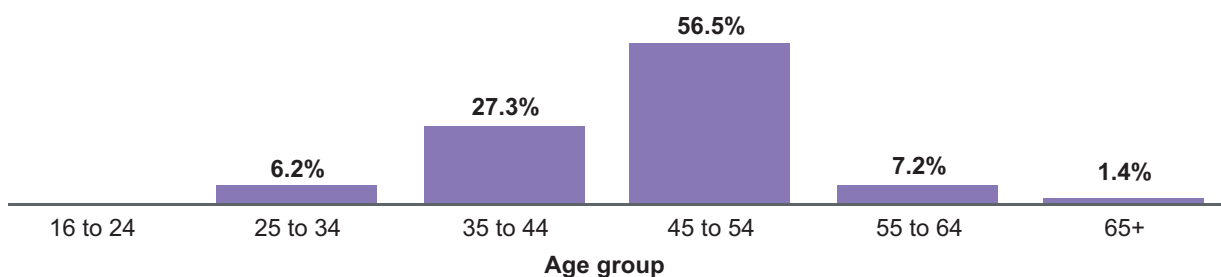
Figure 6. Ethnic breakdown of the founding cohort, based on baseline survey of members

Category	Value
White British	83.3%
Other white	5.7%
Mixed	1.4%
Asian	6.7%
Black	1.4%
Other	
Prefer not to say	1.4%

Figure 7. Founding cohort members' primary place of work, based on end-of-year survey of members

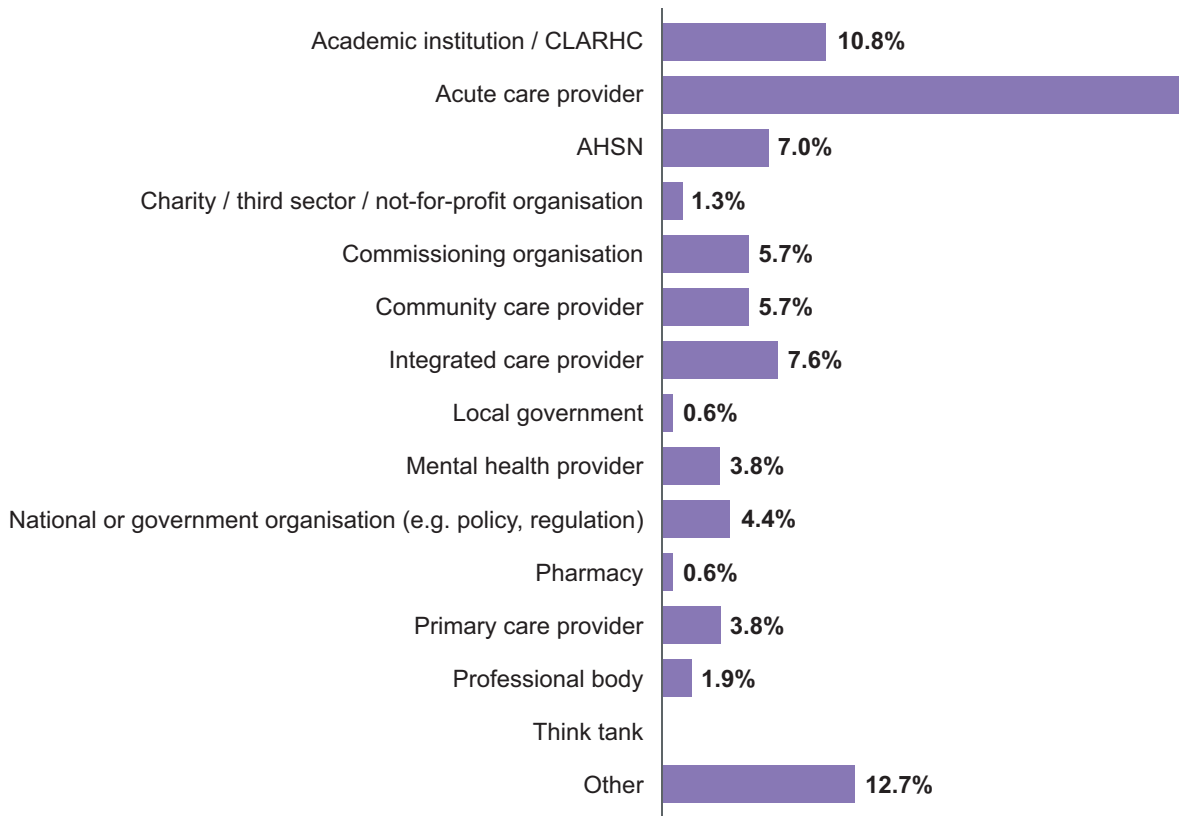| Category	Value
Academic institution / CLARHC	10.8%
Acute care provider	
AHSN	7.0%
Charity / third sector / not-for-profit organisation	1.3%
Commissioning organisation	5.7%
Community care provider	5.7%
Integrated care provider	7.6%
Local government	0.6%
Mental health provider	3.8%
National or government organisation (e.g. policy, regulation)	4.4%
Pharmacy	0.6%
Primary care provider	3.8%
Professional body	1.9%
Think tank	
Other	12.7%

Figure 8. Frequency of face-to-face contact that founding cohort members have with patients or service users, based on baseline survey of members

Category	Value
Yes, frequently	38.0%
Yes, occasionally	45.7%
No	16.3%
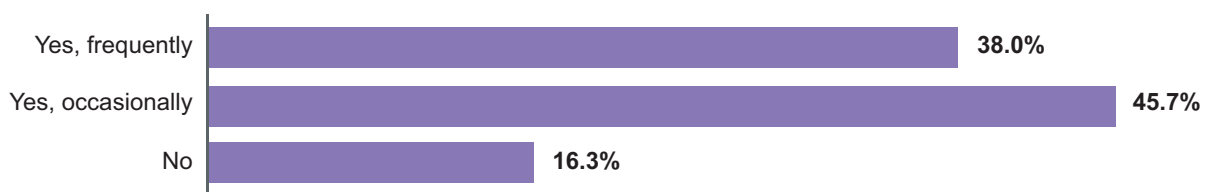
Q founding cohort comprised a broad range of demographic and occupational characteristics. Findings from the end-of-year members' survey on the background and roles of Q members provided further insight into the diversity of the founding cohort (see Figures 9–11). It is evident from the survey results that the role of some members within Q was not consistent with their background. For example 31.8 per cent (49/154) of members identified themselves as patient leaders, according to Q definitions,[4] but only six respondents identified this as their primary or secondary role in relation to Q. In addition, 30.5 per cent (47/154) of members identified themselves as having a nursing background, but only 13 reported a primary or secondary nursing role in relation to Q. The majority of respondents (54.5 per cent; 84/154) reported that their primary or secondary role within Q was as a quality improvement professional.
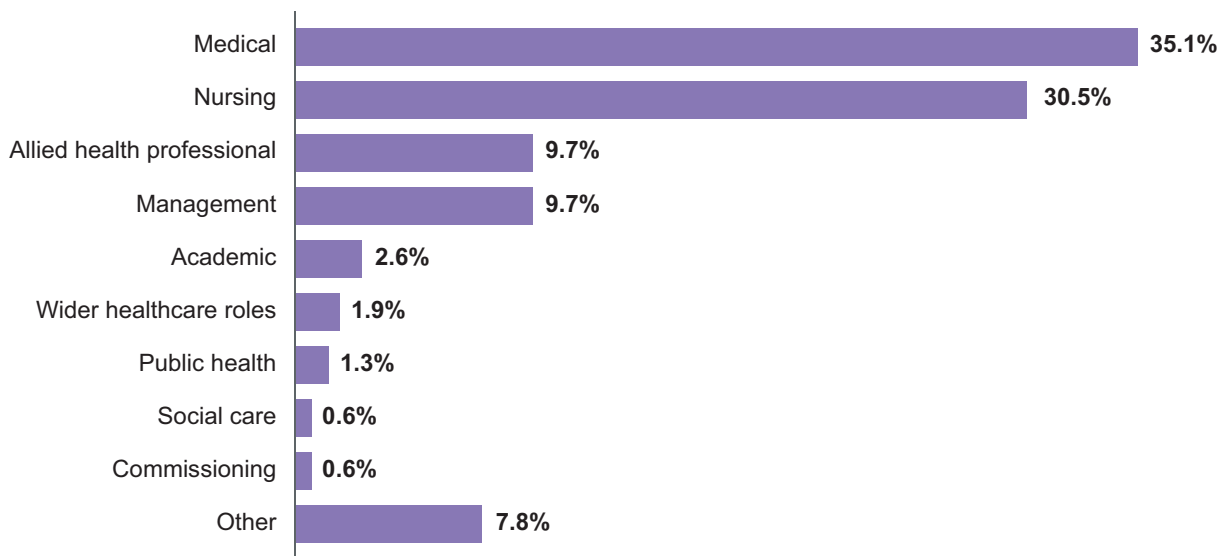
3.1.2. Defining quality improvement

Members provided a range of definitions of quality improvement in interviews and focus groups. In interviews and focus groups members broadly conceptualised quality improvement as a spectrum of activities from a *'mind set'*,[5] which forms part of a continuous process that underpins service delivery rather than being separate from it, to a discipline in its own right underpinned by a formal methodology and set of tools.

> *There's a real issue about language. Is QI[6] about a particular set of methods or about more broadly improving the quality?* (member, interviewee)

Members discussed quality improvement as a mechanism for improving a range of outcomes including safety, efficiency, reliability, consistency, patient experience and person-centeredness of

Figure 9. Professional backgrounds of founding cohort members, based on end-of-year survey of members

Category	Percentage
Medical	35.1%
Nursing	30.5%
Allied health professional	9.7%
Management	9.7%
Academic	2.6%
Wider healthcare roles	1.9%
Public health	1.3%
Social care	0.6%
Commissioning	0.6%
Other	7.8%

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4   'Patient leader' in the context of the Q community means people who combine commitment, understanding and experience of improvement with their perspective as a patient or carer, or as a leader within an organisation that represents patient and public perspectives.

5   Throughout this report, where we use an inline quotation to illustrate a view, this was said by one person and does not imply that everyone used the same precise wording.

6   Quality improvement professionals and Q members often refer to quality improvement as QI. We do not use this abbreviation, except in quotations, to avoid any visual ambiguity with Q.

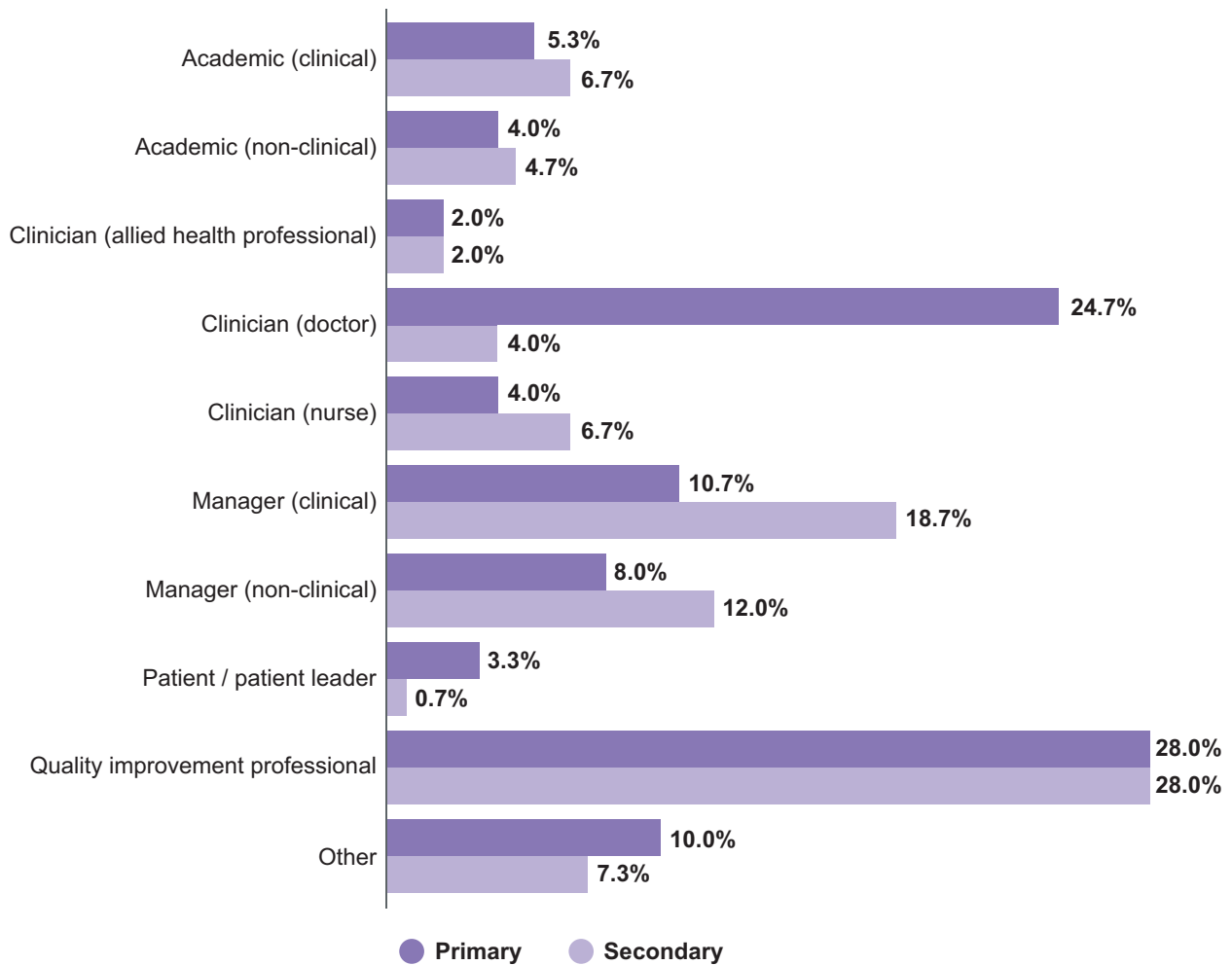**Figure 10. Founding cohort members' primary and secondary roles in Q, based on end-of-year survey of members**

Role	Primary	Secondary
Academic (clinical)	5.3%	6.7%
Academic (non-clinical)	4.0%	4.7%
Clinician (allied health professional)	2.0%	2.0%
Clinician (doctor)	24.7%	4.0%
Clinician (nurse)	4.0%	6.7%
Manager (clinical)	10.7%	18.7%
Manager (non-clinical)	8.0%	12.0%
Patient / patient leader	3.3%	0.7%
Quality improvement professional	28.0%	28.0%
Other	10.0%	7.3%

● **Primary**   ● **Secondary**

Figure 11. Founding cohort members describing themselves as patient leaders, based on end-of-year survey of members

No	68.2%
Yes	31.8%
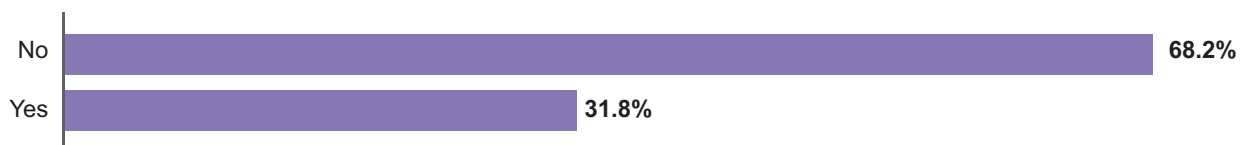
care, as well as for reducing variation and waste. A number of members also considered that quality improvement encompassed staff needs, playing a role in ensuring a *'more sustainable and safe [environment] for them to work'* (member, focus group participant, third design event).

Some members highlighted that Scotland has a relatively well-established culture of quality improvement and patient safety compared to England. Likewise, recent structural changes in Northern Ireland and the announcement of a patient safety innovation hub were reported to present an exciting opportunity to give *'much more of a focus on QI'* (member, interviewee) in the region.

The lack of collective thinking on quality improvement was suggested by some members to have resulted in tensions between *'QI as*

a science done by experts and people on the ground' (member, focus group participant, third design event). Further tensions were reported relating to the use of quality improvement, by employing organisations in some instances, to apportion blame rather than a mechanism to support providers to improve care. One interviewee perceived that there was unlikely to be a consensus on the definition *'until more work is done, and theories are more applied, I can't see yet that there is any real consensus over what quality means in one health condition, or one environment to the next.'* (member, interviewee).

3.1.3. Facilitators and barriers to quality improvement

The majority of interviewed members reported that their organisation supported and valued quality improvement efforts, and this is bolstered by findings from the baseline member survey in which 62 per cent (128/207) of respondents agreed or strongly agreed with the statement 'I get the support I need from my organisation to undertake the quality improvement work I want to do'.

However despite support, members universally reported in interviews and focus groups that they face significant barriers in implementing quality improvement. The principal barrier was stated to be a lack of time; as well as being mentioned in survey free-text responses, this was raised by more interviewees and focus groups respondents than any other barrier, and also described as being the main barrier by those who highlighted it. One reason for this noted by some members in interviews and focus groups is that, despite an apparent willingness to engage with quality improvement, frontline staff and management perceive it to be an *'add on'* to an individual's role, rather than being part of their day-to-day job. In these cases, responsibility for quality improvement falls *'to individuals [who are] motivated and enthusiastic'* (member, interviewee).

There was also the perception among the majority of members that financial constraints within the

NHS placed limits on what quality improvement work could be undertaken. Furthermore, it was believed that quality improvement is hampered by the lack of longer-term thinking needed to realise some of the benefits.

Members noted that there is a danger that some regard quality improvement as *'a fad'*, or that organisational changes in the NHS and management can delay progress. Members suggested that to overcome these barriers requires a culture shift to ensure quality improvement is embedded, *'getting them [staff] to see that it's not out of their control'* (member, focus group participant, third design event), and thus create an '*ethos that we can make this better so anybody could make a difference.'* (member, focus group participant, third design event). A number of members suggested that to achieve culture change requires buy-in at the board level in order to support and enable individuals to make a change, in some cases by *'giving people permission to act'* (member, focus group participant, third design event). Furthermore, board-level support was considered to translate into quality improvement forming *'part of the central business strategy'* (member, interviewee), which was perceived to be critical for attracting funding. There was reported to be a discord between policy and/or board-level thinking and the risks that middle management are willing to take. Middle management was frequently cited to be risk-adverse, and bound by the focus on targets.

Although among members surveyed there was reported to be a high level of skills and knowledge needed for quality improvement work (60 per cent or 125/207; baseline member survey respondents agreed or strongly agreed with the statement 'I currently have the skills and knowledge that I need for the quality improvement work that I would like to do'), interviewees considered more formal training to be a means to embed quality improvement and increase efficiency more widely. While several interviewees reported that there is a growing culture of training facilitated by more programmes and initiatives, in general

the majority of participants reported that quality improvement lacks visibility. One interviewee also raised concerns that the professionalisation of quality improvement might have unintended consequences, suggesting it *'reinforces the idea that QI is a specialised skill, which could exclude a number of people trying something different with the aim of improving quality'* (member, interviewee).

3.1.4. Value and expectations of the Q initiative

Interviewees were optimistic at the start of Q that there was benefit to be gained from the creation of a national initiative. There was reported to be good will, enthusiasm and skills in all parts of the system that already exist, and for some Q was perceived to be an important initiative for harnessing these skills and to build on the capacity of existing organisations such as the AHSNs and Patient Safety Collaboratives. However, others cautioned that the danger was to ignore what had been done before and to *'reinvent the wheel'* (member, interview), rather than building, for example, on the English NHS organisational memory. The involvement of the Health Foundation and NHS England was reported by two interviewees to provide *'weight'* to the initiative.

It was apparent from interviewees' accounts before the first design event that Q had not been clearly defined at this stage and as such, what Q was trying to achieve was still the subject of debate. The most commonly cited aim of Q was to create a network and to provide opportunities for wider collaborations. Networks were seen as a way to operate beyond *'silos'* (member, interview) and to *'raise the game'* in quality improvement (member, interview). Some members talked about the Q networks as being ways of sharing ideas and learning and disseminating best practice and getting like-minded people together to share resources. The majority of members also commented that Q was about reaching a *'critical mass'* of staff, and increasing the capability and capacity

of individuals to support the whole system. Several members saw the potential for Q to become a social movement embedded within the NHS and an opportunity to force leaders' attention onto quality improvement. For some, Q was about aiming to make continuous quality improvement part of business as usual in the NHS, while others perceived Q to be about making a step-change around patient safety and the standardisation of care quality across the UK. The consensus of one focus group was to see Q as a potential vehicle for promoting good methodologies.

3.2. Implementation of a co-design process

Q involved a co-design process between members of the founding cohort, who had been nominated to participate, and the Q project team. The recruitment process was perceived in the survey of nominating organisations and by the Q project team at team meetings to have recruited relevant individuals to the cohort with the breadth of knowledge needed to inform Q, and to have allowed the Health Foundation to engage with existing organisations with an interest in quality improvement. However, the size of the cohort was considered by many member interviewees and focus group participants and project team interviewees to be too large, and this was reported to have limited the extent to which all members were able to engage in the co-design process, and has reportedly made decisionmaking challenging. The recruitment and design process are discussed in turn below. To present a complete picture, in this section we also examine the way that the Q project team worked behind the scenes.

3.2.1. The recruitment process

Recruitment was conducted via a nominating process carried out by 48 nominating organisations: 18 Academic Health Science Networks and national improvement organisations, 3 professional bodies and 27

government organisations and charities. The evaluation team was unable to meaningfully assess the rigour or appropriateness of the selection process employed by nominating organisations as the documentation submitted by the vast majority of nominating organisations was inadequate.[7] While available documentation highlighted a variety of approaches to the recruitment process, ranging from an openly advertised application process to a 'tap on the shoulder', insights from the survey of nominating organisations suggest that the majority (86 per cent; 25/29) took the latter approach and already had candidates in mind before starting the recruitment process. This variable approach to recruitment is not necessarily a weakness or strength, and an after-action review of the process with the Q project team confirmed that it was consciously entered into.

The survey of nominating organisations found that there was considerable competition for places, with over 83 per cent (25/30) of nominating organisations receiving more applications than places. The process for selecting candidates varied between organisations. This may have stemmed from a lack of clarity as to who constituted a suitable nominee, or it might reflect the aim of encouraging each nominating organisation to consider what would work best in their context. For example, nominating organisation survey respondents reportedly found it difficult to balance the aim not to nominate the usual suspects with the requirement for a high level of quality improvement seniority. Furthermore, some organisations reportedly chose nominees who would ensure their organisation was well represented, while others ran the nomination processes with the intention of finding the most suitable individuals. A lack of clarity was also identified by the Q project team in the after-

action review of the nominating process. This was reported to have stemmed from a desire within the team to maintain a level of flexibility to enable the process to evolve.

The vast majority of nominating organisation survey respondents felt they received support from the Health Foundation during the application process: 96.4 per cent (27/28) reported that the information provided by the Health Foundation was useful or somewhat useful. In free-text responses five survey respondents commented that the workshops were most useful source of support.

> *I attended the meeting, calls and workshops – this [the application process] would have been difficult for those who did not.* (nominating organisation survey respondent)

However, in free-text responses a considerable number of respondents highlighted that the process was too complicated and burdensome, and that the timescale was challenging: across four questions asking how the process could have been improved, the majority of respondents made comments to this effect. The Q project team members, whilst acknowledging some of these challenges, perceived that on balance a nomination process had been the correct choice for ensuring that those organisations with an interest in quality improvement were engaged in the process.

The majority of nominating organisations surveyed reported that their nominated candidates fulfilled the Health Foundation criteria on skills, qualities and diversity [17]; 58.6 per cent (17/29) reported they fulfilled the criteria very well, 27.6 per cent (8/29) that they fulfilled the criteria quite well and 13.8 per cent (4/29) that they fulfilled the criteria somewhat. This

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7   The Health Foundation required all nominating organisations to submit standardised documentation to record the nominating process and rationale for their decisions.

was supported in free-text responses, with the majority of those who responded reporting that with hindsight they had selected the best member. However, a number of challenges were reported including the time-consuming nature of the process for applicants and the need for host organisations to provide cover for staff, which might have deterred some individuals from applying and thus potentially impacted on the diversity of the cohort. Founding cohort members were more critical in interviews. They considered that the members were not representative of the wider NHS environment, and in particular they highlighted too few members from ethnic minorities and frontline staff. The lack of representation of people delivering healthcare was conceded by one of the project team members in an interview, although they speculated that it was potentially more important that the founding cohort engaged with those who were working to improve, and not only deliver, care. Furthermore, members of the project team argued that the aim of the recruitment process was to ensure that a range of views were included rather than being 'representative' per se.

It was clear from observations at design events and project team meetings that the recruitment process for future cohorts has not yet been completely finalised. From discussions that we observed during a breakout session at the second design event, it seems that the vision of the Q project team differed from that of some members. Many Q founding cohort members were supportive of an inclusive recruitment process, open to people who were enthusiastic about improving quality, while the Q project team's vision was a more exclusive model, where people had to demonstrate a level of quality improvement expertise. Citizen ethnographers' observations highlighted how current members had strong views about the recruitment of future cohorts, with many hoping it would include frontline staff, a range of specialities and currently underrepresented groups such as GPs. Two nominating survey respondents also raised concerns about the possible impact of having rejected some high-

quality candidates on their ability to recruit these candidates to future cohorts.

One area that remains particularly unclear is the future role for patients. The founding cohort included only nine patient representatives, although findings from the members' survey suggest that the patient voice within Q is perhaps not restricted only to patient representatives; 31.8 per cent (49/154) of members identified themselves as patient leaders. *A proposed model for Q* discusses a desire to include 'patient leaders' with improvement skills and while the Q project team have discussed their commitment to including patients in the design of Q [4], team members interviewed reported ongoing uncertainty over the most effective way of recruiting patients, their exact role and what the main aim of their contributions would be. This issue was also raised by Q members at design events, particularly the second design event in Glasgow, where some expressed strong views that patients were underrepresented.

3.2.2. The design events and process of co-design

The design events were intended to be the principal vehicle to facilitate the process of co-design. Findings from interviews and citizen ethnography demonstrated that members felt that the events were well organised and that the products and brand developed by the Health Foundation were of high quality, but for many members it was not until the third event that they felt more comfortable with and valued the design events.

The feelings of members expressed in interviews and observed through the citizen ethnographers changed over the course of the three events. In general members in interviews and focus groups were most positive about the third and final event. The first event was described as challenging and vague, with some interviewees surprised at the lack of plans presented for their consideration. They had expected (rightly or not) that they would have something more

concrete to comment on and *'pull apart'*. A number of interviewees reported that while they had been willing to accept this more fluid style of working as part of the process at the outset, by the second event they were frustrated that the design had not moved on, with one interviewee describing the second event as *'treading water'.* In part this may reflect a tension between the model of emergent design and the established working practices of some members. Be that as it may, this was reportedly confounded by the lack of prior communication from the Health Foundation detailing the purpose of the events, and a number of interviewees were unhappy with the lack of opportunity that this allowed for them to prepare in advance. Some members of the Q project team agreed that concrete proposals should have been presented earlier, feeling that not doing so has delayed the process. However, another member of the team countered that they had perhaps been guilty of *'not wanting to say anything until you know it's the right idea'*.

By the third event the majority of members suggested that things had *'crystallised',* and that it was the most productive of the three events; one member reported to a citizen ethnographer noticing less cynicism at the third design event as they saw Q '*starting to come together'.* Members of the project team reported in interviews that changes to the third event had been made in response to comments from Cynergy and the interim evaluation report, which highlights the value of receiving interim findings and evaluative feedback in real time. The aspects of the events most enjoyed by interviewees and observed by citizen ethnographers were the Open Space,[8] the opportunity to network and presentations by external speakers.

In general members were uncertain about the extent to which the process had met their expectations of co-design – although these expectations themselves varied between consultation and collaboration – and found it difficult to pinpoint individual contributions. In interviews, focus groups and citizen ethnographers' observations, several members were surprised to see that some things had not been taken on board or that topics that were not discussed at one event appeared at the next. Some highlighted the fact that the design process did not always feel *'comfortable'*: one felt they were more *'directed'* and that Q was '*done to'* them (member, interview). In the interviews a few of the project team members suggested that this concern was not misplaced, acknowledging that the project team had not wanted to lose control and that, despite their best intentions some feedback had been unintentionally side-lined when it was not what the team wanted to hear. From our observations of project team meetings, we did not notice an unusual degree of confirmation bias in the team's treatment of contradictory feedback from members.

The key challenge identified by both the members and the Q project team was the size of the founding cohort. It was considered too large to allow all members to meaningfully engage. We observed that the events generated many ideas, but that synthesis and decisionmaking was hard to achieve. For example, at project meetings the Q project team seemed reluctant to push ideas forward because they wanted Q to belong to the participants and did not feel empowered to make decisions without participant approval. Members suggested that the events better suited the more outgoing members of the cohort. The plenary sessions in particular were highlighted to be challenging, especially for the more introverted members. In interviews members suggested that the smaller breakout

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8   In Open Space, participants propose and vote for topics for discussion, and are then free to move between discussions as they wish.

sessions and the volunteer groups that met between design events allowed them to contribute in a more tangible way. The project team corroborated this view in interviews. They also questioned whether all members had the necessary skills for co-design, and noted that some members had a tendency to lead the group off topic or to create a negative atmosphere. In weighing up the need to have a large enough group to cover a diverse range of views and backgrounds, the majority of project team members reported that a smaller group potentially would have been more efficient.

3.2.3. Q project team approach

Interviewees who were employed by the Health Foundation all considered that the Q project team's way of working differed from their previous experiences of working at the Health Foundation. The most commonly cited differences were the lack of hierarchy, the ability to be creative outside of normal job roles, and an emergent or unstructured approach to thinking. One interviewee commented that the decision to take a different approach had been intentional, in an attempt to succeed where other quality improvement initiatives across the NHS had failed.

One interviewee felt that a side effect of this different way of working was a lack of clarity over accountability and responsibility, which better communication could have overcome. This interviewee found that task allocation could have been improved, as this was often based on who had made a suggestion or was communicated within longer documents. On the subject of communication, the same interviewee sometimes felt not fully up to date with Q.

Two interviewees commented that, because of time pressures, the second and third design events had been designed by one or two people without much consultation, which limited others' ability to provide useful input. One interviewee felt that ownership of different parts of the programme was not always clear. For

example, by the third event there were no longer ToC strand leads, as strands had merged; in some instances the owner was not clear or ownership was shared; in others it was not clear if someone owned a task or whether they were just required to provide advice, and even if they owned a task they sometimes still needed someone else's sign-off.

Three interviewees commented that the team had a tendency to focus on things that were urgent more than those that were important, particularly in the lead up to design events. One suggested that longer-term planning and theory had suffered as a result, saying:

> *We're constantly working towards the next deadline or the next priority.*
> (project team member, interviewee)

Interviewees reported that Q had involved taking on additional responsibilities above and beyond the remit of their normal job roles. Interviewees were very supportive of this, as it offered team members the opportunity to work in new ways and contribute in ways they were not accustomed. However, the team was also open to opportunities to increase its capability in areas where it lacks capacity and/or existing team members were not well suited.

3.3. Mechanisms of change

'Mechanisms' are the immediate causes of the change being observed. The ToC is a key statement of these anticipated mechanisms. The ToC itself was a subject of considerable discussion and, from our observations at the second design event, diverted attention from the mechanisms themselves onto the ToC as an artefact. As a result, what was intended to provide a structure to the design event was observed to occupy considerable attention at both of the first two design events. This was perceived by the Q project team to have been a cause of friction and, potentially, to have delayed progress towards the design of Q.

Looking at the specific mechanisms described in the ToC, in interviews members provided a multitude of examples of the beneficial impact that participating in the Q founding cohort had had on the 'connecting' and 'developing' strands of the central part of the ToC, and to a lesser extent on the 'mobilising' and 'supporting' strands. An overview of the impact that participating in Q has had within each of these strands is discussed in turn below.

3.3.1. Appropriateness of the Theory of Change

Significant time was devoted to exploring the ToC at the first two design events, and members observed at these events that this may have come at the expense of a more concrete discussion on how to design Q. It was clear that, in general, there was a lack of familiarity among members with the concept of a ToC and how it should be used. For example, in one discussion, participants were observed using the phrase 'the Theory of Change' in a similar way to, for example, 'the Theory of Gravity' – that is, it is a single, universal theory that describes how all change comes about. Another misunderstanding was a comment from one member, which went unchallenged by others at the table, that the importance of the work on the ToC stemmed from the fact that it was part of publicity material, despite the Q project team having explicitly stated in plenary that it was intended for internal use. Perhaps related to this, we witnessed several conversations about the precise wording of the ToC, when there was already sufficient agreement and clarity for the discussion to have moved to how to design Q to effect that change. In the lead-up to the second event the Q project team produced an extended document detailing the work so far on the ToC [27], and by the third event they appeared to have shifted the focus away from the ToC to the implementation of Q; unlike at the previous design event, no session was dedicated to the ToC, and we did not observe discussions of the nature that occurred previously. It seemed that the key principles of the ToC had been accepted by the

members, who were less preoccupied with it, instead concentrating on the design activities.

Some members of the project team also raised concerns during interviews relating to the use of the ToC. One commented that it had been too prominent at the design events, potentially creating a source of conflict that could have been avoided. Another considered that it had led to the co-design being too closely focused on the four strands of activity – connecting, mobilising, developing and supporting – at the expense of recruitment and how Q would encourage the use of evidence in quality improvement work.

3.3.2. Connecting

The *'chief benefit'* of the design events reported by the majority of members interviewed, surveyed and through the citizen ethnographer observations was the chance to network and form new collaborations, one saying that it made the UK *'a wee bit smaller'* (member, interviewee). Interviewed members reported feeling more connected to the other members by the final design event, and were able to provide examples of connections they had made. A number of interviewees praised the organisation of the third event in particular for facilitating the networking. In free text survey responses, interviews and focus group discussions and citizen ethnography notes it was apparent that where more established networks have started to develop these have been at the local/regional level and/ or related to specific clinical areas.

Connections between members were explored in more detail using social network analysis (see Figure 12). Each circle or 'node' represents a member, with blue, green and red nodes representing members from Scotland, Northern Ireland and Wales respectively, and light blue, pink, yellow and black nodes representing members from the NHS England regions – North, Midlands and East, South, and London respectively. Each line or 'edge' represents a connection between two members, where either member reported having a 'formal or informal

Figure 12. Network map of the Q founding cohort before the design events (left-hand side) and after the design events (right-hand side)
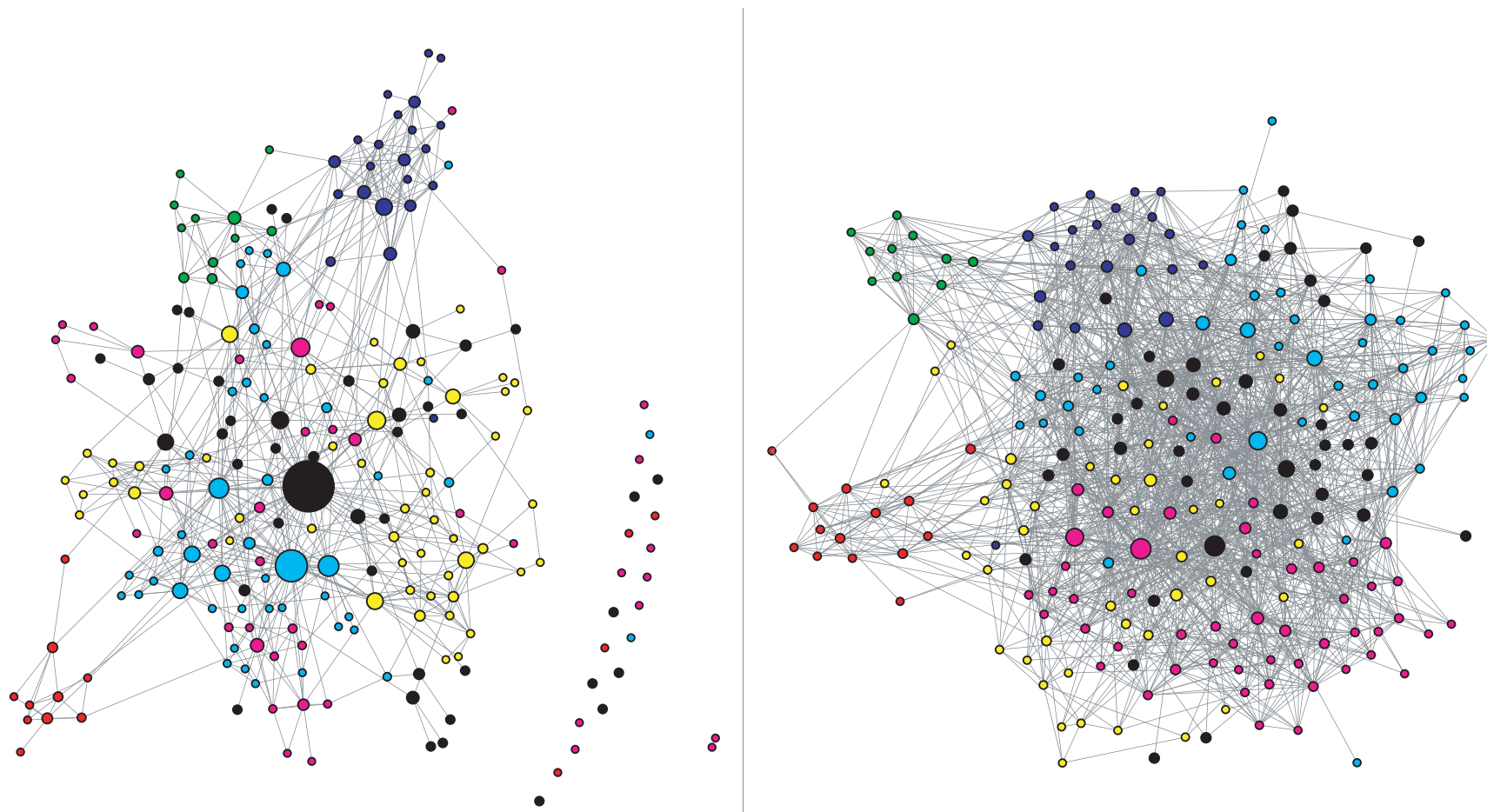
Country or NHS region the member works in:

● Scotland ● Northern Ireland ● Wales ● North ● Midlands and East ● South ● London

NOTE: Each circle or 'node' represents an individual member. The colours represent the country or NHS England region that the member works in. Each line or 'edge' represents a connection between two members, where either member reports a 'formal or informal connection'. The size of the node represents the 'betweenness centrality' of a member.

connection, which relate to quality improvement in healthcare'[9] with the other individual in the survey. We show all connections reported by either member in a pair; this means that non-respondents are not excluded from the diagram, but there is a greater risk of underreporting non-respondents' connections as they have not reported any themselves.[10] The size of the node represents the betweenness centrality of that member, which is a measure of how likely they are to be on the shortest path between any other two nodes.

Comparing the two network maps, we see that the right-hand side map is much denser as a result of the many new connections that have been formed; on average the number of connections between individual members increased by 10.0 (95 per cent confidence interval 8.4 to 11.4) compared to baseline. Overall, standard measures of clustering have decreased, indicating that the new connections forming are bridging gaps between groups of individuals who did not previously know each other as well as increasing the connectivity of groups that were already well connected. It appears that a lot of these connections were on the basis of a shared professional group or geographical connection, even if these groups were not particularly well connected previously. For example, before the events only 2.56 per cent of possible connections between GPs had been made, in line with the average 2.54 per cent of all connections across the whole cohort, and no pharmacists were connected to each other. After the events GPs had 19.2 per cent of connections and pharmacists 17.9 per cent of connections, against 7.24 per cent overall. The most connected parts of the network after

the three design events were the non-English countries, with Northern Ireland, Wales and Scotland having 89 per cent, 58 per cent and 55 per cent of possible connections. Even the least connected NHS England regions, London and Midlands and East, had 13 per cent of possible connections, up from 3 per cent and 5 per cent respectively. It can also be seen that following the design events there were fewer extremely central members (i.e. large nodes on the diagram), meaning that the community is now less reliant on key individuals for knowledge transfer. There were no longer members who reported no connections, although there remain clear clusters of connections between individuals from the same country.

Some members expressed concerns in interviews and focus groups about the extent to which the network can be self-organised if the Health Foundation was not to be involved anymore. In the citizen ethnographer observations participants were concerned that if future cohorts did not have face-to-face meetings it may be harder to form connections. Interviewees reported that connections are still reliant on motivation, and knowledge of what others are doing or looking for, and were concerned about the practicalities of creating a community with people from such diverse backgrounds.

3.3.3. Developing

In general, members reported that participating in Q had given them access to new tools, resources and knowledge. In the survey Q members reported a 6.7 point (95 per cent confidence interval 2.0 to 11.1) improvement, on a 100 point scale, in their ability to access

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9   The full question was: 'Please identify all Q participants from the list below that you have any formal or informal connections with which relate to quality improvement in healthcare. As a guide, if you have simply heard someone speak at a conference then you probably wouldn't identify them as a connection, but if you heard someone speak at a conference, and then met up afterwards to discuss how you could apply the learning from the talk they gave in your own organisation, and have their contact details, then this would count. Any formal or professional collaborations should also be marked.'

10   There were 25 non-respondents in the first survey and 69 non-respondents and in the second survey.

information and resources, and a 6.6 point (95 per cent confidence interval 2.4 to 10.4) improvement in their assessment of their skills and knowledge needed for the quality improvement work that they want to do.[11] In interviews and focus group discussion members cited a range of tools and techniques that they have used from the design events including the thinking hats, the Open Space, improvement labs and some facilitation techniques. The most frequently referenced resources included the Health Foundation booklets that they took away from the event, the online directory (although a couple of interviewees mentioned that the online directory was not yet complete and one interviewee commented that the interface made it challenging to quickly search for those individuals whom you might wish to connect with), the inspiring speakers, the BMJ Quality subscription and access to the Institute for Healthcare Improvement (IHI) resources. From the survey, uptake and positive review of these resources was high: 29 per cent (47/155) of respondents reported that they had accessed the BMJ Quality subscription and found it useful and 32.1 per cent (50/136) of respondents reported that they had accessed the IHI subscription and found it useful.

Finally, several members stated that Q challenged (or has the potential to challenge) the way they think and has pushed them to think differently/better, giving them the *'permission to disrupt'* (member, interview). Some claimed that they were trying to transfer the Q model (network, resources) into their organisation or their region. However, it is worth noting that a minority of interviewees said that they had not yet been able to use the tools/resources in their work because of lack of time or knowledge.

3.3.4. Mobilising and supporting

The majority of members interviewed said that Q has not yet helped them to overcome the barriers they are facing in their quality improvement work, although being able to connect with people who are working on similar things and facing the same issues might help in the future. This was supported by findings from the member survey, which found no significant impact of participating in Q on members' in relation to supporting or mobilising; Q members reported a non-significant 1.8 (95 per cent confidence interval -2.8 to 5.8) improvement in getting the support needed from their organisation and no change in respondents' reported ability to make changes that could improve quality in either their local setting and/or organisation (0.0; 95 per cent confidence interval -3.6 to 3.6) or at the regional/national level (1.6; 95 per cent confidence interval -3.3 to 6.1). Some interviewees thought that Q gave visibility and credibility to quality improvement and their work within their organisation, in particular because of the reputation that the Health Foundation brings and the involvement of high-profile speakers. Others said that Q has given them determination and confidence to take their quality improvement work forward.

3.4. Outcomes

The initial proposal for Q envisaged that it would bring together people leading improvement across the UK [28]. The founding year was intended to take the shape of a co-design process, in order to come up with a clear shape of the programme for future cohorts to participate in. Here, we assess the extent to which the first phase of Q was successful in achieving its aims, and present views on how likely Q is to achieve its ultimate goals.

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11   Received wisdom in the analysis of survey data using this approach is that a change of more than about 3 points reflects a meaningful difference. The confidence intervals do not cross zero, indicating that this change is significant at p<0.05

3.4.1. The aims of Q

We observed at the design events that the overall vision of Q was hotly debated, especially early on in the first design event, in plenary discussions and at a breakout session, and it was evident that the aims of Q remained unclear to members. For example, at the second design event one member stated to a citizen ethnographer that *'the whole thing is too grey'*. Interviewees felt that the aims were still evolving, and that this was demonstrated by a shift in focus of the events from 'learning and development' to 'building a community and networking'. The shift was also observed by a few members of the project team. One project team member was concerned that the shift had *'diluted'* the original aims of Q, when compared against Berwick's recommendation[12] [1], which they interpreted as aiming to create a sustainable, supportive community of quality improvement experts. It is interesting to note that interviewees did not discuss the Berwick Report in relation to the aims of Q. The project team member speculated that the shift might have been driven by what was useful for the founding cohort rather than what was needed to fulfil the aim of having 5000 fellows. Indeed, '5000 fellows' is no longer an aim, but Berwick's principles of achieving a learning and improving NHS are still at the heart of Q, even if members do not specifically relate to these.

In addition to shifting aims, a member of the project team also observed that new aims which the project team had not anticipated at the outset had started to emerge, including influencing policy, practice and working conditions, particularly in regard to time dedicated to quality improvement and the priority of quality improvement within members' organisations.

By the end of the second design event, the output from one breakout session was that a vision of Q as aiming to 'contribute to continuous and sustainable improvement in the health and care of all people in the UK' had emerged. This aim was incorporated into the latest version of the ToC, presented at the third design event, and we did not witness it being the subject of further debate.

3.4.2. Potential for the future

In the interviews after the final design event, the Q project team members recognised that Q had not progressed as far as they might have hoped. They suggested that the focus on the events had perhaps inhibited the long-term thinking needed to move Q on as far as possible. Citizen ethnographers echoed this finding, describing feeling that Q was slow to progress. Likewise, the evaluation team observed that many of the aspects that Q was expected to comprise were still under discussion, with only the online directory and subscriptions to quality improvement resources operational. Other activities such as an expanded online platform, improvement labs, mentoring and coaching were still only at a conceptual stage.

The future shape of Q remained unclear for most members interviewed after the three design events. While some thought that Q should create a central hub, signposting participants towards relevant resources in their own networks and disseminating relevant evidence, others considered that it should the NHS version of IHI. Several members said that Q needed to provide some sort of practical support mechanisms, whether online or face-to-face, to ensure that there are structures in place to connect and support people who are often working on quality improvement in isolation within their individual

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12   'NHS England should organise a national system of NHS Improvement Fellowships, to recognise the talent of staff with improvement capability and enable this to be available to other organisations.'

organisation. One project team member stressed the potential impact on improvement labs, which they thought could be at the heart of Q and help improve productivity.

Despite the lack of future clarity, in general interviewees remained optimistic that Q could add value and that it had the right aspirations. When asked in interviews about their overall feelings about the Q initiative, most members were very positive, saying they really enjoyed their experience. They thought '*it was well organised and well thought through*', '*very useful*', '*valuable*', '*helpful and interesting*', '*invigorating'* and '*inspiring*'; they said they felt '*hopeful*', '*excited moving forward*', '*privileged*', and that it gave them '*a sense of ownership*' and '*a feeling that they have a contribution to make*'.

The vast majority of interviewees stated that they would like to remain involved with Q in some capacity, but displayed caution in highlighting that Q was a promising rather than proven initiative.

The survey results back up this sentiment, with over half of respondents (50.6 per cent; 79/156) reporting that they expect to actively participate in Q in the future, and only one intending to opt out altogether. Responses also suggest that members would be willing to commit considerable amounts of time to Q: 28.8 per cent (45/156) would spend four to six days, 16.7 per cent (26/156) would spend seven to ten days and 14.7 per cent (23/156) would spend more than ten days, on Q activities in the coming year.

Interviewees suggested a range of formats that their contribution might take. For example it was suggested that they could help test the model once Q is fully developed, help with the recruitment of the next cohort, or remain involved in an online capacity. Over a quarter (25.6 per cent; 40/156) of survey respondents expected to take on a leadership role in Q.[13] Other interviewees were interested in continuing to contribute but needed time to reflect on how their skills and interests would best serve Q.

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13   Seven of these also included themselves in the 79 expecting to actively participate.

Chapter 4. Discussion and conclusion

The data analysed in the previous chapter points to a rich picture. In this section, we take a step back and provide an overview that asks more fundamentally 'did Q get it right?' In answering this overarching question we consider a series of sub-questions.

4.1. Right time?

The 2013 Berwick Report [1], following the Francis Report into the breakdown of care at Mid Staffordshire NHS Foundation Trust [11], recommended that patient safety should be rooted in a culture of transparency, openness and continual learning. In response, the Health Foundation recognised the importance of intrinsic values and professional commitment to support not only patient safety but also improvement more widely. Whilst the Berwick Report was rarely mentioned by members as part of the rationale for Q, the underlying appeal to openness and learning consistently resonated. The sense that staff committed to improvement were often isolated and patchily supported was clearly articulated, and the concept of building a community to overcome this enjoyed overwhelming support. The fact that host organisations continued to support staff in attending events, and members continued to participate, even when in the early stages there was a lack of detail about the benefits Q would bring, is testimony to a view that this was the right time for such an initiative. Furthermore, while Q evolved to focus not only on patient safety but also on quality more broadly, anxieties following the Mid Staffordshire inquiry continued to resonate with management, staff and patients. Other contextual factors may have strengthened the sense of the timeliness of Q, including concerns that the NHS was becoming more fragmented (for example, the abolition of strategic health authorities), and as members prepared to attend the first design event the King's Fund reported that staff morale topped the list of NHS finance directors' concerns [29]. Furthermore, the need to achieve efficiency savings shaped the environment where Q began. A longstanding concern shaping the reception of Q was the perceived lack of a national improvement body to champion improvement initiatives. Therefore while the immediate context may have been 'right' for Q, more chronic challenges were also relevant.

4.2. Right approach to delivering aims?

The aims of the first phase of Q were to: a) co-design the future shape of Q, and b) build a network across the UK of individuals committed to collaborating to share and promote ways to improve quality in the NHS. These aims had immediate origins in the Berwick Report, but also reflected longstanding concerns about the need to further build the capacity for quality improvement in the UK. There was a continuing, and possibly unavoidable, tension between the importance of co-design (with emergent aims) and providing a clear narrative about the origins and aims of Q. For some project team members, it was surprising that Berwick was rarely mentioned by founding cohort members, and at least one project team member suggested that the Berwick vision had been 'diluted' over time, while others were comfortable with seeing Berwick as a useful springboard.

On balance, the aim of co-design at scale was ambitious; while some founding cohort members were comfortable with emergence, many members were confused by the process, and the communications around co-design specifically were not always understood. Such communications seemed to be as complex as the co-design process itself. Arguably, and in retrospect, the project team needed to provide a simpler and easier 'story' – even if the process itself continued to be complex. Equally, the complexity of the design events may have been an artefact of what was technically possible rather than what was needed from the perspective of members. In addition, given the project team's timescale for planning and implementing design events, particularly in the run-up to those events, some of the project team's decisions were driven by what was urgent rather than what was important, resulting in missed opportunities to reinforce messages to manage expectations, especially for founding cohort members attending the first design event. Nominating organisations similarly expressed anxieties about pace and progress which may be related to poorly managed expectations. Despite this, not only were all design events well attended, but by the final design event there was a growing sense that the aim of co-design was being achieved, with ideas about improvement labs, mentoring, online sharing of good practice and regionally-based learning groups all emerging to give practical expression to Q. Overall, the project team, in a short space of time, developed a sophisticated process and organised complex events to support co-design, which was seen by members to be professional, energetic and, in the end, broadly successful.

Co-design was only one aim. Equally important was the creation of a founding cohort with the relationships and commitment to help take the initiative forward. Communications around the brand were very well managed (and appreciated by members) even if more practical information about the aims of events, the role of members and the purpose of Q were said by members to be less good. Importantly, by the end of the first

year, focus groups and interviews showed that Q had helped form a cohort of individuals with loyalty and commitment to taking the initiative forward and with a wider network including employers, nominating organisations, NHS England and the Board of the Health Foundation in support, while the social network analysis demonstrated that the group is more connected and less reliant on key individuals than at the start of the process.

4.3. Right members?

While the project team members emphasised that the founding cohort was about ensuring that a range of views were included rather than being 'representative' per se, and nominating organisations reported that nominees fulfilled the selection criteria, some concerns were raised about the suitably of the founding cohort. In particular, there was concern about whether or not the patient perspective was well represented and whether all founding cohort members had the appropriate level of technical improvement expertise. It had not been intended that Q should be a community only open to established experts, and it was noted in the nominating survey that at least some established experts had unsuccessfully applied to be members. However, recruitment clearly focused on people with an understanding of, and commitment to, improvement methods. The question of how expert members should be involved (without Q becoming an elite club divorced from the wider NHS) is still debated.

Less contested have been the benefits of engaging members from all four countries of the UK, and the opportunities that this has brought to expose founding cohort members to a variety of approaches, which reportedly (from interviews and focus groups) have the opportunity to aid learning. Overall, we can see that members arrived from across the UK with a wide range of expertise and participated enthusiastically in learning and networking.

4.4. Right size?

The inclusion of 231 members in the co-design process has proved to be an ambitious undertaking and has posed serious challenges to both managing the process and enabling all founding cohort members to engage and contribute in a meaningful way. However, it was perceived by interviewees from the Q project team that the cohort needed to be sufficiently large to incorporate a diverse range of views and backgrounds.

At the first design event, and to some extent the second, many participants felt confused about how in practice their views were to be articulated within a decisionmaking process. The specific nature of the problem to be solved by Q was neither well understood nor agreed amongst members in the early stages. Similarly, some members felt that they should be presented with specific proposals that they could discuss. However, it is not known whether, if they had been presented with such proposals, other members might have felt disempowered. The size of the cohort may have made this tension more difficult to manage, but despite this concern only one survey respondent intended to opt out of Q, and as a cohort members expressed strong support for Q to continue and for the existing membership to have a role. This reinforces the view that despite anxieties about how a large cohort might actively shape the future of Q, members felt both a sense of ownership and a positive attitude towards that future. As described in Section 3.2.2, the success of co-design activities may have been limited, but (despite views that members were more often giving input than receiving it) the efforts to engage founding cohort members appear to have generated considerable goodwill among the cohort, based on interviews at the end of the process and citizen ethnography at the final event. So it can be said with confidence that the project team demonstrated the capacity to build relationships with a cohort of 231.

4.5. Right place to move forward?

We have described some challenges around the first and second design events but the project leadership learned and responded to these challenges. Based on interviews with the Q project team and our observations at meetings, the Q project team perceived the first stage of the initiative to have finished more-or-less where it was hoped to be when the initiative was launched, which was supported by papers produced for the Health Foundation board by the project team at the time of the launch. Given the uncertainties and hazards described in this report, whose impacts we observed during project team meetings, this was a considerable achievement. However, there are also future risks to highlight. The first is that the success of the networking among the founding cohort was linked strongly to the design events and opportunities to meet face-to-face. This level of face-to-face activities is not in the current plans for Q going forward (and indeed might not be compatible with the scale of ambition). This presents a challenge that might be exacerbated if future members are not as enthusiastic as the founding cohort or do not have the same sense of ownership. Finding ways to compensate for this, for example by maximising the opportunities for online collaboration, building on plans for mentoring, strengthening regional and clinically defined networking, building a valued online repository, and locking into other entities such as AHSNs, would therefore be important. Continuing network analyses would help provide intelligence on how well these are working. Second, the improvement labs are an important dimension of the current plans for Q and these are as yet promising but unproven. Third, the single biggest barrier to participation for the founding cohort is that of time and this, in turn, depends upon the willingness of employers to support members' participation. To date they have remained strongly on board but will need to be kept informed, motivated and committed for the initiative to step up to the next level.

Chapter 5. Future evaluation framework

5.1. Reflections on the experience of the first phase of evaluation

Traditional monitoring and *ex post* evaluation provide the core 'knowledge activities' needed to support both accountability and learning in simple interventions. 'Traditional monitoring and evaluation' is characterised by monitoring activities along a linear logframe against milestones that are predictable and fixed and the characteristics of 'success' are agreed by all stakeholders and delivered within the timescales of the evaluation. In this approach the evaluation team is largely 'external' to the implementing team and focused on providing an end-point evaluation that allows judgements to be made about the success or otherwise of the intervention and supports lessons for future similar activities. From the outset, the Health Foundation recognised that this model of working would be inappropriate for Q. Equally, the evaluation team was familiar with an alternative approach more suitable for emerging and complex projects which required a stream of evaluative evidence to support course correction and adaptation [20]. As outlined in earlier chapters in this report, this required a different way of working (beyond simply the details of the methodologies already described) and it might be valuable to capture here our reflections as an evaluation team about how this worked.

Both the Health Foundation and the evaluation team were keen to establish what an 'embedded but independent' evaluation means in practice, and this was the subject of significant discussion both within the evaluation team and with the Health Foundation. The 'independence' was important to both parties.

For the Health Foundation, they needed reliable data to understand better the demographics, expectations, experiences and doubts of members, and how well activities such as learning events and recruitment were being perceived. It was apparent to the evaluation team that the project team not only listened to the emerging evidence but also used that evidence in their decisionmaking. On a more ad hoc basis, the evaluation team also fed in evidence and approaches from outside Q that were reported to be helpful. These included ways of conceptualising issues – such as Normalisation Process Theory – and evidence from other projects. The project team's feedback was that the provision of this 'stream' of evidence and critical challenge was helpful. The Health Foundation, and the project team in particular, also facilitated lasting and helpful relationship building including the practice of social network analysis in particular and improving quality more generally. The evaluation team–project team partnership is planned to continue, including joint conference presentations, and other relationships developed on the edges of Q are also being sustained. For the evaluation team, the potential benefits were therefore considerable with perceived benefits that were both substantive (the collection of new evidence) and practical (understanding the realities of delivering an embedded evaluation). Risks included reputational risk and a professional concern for rigour. On reflection, the internal challenge within the evaluation team and RAND's own Quality Assurance approaches worked well as a check in this respect. However, a different risk was more subtle and involved the danger of being absorbed into the tacit

world view of the project and in particular being captured by the implementation team's enthusiasm and desire for Q to succeed. This risk was in practice managed less by formal Quality Assurance processes and more by evaluation team members who were less involved in Health Foundation team meetings acting as a 'reality check' on team members with a more routine connection to the project.

The evaluation in practice also acted as part of the interface between the implementation team and the members and this added a level of complexity. Despite using branding on slides, wearing different coloured lanyards at events, emphasising that data collection requests came from the RAND team and so forth, there were still times when members referred to the evaluation team and the implementation team as a single entity. Also, focus groups, for example, were generally well received by members not only as data collecting opportunities for the evaluation but also because they were seen as valuable opportunities to discuss and to reflect with others on being a Q member. So the data collection was also part of building a narrative about Q. In legitimising this narrative the wider reputation of RAND for independence and rigor helped. Similarly, the evaluation team's participation in the project team's after action reviews involved both collecting insights and contributing to decisionmaking.

Members were very supportive of the evaluation with high levels of recruitment to every aspect of the data collection. This enthusiasm also allowed innovation, for example in the use of 'citizen ethnographers' at the learning events when, at the second and third learning events, a group of around 12 participants volunteered to provide ethnographic (anonymised) observations to help uncover more information about the enthusiasms and anxieties of members. They were equipped

with brief guidelines covering reporting requirements (as well as ethical constraints) and reported back towards the end of the event.

Overall, on the basis of feedback from the project team at meetings and informally, the evaluation team is confident that risks were well managed and that both independence and partnering were successfully balanced: while evaluative evidence has been explicitly requested and used on an ongoing basis, on occasions the reaction to some of that evidence has indicated that it went against working assumptions at the time. The need for checks and balances was considered from the outset but there was also room for adaptation and improvement as the evaluation developed. However, there are clearly risks in this sort of working and negotiating these requires a degree of trust and mutual understanding, which was demonstrated by members, the Health Foundation and the evaluation team.

5.2. The task ahead; scoping the evaluation framework

In this section we outline the shape of the evaluation framework for the next phase of Q. This will be refined in a more detailed evaluation protocol (including the management structure and specific milestones) in preparation for an inception meeting with the Health Foundation in April 2016. Here we identify the key evaluation questions, the data we would need to successfully answer these questions, and options for data collection and analysis. We conclude with a discussion of implementation risks.

5.2.1. The Theory of Change and the evaluation questions[14]

At the heart of the future evaluation of Q should be the Theory of Change (ToC). The ToC has

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14   We have not included here specific reference to improvement labs which will most likely be subject to a separate evaluation. Their performance, however, will be an important dimension of the overall evaluation of Q and would be cross-referenced in the overall evaluation.

been a focus of discussion and iteration before and after the first cohort of members was recruited and it is now a well-established and agreed summary. From it we can derive our core evaluation questions:

Overarching question: Is Q achieving a sustainable improvement in health and care across the UK and, if so, how?

This will be answered by addressing the following sub-questions.

Sub-question 1: Is Q achieving a connected community leading to quality improvement becoming routine in health and care across the UK?

1. Connecting: has Q developed flexible and enduring connections within and beyond the members?

2. Mobilising: are members collaborating efficiently to organise, undertake, promote and spread improvement activities?

3. Supporting: are members supporting each other and better able to access support externally?

4. Developing: are members learning individually, together, and engaging others in learning?

Data required: demographics of members, diversity data, activity logs, relationships and networks, members' experience of collaboration, improvements to healthcare system achieved, anticipated and actual benefits for patients.

Methods to be used: survey and social network analysis, online activity logs, in-depth improvement case studies.

Sub-question 2. Is the initiative being delivered efficiently?

1. Is recruitment and onboarding[15] well managed with the intended diversity and range of members?

2. Is there a clear and compelling brand, clearly differentiating Q from other initiatives, and one that is attractive to members?

3. Do members understand their individual and collective roles in successfully delivering Q?

4. Are employers/host organisations/resource holders committed to supporting members to join?

5. Is there a sustainable governance and funding model?

6. How has Q managed the tension between being perceived to be not elitist but also as high value?

Data required: demographics of new members, members' experiences on joining, visibility and characteristics of Q brand (to members and to wider stakeholders), attitudes of employers to participation, sustainability of governance and funding models.

Methods to be used: members' survey (as above), Normalisation Process Theory questionnaire [30], modified version of Community-Based Program Sustainability Model (Mancini & Marek, 2004); strategic analysis of financial model.

Sub-question 3: Has Q created a learning and improvement infrastructure?

1. What activities are in place to enable peer support and leadership to strengthen the improvement infrastructure?

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15   Onboarding is the mechanism through which new members acquire the knowledge, skills and behaviours needed to be effective.

2. What opportunities have been developed to spread knowledge, skills and expertise?

3. What systems have been put in place to enable discovery, visibility, connection, exploration, sharing and collaboration?

4. What procedures and spaces have been created to enable coordinating, co-developing and spreading improvement?

Data required: assessment of existing state of learning and improvement infrastructure, changes to infrastructure achieved by Q, perceived value of improved infrastructure.

Methods to use: gap mapping of existing learning and improvement infrastructure, activity mapping of learning and improvement infrastructure created by Q, focus groups on contribution of Q to learning and improvement infrastructure.

Sub-question 4: Has Q contributed to a health and care system devoted to learning and improvement?

1. Has Q achieved a change of culture supporting a health and care system devoted to learning and improvement?

2. Has Q achieved a change of policies supporting a health and care system devoted to learning and improvement?

3. Has Q achieved a change of conditions supporting a health and care system devoted to learning and improvement?

4. Has there been a clear improvement in capability and understanding to deliver a health and care system devoted to learning and improvement as a result of Q?

5. Has there been a clear improvement in the capacity and leadership for learning and improvement across the system as a result of Q?

Data required: changes in attitudes and experiences across the NHS and how these vary in cases where Q is active, review of policy change and assessment of influence of Q on this,

effective organisational support for improvement activity as a result of Q, assessment of capacity and leadership in the NHS.

Methods: secondary and longitudinal analysis of NHS Staff survey highlighting any patterns associated with where Q has been most active, discourse analysis of policy debates and content, interviews with policymakers, employers survey to understand organisational support for improvement and leadership capacity. A bespoke online survey of NHS staff cascaded through AHSNs and other Q contacts.

Additional sub-question 5 to help answer overarching questions (based on evidence from answering sub-questions): How well does Q fit with the wider changes taking place across the UK healthcare systems?

1. Is the Theory of Change (still) appropriate (for example, is it a victim of its own success or are its aims being better achieved through other initiatives)?

2. What variations can be detected across the UK, with particular attention to differences in Scotland, England, Wales and Northern Ireland?

3. What synergies exist with policy directions, have these been well harnessed, and how have these changed during the lifetime of Q?

4. Has Q been able to learn and adapt in the face of changing circumstances?

5. Are there other 'public goods' being achieved by Q that are not well captured through the above questions and, conversely, are there hidden costs?

Additional sub-question 6 on costs and impacts

Whilst a cost-benefit analysis would not be helpful because of the difficulty of quantifying and monetising benefits it would be important to establish an understanding of the overarching programme costs (calculated as the total cash and in-kind costs to the Health Foundation and

the costs to employers and patients of their time). In addition, if the sustainability of the Q approach beyond the formal lifetime of Q is to be achieved, it will be important to understand the scale of costs and effort associated with different interventions. These costs will be identified through the improvement case studies.

Impacts on patient outcomes and experiences are of course central to the success of Q. Because of the very different clinical and organisational settings, aggregating these impacts would be difficult and probably unhelpful. Rather we need quantified accounts of how different activities supported by the umbrella of Q have, or have not, led to improved patient experiences and outcomes. We will provide a template for a simple online survey that contains an impact statement, along with guidance on the appropriate tools for measuring such impact. We recommend that it should be a clear expectation of being a Q member that any initiatives developed within Q should include the completion of the impact statement. This would also support sharing good practice.

5.3. Implementation of the evaluation and associated risks

The next phase of the evaluation must arrive at a judgement about the overall value or worth of Q. However, the criteria for making such a judgement are still contested in certain respects. The evaluation team is aware of a wide range of expectations for Q, ranging from the belief that it can lead the 'next revolution in healthcare after evidence-based medicine' through to more limited expectations that it can contribute to modest but sustainable continuous improvements. The evaluation team will need support from the Health Foundation to navigate a path through these expectations and establish clarity about success criteria.

The next phase of the evaluation will be summative – asking how well it is working – but it is also to be formative – identifying pragmatic

and actionable lessons and feasible and implementable recommendations. It will therefore be less 'embedded' than the first evaluation but it can only be useful if it takes fully into account the intrinsic values and tacit concerns that shape relationships within healthcare as well as the more extrinsic and organisational factors that shape behaviour. Gaining knowledge of the former – intrinsic and tacit – motivations requires approaches to data collection and the conduct of improvement case studies that are collegial, professional and diplomatic. However, delivering an evaluation that also passes judgement on the capabilities and achievements of the members (and others) may not sit easily with maximising openness. How the Health Foundation signals and supports the role of the evaluation will therefore be important.

Members themselves will be a crucial source of data. Indeed, an important part of the role of members will be to engage with many and varied 'knowledge activities' necessary to deliver a sustainable improvement in healthcare across the UK. The evaluation team will also have requirements on the members and it is important that members are clear about their responsibilities to engage with this and that the Health Foundation will reinforce messages from the evaluation team.

An inevitable challenge will be to evaluate the success of Q in the light of wider changes to healthcare that are unrelated to the work of Q but which either dampen or multiply its effectiveness. Although the evaluation will make comparisons between sites where Q is active and elsewhere, and will draw comparisons across the countries of the UK, there will not be a rigorous counterfactual. Instead there will be a focus on what the evidence shows about the contribution of Q to the intended outcomes in different settings.

Chapter 6. Recommendations

We split our recommendations into two sections. In the first, we make recommendations for Q over the next phase of its operation. In the second, we make recommendations for the Health Foundation if it were to run a similar initiative to Q in the future.

6.1. Recommendations for the next phase of Q

6.1.1. Focus early on bringing substance to Q's features

We have described how Q members have talked in interviews and in focus groups about wanting a clearer idea of what Q will look like. From our observations at project meetings since the final design event, many details are now being fleshed out. The Q project team's main priority at this point should be getting Q to identify specific and time-bound actions, confident that they have 'permission' from the members and other stakeholders to act, and aware that there will then inevitably be a need to learn from members' experiences and adapt.

6.1.2. Strengthen clarity and good will by making clear the relationship between leadership and membership

We have shown how the considerable challenge of balancing leadership with co-production inevitably leaves some dissatisfied, with some Q members not completely sure about their role in the co-design process, and the limits to their power. We suggest that the Q project team should make clear how much control NHS Improvement and the Health Foundation have over Q, where the boundaries are, what is non-negotiable, where there are only a few options, and so on. Q members are very positive about Q

and will most probably continue to be so as long as they know what they can influence and feel they are being appropriately involved.

6.1.3. Avoid confusion over the recruitment strategy for members

There have been disagreements about the inclusivity or exclusivity of Q and its role in improving expertise versus making best use of existing expertise. From our observations, there is unlikely to be a single solution that satisfies everyone. As a matter of urgency, it is important that the project team makes a clear decision on the criteria for being a Q member and how they will be recruited, and publicises their plans to Q members and the wider stakeholder audience.

6.1.4. Stick with the current ToC for now but schedule a future 'step-back' moment to review and if necessary improve it

The current ToC was intended to capture the problems in the health and care system and outline potential mechanisms to address them. It then helped shape the design of Q. Observing how it has been used in project team meetings, we believe that the ToC can helpfully inform the next stage and the early stages of operation. Thereafter, there would be value in refining the ToC as Q evolves and the landscape changes. This would help ensure the feasibility of Q's activities and address any of its shortcomings in relation to original intentions, and aid a future evaluation.

6.1.5. Harness diversity through a shared core of values supporting a wide variety of activities

Our evaluation has shown that Q members come from a variety of backgrounds, and often have

very different needs. They also articulate a shared set of core values. A foundation exists, therefore, to reinforce even further a very clear set of core values that would then support a wide range of different activities, providing a means to manage the tension between diversity and disintegration.

6.1.6. Structure a staged approach in transitioning from a formative to a summative evaluation

As Q recruits and consolidates in the coming months, there would be a benefit in continuing for a short time the more formative approach to the evaluation to support continued learning and adaptation before transitioning to a more summative evaluation once this stage is over.

6.2. Recommendations should the Health Foundation run an initiative similar to Q in the future

6.2.1. When recruiting a founding cohort, be clear about its role and recruit accordingly

We have described in this report how the appropriateness of the size, diversity, knowledge, skills and experience of the founding cohort was highly dependent on whether its role was to be part of a co-design process or an engagement exercise (or where it stood on the spectrum in between). If in the future the Health Foundation wishes to engage a founding cohort in co-design, we recommend that fewer participants be recruited initially, with diversity of experience but with skills specifically suited towards a co-design process. However, this would involve reducing the level of engagement.

6.2.2. Ensure that events and activities fit within an overall vision and tailor them to this

Q project team members reported that there was a natural tendency for planning to focus on the next event or deadline, and that long-term goals and strategy could be neglected as a result.

We recommend that the purpose of events and activities be mapped in outline in advance, so that their places in the wider aims of the initiative remain clear. Deviations from earlier plans might well be appropriate but should be considered in the context of overarching goals. These goals can of course be revisited themselves if necessary, but decisions on changing the aims of individual parts of the project should not be taken in isolation.

6.2.3. Make sure that accountability and processes for decisionmaking are clear to everyone in the project team

There was universal agreement amongst the project team that its strengths included its sense of team spirit, its adaptability and its creative and flexible ways of working, a view broadly shared by the evaluation team. We would not wish any of this to be lost in the future. However, while being careful not to introduce unnecessary bureaucracy, everyone in the team should have a clear understanding of who is ultimately responsible for which parts of the project, and how decisions in different areas are made and when they are considered to be definitive.

6.2.4. Maintain the strengths of Q in any similar future initiatives

We have made some recommendations for how the management of a Q-like initiative could be improved in the future. However, it is also vitally important that the many strengths of Q are not lost as an unintended consequence. Some of the key successful aspects of the management of Q, which we recommend be retained in the future, are listed below (in the form of principles rather than their specific applications in the context of Q):

- The inclusivity of the team and empowerment of individuals within it

- The lack of stifling hierarchies

- The creative and stimulating ways of working

- The commitment to self-awareness, reflexivity and improvement

- The desire to listen to and respond to all views, however challenging or contradictory

- The personal and emotional commitment to the success of the project

- The high quality of the branding and event management

- The positive and constructive relationships with the members

- The high level of expertise within the team and willingness to fill in knowledge gaps

- The commitment to the inclusion of underrepresented groups

- The recognition of the value of evidence and theory in shaping an initiative.

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Q is an initiative, led by the Health Foundation and supported by NHS England, designed to connect people skilled in quality improvement across the UK in order to contribute to continuous and sustainable improvement in the health and care of all people in the UK. The Q founding cohort comprised 231 members recruited in the summer of 2015, primarily via Academic Health Science Networks and national improvement organisations. Members attended three two-day 'design events' in the second half of 2015. RAND Europe was commissioned to carry out an independent, embedded evaluation of the Q initiative during its first phase (spring 2014 to January 2016, with the evaluation starting in April 2015), to look at both the success of the design process and the potential for success for Q, while providing continuous findings to the Q project team alongside that process.

The evaluation used a multi-method approach comprising document review, interviews, focus groups and surveys with members of Q, including a social network analysis, surveys of nominating organisations and employing organisations, interviews with Q project team members, and a novel method that we have called 'citizen ethnography'. As part of the embedded approach, evaluation team members attended fortnightly project team meetings and design events, and provided evaluation findings soon after the completion of research activities at both.

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