**A thing called Q**

**Catherine Pope**

While ‘improving health care’ is seen as fundamental to control health spending and achieve better health outcomes, the mechanisms for delivering ‘quality improvement’, ‘safer care’ or simply ‘better services’ are less clear. Large scale improvement initiatives have been attempted in different countries and in a variety of health care settings. Examples include the Scottish Patient Safety Programme (1) across hospitals and community health services begun in 2013, and the ‘Best Care Always’ campaign in South Africa, (2) itself modelled on the Institute for Healthcare Improvement 100,000 lives Campaign (3). Improvement has been institutionalised, notably in the USA in Institute for Healthcare Improvement (IHI) and in the UK in NHS Improvement (an umbrella organisation encompassing service monitoring, development and change functions of the NHS). Unsurprisingly this has been accompanied by the growth of a ‘new’ methodology and new language of ‘Improvement Science’ (4). Alongside these large scale initiatives, a plethora of smaller, local quality improvement (QI) activities have been initiated in healthcare organisations, often led by individual clinicians or managers and undertaken by small teams.

Improvement seems to be modelled as either ‘go large’ and attempt system wide transformation, or ‘try small’ with more incremental, macro level work. Both approaches have fallen hard on the rocky barriers to implementation (5,6) and it seems that health services still require improvement. This editorial focusses on an innovative attempt to break out of this binary in the context of UK NHS, and offer a distinctive ‘third way’ for improving care – a thing called Q.

First, some background. Care failures, particularly those at the Mid Staffordshire hospitals and the subsequent series of high profile inquiries led to promises that the NHS would learn from the mistakes made and to move forward with a new awareness about safety and quality of care. Alongside the largely predictable 290 plus recommendations made in the Francis Report (7) directed to preventing another hospital scandal, Don Berwick, the healthcare improvement guru and director of IHI was asked to consider the improvement challenge facing the NHS. His report, *A promise to learn, a commitment to act,* (8 annex B) urged the NHS to “*focus on the culture that you want to nurture: buoyant, curious, sharing, open-minded, and ambitious to do even better for patients, carers, communities, and staff pride and joy*”. This fascinating set of adjectives emphasised the personal and cultural shifts required to improve care, rather than the more typical remedy of further regulation and standardisation.

Berwick’s solution to the problems identified by Francis and others lay with the people who worked in the NHS and delivered healthcare. He called for the establishment of an NHS Improvement Fellows programme comprising 5,000 fellows over five years who would be champions, experts, leaders and motivators in patient safety capable of devising and implementing healthcare improvement. To borrow the short-hand slogan that accompanied this programme this was “5000 fellows to save 10,000 lives”. Nothing quite like this, in terms of scale or philosophy had been tried in the NHS before.

The Health Foundation and its co-funder, NHS Improvement, committed nearly £2 million of initial funding to launch the Q initiative. Q was collaboratively co-designed during 2015 with a founding cohort of 231 members. As such it is possibly one of the largest attempts at co-design and certainly a novelty in the field of health care improvement. A further 216 members have been recruited and it is envisaged that eventually Q will involve thousands of ‘improvers’. As Berwick himself commented, if this initiative “*succeeds, the NHS in the UK will be leading the world in creating, at national scale, system-wide capacities for improvement”* (9 p2). Q is both infrastructure support and a dispersed member network designed to enable learning and improvement work. It resembles organic social movements such as those formed around campaigning, civil and disability rights movements (10) but it is also a deliberative change project by the second largest endowed charity foundation in the UK in partnership with the largest public health system in the world. The tensions between the macro-level institutional aims of the Foundation and the NHS leading the initiative and the diverse membership engaged in the emergent design process have been characterised as ‘challenges’ (11 p11) and ‘critical engagement’ (11 p30) but nonetheless the initiative now has significant national membership across the UK, an operating model (9) and ambitions to grow the capacity of the UK health and care system to improve. The early phase was subject to an independent multi-method evaluation (12) which suggested that while the initiation work had been largely successful the future success of the initiative “*faces wider challenges in the shape of fragmentation of the NHS, low staff morale, efficiency savings and the lack of a national improvement body*. ” (12 p.xiii). There is evidence that Q has increased social networks and connectivity amongst people engaged in healthcare improvement work and the recruitment of a second cohort indicates appetite for joining this new social movement. The Health Foundation and NHS Improvement and their partners in NHS Trusts and other bodies will no doubt monitor this initiative as it moves forward. In the longer term it will be up to the health services research and policy community, and ultimately patients, to assess whether Q has delivered.

**References**

1. Scottish Patient Safety Programme <http://www.scottishpatientsafetyprogramme.scot.nhs.uk/about-us> accessed 16.1.17
2. Best Care Always <http://www.bestcare.org.za/home> accessed 16.1.17
3. Berwick DM, Calkins DR, McCannon CJ, Hackbarth AD. The 100,000 Lives Campaign: Setting a goal and a deadline for improving health care quality. *Journal of the American Medical Association.* 2006;**295**(3):324-327
4. <https://isrn.net/about/improvement_science.asp> accessed 16.1.17
5. Kaplan HC, Brady PW, Dritz MC, et al. The influence of context on quality improvement success in health care: a systematic review of the literature. *Milbank Q* 2010;**88**:500e59
6. Dixon Woods M, McNicol S, Martin G. Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature *BMJ Qual Saf*2012;**21**:876-884.
7. Francis R.  *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London: The Stationery Office, 2013
8. National Advisory Group on the Safety of Patients in England. *A promise to learn—a commitment to act.* Department of Health, 2013.
9. The Health Foundation/ NHS England. *A proposed operating model for Q.* London: The Health Foundation, 2015
10. Shakespeare T. Disabled people's self-organisation: a new social movement? *Disability, Handicap & Society* 1993;**8**(3):249-264
11. O’Malley H, Pereira P. *Building Q: Learning from designing a large scale improvement community.* London: The Health Foundation, 2016
12. Garrod B, Exley J, Harte E et al. *An evaluation of the first phase of Q: Engaging the founding cohort in a co-designed approach to health care improvement.* Cambridge: RAND Europe, 2016

**Acknowledgements**

The author was a member of the founding cohort of the Q Initiative, and is also a member of the NIHR Collaboration for Leadership in Applied Health Research and Care Wessex (CLAHRC Wessex). She receives research funding from the Health Foundation and NIHR but the views and opinions expressed in this editorial are those of the author and do not necessarily reflect those of the Health Foundation, NIHR the NHS, or the Department of Health.