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The London Quality Standards

A case study in changing clinical care

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About the report

The London Quality Standards (LQS) were conceived as part of a longer journey to reduce variation and improve quality of care. The programme was distinctive in its scope of ambition, aiming to improve the care of acutely unwell patients admitted to London hospitals.

This summary accompanies a full report that reviews the construction, impact and implications of the LQS in acute medicine using a mixed-methods approach. The programme was, as a whole, well constructed, fuelled by strong clinical leadership, highly active professional and public engagement and the use of experience-based co-design to develop the standards. This led to a remarkable degree of clinical and managerial buy-in and a genuine sense of ownership by London clinicians and hospitals. However, changes in the political landscape prevented the programme from directly intervening in hospital service redesign and delivery. This was intensified by mounting service pressures and hospitals' overall lack of capacity to manage complex change.

The programme undoubtedly focused attention on the gaps in the delivery of care and drove varying degrees of service redesign within hospitals. However, no single organisation fully implemented all the standards and a link between the implementation of the standards and better patient outcomes was unable to be made.

The full report presents insights about the implementation of complex intervention in the NHS. This work provides critical learning for future similar initiatives, particularly the Seven Day Services Clinical Standards being introduced across England.

Suggested citation

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The full report can be accessed at: www.nuffieldtrust.org.uk/research/the-london-quality-standards-a-case-study-in-changing-clinical-care

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Introduction

In 2011, London Health Programmes, a coalition between NHS London and London's primary care trusts (PCTs), embarked on a London-wide attempt to improve the quality of acute and emergency care. The primary vehicle for improvement was the development and implementation of professional consensus standards, the London Quality Standards (LQS). The standards set out the minimum quality of care that patients with medical illnesses should expect when admitted to hospital. They stipulate, for example, that patients should receive timely clinical reviews by medical and multidisciplinary staff, have key diagnostic investigations (such as CT scans) and critical interventions (such as endoscopy) promptly and should be robustly monitored for clinical deterioration. The standards also mandate patterns of extended working seven days per week for consultant medical staff. The programme was led by a PCT chief executive, together with the NHS London Medical Director, and was distinctive in its high degree of clinical engagement. In 2013, London Health Programmes ceased as a separate NHS organisation, a consequence of the restructuring of the strategic health authorities (SHAs). A number of the key London standards have subsequently been captured by the national Seven Day Services Clinical Standards,[1] led by Sir Bruce Keogh, which are designed to drive improved seven-day working across the NHS.

1 For more information on the Seven Day Services Clinical Standards: www.england.nhs.uk/ourwork/qual-clin-lead/seven-day-hospital-services

Key findings

- The LQS worked well as a means to raise awareness of the deficits in emergency care, and drove forward change at a local level, but primary statistical analysis was unable to establish a link between the implementation of the standards and consistent improvements in patient outcomes.

- While there was strong evidence behind the need for change, there was little evidence available that compliance with the LQS would reliably improve outcomes. Caution should be exercised in developing mandatory input standards where the evidence for the prescribed interventions is limited or partial.

- Where the LQS were implemented, this was heavily driven from the bottom up by clinicians convinced by the case for change, rather than by top-down processes or commissioning mechanisms.

- Our study revealed marked deficiencies within hospitals around complex change management, including:

  - an almost complete disconnection between frontline clinicians and senior managerial staff
  - a lack of strategic thinking at multiple levels
  - a lack of knowledge around, and failure to consistently use, change management/quality improvement tools
  - a heavy reliance on individuals
  - failure to address underlying cultural and organisational matters
  - long-term lack of capital investment in diagnostic and other critical services.

  These were all amplified by managerial 'churn' and an absence of consistent leadership over time. The combination of rising service pressures and clinician burnout emerged as a major barrier to change.

- The switch from the more supportive model of earlier London change programmes was not helpful, with clinical and managerial teams expecting, but not receiving, the levels of support provided for previous major service reconfigurations.

- Many of the perceived weaknesses in the programme appeared to stem from the insertion of commissioning into the process. Primarily, the commissioners did not appear to understand the workforce and financial implications of complying with the standards. Other major criticisms included: the lack of visibility of the economic and workforce analyses; the lack of a consistent mechanism to support the introduction and ongoing expense of the standards; and the absence of 'carrots' and the threat of reconfiguration as a 'stick'.

- In some areas, threatened penalties for non-compliance with the standards were used by some CCGs to drive service reconfiguration. This became a governing motive for some hospitals and pushed aside the original aim of improving patient safety, demotivating some staff. It also proved an unreliable driver, as hospitals eventually came to see the threat as empty. Professional standards that describe complex behaviours should not be used rigidly nor have major penalties attached without a detailed exploration of the potential for unintended consequences and perverse behaviours.

- The use of peer audit was seen as helpful to drive the implementation of the standards. However, there were problems with the level of complexity involved, and some degree of gaming was an issue.

The report

The full report outlines the findings of a year-long research project that explored the strengths and weaknesses of the LQS programme and its impact. We investigated these through interviews, focus groups and a survey of those who developed and implemented the LQS.

We focus specifically on the development and implementation of the 21 standards for acute medicine, rather than the whole LQS programme which also covered other areas with high emergency caseloads, such as paediatrics and maternity. Our findings will be relevant to those continuing to implement the LQS and the Seven Day Services Clinical Standards, as well as others considering the use of clinical standards as a means to drive improvement. Thematic summaries of the research are given at the end of each section.

LQS – part of a longer journey of improvement in London

The development and subsequent implementation of the LQS were part of a longer journey of improvement in London. The team leading the LQS programme had a proven track record in complex system change at a regional level, having previously delivered successful changes to trauma and stroke services as part of the 'Healthcare for London' programme.[2] As with trauma and stroke, they found evidence of wide variation in the care of acutely unwell patients and their outcomes both between different hospitals and within individual hospitals depending on the day of admission (weekday versus weekend).

2 For more information on the Healthcare for London programme: www.londonhp.nhs.uk/healthcare-for-london

Strong professional consensus but lack of hard evidence to support standards

However, while there was a strong case for change, there was a paucity of evidence, unlike with stroke and trauma, to guide which changes in the clinical pathways and processes would be most likely to improve outcomes for patients. The standards therefore relied on professional consensus rather than hard evidence. This consensus was achieved through a clinically led and experience-based co-design process, and included well-constructed patient and public involvement. As a result, the programme achieved wide clinical engagement and general buy-in for the need for change.

A changed policy environment – lack of regional oversight

The approach the LQS programme took had to adapt to a changed policy and regulatory environment. The Health and Social Care Act (2012) removed the regional infrastructure and oversight that was responsible for the successful re-engineering of stroke and trauma care across London. Successful implementation therefore became reliant on local clinical commissioning decisions and negotiations. We found considerable variation in how local commissioners applied and supported the implementation of the standards; some commissioners provided additional funding to support implementation and resulting additional costs, while others did not.

The pursuit of secondary agendas

Consensus was lacking at all levels about the degree to which the standards were mandatory or aspirational. Additionally, the standards were used to pursue a number of secondary agendas, ranging from changes in behaviour by individual clinicians, through to wholescale reconfiguration of acute services. Many clinical commissioning groups (CCGs) were pursuing strategies that relied on hospital closures and the presumed incapacity of some hospitals to comply with the standards was seen as a potential mechanism for deciding which acute services should be closed or downgraded.

Variation in provider response

The provider response to the standards was also variable and driven by a range of factors. Some early adopting organisations were alert to the potential commissioning threat posed by non-compliance with the standards and invested early and heavily in the LQS. A number of late adopting organisations were resistant on the grounds that their good patient outcomes demonstrated that their systems and processes were not in need of change, or that the LQS conflicted with existing improvement strategies.

There was variation in trusts' responses to individual standards. Hospitals actively prioritised the implementation of some standards over others, based on a complex calculus of cost, feasibility, alignment with existing plans for change and the perceived credibility of the prescribed interventions.

Implementation challenges

Most hospitals struggled with implementation. The lack of financial support from commissioners was a major impediment, and was in marked contrast to the trauma and stroke changes, where trusts had received significant financial support. The lack of compelling evidence for the standards compounded the problem, as trusts were reluctant to invest their own resources in the implementation of relatively untested changes to clinical processes.

Other key obstacles were the lack of improvement capacity and receptivity to change. Few trusts consistently used formal quality improvement approaches to change. Some of the LQS required major reconstruction of consultant working patterns, something that managerial and even clinical colleagues often had great difficulty in negotiating, and was occasionally a show-stopper to successful implementation. Interviewees talked extensively about the gulf between managers and clinicians, as well as the board and the front line, with these groups seeming to pursue different agendas. Trusts told us that a high degree of frontline clinical engagement was critical to success.

The use of audit as a means to drive compliance and improvement

London Health Programmes undertook two peer-led audit cycles to assess progress in implementing the standards (one in 2012 and the second in 2013). The first audit included a self-assessment followed by a well-structured validation audit visit; the second audit involved a follow-up self-assessment.

The audits aimed to encourage LQS compliance, but also identify organisations and service areas which might need additional support. Most respondents saw the audit process (particularly the visits) as beneficial and felt that the audits had acted as a spur to the engagement of senior management and LQS implementation. However, the value of the audits was hindered by the complexity of the audit tool and the accompanying information burden. Although no hospital admitted to deliberate manipulation, individual clinicians confessed to having witnessed 'gaming' of the standards to mitigate the threat of negative consequences of failure to meet the standards.

Progress made on implementing the standards

The original compliance with, and progress made in implementing, the standards varied considerably. Four trusts were consistently high performing (meeting 13+ of the 21 standards) over both audits. Seven sites were high performing (meeting 10+ standards) on the first audit and then improving on the second audit. Five sites were low performing (meeting <10 standards) and then improving. Three sites were consistently low performing, and unable to meet more than eight of the 21 standards over both audit cycles.

There was no direct relationship between organisational size and the ability of hospitals to implement the LQS. However, hospitals with either highly specialised services, such as stroke or trauma, or reputations for academic excellence, were more likely to fully implement the LQS – indicating that access to a wide range of 'resources', such as additional diagnostic services and a larger consultant body, was more of a factor than size per se. Commissioning and the threat of regional reconfiguration also seem to have

played a major role in implementation – ten of the 13 less well performing hospitals were in trusts where mergers took place, or were in areas where plans were in place for hospital closures.

Of the 21 standards for acute medicine, those which were most consistently met were the requirements to deliver core services, including the provision of critical care, acute assessment and ambulatory care units. The standards for which compliance improved the most included: extended consultant working hours; screening by the multi-professional team; access to key diagnostic services; and discharge planning and a structured medical handover. There were standards that a significant proportion (over 40 per cent) of the hospitals never met. These included twice-daily ward rounds on the acute medical unit; consultants reviewing high-risk patients within an hour; psychiatric liaison and assessment services being available 24/7; and the use of a shared record by all professionals involved in the care across the emergency pathway. The first three of these standards are now also Seven Day Services Clinical Standards.

Impact of the standards

The LQS drove some significant improvements in patient pathways, and multidisciplinary and cross-departmental working, as well as encouraging boards to put a greater focus on issues that threatened patient safety, particularly in the district general hospitals. The standards encouraged trusts to recruit additional consultants in order to deliver extended cover and ensure timely consultant review out of hours and on weekends. However, it was felt that the standards had also had a number of negative effects. The introduction of complex patterns of shift-working for all medical staff was considered to have triggered a retreat of a number of experienced consultants from the hospital front door, increased reliance on locum staff and contributed to the further fragmentation of clinical teams. The emphasis on consultant-delivered care was perceived to adversely impact on the training of junior doctors. Some also felt that the standards encouraged junior doctors to defer decisions until consultant review, delaying care for some patients. Importantly, the use of 'input' standards hindered local service innovation, which may have delivered the desired outcomes more cost effectively. We have not been able to show that the introduction of the LQS improved hospital performance or outcomes relative to other parts of the country (further statistical analysis is planned).

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