Tackling unwarranted clinical variation: a practical approach

Dr Ruth Chambers and Tracy Cox share some practical lessons about how to tackle unwarranted clinical variation

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The NHS Alliance strives to lead all commissioners and providers, clinicians and managers to deliver excellent, sustainable, patient-centred primary care. To do so requires every person working for and with the NHS to take responsibility for minimising unwarranted clinical variation – whilst preserving quality and safety. Tackling such variation should be measurable and integral to service redesign & service improvement. Our professional and managerial interpretations of minimising clinical variation should complement patient perspectives of experience of their care; focus on the comparative usage of healthcare services that cannot be explained by variation in the extent of frequency of patient illness or patient preferences.

Everyone should reflect on and learn from mistakes and failure – from individual and organisational perspectives. Human error is a given; so, we should minimise opportunities for error, supporting people who work in the NHS system to deliver consistently better quality & safer care.

Take into account the background inequalities that exist when interpreting apparent clinical variation. This might be from health inequalities present in deprived communities or some minority population groups; or lack of equity in healthcare funds per patient across England and the UK. Areas of greatest need have proportionately fewer doctors, so you’d expect more difficulties with access that may in turn provoke poorer reported patient experience and worse clinical outcomes.

NHS Alliance essential components – for you to minimise unwarranted clinical variation

Overall: good leadership with an organisational understanding of when clinical variation can be justified, with an underpinning learning and development culture to drive quality improvements and:

- Be open & transparent; by collecting and publishing health intelligence in transparent ways – then you can have honest discussions with practices/ providers & with the public.
- Invest in the quality of your workforce: competence, confidence, enhanced skills, capability, continuity etc in skill mix, consistent application of knowledge & skills, positive attitudes. Identify, clarify and redress underperformance of individuals.
- Ensure clinical effectiveness: eg adherence of clinicians to NICE guidelines; attainment of clinical outcomes that are owned by local clinicians.
- Plan capacity / access realistically for all providers big and small: achieve consistent availability and accessibility to all elements of provision of care.
- Agree integrated working with all providers in health and social care: strive for and measure consistency; focus on quality & safety across interfaces/pathways.
- Prioritise positive patient experience: so there is equity for various population groups; capturing how user views define quality and their insights on the extent to which these are met.
- Drive efficient delivery along clinical pathways: across different organisations and health and social care settings/ various disciplines of staff – with underpinning clinical and management harmony.
- Promote self care and patient empowerment: provide self care/dual management pitched at the level and of the type that suits the patient with any associated anticipated risks covered.
• Ensure early identification of individuals with long term conditions: through encouragement of uptake of screening and clinical acumen to recognise and confirm previously unidentified long term conditions. Optimise prevention of deterioration of the condition; as reflected by actual prevalence rates for different localities matching predicted rates for that local population.

• Learn from mistakes – at individual and organisational levels: within an overarching learning and development culture. So adverse/significant events are analysed promptly – risks of harm are identified, anticipated, with proactive prevention of recurrence.

• Debate and agree acceptable reasons for breaching standards or apparent low quality or productivity that may explain the variation (eg special causes, population type, unfair allocation of resources, blips- such as time of year or healthcare usage data unduly dictated by single patients) with associated evidence of investigation and clarification and quality improvement.

• Focus on patient safety in commissioning, and delivery of care: that will range from avoidable deterioration in long term conditions/avoidable harms with associated learning from mistakes and failure in systematic ways.

• Invest in innovation: whilst optimising opportunities for innovation, minimise risks by monitoring progress / taking consistent measures to improve quality & safety. Then work on disseminating and sustaining successful innovation initiatives across the organisation or local health economy or beyond.

**Priority actions for tackling unwarranted clinical variation**

1. Health intelligence and benchmarking: To make this meaningful generate and utilise data that presents quality & safety in ways that NHS staff/patients understand – interpreting benchmarking and not just circulating oodles of graphs and bar charts. Enable all to understand and interpret data relating to the quality & safety of services delivered – and monitor their relative improvements (or dips) in line with changes in service provision. Understand what constitutes reliable & valid & current information, tracking changes over time. Aid people to understand, interpret and apply information & intelligence – clinicians, managers & patients/public; the more localised the data, the greater will be the ownership by local teams.

Some good sources of data are: www.nhsbenchmarking.nhs.uk; www.statistics.gov.uk; www.healthprofiles.info

www.rightcare.nhs.uk.

2. Leadership: develop and support leaders at all levels in all healthcare settings. Evolving leaders can be energised to tackle unwarranted clinical variations. Leadership development is run by many professional organisations, Universities, local/central NHS – make sure it’s the right course for you – for your developmental needs and aspirations.

3. Share ‘customer insights’: develop local system that incorporates input from - patients and the public (eg complaints, compliments, comments, PALS), and clinical incidents. This should help to trigger awareness of trends in patient experience, highlight variations. Set up a system for reporting apparent clinical variation that one set of clinicians note about others eg GPs describing secondary care variation or possible underperformance of secondary care or mental health consultants; or vice versa. But you need to set up the associated resource to monitor the database and take action to investigate possible problems. A good example of such a resource has been established by Staffordshire & Shropshire CSU – email Lesley.Goodburn@staffordshirecss.nhs.uk for details.

4. Enhance communication between providers: make the usual plans for stakeholder engagement between providers and commissioners; or different providers (eg groups of general practices, or acute/community/mental health trusts) really happen at all levels. So get joined up education – workshops with clinicians from all settings where they learn as much from informal social interchange as formal presentations; or shared innovation eg, telehealth deployment along a patient pathway with patients signed up and overseen at different stages in the pathway by the responsible clinicians sharing clinical information.

5. Emphasise and synchronise self care and joint management (patient/clinician) across the local health economy with an agreed set of dual management plans to aid patients’ self management and clinician consistency with agreed local patient pathways.

6. Match learning and development resources to needs – with varied modes of easily accessible and available delivery (online, face to face, small group etc), and well described expected learning outcomes. Set up system to identify apparent clinical variation, investigate if may be justified, visit the selected individuals or teams to discuss the data and contributory factors, and agree if actions are needed or possible to reduce the unwarranted clinical variation. Track what happens and continue to support or take remedial actions.

The Alliance could provide consultancy if you require impartial expertise.