EVO

Engagement Value Outcome

Case studies

Gloucestershire Health and Care NHS Foundation Trust

February 2020

Allied Health Professionals

Diabetes

Wound Care

Contents

Foreword

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In today's NHS, organisations can only deliver effective patient care within available resources by creating an environment where working relationships between clinicians and finance teams are thriving. Clinicians are responsible ultimately for the way in which services are delivered and for committing resources. They can only do this effectively with input from finance colleagues. For instance, through sharing cost and patient outcomes data for better informed decision making.

"

– Department of Health and Social Care, Effective clinical and financial engagement: a best practice guide for the NHS, 2013

This quote from the Department of Health and Social Care emphasises the importance of building collaborative relationships between finance and clinical teams to ensure that value is at the centre of decision-making.

Value in healthcare – maximising the outcomes which matter to people at the lowest possible cost – is increasingly seen as a key lever for supporting the delivery of high-quality sustainable healthcare.

The roll-out of patient-level costing (PLICS) across the NHS means that services have an increasingly rich source of information to help them understand their patients and services, however awareness of this data outside the costing team is not widespread.

The HFMA's Healthcare Costing for Value Institute and Future-Focused Finance have worked together to develop the Engagement Value Outcome (EVO) framework. EVO promotes collaborative working between clinical and finance teams and their collective understanding of PLICS, providing the NHS with a framework to ensure resources are used in the most effective way possible to provide high-quality care to patients.

During the second half of 2019 we piloted the EVO framework with four trusts, covering acute, mental health and community services.

This report describes the experience of those involved in EVO at Gloucestershire Health and Care NHS Foundation Trust who chose to look at Allied Health Professional services, Diabetes and Wound Care.

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What is EVO?

EVO facilitates the **engagement** of multidisciplinary teams in the understanding and use of patient-level information and costs, and its relationship to **value** in healthcare. The ultimate purpose being to achieve the best **outcome** for the patient within the resources available.

A trained facilitator works with a core group of individuals at specialty level over the course of a few months. The aim is to improve their understanding of PLICS data, so that they start using it on a regular basis to support improvements in the efficiency and effectiveness of how patient care is delivered. EVO can be delivered at any NHS trust that has implemented PLICS in any sector.

''EVO helps clinical teams identify how they can use their resources in the most effective way possible to provide high-quality care to their patients''

Patient-level information and costing systems (PLICS)

The NHS has increasingly detailed information – on both activities and costs – about how its resources are used at patient level.

All acute trusts are required to calculate their costs at patient level and over the next couple of years the same will be true for mental health, community and ambulance providers. Reference costs, which are the average costs of a particular treatment, are gradually being replaced by PLICS.

Combined with other data sources, PLICS provides clinical teams with a rich source of information to help them understand their patients and services. Linking patient-level costs with outcomes allows the NHS to promote value for the patient, ensuring that resources are used in the most effective way possible to provide high-quality care.
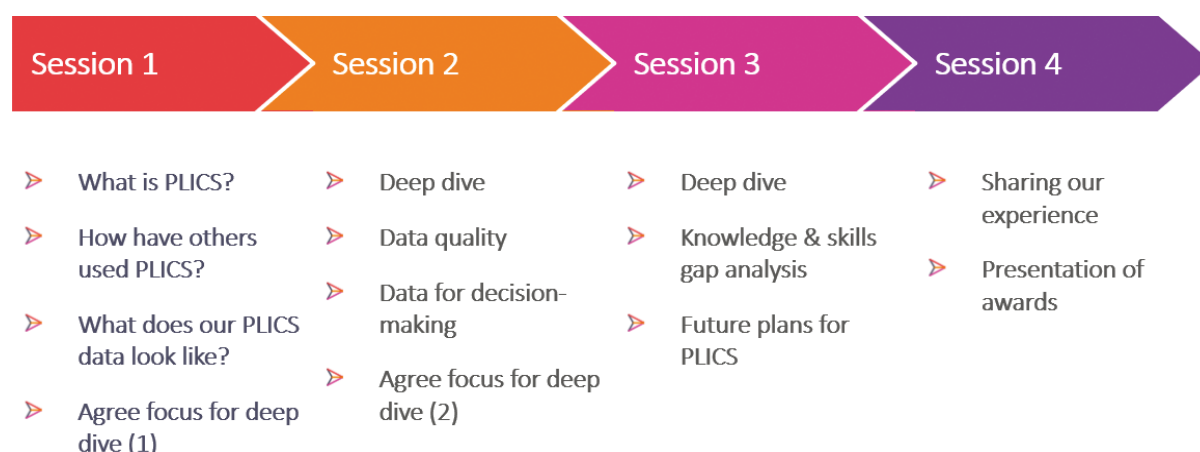
"PLICS provides clinical teams with a rich source of information to understand their patients and services"

EVO in practice

Trusts that have implemented PLICS often struggle to find the time, resource or direction to begin using the data collaboratively. Taking part in EVO provided the four pilot trusts with the support they needed.

Each pilot trust identified three specialties or clinical services which would benefit from the EVO experience. Appendix A provides more information about the trusts and their chosen services.

Each team met for three two-hour sessions over a period of three months. The final fourth session provided the opportunity to share learning across the trust. Sessions were delivered by trained facilitators using a mixture of video case studies, deep dives into local PLICS data and group discussions.

Session 1	Session 2	Session 3	Session 4
➤ What is PLICS?	➤ Deep dive	➤ Deep dive	➤ Sharing our experience
➤ How have others used PLICS?	➤ Data quality	➤ Knowledge & skills gap analysis	➤ Presentation of awards
➤ What does our PLICS data look like?	➤ Data for decision-making	➤ Future plans for PLICS	
➤ Agree focus for deep dive (1)	➤ Agree focus for deep dive (2)		

Who was involved?

Key to the success of EVO were the two EVO sponsors at director level:

➤ clinical champion

➤ finance champion

A multi-disciplinary team made up of clinicians, operational managers, and finance and informatics staff attended all the EVO sessions for a particular specialty or clinical service.

"Getting the right people in the room is key"

Trust summary

Gloucestershire Health and Care NHS Foundation Trust (the Trust) describes the EVO pilot experience as being one which 'brought us together' and 'allowed us to use data to trigger clinical conversations'.

Clinicians, service managers, the costing team and informatics colleagues were already seeking to work together on specific initiatives to improve the quality and depth of activity data in PLICS before the EVO pilot. (Appendix B describes the Cheltenham pilot). The EVO pilot came along at just the right time to capitalise and build on the energy, enthusiasm and commitment that the work to date had started to engender.

The case studies in this report provide a flavour of some of the conversations the multi-disciplinary teams had within their EVO sessions as they explored their PLICS data. These conversations varied depending on the maturity and depth of the data. EVO was not about completing detailed improvement projects, but rather about providing teams with some facilitated time to start thinking about how PLICS data might help them to better understand their patients and services.

Impact of being involved in EVO

Even with the backdrop of an open and collaborative approach between clinical, managerial, financial and informatics colleagues, the Trust recognised that more needed to be done to ensure that its clinicians were confident in using the potential of PLICS in everyday decision making to understand clinical variation and to drive patient benefit. The EVO pilot, as the three case studies set out, provided the ideal mechanism to help the Trust make important and meaningful progress in this.

All those involved in EVO agree that it has ensured that there is a common understanding of the opportunities, challenges and inter-dependencies involved in using PLICS data to drive day to day clinical, service planning and other business decisions. This has significantly improved the chances that costing data will be used across the Trust in everyday 'business as usual' rather than in a narrowly defined area. As the deputy director of finance commented at the end of the fourth EVO session where all three services shared their experiences, 'this is immense and inspiring'.

EVO achievements

- Clinical services have a better understanding of how PLICS data can support service improvement

- Working relationships between clinical services, informatics and finance strengthened

- Opportunities for improving the quality of PLICS data were highlighted

- Improvement opportunities for the efficiency and effectiveness of patient care were identified

Key learning points from the EVO experience

Comments from those involved in the EVO pilot include the importance of:

- ➤ 'carving out' dedicated time for clinical and operational staff, the costing team and others to work together in a focused way

- ➤ the discipline of having external facilitation – from the point of view of:
  - » structuring the sessions
  - » making sure scheduled meetings did not fall victim to 'the day job'
  - » setting and meeting deadlines

- ➤ sharing information with staff at all levels within the three services as early as possible, so that successful pilots can move into 'business as usual' as soon as possible

- ➤ making the most of early data - even before data quality is good enough for external comparison, it might be useful for internal benchmarking across localities and teams

- ➤ using the learning from a service's involvement in improving PLICS data and translating it for other services. For example, physiotherapists (physios) and occupational therapists (OTs) designed from scratch a template for data collection to help improve clinical practice and steer service development. In establishing patient categorisation and types of interventions, they created a 'blueprint' for any service to pick up and to adapt for its own use.

- ➤ recognising that Clinical Commissioning Groups will be interested in the EVO process and outcomes. The Trust's commissioners are aware of the importance of what clinicians have helped achieve and the value of the information now being produced.

- ➤ in the next phase, taking one clinical area at a time rather than running three in parallel. The pilot has given the Trust the tools it needs to repeat the process for other services, and while there were 'cross-over' benefits to looking at three services as part of the EVO pilot, in future one area at a time will be tackled.

Challenges and top tips for overcoming them

The EVO pilot raised a number of challenges, which those involved in the pilot had to overcome.

Presentation of finance and other data for clinical services

Presenting finance and other data in a way which immediately supports clinicians in their decision-making can take time to get right. But getting it right is crucial to maintaining interest and momentum. It can require large volumes of data to be filtered to the point that it is meaningful and answers a question. This needs to be properly resourced.

Keeping everyone engaged

For one of the Trust's services in particular, there were very tangible beneficial outcomes from the EVO pilot work. For two others, there was solid progress and a clear understanding of what was needed next. Using 'quick wins' to motivate those areas where there is further to travel can be useful in keeping everyone engaged. The shared 'session four' of the EVO pilot process leant itself to this, as well as to informing those from services not yet involved in EVO what the pilot had helped colleagues to achieve.

Data quality

Making sure that the data recorded for PLICS was fit for purpose was key to making progress. The Trust uses a 'Plan, Do, Study, Act' approach to gathering views on how meaningful coding options are, and embeds guidance in the templates to support consistent use. The EVO process clarified that the touchstone is making sure that the data recorded enables a judgement as to whether any clinical variation is significant enough to cause a change in clinical practice or other aspects of patient management.

Burden of data collection

Understanding the administrative burden placed on clinicians to log details of patient interventions is important when adding new data items. The Trust has set up a workgroup to understand current procedures and identify opportunities for streamlining these.

Investment of time and energy

The EVO pilot has involved what the Trust describes as 'a huge investment of time and energy'. However, the Trust reports that the value derived from the process has already made the investment worthwhile. Staff from across the Trust – clinicians, service managers, informatics and finance – have developed new working relationships to provide a joint focus on ensuring that they maximise the use of resources to achieve real patient benefit.

Further information

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Case study one - Allied Health Professionals

Introduction

The Cheltenham pilot work significantly improved the richness of data available about physio and OT services (Appendix B). It was a good start in building stronger connections between clinicians, service managers, the costing team, finance and business staff and informatics colleagues. Therapists had been proactive in getting involved: they saw the benefits that nursing colleagues had and wanted access to the same level of detail. This meant that the opportunity to get underneath the emerging information as part of the EVO pilot was very welcomed. The four externally facilitated sessions allowed the momentum to continue and the process to accelerate.

It is hard to overstate the potential impact of the data that physios and OTs now have access to. Before July 2019, all therapy sessions were simply recorded as 'physiotherapy' or 'occupational therapy' with no ability to specify the type of intervention actually carried out with the patient. This meant that the services had no way of assuring that the same high-quality clinical practice was being delivered across all localities. The lack of ability to compare 'apples with apples' meant that any clinical variation between patients with similar needs could not be identified, its impact assessed and best practice promoted.

With enhanced PLICS data about the actual activity undertaken by therapists, the EVO pilot process provided the focus for colleagues to work together to:

- critically analyse the Cheltenham pilot results
- ask more questions of the data
- further improve data quality
- better-understand the service from multi-disciplinary perspectives.

Topics explored

In the first EVO session, the costing team introduced the PLICS data available to the service. This involved very actively seeking input from the clinicians and service leads to understand what might be useful 'levers for change' within their service. It also enabled data gaps to be identified.

The initial focus was exploring the more granular information now available on the activities undertaken by physios and OTs. What was it suggesting in terms of the nature of patient contacts, and what more was needed to identify clinical variation and best practice? Therapists selected three key interlinked areas of focus for analysis and evaluation:

- the percentage of patients seen in each patient category
- data at sub-team level
- linking patient outcomes with interventions.

The key aim was to identify unwarranted clinical variation and recognise best practice – and therefore best value - treatment options, so that these could be standardised across all teams and localities.

Exploring patient categories and associated activity undertaken

The multi-disciplinary approach at the heart of the EVO process has helped to provide assurance around the quality of the data being produced: having the right people around the table for extended periods of time, examining data from different angles, has thrown up some interesting challenges.

Analysis of the early Cheltenham pilot therapy data in the EVO facilitated sessions highlighted areas where physios and OTs could learn from the 'data journey' already undertaken by district nursing.

For example, therapy data showed a high percentage of patients with long term conditions (LTCs), as set out in figure 1.

Figure 1: A high proportion of patients seen by therapies have long term conditions
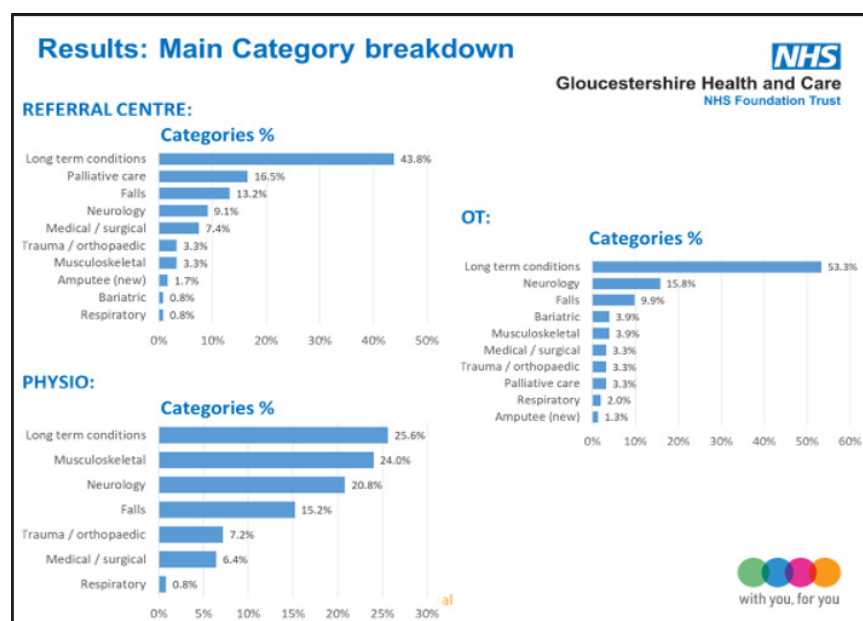
The district nursing service had previously had some concerns that LTC might be used as a 'catch all', masking more meaningful patient categorisation data. When nurses examined the activity undertaken with these patients, palliative care interventions were higher than had been anticipated. This indicated that the patient category 'palliative care' had previously been under-reported.

Therapists took this learning and as part of their EVO review of 'data gaps' made the decision to remove LTC as a category option. This meant that in the future, therapists would need to choose a specific patient category more closely associated with the intervention undertaken.

Differences in patient categories at team level in each locality

Therapists were also interested in data at a team level. Exploring the data in the EVO sessions showed that within the Cheltenham locality, the three physio and three OT area teams varied widely in the percentage of patients in particular categories.

Figures 2 and 3 indicate that in Team 1:

> both physios and OTs have the highest percentages of all teams of patients categorised as having trauma and orthopaedic (T&O) needs

> whereas physios see the highest percentage of patients presenting primarily neurological conditions, the equivalent OT team sees the lowest percentage of patients with neurological conditions.

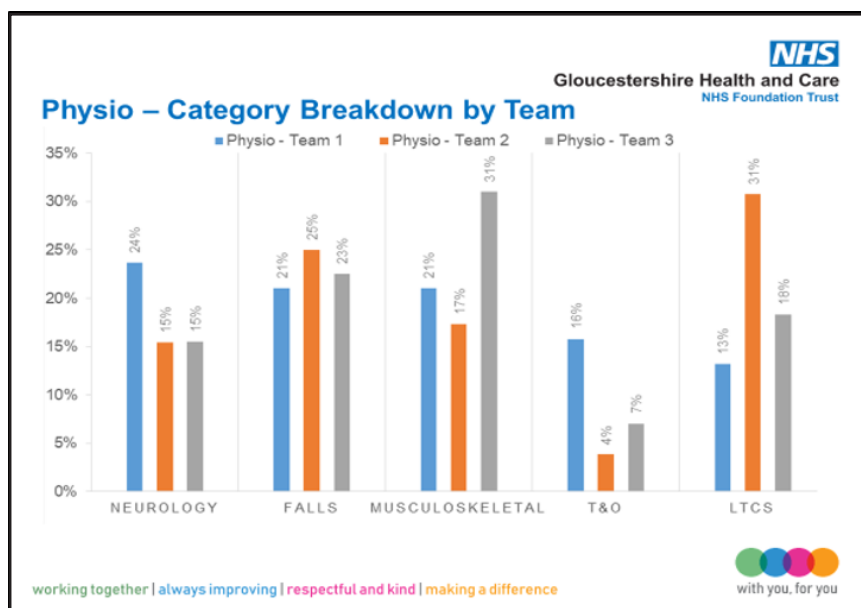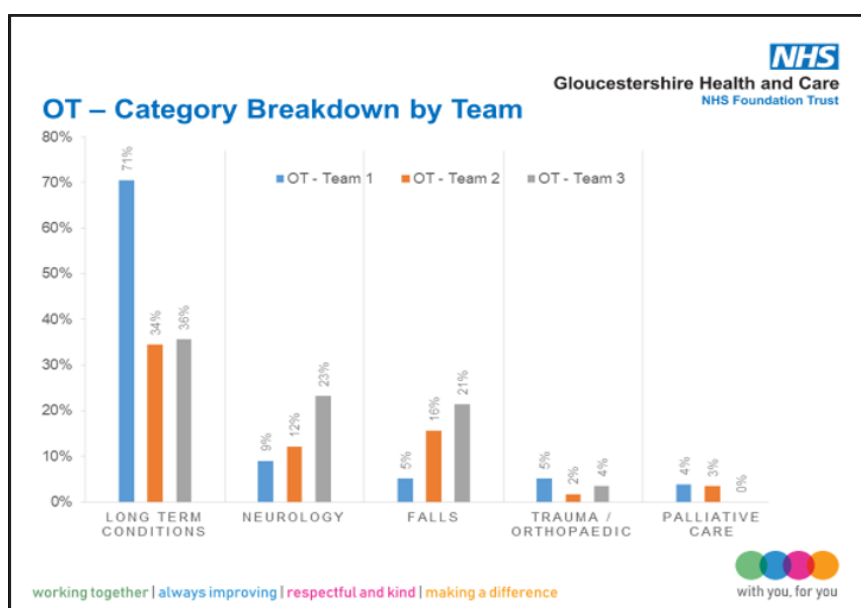Figure 2: Categories of patients seen by different Cheltenham teams – physio

Figure 3: Categories of patients seen by different Cheltenham teams – OT

In future, when LTCs are re-categorised to make the data richer, this sort of data at team level will lend itself to supporting 'place-based working'. Having information about the specific needs within an area will support services to work collaboratively in service planning and delivery in a joined-up system. For example, it might be that closer working with specific voluntary sector groups is indicated through a better understanding of patient category and interventions needed in particular locations.

Linking patient outcomes with interventions

Using the data to break down the types of interventions delivered to patients in each category and linking this to outcomes is in its infancy. But as part of EVO, clinicians, service managers and costing leads were keen to make progress in understanding how this information can be used in the future. The groups discussed available data and identified, for example, that currently in the Cheltenham locality 10% of OT interventions for 'falls' patients are self-management or health coaching (figure 4).

Figure 4: Main interventions undertaken with patients in different categories
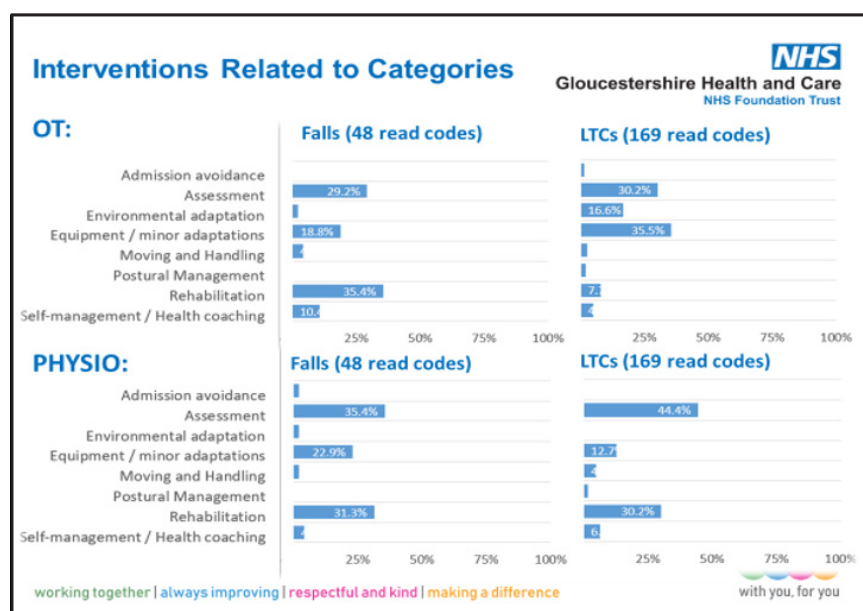
The EVO session discussed the relevance of this and the need to analyse patient outcomes against intervention types used, to understand what works best. For example, are two teams producing the same patient outcomes but with very different interventions - and different costs - of pathways?

Understanding the contribution of specific activities such as self-management and health coaching to patient outcomes will enable best practice pathways to be standardised for patients with similar needs, and best value achieved.

Improving data for Allied Health Professionals

During the EVO sessions the multi-disciplinary team identified a number of key challenges with the data.

➤ **Evaluating activity undertaken with patient using patient-reported outcomes**

Physios and OTs have been collecting patient-reported outcome data (PROMS) since July 2019. Phyios use the patient-specific functional scale (PSFS) and OTs use goal- based outcome measures. Both tools are designed to measure progress and outcomes of an intervention. Triangulating the aggregated PROMS data with PLICS will allow the service to measure the value of different clinical interventions.

➤ **Ensuring that clinicians record information in a consistent way**

There is an absence of guidance on best practice and so inevitably different approaches are used by teams and localities. To tackle this, EVO members worked with clinical staff to ensure that patient categories and intervention codes were understood and agreed. The focus has been on identifying the right level of 'umbrella' category and intervention codes so that there is not too much choice, but that information is rich enough to be meaningful.

It was important to communicate that this was not just a tick box exercise and that all staff needed be actively involved so that the information recorded can support learning and service planning.

➤ **Capturing specific information on time spent on social care activities, including the associated administration**

EVO discussions concluded that enabling the cost of social care to be fully captured would require a significant amount of additional data. Much of this activity is not face-to-face and ways to ensure this can be easily logged need to be carefully considered with a wide range of staff.

➤ **Improving the completeness and accuracy of LTC information in SystmOne**

There are known limitations which might be able to be overcome using a different data set from the Clinical Commissioning Group.

➤ **Capturing in SystmOne those visits where there are multiple practitioners present**

The current system only allows recording of when any other individual such as a carer or spouse is present.

Conclusions and next steps

The Trust's heads of service for both physio and OT agree that EVO 'created a buzz'. It provided dedicated time and resources for exploration of the recently enriched PLICS data, and enabled the multi-disciplinary team to understand the data's potential in building a stronger evidence base for clinical practice, service planning, workforce training, staff development and spending decisions.

It is anticipated that the richer information on the nature of referral types and interventions undertaken will help teams to understand whether they have the right skills, to inform training, development and recruitment.

The EVO pilot has stimulated interest in resolving long-standing issues and also exploring areas not previously considered. For example, it has long been recognised that a consistent Trust-wide approach to logging travel time is needed.

Other areas which are felt to be worth consideration include:

➢ fully understanding the impact of getting the right clinician to undertake the first patient visit on the length of episode and patient outcome, to ensure triage is consistent and of a high quality

➢ comparing planned (as proxy for best practice) against actual clinician mix providing the programme of patient interventions, with length of episode and patient outcome

➢ the prevalence and implications of patients who receive a single contact episode – to understand whether the referral was appropriate and the implications for other services.

Key to taking these forward will be moving the Cheltenham pilot approach into a 'live' phase rolled out across the county. This will immediately enable internal benchmarking even before data is externally comparable.

The EVO pilot has also enabled the therapy services clinicians, service managers, the costing team and informatics colleagues to consider wider factors impacting on service costs. For example, some of the variation in episode length, and therefore the cost, is explained by the level of availability of third-sector and voluntary support organisations. This demonstrates the maturity of the approach now being taken to understanding what the data is saying, and links to the potential to use PLICS information to develop 'place based working'.

Case study two - Diabetes

Introduction

Diabetes specialists work with a wide range of the Trust's patient groups, including service users with learning difficulties and those who have experience of mental health issues.

It is fair to say that the diabetes clinicians invited to take part in the EVO pilot initially had concerns about what the EVO pilot sought to achieve. Early conversations were friendly but challenging, and one clinician half-jokingly said she saw finance as 'the enemy'.

However, it took only the first facilitated EVO session for a shared view to emerge that exploring PLICS data together could provide opportunities to deliver higher value services to diabetes patients. During the second EVO session, the group settled on quantifying the 'health gain' from a particular intervention with diabetes patients: ever practical, the clinicians ensured that even early PLICS data provided tangible and immediately useful intelligence for planning and delivering services.

Topics explored

By the end of the first session, the group had agreed that the following would be useful to explore:

> the 'patient journey' for a patient with diabetes to see the services accessed

> profiles of diabetes patients including how PLICS data relates to demographics, particularly age

> a wider cohort of patients with and without diabetes, to understand the impact of diabetes on patients' dependency on other community based health services.

Mapping the patient journey

Analysis of a complex patient journey (figure 5) was a powerful way of highlighting what can happen when care is disjointed.

Figure 5: Example of a diabetes patient's use of health services
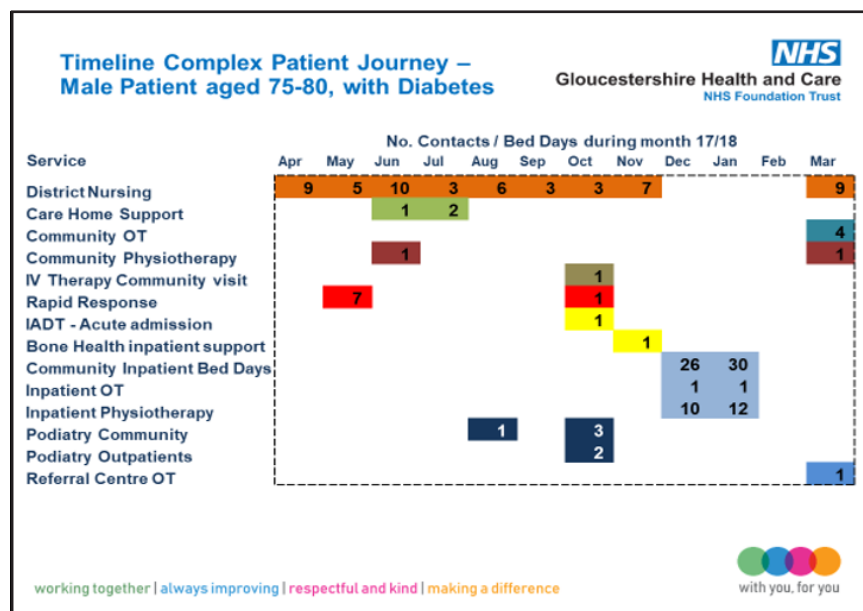
The patient starts out with the district nursing service but experiences a crisis and needs support from the rapid response team. A period of respite care follows, and then intravenous (IV) therapy at home – probably antibiotics. The patient though becomes very unwell and again needs rapid response services. The patient is admitted to inpatient care but quickly steps down to residential community rehabilitation services – but is there for almost two months. On discharge, the district nursing, community OT and community physio services are involved again.

Presenting PLICS data in this way lends itself to supporting clinical audit. The EVO pilot group agreed that more could be done with this sort of information presentation. However, this area of exploration did not seem to be the right focus for the rest of the EVO pilot sessions as it did not present an obvious way to test the 'health gain' of one specific intervention.

Understanding patient profiles

Looking at the demographics of patients with diabetes and the implications for costs confirmed what district nurses believed to be the case but had no supporting evidence for: the highest cost patients are the youngest and the very elderly entering End of Life care (figure 6).

Figure 6: Number of patients by age and the cost of patients in each age group
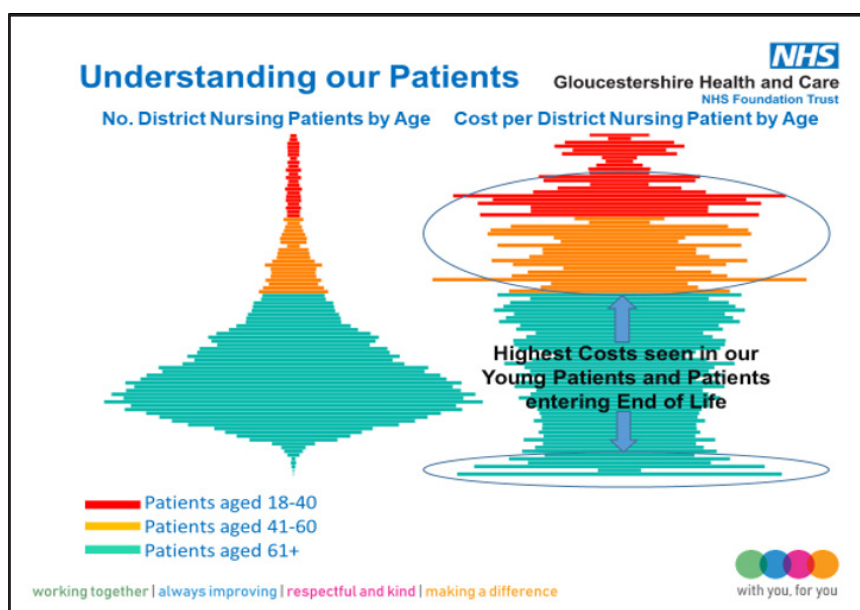
This raised specific questions about:

➢   complexity - what leads some patients to consume resource more heavily?

➢   how does their treatment compare across localities and teams, given their complexity?

Evaluating the diabetes service dependency factor

The group then settled its focus on PLICS data for patients with and without diabetes, to understand what evidence there was for a 'diabetes service dependency factor'.

Clinicians and the costing team explored PLICS data showing the use of services such as district nursing, tissue services and podiatry, by those with and by those without diabetes. The findings were compelling. Overall patients with diabetes cost almost six times as much as those without (figure 7).

Figure 7: Average costs of services used by diabetic and non-diabetic patients

Service Dependency factor   **NHS**
Gloucestershire Health and Care
NHS Foundation Trust

Using Costing Data to Understand the Impact of Diabetes on Patient Pathway

Average Pathway Cost across Key Services known to be associated with Diabetes

Service	All Diabetic Patients	All Non-Diabetic Patients	Diabetes Service Dependency Factor
Cardiac Services	£ 32	£ 7	4.45
District Nursing	£ 531	£ 83	6.40
Early Supported Stroke Discharge	£ 13	£ 6	2.36
Complex Care & Home	£ 30	£ 6	5.19
Podiatry	£ 132	£ 18	7.20
Tissue Services	£ 25	£ 5	5.04
Rapid Response	£ 75	£ 21	3.55
Total Pathway Cost Across Key Services	£ 865	£ 147	5.89

working together | always improving | respectful and kind | making a difference

with you, for you

Demonstrating the value of education programmes for patients with diabetes

This was proving interesting – and while the diabetes clinical nurse specialist commented that she 'liked the data' she was more concerned with 'but what can we do with it?'.

At the end of the second EVO session the group had a 'lightbulb moment'. Based on their developing understanding of what PLICS data could tell them about their service, clinicians identified an area to explore in more detail. The specialist diabetes nursing team knew 'intuitively' that providing structured education for patients should help them to take control of their diabetes and so be less dependent on clinical services. Specific patient audits had been undertaken which indicated benefits, but clinicians lacked a picture of the overall value of the education programme on patient experience and on costs. Could PLICS data be used to forecast the impact on future use of healthcare services?

The costing team got to work with the relevant PLICS data. At the third EVO session information was shared to show that patients who had attended diabetes education programmes in 2016/17 had a significantly lower need for healthcare services in 2018/19 than those who had not. The data indicated the value of education programmes on patient outcomes: in preventing ill health, and thereby reducing the 'service dependency factor' associated with diabetes (figure 8).

Figure 8: Use of clinical services by diabetes patients who have and have not accessed the education programme – average cost per patient all ages
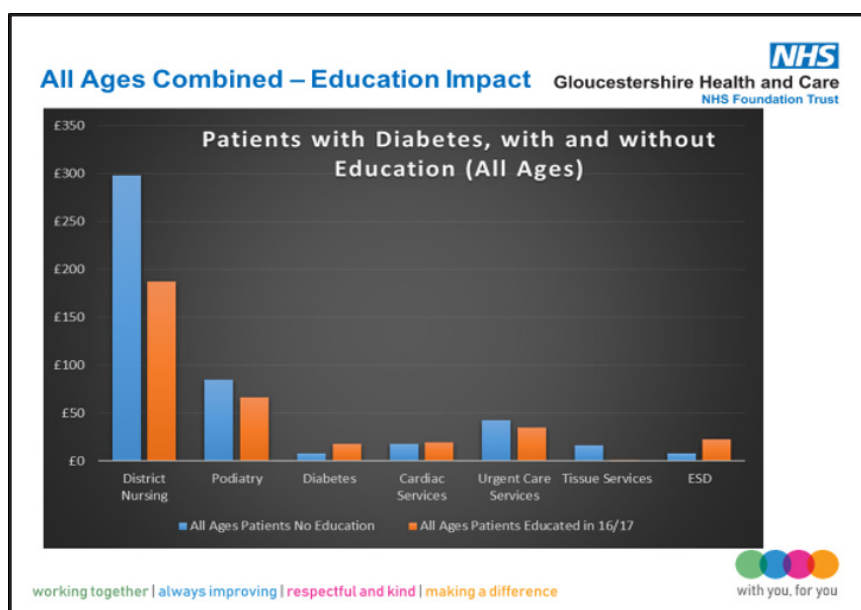
While there is more to do to ensure all other variables are considered, this is potentially powerful evidence for investing in education programmes to prevent future ill health and to avoid associated costs. The group concluded: 'We got there by working together and having the right people in the room'.

Patients of all ages who had received education used tissue services much less than those who had not. The dependency of patients aged 45-64 on podiatry services was much reduced for those who had undertaken the diabetes education programme (figure 9).

Figure 9: Use of clinical services by diabetes patients who have and have not accessed the education programme – average cost per patient by age bands
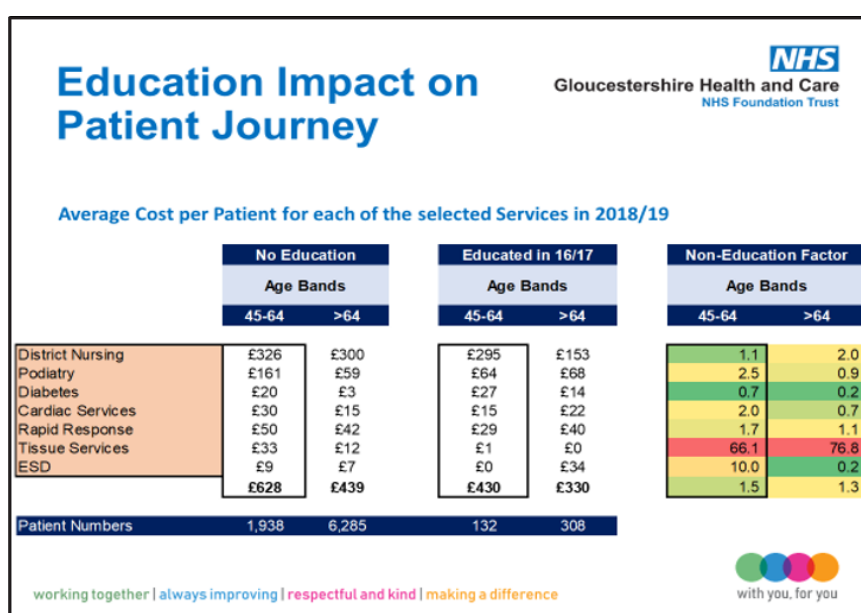
This has stimulated the diabetes service to focus its efforts on how best to support diabetes patients with structured education, including:

- identifying and targeting those General Practices that do not refer diabetes patients for education

- making education more accessible to working age patients. There is already a programme of out-reach where diabetes nurses visit significant employers and this is being expanded.

- maximising the benefit of the education programme to all patients, recognising:
  - the range of drivers likely to be successful in changing patients' attitudes, by understanding more about Patient Activation Measures (PAMs)
  - the benefit of educating other healthcare professionals
  - the potential to refocus education programmes to reduce longer-term complications.

The evidence explored through the EVO pilot is being integrated as part of a business case to access funding for increased provision of structured education programmes.

Improving data

Inevitably the EVO pilot highlighted areas where the quality of data could be improved, for example the Body Mass Index (BMI) is not always recorded in SystmOne for diabetes patients and might be significant in the patient's dependency on other services.

Another challenge, as noted in the Allied Health Professionals' case study, is refining patient data further by accessing information held in other places. Integrating the Clinical Commissioning Group data on patient multi-morbidity with the Trust's PLICS data would provide a more reliable picture of how 'complicated' patients with and without diabetes compare in the services they use.

Conclusions and next steps

Building on the positive outcome of the four EVO sessions, the group intends to explore other areas of potential interest, including:

- identifying sub-sets within the diabetic patient group, such as:
  - those with learning difficulties where there might be a higher 'diabetes service dependency factor' and a particular approach to education is needed
  - understanding any differences in patients with Type one and Type two diabetes
  - exploring the impact homelessness has on diabetes care

- considering data on amputation rates to understand the impact of education

- mapping the patient journey for the 'top 20' patients by cost, with and without diabetes, to understand where the biggest differences in cost lie

- working to establish a consistent approach to ensuring all healthcare professionals offer the same high-quality advice to patients living with diabetes.

Case study three – Wound Care

Introduction

The Cheltenham pilot (Appendix B) revealed the full extent of wound care intervention undertaken by the Trust's district nursing teams in that locality (figure 10). When they came to decide a topic for the EVO process, a deep dive into an aspect of wound care was the service's obvious choice.

Figure 10: Tissue viability is the key intervention recorded by district nurses
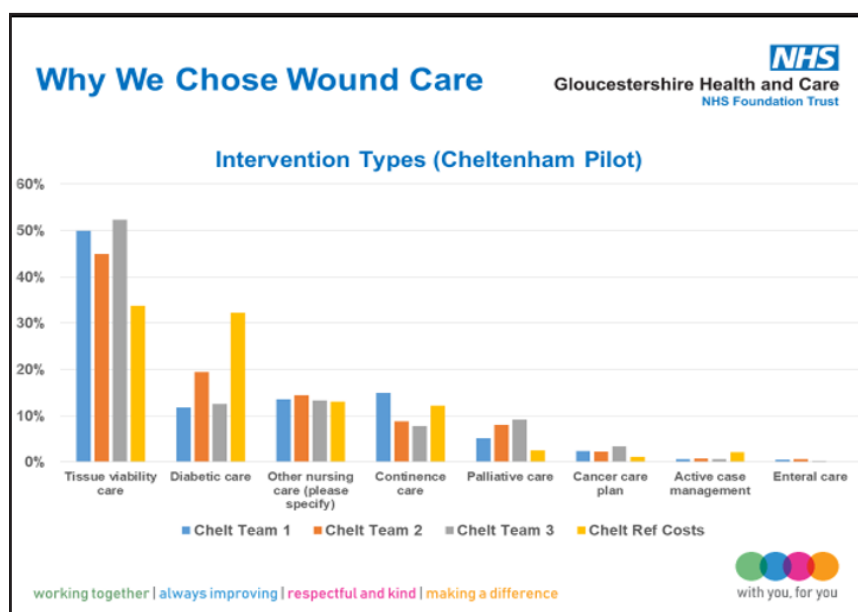
Lord Carter's review of community health services noted that the NHS spends about £5 billion a year managing wounds.[1]   The review identified the scope for improving patient care and reducing costs by tackling unwarranted variation, but also highlighted the need for trusts to improve the capture of information to understand their services.

The Trust recognises the significant gaps in its data for the wound care service. The Cheltenham pilot had helped to standardise information recording, but at the time of the EVO pilot the clinicians had not yet had the opportunity to use the new information and explore what the PLICS data could tell them. Neither had finance colleagues had the chance to explore what the improved PLICS data would tell them about spending patterns in this important area.

By including this key service in the EVO pilot process, clinicians, service managers, the costing team and finance colleagues had the time and space to consider what the service really needed to know, to understand what PLICS data was available, and to identify what further data would be required to provide the full picture.

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[1] NHS England and NHS Improvement, *NHS operational productivity: unwarranted variations Mental health services Community health services, 2018*

Topics explored

The EVO session started with general discussions about how to use the available data to identify best clinical practice. Over time the clinicians, with input from the costing team and informatics colleagues, narrowed this down to a key area where they felt that data could help support service planning and delivery. This focused on exploring the potential influence that 'team stability' might have on patient care. Was it the case, as was anecdotally 'known', that wound care was delivered more efficiently and effectively by a team used to working together?

Team stability

A 'confidence' factor was believed to be in play, where colleagues who know each other better trust each other to make correct decisions. This could have an impact on patient pathways. To test this, data on the number of contacts and hours of nursing care consumed in patients' episodes of wound care was analysed against nursing team stability (figure 11).

Figure 11: Patient episodes of care compared to stability of the team
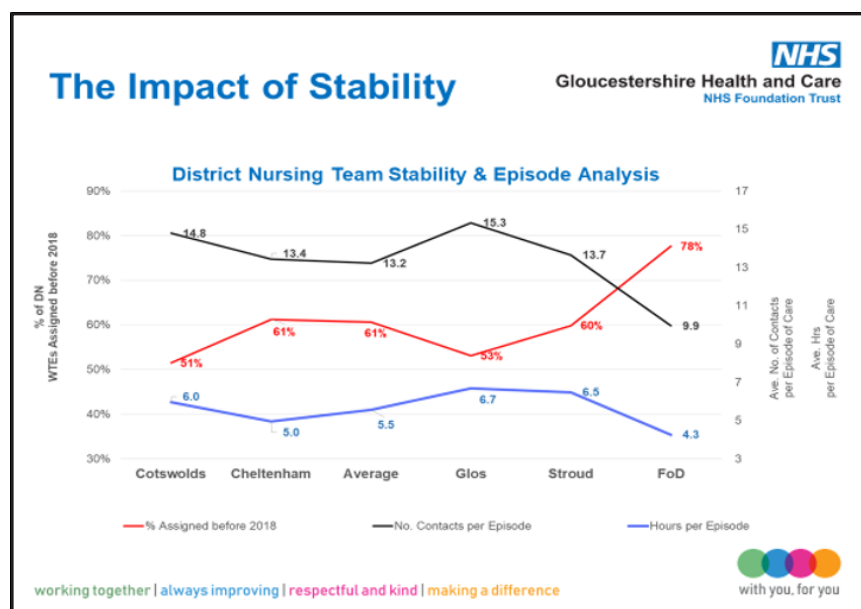
The data indicated that in the localities where a higher percentage of the district nursing team had been working together for more than two years (i.e. were assigned before 2018), generally the contacts per episode and the hours per episode were lower. This was most marked for the Forest of Dean locality. The Trust plans to carry out further analysis in this area to better understand the correlation between the number of contacts a patient receives and other factors including the make up of teams (see Conclusions and next steps below).

Standardising the data collection template

The key to understanding the impact of team stability was the introduction of standardised recording and reporting, which meant that data in this area was robust enough to be meaningful. The early success in using data to confirm an 'instinct' has refocused the service on continuing to

improve and to actively use PLICS information to come to decisions on best practice and to reduce unwarranted clinical variation. By pairing this with richer data on patient outcomes, the Trust intends to identify and implement the best value care pathway for different types of wound.

Improving data

The EVO pilot provided the opportunity for a multi-disciplinary group to plan how to tackle known data issues in wound care. Higher quality data in PLICS for wound care is needed so that the service can:

➤ more fully understand costs

➤ highlight variation in the clinical approach for patient cohorts with the same type of wound

➤ internally benchmark including understanding variation in healing rates.

The ultimate aim is to be able to use PLICS data to demonstrate where improved patient outcome is being achieved for less cost, so that clinicians can identify and standardise on best value care pathways.

Following the EVO pilot, clinicians, the costing team and informatics colleagues are continuing to work together to develop a set of data collection templates to help:

➤ improve information recording by reducing the amount of free text, instead using standardised options, so that data can be more easily extracted and compared

➤ clearly demonstrate the logical process and rationale for a treatment choice

➤ improve granularity by setting out consistent criteria for sub-categorisation of wounds as 'simple' or 'complex' within:

 » surgical wounds

 » leg ulcers

 » pressure ulcers.

Data may also help support a business case for investment in staff training to reduce variation in clinical practice.

Conclusions and next steps

EVO enabled the teams to identify where data wasn't yet fully available for a deep level of analysis to take place. However after the new, standardised wound care templates are live, the teams will use the data to fully analyse patient care, stratified by wound type and across different services for similar patient cohorts.

Other areas of focus to be explored are:

➤ analysis of the use of qualified and unqualified staff in the patient journey against outcomes, stratifying patient groups by complexity

➤ readmissions into the district nursing service because of failure of a maintenance pathway

➤ making sure that data captured in podiatry is included in future evaluations.

Overall conclusion from pilot sites

By developing EVO, HFMA's Healthcare Costing for Value Institute and FFF set out to promote collaborative working between clinical and finance teams, and to unlock the power of PLICS by encouraging the use of the rich data set by clinical services.

EVO strengthened working relationships between clinical services, informatics and finance at all pilot sites. One participant described the EVO framework as a 'launch pad for trusts struggling with clinical and financial engagement.'

For many clinicians – doctors, nurses, allied health professionals – this was the first time they had seen PLICS data for their own patients. It was also the first time for some finance business partners.

Pilot sites demonstrated that the EVO approach can lead to important action, for example improving productivity and patient care, or building the case for new models of care and prevention programmes.

EVO bridges the gap between a theoretical model of value-based healthcare and one that is embedded in the day-to-day delivery of better care for patients. As one EVO participant said: 'If you do the right thing for the patient, your money will come right and EVO has evidenced this beautifully.'

Embedding EVO

It is important that EVO is sustainable and can be used in its own right beyond the initial facilitated implementation. This is about equipping trusts with the tools to instigate positive change and incentivising them to use this framework at scale.

Pilot sites have been provided with online resources to support the roll-out of EVO. Specialties and services will have varying needs and will be looking for a variety of outcomes from EVO. The EVO Pilot Tools are designed to give teams flexibility to use them in whatever manner they feel is most appropriate.

EVO accreditation

By successfully completing EVO in three specialties/ services, the four pilot sites are the first trusts to be accredited as 'EVO Bronze' sites. If they roll out EVO further, they will have the opportunity to be accredited as EVO Silver sites.

Future plans

The EVO website will be regularly updated with new case studies and information about future plans.

If you are interested in receiving information on the upcoming beta version of EVO, please email richard.sawyer@hfma.org.uk to register your interest.

Appendix A EVO pilot sites

Organisation	Sector	Specialty/service
Gloucestershire Health and Care NHS Foundation Trust	Community	• Diabetes • Allied Health Professionals • Wound Care
Great Western Hospitals NHS Foundation Trust	Acute	• Cardiology • Gynaecology • Trauma and Orthopaedics
North Staffordshire Combined Healthcare NHS Trust	Mental Health	• Adult Community Mental Health Teams • Crisis Care • Memory Service
University Hospitals Birmingham NHS Foundation Trust	Acute	• Dermatology • Trauma and Orthopaedics • Vascular Surgery

Appendix B Cheltenham pilot

In early 2019 the Trust launched its 'Cheltenham pilot' to explore ways to tackle nationally recognised data issues. Focusing initially on the Cheltenham Integrated Community Team (one of the Trust's five localities), the pilot covered district nursing, community physiotherapy and community occupational therapy services.

By July 2019, more meaningful clinical data was being gathered and included in PLICS.

Therapy services

The focus for therapy services was on 'levelling up' so that data already available to district nursing was also available in therapy services. In the past, the activity recorded in PLICS following a visit by a physiotherapist (physio) or an occupational therapist (OT) was simply logged as 'physiotherapy' or 'occupational therapy', without any information on the interventions the patient received. Therapists in the integrated community teams could see the benefits of the better information their nursing colleagues had and were proactive in developing ideas to improve their own activity recording.

As part of the Cheltenham pilot, therapists completed a template of planned activity at the start of an episode of care. At the end of each visit the specific activity carried out was recorded.   This has resulted in a much more comprehensive understanding of:

> ➢ the nature of patients, their needs and the provision in the locality

> ➢ clinical variation, with the potential to benchmark across the Trust's five localities.

District nursing

While the available activity information was already richer for district nursing than for therapy services, the Cheltenham pilot refined things further by logging the key specialist nursing activity undertaken when visiting a patient. Previously activities recorded by district nurses were 'translated' into the most likely Healthcare Resource Group (HRG) code by way of a specialist algorithm. This had its limitations, including being subject at times to interpretation by non-clinical staff.

As a result of the Cheltenham pilot, district nurses now record what they have spent the majority of their time doing at the end of each visit to a patient's home, for example, diabetes nursing, tissue viability nursing or palliative nursing.

In both of these clinical areas, the richer and more meaningful PLICS data now provides a much better understanding of patient need and resulting clinical practice. The Trust intends to roll out the approach to all its integrated community teams by mid-2020.

Appendix C EVO Expert Panel

We are grateful to the expert panel who contributed to the development of EVO. The panel covered three sectors: acute, mental health and community services.

Name	Job title	Organisation
Dr Sanjay Agrawal	Consultant in Respiratory and Critical Care Medicine	University Hospitals of Leicester NHS Trust
Stuart Burney	Finance Business Partner and Head of Costing	South Tees Hospitals NHS FT
Dr Jane Carlile	Consultant Psychiatrist and Group Medical Director	Northumberland Tyne and Wear NHS FT
Sheelagh Carr	Head of Costing, Systems and Projects	Greater Manchester Mental Health NHS FT
Chris Chapman	Professor of Management Accounting	Bristol University
Dr Clara Day	Renal Consultant and Associate Medical Director for Finance	University Hospitals Birmingham NHS FT
Sarah Hall	Implementation Lead IAPT Service	Dorset HealthCare University NHS FT
Scott Hodgson	Head of Costing	Nottingham University Hospitals NHS Trust
Clare Jacklin	Costing Manager	Humber NHS FT
Dr Jean MacLeod	Consultant Physician in Medicine and Diabetes	North Tees and Hartlepool NHS FT
Mike McEnaney	Director of Finance	Oxford Health NHS FT
Matt Miles	Finance Business Partner	Lincolnshire Community Health Services NHS Trust
Andrew Monahan	Policy and Research Manager	HFMA
Mike Newton	Deputy Director of Finance	North Staffordshire Combined Healthcare NHS Trust
Duncan Orme	Deputy Director of Finance	Nottingham University Hospitals NHS Trust
Alex Packard	Commercial Finance Manager	Berkshire Healthcare NHS FT
Ros Preen	Director of Finance	Shropshire Community Health NHS Trust
Jenny Richards	Senior Planning and Costing Manager	Gloucestershire Health and Care NHS FT
Hayley Ringrose	Chief Financial Analyst	Stockport NHS FT
Ben Roberts	Senior Finance Business Partner	Leeds Teaching Hospitals NHS Trust
Sheila Stenson	Executive Director of Finance	Kent and Medway NHS and Social Care Partnership Trust
Ella Worsdale	Head of Information	Pennine Care NHS FT

About the Healthcare Costing for Value Institute

HFMA's Institute champions the importance of value-based healthcare for supporting the delivery of high-quality financially sustainable healthcare. Through its member network, it supports the NHS to improve costing and make the most of patient-level cost data to drive improvements in patient care and deliver efficiencies. By bringing together senior finance and clinicians to explore what value means, the Institute helps the NHS to turn the theory of value into practice and make value-based healthcare a reality.

About Future-Focused Finance

Future-Focused Finance is a national programme designed to engage everyone in improving NHS Finance to support the delivery of quality services for patients. We want to bring finance staff at all levels of the profession together with the teams we work with in our own organisations and make sure that everyone has access to skills, knowledge, methods and opportunities to influence the decisions affecting our services. We believe by working together in this way we can harness our diverse and talented NHS workforce to produce high quality services and reduce waste in NHS spending.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff working in healthcare. For 70 years it has provided independent support and guidance to its members and the wider healthcare community. It is a charitable organisation that promotes the highest professional standards and innovation in financial management and governance across the UK health economy through its local and national networks. The association analyses and responds to national policy and aims to exert influence in shaping the healthcare agenda. It also works with other organisations with shared aims in order to promote financial management and governance approaches that really are 'fit for purpose' and effective.