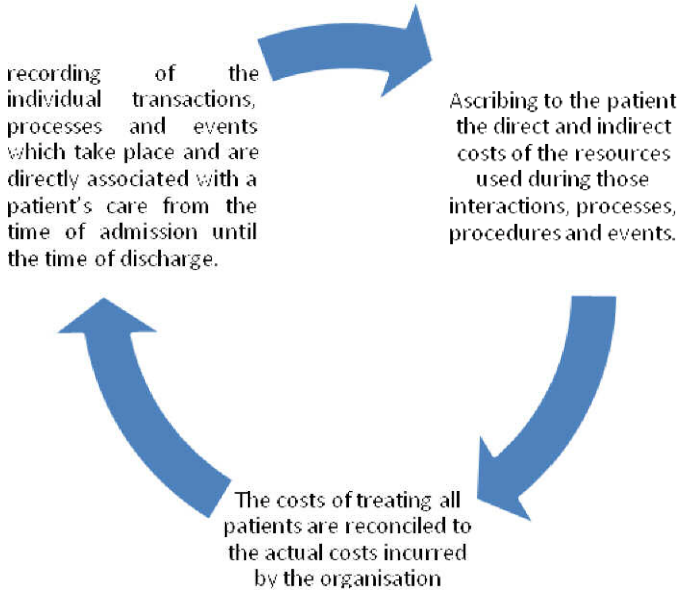
PLICS UPDATE

The main principle of Patient Level Information and Costing (PLICS) is to trace the resources used by an individual patient in diagnosis and treatment and then calculate the expenditure of those resources using the actual costs incurred by the healthcare provider. This should be done in conjunction with Service Line Reporting. Broadly speaking, PLICS can be broken down into three basic steps:



Resources should be allocated to patients based on actual patient activity using the principles of activity based costing. As very few patients are identical in how they are treated, PLICS can reveal outliers and variations from average cost to provide a focus for clinical discussion about how to promote the adoption of more successful and cost effective clinical outcomes.

From a Payment by Results (PbR) point of view, it is likely that PLICS will be used to inform the tariff in the future. Quality information at the patient level is recognised internationally as being the best type of information to inform currencies and tariffs. Information provided by a PLICS system can improve the ability of an organisation to understand their financial drivers and provide valuable evidence-based analysis in discussions with both clinicians and commissioners.

Clinical engagement is a key requisite of any PLICS system. Clinicians should be involved from an early stage in the process as PLICS requires them to validate and verify the processes that capture the data and the costs, in order for them to be confident that the information produced is reliable. A lack of clinical input can lead to poor costing, with clinicians complaining that there is a failure of the system to reflect the costs that they know are involved with the provision of each service. As PLICS information will eventually be used to inform tariff, it is doubly important for clinicians to be happy with the information being produced. Information on individual components and costs of a patient's episode of care provide clinicians with evidence to assist in understanding variation and eliminating the unnecessary use of resources. As well as providing cost information, with the recording of clinical interactions, PLICS also enables recognition of adherence to or variation from standard clinical pathways and protocols.

By generating costs at patient level it may ultimately become possible to use comparative cost performance as a performance measure for consultants or clinical teams, however such information will only become credible with buy-in from clinicians

It is recommended that a **Steering Group** is established to set up for the implementation of PLICS, consisting of a mix of clinical directors, directorate managers and senior IT and finance staff. This should meet regularly to ensure the objectives of the system are met and to make decisions over allocation and pricing methodologies where appropriate. Having high level members should provide the authority to clear any bottlenecks and resolve any issues

arising.

Feeder systems are the information systems which provide the patient level data for the PLICS model. The reliability of these systems is obviously a key factor in the development of an accurate PLICS system. Some of the key factors which make up a typical patient episode include ward bed days, diagnostic imaging, pathology tests, pharmacy drugs and operating theatres. These areas will have their own individual systems on which the patient level information is recorded and this data will need to be exported from each system into the PLICS model. However, experience shows that while these systems are designed to fit the purposes of a specific area, the needs of a PLICS model may not be accommodated. A typical example of this is a lack of an excel data export facility. In practice most feeder systems will require some development for PLICS while there are likely to be some areas where there are no feeder systems currently in existence. The assessment and development of feeder systems is a major component in implementing PLICS and the amount of work needed for this should not be underestimated. The key component is the ability to export data with a common patient identifier field linked.

Income is obviously a key factor in determining the profitability at a patient level. While the majority of income will be available at patient level, there are likely to be areas which are received on a block contract. This will require the income to be apportioned on a basis agreed by the steering group. In some cases, as the income is fixed, there may be no patient level data recorded at all. Typical examples of this are Specialist Nurse activity and some community services where all of the activity is not recorded on the main PAS system.

Theatre information is a key driver of patient cost but from experience this is an area where accurate information can be lacking. The accepted

methodology for allocating theatre costs is to base it on the breakdown of the times spent in theatres (anaesthetic time, cutting time and recovery time). However, in many cases this information is not recorded or is incomplete. Apportionment of medical staff time can also be tricky. The consumption of non pay items in theatres is also an area where sufficient data is often not available. Pathology systems are probably the most commonly outdated systems, and Physio and other therapies may have limited information. Most Trusts have Theatre systems that record time albeit the export of data may be a problem.

Robust **Pricing** and weighting methodologies are required for any meaningful PLICS system to work. In many cases this can follow on the work done in setting up Service Line Reporting where price lists may have been developed for areas such as radiology and pathology while prices will be known for drugs. Where price/weighting methodologies do not exist, the steering group can help to develop them to ensure that relative costs are accurately reflected.

The choice of **Software** chosen for PLICS should not be taken lightly. There are major variations in the functionality between available products, even those on the NHS preferred supplier list. A key area to look at is how income is imported into the system and calculated. Some products neglect this somewhat, with income having to be entered and calculated manually. The reporting side of any PLICS software is also important and should support the needs of both finance staff and clinicians. It is suggested that existing users of

various products are contacted in order to gain feedback on the relative strengths and weaknesses of each.

In conclusion the main points when implementing PLICS are:

- Include clinicians from an early stage and continue to engage with them throughout the process by use of a steering group. An enthusiastic and committed Medical Director is an important ally in achieving this.

- The development of feeder systems is a major part of the process and will take a significant amount of time. This is especially true for areas where no patient level information is currently available and areas such as theatres where key information may be incomplete.

- Accurate pricing methodologies should be developed to ensure that patient cost is fairly allocated.

- The choice of software is a key decision. Ensure that all key functionalities are met by the product.

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