Guide to implementing Patient Level Information and Costing Systems (PLICS) Updated - May 2009

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Introduction

This paper sets out the broad principles and processes that NHS Trusts might want to consider when implementing a patient level information and costing system. Many of the project management principles and some of the detailed steps are similar to those applicable to introducing service line reporting. Acknowledgement is given to guidelines previously issued in respect of service line reporting by Monitor, the independent regulator of NHS Foundation Trusts.

The time that it will take and the benefits to be gained from implementing PLICS will be commensurate with the commitment from executive management, the engagement of key staff and the resources applied. Once a decision has been taken to proceed with PLICS, 7 basic steps as outlined in this document are usually required. This does not however disallow for flexibility and NHS organisations are free to use and adapt these as required for local circumstances.

A: Explain the need for change

Change is often seen as threatening. Explaining the need for change and the consequent benefits are a prerequisite to ensuring a successful implementation. In order to deliver better patient care in a time of financial constraint, organisations need to know the details of what is happening in the current delivery and models of care for individual patients. PLICS has numerous benefits for the whole organisation in terms of financial and clinical transparency and most importantly better care for individual patients and more care for the community as a whole.
Responsibility for explaining the need for change should be assigned to an individual or a group which should report back regularly to the Project Board. This person or group must make sure that the relevant audience understands the true benefit of their work.

B Involve all key stakeholders

Top management and all key stakeholders should be involved continuously in the initial implementation and ongoing improvement of PLICS. PLICS should be seen as naturally belonging to the whole organisation and not to the finance or information departments. Top management should ensure that this and their personal commitment is communicated to the whole organisation. The management should understand that this is an ongoing project where evolving goals will be set to ensure the true targets are achieved.

It is recommended that a special Project Board is set up to oversee implementation. The Project Board should include senior clinical personnel, the Director of Finance and the CIO. This Board will be primarily responsible for meeting milestones and final delivery.

The project board will be responsible for identifying key stakeholders, usually medical directors, clinical leads, general managers and financial managers. The project board will identify how the stakeholders will be continuously involved and their requirements for teaching. They will also identify their performance information needs. This should be documented. It is recommended that the project board appoint an individual who will be personally responsible to ensure the ongoing involvement of stakeholders.

The project board should determine and choose the specific dedicated resource which will be used in the project and ensure that the dedicated lead is included in all project board meetings. The project lead should ideally be someone who is numerically literate and who is capable of liaising with clinical staff in a manner which inspires trust and who has a record of resilience and accomplishment.

Clinical personnel and other information providers may well require additional remunerated time to fulfil their role in setting up and implementing raw data collection systems.

It is recommended that a brief status report be provided to the Trust Board each month detailing the Projects progress against the pre-agreed time frames, outlining any variances, the reason for them and how they should be resolved. Such an approach reinforces the overall corporate nature of this activity.

C: Choose a specialist PLICS system supplier

The Project Board has the ultimate responsibility to ensure that the project is successfully implemented and operates corporately. The supplier should ideally be chosen by this board.

Minimum Requirements

A specialised PLICS system will normally consist of a full data integration and costing engine and a front end reporting and analysis tool, suitable for both management and analyst staff use. The minimum requirements for a specialised PLICS system/supplier should include the following:

1. The PLICS system must be capable of reporting both cost and resource consumption data on a daily basis. The resource data produced must be readily identifiable where it is available (e.g. the pathology or imaging test name, drug name, ward name, consultant name or code). The ability to produce patient level cost and activity data on a daily level is necessary to ensure maximum clinical engagement with the data. It enables clinicians to understand where there may be areas for efficiency savings and monitor adherence to or variance from established clinical protocols. For example, what variations exist in pre-operative pathology, day of surgery admittance rate, theatre time (etc) for similar patient cohorts? On another level, producing patient cost and resource consumption data on a daily level will also be necessary to assist the Department of Health to set robust outlier payment policies in future. An example of the production of patient level cost and activity data on a daily level can be found at Appendix 2. This should be the minimum level of information

required. This Appendix also shows a sample report which would not be acceptable.

2. The PLICS system must be capable of reporting on the underlying diagnoses and procedure code information associated with patients. This information is necessary to enable the full engagement of clinicians as their language is not one of HRG's but the actual diagnoses and procedures associated with patients. This level of information provides clinicians with the ability to easily identify the underlying severity of the patient's illness – and hence the appropriateness of the resources they have consumed. PLICS is not solely about patient level costing, it is also about patient level ***information***.

3. The greater the effort, thought and discussion in determining what information clinicians and clinical management will find most meaningful as well as your current data gaps before discussion are held with suppliers, the greater the likelihood of choosing the best supplier as a result of a robust selection process.

4. Post implementation, ownership of the processes involved in generating PLICS data on an ongoing basis must reside within the Trust and the Trust must be capable of making any changes to the cost (or income) model(s) and the underlying methodologies that have been applied to the construction of the PLICS data. The PLICS supplier must be able to provide evidence of how ownership and knowledge is transferred to Trusts to allow them to effectively run PLICS independently. Finally, the data inputs should be easily changeable to meet any revisions to DH costing guidelines.

There are a range of suppliers operating in the UK. The department **does not** endorse any individual supplier.

PLICS system providers can play an important role in assisting an organisation in project implementation. Most organisations will benefit from the experience that PLICS suppliers can provide and the purchase should be seen as more than just a supply of software. It is suggested that potential suppliers should be exhaustively questioned regarding the support that they could provide in ensuring that their software works as a business intelligence solution rather than merely technical IT support for software and/or software support. The right supplier can be a key resource in a timely and effective implementation. The objective is to supply accurate, timely, credible information and the extent to which a supplier is able to work internally with the Trust to ensure that this is achieved can be a vital determinate in the right choice of supplier. For this reason, as well as to eliminate any possible reformatting of raw data, it is highly recommended that the Trust choose a supplier early in the process. This does not mean however that the PLICS process is unable to begin until a supplier is chosen. Forethought and understanding of what the Trust really needs and where its information shortfalls exist should be a precursor to supplier selection.

In addition to the above, buyers should make purchase decisions based on the normal parameters of value for money, experience, reliability, quality of product, back up and ongoing service. A sample list of questions which buyers might choose to ask of their suppliers in order to elucidate and test for the quality of the

offering is attached at Appendix 1. A true PLICS system can integrate information from operational systems and a data warehouse simultaneously and change the raw data source at any time without affecting the quality of the costing process.

It is not proposed that this list is all-inclusive and each organisation will have their own concerns which require addressing when assessing suppliers e.g. integration with existing IT systems. Buyers should go through the normal commercial procedures in evaluating prospective suppliers. Extensive reference sourcing of other users is highly recommended.

It is important to set out an appropriate evaluation period to adequately review all the short listed products. Given the complexities involved, it is not possible to make an informed decision about a system's suitability in a demonstration that is less than an hour in duration. It is suggested that an agenda is forwarded to suppliers in advance of a meeting to outline all the topics you would like a demonstration to cover.

To further evaluate the capabilities of systems and companies shortlisted from the demonstration process, it is worthwhile arranging a half day workshop with a supplier so that a more detailed review of the system can be provided and tested. Methodologies and time frames can be discussed in more detail.

D: Define the scope and expectations of the "initial" implementation

It is important that expectations and deliverables are clearly defined. Implementing PLICS is often an iterative process with information gaps only becoming obvious when data is requested. In most cases this change will not be able to be implemented as a complete final blue print but rather as an interactive process in a known and accepted direction. It is important to define a scope which is deliverable within a period of time which is not so long that the project loses its momentum but that is long enough to demonstrate some beneficial results. It is very useful if some tangible benefits can be delivered quickly from the system even if those deliverables may not always involve actual costing. This ensures visibility and encourages support.

It is suggested that initial reports for review and feedback should be made available within 3-6 months. There should be no expectation that these initial draft reports will be 'perfect' but will rather be a learning exercise to expose gaps in raw data, business terminologies, object coding and allocation methodologies. It is important to be realistic about time frames and early results.

Most organisations should be able to produce meaningful and fruitful data within 9-12 months as an output from the initial implementation project. There-on-in PLICS becomes a series of continuous improvement projects.

The scope of the initial implementation should therefore be clear and transparent e.g. inpatients or part thereof / outpatients/ individual services e.g. renal dialysis, chemotherapy. The timetable for results should also be clear.

E: **Ensure the availability of meaningful raw data**

All management and clinical reporting systems can only be as good as the input data. Although most hospitals have a lot of available information that has not been collected, collated and synthesised, it is most unlikely that all the raw data will be as good as desired.

It will be important therefore to prioritise the most important areas of data and their quality. The materiality of the costs to be allocated and the likely variability of expenditure of those costs between patients should serve as a guide to where effort and attention should be placed.

PLICS aims to record meaningful clinical interactions, processes and events which take place during a patient's episode of care and to ascribe the actual costs of those interventions to them. The quality of allocation methodology is a crucial determinate of good PLICS data and its subsequent use. Ensuring relevant granularity, without becoming lost in the unimportant minutiae, is a pivotal judgement for each organisation.

The Acute Health Clinical Costing Standards sets out the major areas of activity that relate directly to patient care. Guidelines on the relevant usefulness of varying allocation methodologies, including the attribution of indirect cost and overheads to patients via direct intervention activities are set out in these standards.

To assess the availability and meaningfulness of data will require close communication with a number of staff, particularly clinical personnel. Project staff visiting clinical units to gain a very clear understanding of what they do and how they do it. Together with the clinical staff, they will examine existing information as to its suitability. The rationale for data collection should always be fully explained to information providers. It is important that an action plan and timetable be agreed to bridge any gaps between existing and required data. A training programme should be determined and regular follow up assessment should occur to ensure that the required improvement is actually taking place.

There are significant benefits available to clinicians resulting from PLICS but it does require that they work with the project team to develop and validate processes. Without this input, the information delivered will lack the clinical credibility required to be meaningful.

Wherever possible existing sources of information should be used creatively. e.g. a prosthetic feeder system can be introduced by stapling the label from the prosthesis packaging onto a theatre note with the patient's name. Alternatively, the surgeon can tick the box on a list of available prosthetics for a procedure for the particular item which has been used. It is not necessary that all items have purpose built IT feeder systems. The advance in computer technology has meant that most costing software engines can take data in a wide variety of formats and the data can be loaded regularly so that information is always current.

F: Separate patient care from other activities

The aim of PLICS is to ascribe the actual cost of clinical activity to individual patients. This means that other activities carried out by Trusts need to be identified and both their income and cost measured accurately and excluded from those related to patient care. The major non patient care activities are R&D, teaching and training and other commercial activities.

R&D income can come from a variety of sources including NHS funding, commercial funding and charity sources. Direct costs can include the time of consultants and other clinical staff, drugs and supplies as well as services such as diagnostics, pathology and radiology. Indirect and overhead costs can include facilities usage, management and administration costs in addition to a share of general Trust overheads. Methods to capture the activity and measure the costs will need to be considered and implemented. A number of organisations will already have implemented a number of measures to carry out Service Line Reporting as required by Monitor.

Ascertaining the costs of teaching and training allied to SIFT, MADEL and NMET funding is a difficult task. Nevertheless, the starting point should not be an assumption that expenditure is equal to income. Recent research has shown that this is clearly not so particularly in the area of facilities income and cost.

Some teaching costs can be measured relatively easily as they are discrete activities e.g. a lecture to undergraduates. Other costs may be incurred during episodes of patient care and these are far less easily disentangled. These are often centred around ward rounds and outpatients. A judgement must be made as to the amount and cost of lost productivity during these episodes. Judgement is also necessary to determine the cost/benefit relationship as to how much effort is undertaken to fully and accurately separate all costs. As with the allocation of all costs, the allocation methodology should take account of the materiality of the cost and variability of the expenditure in relation to service lines and individual patients.

Costing methodologies and templates to calculate the cost of these activities have recently been developed by the Department in conjunction with NHS London and others, these will be available on DH website later in the summer, they are also included in draft form in the latest version of the Acute Health Clinical Costing Standards.

Commercial activities can take a variety of forms from the operation of a public cafeteria and florist shop to sophisticated joint venture operations with the private sector. Corporate income is defined as income that is not directly or indirectly related to patient care, R&D or teaching and training. This should be separately identified and matched against the relevant costs of producing the income. Under no circumstance should this income, either gross or net after costs, be deducted from the cost of patient care, R&D or teaching and training.

Patient care income received from non-NHS sources e.g. private patient income, overseas visitor income Road Traffic Accident (RTA) income should be treated in

the same way as NHS clinical income i.e. at the patient level and not deducted from patient costs.

G. Recognise Ongoing Development

It is important to realise that the installation of a PLICS system is not a one-off quick fix exercise, this will be a start in the improvement and development of meaningful information to be used by clinicians and management in achieving the organisation's strategic, clinical and financial goals. For this reason. It is essential that the ongoing development and improvement of the system be managed in the same manner as the implementation, i.e. with challenging but achievable project plan, status reports and Board reviews. Improvements may include the upgrading or inclusion of additional feeder systems, the refinement of acuity allocations or enhancement of cost allocation statistics. Failure to recognise this phase may limit the benefits attainable through the full potential of PLICS.

Appendix 1

PATIENT LEVEL INFORMATION and COSTING SYSTEMS

Suggested questions for suppliers

A: Technical

a. What is the core database used within the system?

b. At what level is data stored in your system? E.g. at the patient, department, service, date/time of service level?

c. Is open access provided to the resulting databases or only the reporting information?

d. Can you demonstrate the ease at which systems interfaces are created?

e. Are there any limitations in terms of size for data files for integration within the system?

f. How open is your black box? I.e. business intelligence/interface

g. Does your system include quality control reports for analysing incoming data which will improve the time & quality for calculating results? e.g. warning of new codes that will affect the costing process.

h. Are users required to learn a new programming language to make changes to the patient data linkage script or cost model? If so what programming language is this?

i. Will users be required to 'bolt on' an additional query tool, e.g. business objects In order to fully integrate and manipulate the data?

j. If you were provided with a small data set of data that included the information required for costing purpose, i.e. GL set ups, inpatient, ICU, theatre and pharmacy extracts, how long would you require to implement your system using this data?

B: Ability to engage clinicians and obtain clinical ownership

1. Method

What will you bring /do to assist us in obtaining clinical ownership?

Can your system automatically run daily or weekly updates of patient level data in order to support more timely clinical level information?

2. Tracking resources to patients

a. Relevant variables:

- Wards
- Pathology
- Imaging
- Pharmacy Services and Drugs
- Prostheses/Implants
- Therapies
- Critical Care
- Operating Theatres
- Special Procedure Suites
- Other Diagnostics
- Emergency Department
- Outpatients

Explain the ability of your system to accept and report input at the above level and at greater levels of granularity e.g. nurse time/cost within ward by patient by day *******

Can you drill down into this systematically?

b. Explain how you would help us deal with different levels of patient acuity.

c. Explain how you would help us cope with inadequate /non-existent data feeds**.**

d. How easily can users obtain "self designed "reports? *******

i.e. - data can be manipulated by clinicians themselves via the reporting tool
- new report can be written by internal personnel with no specialist IT programmer knowledge
- new report can be written internally but requires personnel with specialist IT programmer knowledge
- new report can only be written with external assistance

e. Is your system capable of reporting both cost and resource consumption on a daily basis. Resource data means, for example, the pathology or imaging test name, drug name, ward name, consultant name or code.

f. Is your system capable or reporting on the individual diagnoses and procedures associated with a patient?

3. Comparability

a. Can your systems produce reports for comparability: ***
   - by PdX / SdX
   - by procedure
   - by types of procedure
   - by patient age or other demographic

Can these reports be also produced by clinicians?

e.g. - surgical time by procedure by clinician comparison
- Rx by consultant by diagnosis

b. What patient level reports have you actually provided to clinicians? ***

C: Costing Standards

a. What /how complex or fixed (e.g. hardwired) are any definitions or algorithms underpinning your costing methodology?

b. Are you able to construct and resolve simultaneous equations in the allocation of costs where departments both distribute charges to and receive charges from another department? If not what do you do?

c. Do you or can you attribute overheads and indirect costs to intermediate products e.g. ward costs, pathology tests before allocation to patients? Do you have the flexibility to then, if required, disintegrate and report these overheads separately by cost bucket in a patient's final cost bill? E.g. ward costs direct + ward costs indirect/overhead

d. Does your system allow users to easily review allocated indirect/overhead amounts by indirect/overhead and patient care area?

e. Is there a limit to the number of cost components, RVU's, weights etc that can be defined as part of the costing process? Are you restricted in what you call them?

f. Can you allocate direct costs to several different cost buckets e.g. nursing to theatre, wards etc. Can this be done directly from individual account codes in the ledger or does information have to be "re-assembled "?

g. How flexible is your system in using differing allocation methodologies for the same expense types within a hospital? e.g. some administration cost may be indirect and some may be overhead. Some nursing may be allocated by patient numbers and some nursing costs by minutes on the ward. I.e. are expense types in the General Ledger (GL) hard wired into cost types.

h Can your system meet the reporting standards as categorised in the Acute Health Clinical Costing Standards, published by the Department of Health?

i. What is your ability to reconcile back to GL?

j. If updating the patient level data more frequently than monthly, can your system use previously calculated costs to estimate the costs of recent patients, or do you need to wait until the GL is closed and then the costing process is carried out again?

k. Is your system able to modify the GL so that it better supports patient costing activities and enables the clinical costing standards to be met? E.g. by offsetting revenue, moving values from one cost centre to another, creating dummy cost centres and account codes.

l. How do you handle Work in Progress?

D: Will your system be able to adequately inform the tariff?

a. Are you able to group patients by HRG?

b. How would you go about providing a feed of the cost of individual patients by cost buckets by HRG?

c. Is your system able to calculate the PbR and non-PbR revenue at spell level?

d. Can your system allocate spell based revenue to FCE level, if so what is your approach?

E: Ease of use

a. How user friendly is your report writer? Is there a need for an external system report writer or specialist IT programmer knowledge?

b. Demonstrate the ease at which knowledge of the system can be transferred and users can become self-sufficient. ***

c. Are the reporting & analysis standards within system suitable for all levels and job specifications within the organisation? (e.g. business analysts, high-level management, clinical consultants). ***

F: Experience

a. How long has your product been on the market?

b. What is the PLICS experience of the staff that you have in England?

c. How many sites have implemented your system and in what countries? If applicable, what extra value can you bring to this hospital as a result of your overseas experience?

d. What demonstrable experience do you have in talking to clinicians and managers and securing engagement to push the envelope in this area?

e. How will you help us access the necessary granular information within our hospital to deliver a successful business solution? Please provide examples of your experience in this. ***

f. How many hospitals have implemented your **full** PLICS system in England? i.e. costing to the patient at a granular level and subsequent reporting. Do not include sites where you have not supplied the costing engine as part of the solution. References of all sites please to allow independent verification by random sample

g. Do you have staff with NHS knowledge?

h. How will you help us ensure the integrity of information? Please provide examples of your experience in this. ***

i. How long you think it will take to properly implement your system? What will be your key steps?

G: Commitment to market/resources/capacity.

a. What resources do you intend to commit to this market?

b. What are the ongoing system support capabilities of your company?

c. What are your ongoing training/knowledge transfer capabilities?

H: General

a. How can we assess your financial stability?

b. How much is your solution likely to cost?

c. Why should we choose you?

*** ***Please demonstrate or provide written examples***

Appendix 2

Example 1: MINIMUM Outputs from a PLICS System

HRG: P13 - Other Gastrointestinal or Metabolic Disorders

Patient ID: C12345
Consultant: Mr Smith
Admission Method: Non Elective
Specialty: Paediatric Surgery

Day	Date	Resource	Resource Item	Units	Total Cost
1	30/04/2007	Diagnosis	Haematemesis		
1	30/04/2007	Diagnosis	Other and unspecified abdominal pain		
1	30/04/2007	OPCS	DUODENUM		
1	30/04/2007	OPCS	FIBREOPT ENDOS EXAM OF UPPER GI TRACT & BIOPSY LESION TRACT		
1	30/04/2007	Biochemistry	Liver Function Tests	1	£7.33
1	30/04/2007	Biochemistry	Urea and Electrolytes	1	£7.33
1	30/04/2007	Haematology	Full Blood Count	1	£2.91
1	30/04/2007	Imaging	Abdominal Xray	1	£46.56
1	30/04/2007	Imaging	Ultrasound Abdominal	1	£116.40
1	30/04/2007	Imaging	Ultrasound Pelvis	1	£116.40
1	30/04/2007	Blood	Group 1	1	£248.57
1	30/04/2007	Blood	Group 2	1	£248.57
1	30/04/2007	Ward	Ward A	720	£104.83
1	30/04/2007	Ward	Trasfer Ward	720	£33.69
1	30/04/2007	Consultant	Dr Smith	1440	£223.58
2	01/05/2007	Biochemistry	Amylase	2	£14.66
2	01/05/2007	Biochemistry	Urea and Electrolytes	1	£7.33
2	01/05/2007	Haematology	Clotting screen	1	£24.96
2	01/05/2007	Haematology	Full Blood Count	1	£2.91
2	01/05/2007	Ward	Ward A	1440	£209.66
2	01/05/2007	Consultant	Dr Smith	1440	£223.58
3	02/05/2007	Ward	Ward A	1440	£209.66
3	02/05/2007	Consultant	Dr Smith	1440	£223.58
4	03/05/2007	Drugs	OMEPRAZOLE 40 mg I/V inj	1	£30.48
4	03/05/2007	Biochemistry	Urea and Electrolytes	1	£7.33
4	03/05/2007	Haematology	Full Blood Count	1	£2.91
4	03/05/2007	Imaging	Abdominal Xray	1	£46.56
4	03/05/2007	Imaging	Pelvic Xray	1	£46.56
4	03/05/2007	Anaesthesia	Theatre 1	37	£175.59
4	03/05/2007	Surgery	Theatre 1	31	£400.18
4	03/05/2007	Histology	Duodenal biopsy	1	£115.11
4	03/05/2007	Histology	Gastric biopsy	3	£339.10
4	03/05/2007	Histology	Oesophageal biopsy	1	£117.78
4	03/05/2007	Blood	Group 1	1	£248.57
4	03/05/2007	Blood	Group 2	1	£248.57
4	03/05/2007	Ward	Ward A	1440	£209.66
4	03/05/2007	Consultant	Dr Smith	1440	£223.58
5	04/05/2007	Drugs	RANITIDINE 150 mg Tablets	1	£22.37
5	04/05/2007	Ward	Ward A	1440	£209.66
5	04/05/2007	Consultant	Dr Smith	1440	£223.58
5	05/05/2007	Biochemistry	C-Reactive protein	1	£7.33
5	05/05/2007	Haematology	Full Blood Count	1	£2.91
5	05/05/2007	Haematology	Ward Collection	1	£13.31
5	05/05/2007	Ward	Ward A	1440	£140.56
5	05/05/2007	Consultant	Dr Smith	1440	£223.58
6	06/05/2007	Haematology	Erythrocyte Sedimentation Rate	1	£4.16
6	06/05/2007	Haematology	Full Blood Count	1	£2.91
6	06/05/2007	Ward	Ward A	1440	£140.56
6	06/05/2007	Consultant	Dr Smith	1440	£223.58
			Total Cost:		**£5,498.98**

Diagnosis and Procedure codes enable clinicians to understand severity.

All PLICS systems must be capable of reporting resources consumed and cost on a day of stay basis. Resources must be identified (eg, 'Pathology' alone is not sufficient - the test must also be identified where the data is available).

Example 2: UNACCEPTABLE Outputs from a PLICS System

HRG: P13 - Other Gastrointestinal or Metabolic Disorders

Patient ID: C12345
Consultant: Mr Smith
Admission Method: Non Elective
Specialty: Paediatric Surgery

Resource	Total Cost
Ward	£1,258.27
Consultant	£1,565.07
Theatre	£575.77
Pathology	£680.29
Imaging	£372.47
Blood	£994.27
Drugs	£52.85
	£5,498.98

While a PLICS system may be able to 'roll up' cost data (see left) for the purposes of reporting against the clinical costing standards cost groups, if this is the extent of the granularity of data provided then this is not considered sufficient from a PLICS system.