The Nursing Specialist Group

The INFOremed Touch Series

Volume 1 - Sharing Information: Key issue for the nursing professions

First published March 1997 - ISSN 0901865 72 9
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EPPIC - A community information systems project in Scotland

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The EPPIC programme's title stands for Effective Purchasing and Providing in the Community. The two key things about the title are the collaboration between the different parties - purchasers and providers, and the emphasis on the word effective. What we are trying to do in Scotland is to focus on the use of information to make things better; to make the purchasing of care better. Context is important. Huge upheavals have been happening with the shift towards developments in primary care and health care teams. There is now a huge range of staff, working for a wide variety of organisations. Sometimes they wear several hats: private agencies, statutory bodies, voluntary bodies. There are only two constants: patient care as the focus of the business and accountability. A lot of the health reforms have blurred accountability. Sometimes there is no accountability. If information has one use it is to ensure accountability.

In Scotland about three years ago we started a project called the Core Community Data Set Project. This was to figure out what the information requirements were, then to work out a simple way to address the long list.

We came up with a simple, feasible way of describing patient care on a computer. To record the smallest amount of information about a patient that would achieve the most by addressing some of the tasks. That project did well. It has been voluntarily taken up by several Trusts in Scotland. The EPPIC Programme also takes it forward.

A purchaser wants to assess the needs of a population for health care, then to contract for the needs to be addressed. Operational managers receive these contracts and want to put in place clinical practice, to give care and so on. What happens at the moment is that these activities are not integrated. The information, the common language which should flow from one to the other is not present, so we have poor information about the community - both north and south of the Border. Therefore what we have decided to do is to use the project to cement together a mandatory core of information. It might resemble a discharge summary, completed for every referral on discharge or at an appropriate time. It would go back from the provider, who ever the provider is, to the general practitioner and the purchaser or Health Board. It will assist the communication process, perhaps by providing a way of recording clinical data, if possible, electronically. We have used words such as 'package', 'aim' and 'patient profile' which the rest of this paper will explain.
The EPPIC Programme hopes to explore the use of information to demonstrate that service improvements can be obtained. It is not oriented towards costing, the provision of central-returns, better management or productivity. If we improve service these other aspects will occur as a by-product. We want a standard and flexible contracting model: everyone doing some things in the same way but with lots of scope for local flexibility. We want to replace the current central returns with something meaningful. There has to be outcome assessment and clinical audit — both ends of the evaluation spectrum. That is very much the corner stone of this project. There will be a common costing methodology from the project and a lot of material to help make that happen.

We have twelve consortia. They represent the focus on each of nine different professions: community nursing, health visiting, community psychiatric nursing and the six main PAM groups (physiotherapy, speech therapy, podiatry, clinical psychology, occupational therapy and dietetics). They are doing all the work. Scotland being a relatively small country they have each set up a network of colleagues across the country. They are just finishing the definitions of the simple information. Over a thousand practitioners have been involved in trying out the information for one day. A huge amount of comment was received. Each consortium is a collaboration between a health board, a health trust and a general practitioner fundholder. This is not an information driven project. The main customers for the work are the management executive and joint working group structure. We are not seen as a computer project but about doing things better.

**Getting the right data**

The two main things to be produced will be the community contract minimum data set, and service profiling. We are doing a lot of work to get the data set right. We owe a huge debt to the CISP Project: the seminal work and inspiration. We have changed some of the words. Instead of talking about 'care packages' we talk about 'care profiles'.

At the heart of the contract minimum data set are the usual things like contract referral and post code. There will also be simple, care descriptions which we call care packages. Each profession is completing these, defining in two or three sentences what the service is trying to achieve. The application criteria define the sort of patients to whom this service would be offered. For example for hospital aftercare it would say exactly how many weeks after discharge from a hospital this service would be received. All nine professions have produced these well defined lists for testing.

There are two aspects to these care descriptions: that of the service, essentially of the aims of the service which line up with CISP, they call it care objectives, we call it care aims. In our view a more appropriate term because this is a broad, highest level statement of intentions. For example, Mrs Smith's aftercare - having been assessed, is the aim to make her completely well - problem resolution? Or is the aim maintenance care - keeping her stable? The exciting thing is that this list with its definitions has been enthusiastically endorsed by all nine professions as being a meaningful adjunct to describing the service or indicating the patients' needs. The care package and care aim are the heart of EPPIC.
Service profiling

We have on the one hand a very simple description in the minimum care data set. We see care profiles as a way of elaborating on the Scotland-wide definitions. The terms and the matrix are clear and will be used in all settings whether trusts or private or voluntary sectors. They can then shine the local spotlight on part of the framework, for example palliative care. We are working on a method and structure to help them flesh-out the kind of expected pattern of service. This is at the heart of the outcomes and quality material we are trying to achieve.

All twelve sites are producing three each. We will produce material to guide staff in how to do it. Once it has been done, perhaps producing a couple a year with the agreement of the purchaser and provider, periodically more detailed data can be collected to monitor that service. A classic audit cycle approach. This is also eminently costable.

There is a lot of sense in having a basic standard. It promotes communication apart from its clinical uses. The data set can help with contracting, monitoring, activity analysis and needs assessment. What we hope to do is produce very simple computer systems on pcs which can be used by the community staff to manage their personal caseloads. The discharge letter can easily be run off. It would be suitable to try out with the Read Terms and codes.