



Frequently Asked Questions

1. [About KIS](#)
2. [Special Note](#)
3. [Anticipatory Care Plan \(ACP\)](#)
4. [Technical](#)
5. [Formats and Printing](#)
6. [User Interface](#)
7. [KIS Consent Model](#)
8. [Patient Information](#)
9. [Access](#)
10. [Audit](#)
11. [Information and Publicity](#)
12. [Future Plans](#)

1. About KIS

1.1 What is a Key Information Summary (KIS)?

The KIS (Key Information Summary) is a summary of medical history and patient wishes which replaces paper based faxing of patient information between GP Practices and Out of Hours (OOH), and is a more generic version of the electronic Palliative Care Summary (ePCS). It is a replacement for the “special notes” sent to OOH and for Anticipatory Care forms for Patients with Long Term Conditions. It shares fields with ePCS and includes other information as required. The KIS form is pre-populated from the GP system as much as possible: KIS messages automatically include Emergency Care Summary (ECS) information (demographics, medications and adverse reactions).

KIS utilises the existing ECS infrastructure to send messages from practices to the ECS store.

1.2 How is a KIS created?

KIS is created from within the GP clinical system (e.g. EMIS or Vision). It is not a stand-alone system.

1.3 What are the benefits of KIS?

KIS can provide support for patients with:

- Anticipatory Care Plans (ACP)
- Long-Term Conditions (LTC)

- Mental Health Issues
- Complex Medical Issues

There are many potential benefits, including:

- Reduction of errors in the transcription of data from paper-based records, as all patient data is automatically downloaded from GP Practices to the Emergency Care Summary (ECS).
- Reduction of the risk that inappropriate care is given by displaying patient information on one easy-to-access user interface.
- The KIS is patient-centred: the patient and/or the patient's carer can be involved in the creation of the KIS.
- The KIS information is available quickly for OOH and Emergency users.
- The KIS contains up-to-date patient information, which saves time for clinicians, as they will not have to phone GP Practices to obtain critical information.

1.4 Who might benefit from having a KIS?

- Persons with long term conditions, in particular if they take multiple medications and attend multiple specialist clinics
- Persons who are likely to need care at the weekend or out of hours
- Persons who may find it difficult to give details in an emergency (for example, people who have communication or memory problems, mental health issues or learning disabilities)

2. Special Note

2.1 What is a "Special Note", or "Special Patient Note"?

The "Special Note" or "Special Patient Note" on the KIS form refers to a message that the clinician can add in order to send important patient information for OOH. This is a free text field on the KIS form.

Existing "Special Notes" are held by NHS 24 and OOH hubs as part of their patient record. A dual system will remain in place to maintain the current process for sharing information between OOH hubs and NHS 24. Existing "Special Notes" will not automatically be transferred, and a process is being developed to support migration. Special Notes will be used in conjunction with KIS until the new system is fully functioning. In future, KIS will replace the current method of sending "Special Patient Notes".

It is possible for a patient to have a KIS containing only a "Special Note" and nothing else, and it is not expected that any one patient will have all fields on the KIS form completed.

2.2 What are the rules for the expiry of the "Special Note"?

Any message that has passed its "date expired" will not be shown to end users of ECS. A 24-hour "grace period" after expiry was agreed during the development of KIS.

2.3 How will I know when a patient KIS has expired and the information needs to be updated?

As part of the creation of a KIS record, the user will be asked to enter an expiry date for the record. EMIS and Vision have developed appropriate alerts and reminders for the GP Practice, to ensure that information is kept up to date. More detailed information is available from EMIS and Vision as part of the training material delivered for KIS.

2.4 If no information has been recorded in a "special note" field, will these fields be sent to the ECS system?

No. If there is no information recorded, the "Special Note" field is not part of the KIS extract to ECS.

2.5 Which date will be attached to the patient's special notes?/What does the date next to each special note refer to?

The date attached to any special notes on the KIS form will always refer to the date that the information was recorded.

2.6 Does every field of the KIS form need to be populated?

No. On the KIS "form", GP Practices must complete the boxes titled "KIS upload decision", "Patient aware?" and "Patient consented?" as well as the date/time of expiry if sending a "Special Note", but all other information can be used as required. Some patients will only need the free text box, which can be used for anything from a short message for OOH "for the weekend" or a longer and more enduring message for a longstanding problem.

On the KIS form, all sections will default to blank, unless completed by the GP system user.

Please note that every item completed will be date recorded.

3. Anticipatory Care Plan (ACP)

3.1 What "makes" a KIS an ACP?

Clinically: Starting off by opening a KIS and sending on only the pre-populated data is a good beginning, and then a full ACP can be developed over time by adding an advance care planning element. Much of this is covered by filling in the drop downs where appropriate, but the user is advised to also click on the "patient has ACP" box and add any additional information there that is not covered anywhere else on the form. This action then adds the ACP code to the patient record, allowing specific searches for ACPs and generating patient lists to discuss at meetings.

Contractually: For the purposes of contract year 2013/14, payment will simply be based on the total number of KISes sent (which in fact includes special notes, ACPs and Palliative Care Summaries) rather than those that specifically have this code in the notes. A practice can see what their total number of KISes is by clicking on the report tab and looking at the number of KISes with a "decision to send". For contract year 2014/15, payment may be more specifically linked to the ACP code, so it is worth getting into the habit of ticking the ACP box.

3.2 What information should be included in the ACP box?

The ACP box should be used for information that is not asked for anywhere else on the KIS template and that is specific to the KIS user's unique knowledge of the patient and the patient's circumstances. The ACP box is often the most useful part of the KIS for other clinicians who see patients in the emergency setting, but who do not know the patient. Useful things to include are baseline functional status, when and how to escalate treatment, how far treatment should go, any patient-specific wishes, etc. Many of the discussions with clinicians in secondary care around ACPs have reinforced the fact that GP knowledge of the patient is highly valued, with its potential to be more contextual and holistic.

3.3 What information goes into the ACP box and what information goes into the special notes box?

This is a clinical judgement, as the KIS is designed to be generic, but a suggestion would be:

In the ACP box:

This is useful for **long-term** clinical information and can be viewed by clinicians. Include information such as that outlined in Question 3.2.

In the special notes box:

There is both **short- and long-term** information that is useful to consider for this box, which can be viewed by ALL users including call handlers in NHS 24:

Short term – set expiry date

Examples:

- worsening statements for cellulitis
- trial without catheter – patient will contact OOH if unable to PU
- worsening statement for treated infective exacerbation of COPD
- when the expiry date has passed, the information will no longer appear in the KIS, but a record will remain in the GP record.

Long term – choose expiry date “never expires” (the default setting)

Examples:

- Safety issues – e.g. patient has a history of violence towards healthcare staff; should be seen in 2s
- Communication issues – e.g. patient requires an interpreter, patient is hard of hearing, etc.
- An alert that a patient has additional information that requires to be considered before making a triage decision – e.g. patient has exceptional care needs – please see ACP through KIS.

4. Technical

4.1 How are ECS and KIS interlinked?

All of the information on the Emergency Care Summary (ECS) is included in the KIS. KIS is an extension of ECS and is available to all ECS users.

4.2 Is the KIS an enhancement of the current ECS?

The KIS builds on patient information already contained within the patient's ECS. In addition to the basic medication, demographic and adverse reaction information on ECS, the KIS holds the following information:

- Medical History (High-priority read codes are automatically included)
- Diagnoses
- Patient Wishes
- Special Alert Messages
- Future Care Plans
- Resuscitation Status
- Emergency Contacts and Next of Kin Details
- Legal Information such as Power of Attorney
- Preferred Place of Care

4.3 Is any of the data in ePCS (electronic Palliative Care Summary) shared with the data in KIS?

All ePCS-specific fields can be entered using KIS screens on the GP system:

For example:

- Awareness of Diagnosis
- Awareness of Prognosis
- Chemotherapy*
- Radiotherapy*

* Please note that chemotherapy and radiotherapy have been added to the KIS screens in EMIS in Release E 2013.

Some data is shared between ePCS and KIS:

- Patient Alerts
- Patient Medical History
- Patient Wishes
- Patient Resuscitation Requirements
- Preferred Place of Care
- Special Note

4.4 Under what circumstances would a KIS be created?

A KIS will only be created with specific patient consent. The patient and her/his GP will discuss patient needs and instructions for future care. If the patient wishes it, a carer, guardian or relative can be present to discuss these topics with the GP.

4.5 Can a GP create a KIS if the patient is not present?

Ideally, the GP or Nurse will have discussed with a patient beforehand, but if this is difficult

(e.g. if a home visit had to be carried out just to get consent) then the clinician can make a clinical decision to upload the KIS record and record “no consent” and “vulnerable adult” and also “patient unaware”. Retrospective consent can be added when the GP next sees the patient.

This would normally only be used in exceptional circumstances; for example, if a patient is discharged from hospital on a Friday night and is particularly vulnerable. The normal process of asking for consent from the patient should be used wherever possible.

(This links to Question 7.10.)

4.6 Where does the KIS go and how often?

Every GP Practice will send updates to the ECS store several times a day, and the frequency of these updates will vary from practice to practice.

The KIS data that is entered into Vision or EMIS is exported automatically from the GP clinical system once a KIS has been activated in a patient record. Users can look at the patient's KIS record to see if it has been updated through the reports on the KIS screen or by logging into ECS.

4.7 What will trigger an update to the KIS patient record?

Once an initial KIS has been created with consent from the patient, any update to the following fields/categories/statuses will result in an update being sent:

- Demographics, allergies or prescriptions
- Update to patient registration status, e.g. “deducted”
- Any change of registered GP for a patient
- Change of a patient's consent to “withheld”
- Change of a patient's consent to “consent given”. This update should contain the full patient details (e.g. demographics, consent, deducted status, registration status, GP details, practice details, allergies and medication).
- A repeat prescription should only have one entry within a patient update. The “medication start date” should indicate the first date of prescription, and the “prescription date” should indicate the most recent date of the repeat prescription.
- Changes to the KIS information added through the KIS screens on GP Practice systems

4.8 Under what circumstances will patient information not be sent to ECS?

- No updates to patient details will be sent to ECS while the patient's consent is set to "withheld" in the initial practice upload.
- No test patients should be sent to ECS, and practices need to ensure that test patients do not have a valid CHI number; otherwise this could overwrite a genuine patient.
- If a patient has opted out of ECS, no KIS data can be sent unless the clinician decides to override patient consent. (See Question 7.3 for further information.)

4.9 What kind of prescription information from KIS will be sent to ECS?

- All acute prescriptions issued in the last 6 months will be sent to ECS.
- All active repeat prescriptions will be sent to ECS.

4.10 Who manages the upload of patient data?

The GP Practice has the ability to perform a full reload of patient data.

4.11 How do I know if the KIS information has been sent?

EMIS and Vision have developed notifications and alerts for users to indicate when KIS information has, or has not, been extracted to ECS. This information will be clearly shown to GP Practice users for each patient where a KIS record has been created.

4.12 Are there plans to expand the KIS dataset?

No.

5. Formats and Printing

5.1 Can a KIS be printed off?

Yes. The patient can ask their GP for a printed copy. The print-out only shows fields that have been completed. The system does not allow placeholders (fields where there is no information) to be printed. It is also expected that ECS will be printed off by hospital pharmacists as part of the medicines reconciliation process. It is possible for KIS to be printed for any users that don't have access to ECS, but the aim is for users to have secure access through their own systems.

5.2 Can a KIS be converted into a different format?

KIS is accessible via Web Services and can be reused as desired, depending on the user's system. For example, the medication section can be used to start off an electronic discharge letter in the clinical portal.

5.3 Can GP Practices charge for printing the KIS for patients?

No. Providing a print-out of the patient's KIS is free of charge.

6. User Interface

6.1 What does the KIS User Interface look like?

This depends on how you access ECS (e.g. Clinical Portal, NHS 24, Web). The KIS is viewable in an easy-to-access user screen, possibly with sub tabs, depending on the system used.

6.2 Is there a visual representation of the KIS User Interface?

There is a visual representation of the KIS User Interface in Excel format. This document is called "2013-12-04 KIS Form v20.xls", which shows the data fields that make up the KIS, with descriptions in the various fields. Character limitations and "free text" fields are specified on the document as well. The document can be accessed on the KIS webpage at the below link (N3 only):

<http://www.ecs.scot.nhs.uk/wp-content/uploads/2013-12-04-KIS-Form-v201.xls>

6.3 How can I update KIS if I am not able to access the GP Practice System?

NHS Lothian have developed a form that allows district nurses or other community staff to update a KIS without having access to the GP Practice system. The document can be accessed on the KIS webpage at the below link (N3 only):

[ACP-Final](#)

7. KIS Consent Model

7.1 What is the consent model for KIS?

Explicit patient consent is required for patient information to be entered onto the KIS form. There are exceptions to this. Please see 7.2, below.

7.2 If the patient is not able to give consent, where can I find further guidance?

If patients cannot give consent (e.g. the patient lacks capacity, is too ill or confused, or has an adults with incapacity form completed), clinicians can make a clinical decision to create a KIS on behalf of the patient. If the patient is a potentially violent patient, etc., further guidance is available at:

http://www.scimp.scot.nhs.uk/wp-content/uploads/documents/use_of_violent_warning_markers.pdf

7.3 When can patient consent be overridden?

It is possible to override this consent only under special circumstances, which are described in the Data Protection Act. These are:

- If the patient is a vulnerable adult
- If the patient is a vulnerable child
- If the threat of danger to a patient exists

- If the patient poses a threat to others

In these circumstances, the clinician or NHS staff member MUST annotate on the KIS why consent has been overridden. Clinical staff must be able to view the free text comments for a consent record to explain why consent has been overridden.

7.4 What are the options for patient consent for KIS?

There are five possible consent statuses for each patient:

- KIS Consent
- KIS Consent declined
- KIS Consent overridden – patient aware
- KIS Consent overridden – patient unaware
- KIS Consent status unknown

Read codes are available to record these consent status values in case a patient moves to another practice.

The default option will be “KIS Consent Status Unknown”.

7.5 What are the consent rules with regard to KIS and ECS? Can you give examples of possible scenarios?

- If ECS consent has been declined (patient opt-out) and the KIS Consent status is “KIS Consent given”, it is not possible for the KIS to be sent.
- If ECS Consent has been declined (patient opt-out) and the KIS Consent status is “overridden”, it is possible to send the KIS, but only the “KIS Special Note” and no other ECS or KIS information.
- If ECS Consent is “yes” and KIS Consent is “overridden” and the KIS send value is “send”, then all the KIS information can be sent.
- If ECS Consent is “yes” and KIS Consent is “yes” and the KIS Send value is “send”, then all the KIS information can be sent.

7.6 Under what circumstances would a patient record not be sent to ECS?

If a patient has opted out.

7.7 Are there portions of the KIS form that can be exported/downloaded without ECS consent?

Yes. The “special note” can be exported without ECS patient consent if the clinician decides to override consent.

7.8 How/when should a member of NHS staff obtain consent from a patient?

A Clinical Decision or explicit consent is required to send information to KIS from the GP Practice. Further patient consent is not required to view the KIS record, but users

may still wish to check with the patient out of courtesy.

7.9 Is explicit consent from a patient carer required for his/her contact information to be shared on a KIS?

Explicit carer consent such as a signed consent form is not required; however, as a courtesy, it is recommended that carers be notified when their contact information is entered on a KIS. The standard procedure is that a carer's details will come from the GP Practice system and the practice should have its own procedures for ensuring that any carers' details are added with the agreement of the carers themselves.

7.10 Can a GP create a KIS if the patient is not present?

Ideally, the GP or Nurse will have discussed with a patient beforehand but if this is difficult (e.g. if a home visit had to be carried out just to get consent) then the clinician can make a clinical decision to upload the KIS record and record "no consent" and "vulnerable adult" and also "patient unaware". Retrospective consent can be added when the GP next sees the patient.

This would normally only be used in exceptional circumstances; for example, if a patient is discharged from hospital on a Friday night and is particularly vulnerable. The normal process of asking for consent from the patient should be used wherever possible.

(This links to Question 4.5.)

8. Patient Information

8.1 How does a patient obtain a KIS?

A GP can create a KIS for the patient if required. It is the responsibility of the GP to explain to the patient how the KIS works, how it will be updated, and who will have access to it. If the patient is happy for their information to be shared with other NHS staff and gives consent, the GP can then set up the KIS for the patient. A Patient Leaflet, Patient FAQ's and Patient Poster about KIS are available for practices.

(See Question 8.6 for further information.)

8.2 Can a patient decide not to have a KIS?

Yes. The KIS is optional. The decision to have a KIS should be made in partnership between the patient and their GP, or the patient's carer and GP, if appropriate.

8.3 How does a patient opt out?

This doesn't apply in terms of KIS because the KIS is optional to begin with. However, if a patient KIS has been created and the patient later wishes to opt out, they can ask their GP Practice to delete their KIS record.

8.4 Will a patient's ex-directory telephone number be included on their KIS form?

Yes. If the telephone number is included in the Practice Computer Systems record then it will be transmitted with the rest of the ECS data.

8.5 Will all of Scotland's territorial Health Board area patients be

offered a KIS?

Yes. All patients throughout Scotland, where appropriate to do so, will be offered a KIS by 2014.

As part of the GP contract, which was initiated on 1 April 2013, GP Practices are now able to complete ACPs (Anticipatory Care Plans) and KIS information for high-risk patients.

(See Section 3 for further information on ACPs.)

8.6 Where can patients find out more information about KIS?

A Patient Leaflet, Patient FAQ's and Patient Poster about KIS are available for practices to use and print out for their patients at the below links:

NHS 24: <http://www.nhs24.com/Explained/MyInfoNHS24/WhatisKIS>

In addition, the Patient Leaflet is available in Mandarin Chinese, Polish, Scottish Gaelic, Easy Read and British Sign Language formats at the below link on the SNUG site. All of this content (except Easy Read) is also available at the above NHS 24 link.

Scottish National Users' Group (SNUG):
<http://www.snughealth.org.uk/members/areas-of-interest-for-vision-and-emis-users/key-information-summary/>

A video of the Patient Leaflet in British Sign Language is also available at the below link:

<http://www.commtacs.co.uk/nhs24/kis/draftclip.html>

For persons with learning impairments, the Easy Read version of the Patient Leaflet will soon be available on the NHS inform Easy Info Zone here:

<http://nhsinform.co.uk/Easy-Info>

9. Access

9.1 How is KIS accessed?

Because KIS is part of ECS, all users who have access to ECS also have access to KIS.

Currently, this means clinicians in:

- Accident and Emergency departments
- Out Of Hours Organisations
- NHS 24
- Scottish Ambulance Service
- Acute Receiving Units
- Hospices
- Hospital Pharmacies
- Mental Health Units

- Other approved Scheduled Care Departments.

ECS is being piloted in emergency dental units.

Practices can access their own patient ECS records directly with their password. NHS 24 clinicians can access an ECS record directly through their system if they have a call from a patient and a direct match with the patient's CHI number. NHS 24 Call Handlers do not have access to any clinical information held on ECS.

OOH clinicians can access an ECS record directly through their OOH system Adastra. Hospital clinicians who see patients in unscheduled situations can access ECS records via the web browser with a password allocated by IT.

ECS and KIS information will be available through the national Clinical Portals in the near future.

9.2 In which situations would KIS be accessed?

As with ECS and ePCS, the KIS would be accessed and used in emergency situations or if a patient required OOH care when their GP Practice is closed.

9.3 Can practices check to see if a patient's KIS has been accessed?

Yes. The ECS access report lists accesses to KIS in the same way that ePCS accesses are listed.

9.4 Can an OOH Clinician or A&E staff update patient details if necessary?

No. Changes can only be made by the GP Practices, and any requests for changes to the patient record need to be notified to the practice.

10. Audit

10.1 What audit controls are in place?

KIS has the same audit controls in place as ECS, described here:

The ECS Store keeps a record of who logged on, and what was viewed.

- Health Boards must run reports of accesses and provide reports to NSS on a monthly basis.
- Collated reports are checked by the Caldicott Guardian for NSS.
- GP Practices can look at reports whenever they wish.
- GP Practices can see the record of what was viewed.
- All organisations viewing ECS records are required to run audit reports regularly, e.g. OOH and NHS 24.

All of these reports detail individual access with name, date and user role.

Practices and Health Boards are able to run reports on ECS at any time.

FairWarning® is an electronic privacy auditing solution that helps detect potentially unauthorised access to electronic health records by simplifying the analysis of audit files from clinical systems, including ECS. Unusual or suspicious activity can be highlighted for further investigation. FairWarning® is already used in several Health Boards across Scotland and will be rolled out across all Boards as part of a national Information Assurance Strategy. Investment in this system confirms the level of importance NHSScotland places on the management and security of sensitive personal information.

10.2 What constitutes an inappropriate access and what steps will be taken?

Access to ECS or KIS records is only appropriate when necessary as part of an individual's job function. A fundamental safeguard is the fact that confidentiality is a professional and/or contractual obligation on all NHSScotland staff and they should be fully aware of their obligations. The use of privacy auditing solutions such as FairWarning® further reduces risk by influencing behaviour and organisational culture. All Health Boards have procedures in place to deal with any breaches of IT Security Policy or professional codes of conduct. A range of disciplinary measures are available at the discretion of each Health Board.

10.3 How much of an administrative burden does KIS audit cause for practices?

Practices can look at audits whenever they wish, but there is no compulsion to do so.

11. Information and Publicity

11.1 How are patients being informed about KIS?

A Patient Leaflet, Patient FAQ's and Patient Poster about KIS are available for practices to use and print out for their patients at the below links:

NHS 24: <http://www.nhs24.com/Explained/MyInfoNHS24/WhatisKIS>

Scottish National Users' Group (SNUG):
<http://www.snughealth.org.uk/members/areas-of-interest-for-vision-and-emis-users/key-information-summary/>

Please see Question 8.6 for information on the availability of alternative formats of the Patient Leaflet.

11.2 Where can I get further information about KIS?

If you have an N3 connection, further information can be viewed at:
<http://www.ecs.scot.nhs.uk/kis>

Information about KIS is available at the below links:

Scottish National Users' Group (SNUG):
<http://www.snughealth.org.uk/members/areas-of-interest-for-vision-and-emis-users/key-information-summary/>

Scottish Clinical Information Management in Practice (SCIMP) site:

<http://www.scimp.scot.nhs.uk/better-information/care-summaries/kis>

ALLIANCE Health and Social Care site:

<http://www.alliance-scotland.org.uk/news-and-events/news/2013/10/new-electronic-health-record-rolls-out-across-scotland/>

In addition, KIS has been publicised via various other NHS and Patient websites, newsletters, as well as at various health care related events.

12. Future Plans

12.1 How will change requests to KIS be managed in the future?

Any requests for changes or queries about KIS will be managed by NSS IT Service Management. The contact is Andy McCleary at:
NSS.NISGServiceManagement@nhs.net.