Frequently Asked Questions

About ECS

Q1   What is an Emergency Care Summary (ECS)?

A   *The Emergency Care Summary is a copy of data from Practice Computer Systems. The extract consists of the following data:*

- *Patient demographics (CHI number, Forename, Surname, Previous Surname, Address & Post Code, Telephone Number(s), Date of Birth, Sex, Current GP Practice, Seen by GP)*
- *Allergies and adverse reactions*
- *Medication (drug name, dose, qty, date prescribed)*
  - *acute prescriptions from the last 30 days*
  - *current repeat prescriptions (drug name, dose, qty, date prescribed) in the last 12 months*
- *Consent status*
- *Registration status*
- *Deducted field indicating that the patient is no longer registered at the practice (if applicable)*

Q2   What is the purpose of the ECS Summary?

A   *The ECS summary is for patients who need care out of hours or emergency care, especially if they are too ill or unable to remember details about their current prescriptions, allergies and adverse reactions. This will provide clinical staff with important information to manage care safely.*

Q3   Where does the ECS Summary go and how often?

A   *The ECS extracts from Practice Computer Systems are sent to a central data store. Transmissions are sent automatically twice a day from practices. The ECS store is compliant with NHS Scotland security standards.*

Q4   Who will manage user accounts?

A   *Health board IT administrators will manage user names and accounts for hospital based clinicians. Administrators for each Health Board area will also give a password to Practice Managers to enable them to view a report of their practices' patients who have had their ECS data looked at.*

Q5   Clarification of Who can access ECS records (updated in Jan 2010)

A   *ECS is currently available to all clinicians working in Out of Hours (OOH) centres, NHS 24, Scottish Ambulance Service Paramedics, A and E departments and Acute Receiving Units who take unscheduled admissions, provided the patient has given their consent. This includes pharmacists who see patients as part of the unscheduled admission process.*
It is assumed that ECS will be accessed by clinicians dealing with unscheduled admissions at the point of entry to hospital, and that this information will be printed or recorded in the case notes, so that it is also available for other clinicians who will manage the patient during that episode of care. This does not mean that hospital based clinical staff working outside A&E or Assessment Units should not have access to ECS.
Access to ECS has been approved for clinicians dealing with unscheduled care patients, irrespective of the hospital location these patients are admitted to.

Q6   How are the ECS Store and the ECS Summary accessed?

A   *Practices can access their own patient ECS records directly with their password. NHS24 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. NHS24 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, either Adastra or Taycare. Hospital clinicians who see patients in unscheduled situations can access ECS records via the web browser with a password allocated by IT. A&E departments who have the latest version of EDIS can access ECS records for each patient directly through the A&E system.

Longer term it is likely that ECS access will be available through the national Clinical Portal, although it should be noted that the consent model for access will not be changed.

Q7   Can ECS be printed off?

A   *Yes. ECS can be printed off by the practice to give to the patient if they request it.*

ECS can be printed off in hospital or OOH and added to the patient's case notes if required.

Patient Information

Q1   Can a patient opt out?

A   *Yes, a patient has the right at any time to opt out of ECS.*

Q2   How does a patient opt out?

A   *The patient must inform the practice if they wish to opt out. From the moment a flag is set against the patient's computer record, clinical data will be removed from the ECS store and a message will be displayed stating that "patient consent has been withheld". This applies to ALL data, including historic data. GPASS practices have a separate programme installed on the desktop which will allow them to select patients who wish to opt out. Other systems have check boxes to allow patients to be opted in or out easily, for further details please refer the Practice Manager Manual for ECS.*

Q3   Will a patient's ex-directory telephone number be included on their summary?

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

Q4   Who is the data controller?

A   *The data controller for the information leaving the practice is the GP practice. The data controller for the ECS store is the Chief Executive of NSS.*

Q5   Will all of our Health Board area patients be included?

A   *99.5% of practices in Scotland have now been connected to ECS. Over 99% of patients have a record on ECS store.*

Q6 **Can practices check to see if a patient's ECS record has been accessed?**

A   Yes. A practice administrator with a password can log on to the ECS store and see the records that have been accessed for their own practice patients. They will be able to check this against the normal fax or clinical email sent by OOH to practices.

Q7 **Are there plans to expand the ECS dataset?**

A   Yes. The next stage for ECS is to include a Palliative Care Summary (known as ePCS) as part of the Gold Standards Framework provided by the MacMillan Cancer Care Nurses network. The additional summary will only be available with explicit consent from patients. Further information on ePCS is available from the ECS website at: www.ecs.scot.nhs.uk/epcs

Any extension to the ECS dataset will not be considered without further consultations. Depending on the results of such consultations, the ECS summary may include additional information in the future. A sharable summary or "special notes summary" is currently being discussed. If agreed, this "shared summary" would go from the practice only with explicit consent from patients.

Q8 **How will OOH and hospital clinicians know about drugs administered by CPNs to Mental Health patients?**

A   If the information is not in Practice Computer Systems, then it will not be in the ECS summary. Clinicians may decide to enter "drugs prescribed elsewhere" onto the practice computer system so that this information will appear on the ECS and trigger potential alerts and decision support tools. Detailed information on how to do this for each of the clinical systems is available on the ECS website.

Q9 **How many "Acute" prescriptions will be visible?**

A   All acute prescriptions prescribed in the last 30 days will be visible on ECS.

Q10 **Can an OOH Clinician update patient details?**

A   No – Patient information can only be viewed.

User information

Q1 **Can I choose my own username?**

A   No – username will be system generated.

Q2 **How often do users have to change their password?**

A   Every 60 days.

Q3 **As a hospital clinician can I change my own password?**

A   Yes – passwords are initially set when each user account is created and must be altered by the user when they log in for the first time and when their password expires (after 60 days). Passwords can also be changed to suit the user's individual needs. Note that when a password is changed, previous passwords cannot be re-used.

A&E clinicians using EDIS will no longer need a separate username and password to access ECS as the EDIS system allows access to be made to ECS as part of the A&E patient process.

Q4   What audit controls are in place?

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

- Health Boards must run monthly 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 of these reports will detail individual access with name and date and user role.

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

Q5   What constitutes an inappropriate access and what steps will be taken?

A   If a patient's record has been accessed without contact to the OOH service or review at admission to hospital, the Health Board will be notified. This will then be dealt with in line with normal disciplinary procedures in the Health Board concerned.

Q6   How much of an administrative burden will ECS audit cause for practices?

A   Automatic daily updates are made from the Practices to ECS. It takes only a few seconds to opt a patient out of the system. The web based audit facility takes seconds to launch, log in and browse. It is an opportunity for practices to see which patients from their practice have had their ECS summary viewed by OOH staff.

Information and Publicity

Q1   What evaluation of ECS has taken place?

A   An evaluation of the pilot sites has taken place in 2006 and is available to view at www.show.scot.nhs.uk/gmsimt/
Further evaluations have been carried out and are on both the ECS website and the SCIMP website at http://www.scimp.scot.nhs.uk/clinical_ecs.html.

Q2   How are patients being informed?

A   When the National rollout was completed in September 2006, a publicity campaign took place, including press releases and a leaflet sent to each household. A copy of this leaflet can be downloaded from http://www.ecs.scot.nhs.uk/GP/training_information.html
 In addition, local campaigns were organised by Health Boards, and patient leaflets and posters distributed to practices. Practices have been sent several newsletters detailing progress, and encouraged to publicise the project to their own patients.

Q3   How can practices print out a copy of a patient's ECS?

A   Practice Managers or Administrators can apply to their Health Board IT dept to get a password to log onto ECS. They can print out an exact copy of the ECS for any patient registered with them.

Q4   Can practices charge for printing the ECS summary for patients?

A   *No. Providing a print out of the patient's ECS summary is free of charge.*

electronic Palliative Care Summary

Q1   What is in the electronic Palliative Care Summary (ePCS)?

A   *ePCS contains detailed information on patients' wishes, past medical history, current diagnosis and DNACPR status.*

Q2   Is the consent model the same as for ECS?

A   *Patients should be asked for their permission to create and send an ePCS. The information for ePCS will only leave the practice once the "consent to send" button has been activated on the practice system.*

Q3   Where is the ePCS form?

A   *It is part of the GP clinical system.*
      On GPASS there is a small square icon on the left of the PALM screen which is clicked.
      On EMIS, select Option 9 when viewing the patient's medical record.
      On INPS, select the Palliative Care Guideline.

Q4   I have completed the ePCS form but nothing appears on ECS.

A   *The review date must be set before any information leaves the practice. Remember to press the save button at the top L hand side of the first screen, and tick the consent button. The ECS record will be updated within the next 24 hours and can be checked by the practice as described above.*

Q5   I have lost the ePCS icon. How do I find it?

A   *Please see instructions in the document called "LOST ePCS ICON.doc". (Please note this is for GPASS users only.) The guidance document can be found on the ePCS webpage at the below link:*

      http://www.ecs.scot.nhs.uk/index.php/epcs-palliative-care

Q6   How easy is it to produce a report on ePCS?

A   *It is very simple: all of the systems have a report which can either be viewed on screen or printed out.*
      On GPASS you need to click on the palm light bulb which takes you straight into the palliative care page. At the foot of the page you click on "reports" which will give a list of all palliative patients who have a review date which has expired.
      On EMIS, select "R" for reports when in the palliative care demographics screen.
      On INPS, go to the Reporting Section of Vision and select "Palliative Care Reports".

Q7   Can District Nurses access ePCS data from the central store and how would they do this?

A   *There are two ways Out Of Hours (OOH) District Nurses can access ePCS. If they have an ECS logon and password, they can access ePCS via any NHS connected PC. Alternatively, if they have access to Adastra or Taycare, the two Out Of Hours systems, they can view ePCS there either directly or via GPs working with them.*

Q8   Can District Nurses add data to a patient's ePCS record?

A   *Community nurses can add information via the GP system if they have direct access. Most OOH services have processes for OOH staff to communicate OOH patient contacts to GPs and District Nurses.*
These communication processes could include relevant information with a request to the practice to "please add this data to ePCS". This may act as a prompt or reminder to practices, and practices could consider having a process to add ePCS information from the OOH record.

Q9   Why do the ePCS printout "free text details" disappear off the page?

A   *Turn the printer onto "landscape" and it will all appear.*

Q10   Are audit trails of the different updates of ePCS kept on the system?

A   *Yes, all changes will be recorded in the system. Every item in the ePCS form is attached to a Read code which then appears on the patient summary as a '"low priority". This way, each entry is dated and is very easy to follow but is presented as a list. If practices wish to keep each version of the complete form, they would need to print it off and scan it, or save it electronically and then file it into DOCMAN.*

Q11   Will the information on ePCS fulfil the requirements for the palliative care DES?

A   *Currently, the requirements for the palliative care DES are recorded on a separate spreadsheet but consideration is being given for this to be linked directly to the ePCS in the future.*

Q12   What do I do if my patient is a temporary resident and does not have a CHI number?

A   *Continue to use palliative care paper form and fax/email the patient's palliative care summary to OOH.*