Edinburgh **Health and Social Care** Partnership

Managing KISs in General Practice

We all know that person centred care and involving the individual in decisions about their care is important. Future care planning allows us to do this better. Recording these plans in a Key Information Summary (KIS) allows everyone to see it. The challenge is trying to do this in the most effective manner.

Consent

The sharing of a KIS requires specific consent, although this had been waived for at risk groups during the Coronavirus pandemic. Where the person lacks capacity consent can be given by parents and Powers of Attorney and should be discussed with significant others if they do not exist. Consent can also be over-ridden if the clinician feels it is appropriate, for example, where there is a history of violence to health and social care workers.

Some practices obtain consent on registration. However, this creates other challenges as discussed below.

Creating a KIS

Sometimes this is done because of a new diagnosis, such as palliative care, or a move to a care home. At other times it is created because the clinician realises it would be helpful. Sometimes searches for frailty can prompt the creation of a KIS.

This can be done by anyone in general practice. When admin staff are confident that consent has been obtained they are able to create a new KIS. They are also able to edit existing KISs. For further support we have produced two guidance for GP practice teams on how to create new or update existing KISs:

- EMIS: GP User Guide on Uploading and Sharing Key Information Summaries
- VISION: GP User Guide on Uploading and Sharing Key Information Summaries

Gathering information for a KIS

Conversations during clinical contact in primary care are not the only source of information for a KIS. Discharge letters have a section at the end for updates to future care plans. Emails might arrive in the clinical inbox from community-based teams or other organisations, such as those supporting carers. Those practices that have clinical admin staff can empower them to add this information to the KIS special notes prior to getting the clinical staff to review the KIS. For information arriving by email this can be cut and pasted in many instances.

Some branches of secondary care are increasingly sharing information in discharge or clinic letters that could be valuable for the person's KIS. Clinical admin teams should be alert to this and usually send the letter to the GP with this highlighted for action.

Other professionals that have access to the clinical system, such as district nurses should be encouraged to add information directly into the KIS rather than sending this to the practice admin teams to process.

We encourage all of this information to go into the KIS special notes.

What to write in a KIS

You can find more information on what to write in a KIS by reading further guidance in What Constitutes a High Quality KIS

Reviewing a KIS

All practices should have a system to ensure KISs are up to date. Reviews should be triggered by new events, such as major diagnoses, discharge from hospital, annual review by their specialist team etc. However, it is important to have an additional system to prompt reviews as well.

Many use the KIS review date to trigger a review, and admin teams run searches to identify overdue KIS reviews. Do not use the Special Notes review date for this process. Once that date is passed the special notes disappear. Using the KIS review date is impractical for those practices that consent all patients at registration as the numbers are too large. One alternative is to search for just those patients with an overdue review date that have special notes or are coded as having a future care plan.

Using the KIS

Some practices have developed contact sheets or summary documents that include the KIS which can be used for home visits or prior to transfer to another practice. KIS information from one practice is not otherwise visible to their new practice.

Using the KIS as the document that is reviewed at palliative care meetings, dementia reviews, mental health reviews, etc will keep it a live document.

Having a printed copy of the KIS available to care home staff will enable them to ensure treatment of their residents is guided by their KIS.

This resource was produced by Dr Andrew Mackay, GP Advisor on future care planning, on behalf of the Long Term Conditions Programme, Edinburgh Health and Social Care Partnership.

For more information and advice

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