Best Practice Statement for Key Information summary (KIS) from the Scottish Government

Background

Over the last decade the importance of sharing information effectively across our healthcare system has been recognised as one of the most essential yet one of the most challenging objectives to achieve.

The Key Information summary (KIS) was launched in 2013. Since then it has become widely recognised a tool with potential to share important information securely but widely across the system. KIS has been increasingly shown to have a strong link with good anticipatory care planning and palliative care and support delivering better outcomes for individuals.

KIS is acknowledged in being of benefit for:

- individual practitioners planning care for people who have complex health issues
- improved communication between practices and wider community team
- GP Clusters to consider quality improvement, service development and influence change
- better communication with unscheduled care and secondary care services.

As KIS sits on the EMIS and Vision systems, GPs remain the main authors of KIS and it is important to recognise the contribution that GPs make using KIS to share information about clinical issues and an individual's situation, choices and preferences across the interface with other services. KIS can also be an essential part of conveying safety messages across the system.

Evidence for improvement

We know from research and audit studies that at present the quality of information in KIS can be very variable with content ranging from complete and extremely informative to minimal.

Increasing evidence shows that a KIS that contains the right information and is supported by an Anticipatory Care Planning approach can improve personal outcomes by reducing hospital admission rates by 30-50%, reduce the chance of dying in hospital by more than half and help ensure appropriate care co-ordination and improved quality of life (Tapsfield et al, BMJ 2016). In addition the number of primary care contacts can be significantly reduced, including an estimated 15-20% reduction in GP appointments.

Improving the quality of KIS

The current and future focus for KIS is to encourage professionals to consistently include useful and reliable high quality information in the KIS and communicate the individual's situation, preferences and decisions clearly.

Many practices and clusters are already looking at the quality of information in a KIS to support aspects of anticipatory care planning. While we recognise that there is more to ACP than having a KIS, the KIS can be a good indication of focus on an anticipatory care approach.

Selecting individuals for KIS

While any individual may have a KIS generated for them, the purpose of KIS is generally seen as being of most value for particular groups of patients who have more complex needs or where it is important to convey a particular message, including safety messages, to help those who are not familiar with the patient.

Good communication, collaborative work and professional judgement are the most important factors in identifying individuals who should have a KIS but practitioners should also consider using other information available to them from wider communication, risk predictive tools and disease registers.

The number of individuals identified as appropriate to have a KIS can be significantly increased through using risk predictive tools such as SPICT, ACP Triggers and High Health Gain datasets. A trigger for an ACP is often an appropriate trigger for a KIS. The need for a KIS itself will often be a trigger for further conversations with individuals to consider anticipatory care planning.

ACP and KIS Triggers
(Ref - myacp.scot - based on individual condition, situation and assessment)
Situation
- Frequent unscheduled contacts and unplanned hospital admissions
- Complex physical or mental health needs
- Carer and family stress
- Babies, children and young adults with complex or palliative care needs
- Living in a care home or receiving respite care
- Long term housebound (all ages) or living alone recognised as vulnerable due to social or environmental circumstances

Condition

- Deteriorating long term condition or conditions
- Frailty
- Requiring specialist nurse or multidisciplinary team input
- On certain disease registers, including palliative care, dementia, mental health, learning disability

Assessment

- Identified as vulnerable using risk predictive tools or by professional or team at e.g. polypharmacy review or falls assessment

While ACP is often the catalyst for creating a KIS it is still important to use KIS to convey important safety or protection messages to those working across the system who do not know the individual or their environment.

What goes in a KIS? – Improving the quality of information

There have been a number of instances where individuals have been consented for KIS and then no additional information is added. It is suggested that this way of working is avoided as the value of KIS can be diminished to others expecting to view additional, useful information. Consent for a KIS should only be obtained when it is expected that additional important information will be shared

The initial front page KIS summary is recognised by many end users as being most valuable aspect of KIS. When writing a KIS it is worth thinking about what you would like to know if you were meeting that individual for the first time ...and trying to capture that in 2048 characters or less!

Below are a number of areas that it is recognised can support the development of high quality Key Information Summaries. The information should be current and practices are encouraged to have a process to identify KISs that need to be reviewed.

It is valuable to include:

- Good baseline information about the individual's current situation, such as their cognition, normal mobility and measurements such as $pO2$ for patients with COPD to allow an informed assessment recognising the level of risk or frailty that the individual normally functions with.
- Current recent history and main diagnoses
- Patient and carer awareness and expectations
- Preferred place of care and specific wishes
- The home situation, including carer information and support with contact numbers
- Key professionals involved and contact numbers
- Next of Kin and Power of Attorney (if any) – with contact details
- Contingency plans for deterioration of the individual
- Plan if carer becomes unwell
- Outline of any end of life care and resuscitation discussions and if DNACPR form completed
- Whether an Adults with Incapacity Form has been competed
- What anticipatory medicines and equipment are available at home

Workload

Pressure on GP practices and GP workload and capacity is well recognised, and it is important that we do not create significant additional work for GPs. Therefore the development of up-to-date, high-quality KISs for selected patients with complex needs is preferable to large numbers of incomplete KISs.

Current and future development

With increasing use there is greater awareness and opinion on what would enable KIS to become a more intuitive and helpful tool. Work is being led through Healthcare Improvement Scotland to support more effective use of the KIS and to raise the profile of and mainstream ACP.

KIS needs to evolve to a system that more effectively enables broader and appropriate information-sharing that has the capability for multiple stakeholders to update and access the information.

Consideration also needs to be given to determining how appropriate information-sharing can be extended beyond health services to include social care services.

However, this level of change will not happen until after primary care IT re-commissioning is completed in about 2020 and GPs will remain the main authors of KIS until then.

In the interim improvements are being made to help ensure that the correct information is shared effectively. This includes IT fixes around consent decisions and resuscitation choices, and the need to resolve the issue around loss of KIS information when an individual changes practice.

SC 4/8/17