Dear Colleagues,

The Clinical Directors of the GG&C HSCPs have been discussing for some time the issue of Anticipatory Care Plans. We acknowledge that the 32-page document is too large to be practical for widespread use, and we would rather encourage you to use the KIS functionality within EMIS as a proxy for an ACP. A well-completed KIS covers enough useful information to achieve the goals of an ACP.

Why do a KIS?

The eKIS is uploaded, with the patient's consent, to Out Of Hours and Secondary Care, meaning that doctors who aren't as familiar with the patient can get access to much more information than appears on the basic Emergency Care Summary. The same principle applies to other GPs and locums within General Practice who don't know the patient. A well completed KIS can have a big impact on unwanted and unnecessary treatment and admissions. This BMJ article reports a study showing the benefit to end of life care of having a KIS; 65% of patients with one died outside of hospital and only 27% of patients without one died outside of hospital:

http://spcare.bmj.com/content/early/2016/04/13/bmjspcare-2015-001014

Which patients benefit most?

Generally, those with the most fragile health needs and, therefore, most likely end up being seen by OOH or admitted to hospital. This includes, but is not limited to:

- Housebound patients
- Dementia patients
- Nursing home patients
- Patients with fragile significant conditions e.g. severe COPD, bronchiectasis, CF, MND, MS etc
- Patients just discharged after an unscheduled admission
- Frequent A&E attendees (your HSCP can help you identify them)

What are the most important sections of KIS?

The most useful information for OOH/Secondary Care is:

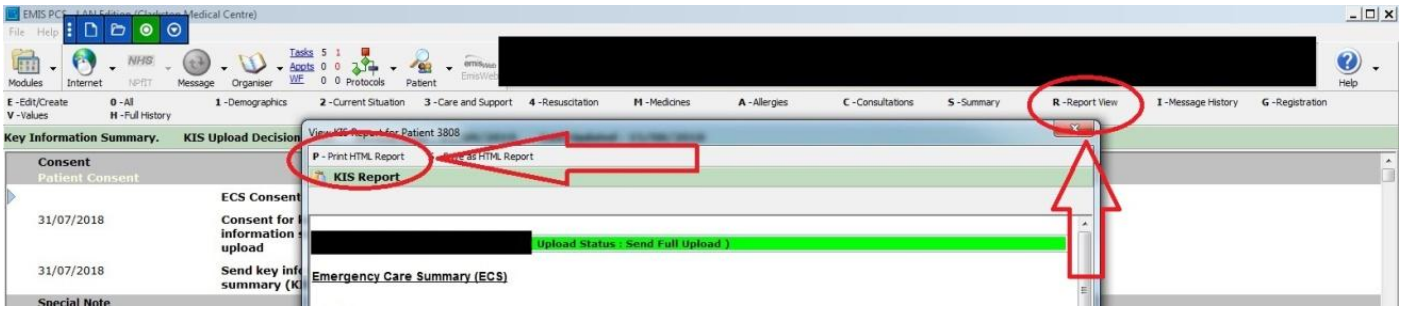
- Information re access to home and emergency contact details
- Main diagnoses
- Baseline functionality e.g. O2 sats, MMSE/6-CIT score, mobility levels
- Patient's known wishes regarding hospitalisation/preferred place of care/ceilings of treatment
- Resuscitation status (if appropriate to discuss - it usually is)

Probably the single most important box is the Special Note – this appears first in the KIS summary and will be what appears first if a secondary care doctor accesses eKIS. It should be used to record all the most important things that you would want another doctor to know about the patient. An example of a useful Special Note could be:

" Patient has severe COPD, MRC Grade 5. Resting sats are usually 92-94%. Sats below 88% usually indicate an exacerbation. Patient holds rescue meds (amoxicillin and prednisolone) at home and has a nebuliser and an oxygen concentrator. Patient usually fully lucid and has indicated with capacity that she does not wish to ever be admitted to hospital and does not wish CPR. She will accept active treatment for exacerbation of COPD. If patient is too confused to discuss care, phone daughter on XXXXXXXX "

How do I share a KIS?

When completed on EMIS, the eKIS uploads automatically to OOH/Secondary Care. When in the eKIS window, if you select "Report View" from the menu, a printable version opens that you can print off to give to the patient/family/care home.



Who else can create a KIS?

Secondary Care doctors and District Nurses might be the best person to discuss many of the matters with the patient, as they may be the most familiar member of the MDT or be in a situation where discussions of ceilings of care and future admissions are appropriate. If your DNs have access to EMIS, they can create the eKIS the same as a GP. For those who don't have write access to eKIS, we have created the attached blank template for them to use. The sections on it run in the same order, with the same headings, as the eKIS template and are colour-coded with respect to mandatory and preferred information. If a Secondary Care doctor discharges the patient with the completed template (may be put on portal) or a DN completes the template on a home visit, administrative staff in the GP practice can transcribe the information to eKIS for electronic upload. Referring to the template can act as reminder of the most important sections of KIS to complete. ***Please note, if the patient already has a KIS and their consultant requests that you add some Key Information to the summary, such as a newly-identified ceiling of care or new DNACPR decision, it is important that you update the KIS with this information, as they cannot directly do this without write permissions*** *(a limitation of KIS/EMIS).*

KIS Review

When creating the KIS, there is a box which is automatically ticked for KIS review due date. If you alter this date e.g. 3m/6m/1y it automatically creates an EMIS diary date, using the code EMISNQKE7, which is then searchable if you want to track patients who are due a KIS update.

KIS is not a perfect system, but it is what we have and using it well can be of enormous value to GPs, OOH, Secondary Care and the wider MDT. Creating good-quality KIS's and keeping them updated, and taking the opportunity to have the good conversations/difficult discussions with patients regarding their wishes for their care helps to prevent unwarranted and unwanted admissions to, and deaths in, hospital. Please view the creation of a worthwhile KIS for vulnerable patients as a core element of good clinical care in the patient with complex health needs.