

**DOAS SAP Concept Paper:**  
**CURRENT SUMMARY RECORD**  
**THOUGHTS ABOUT AN ALTERNATIVE FOR USE IN THE INTERCHANGE**  
**OF INFORMATION WITHIN SAP**

**Source**

The CSR was a record put together initially by a committee within the Single Assessment Process as a view of the critical information that people needed to see. It has helped concentrate minds on the most important items to share. It is an amalgamation of different parts of the process (information from: demographics, captured at the start of the process; the overview assessment; the care plan; reviews). It is not a document typically created at any point within the process.

It was then taken to the NHSIA to be turned into data items, with seemingly several assumptions (or some of these were made in the NHSIA):

- That a system working on the whole process could produce the CSR automatically, or, that people would produce it additionally for sharing
- That it was key to management information
- That it could provide the basis for sharing between health and social services and other provider systems
- That much of the information could be derived (especially from GP systems)

Because the NHSIA dataset was more management information based, it overemphasized dataset collection rather than sharing (for example the landlord field 1.16 tends to repeat codes around tenure, rather than provide the name and address of the landlord, which is the key matter for adaptations etc.)

**Categorisation of an individual**

The Single Assessment Process is as much about support around the impact of medical conditions, as opposed to the treatment of those conditions. The conditions impact on a person's lifestyle (life choices). Such things are very personal, and should not lightly be turned into codes which can be "labelling" (in the experience of social workers – who have written quite a lot of negative comment about tick box assessments). For understanding, it is often best to represent a person in descriptive words (and preferably their own). The Current Summary Record and its dataset tend not to do this. It is one approach to reducing the quantity of material that can potentially be shared.

**Consent to share**

As is very clear in guidance, sharing material (especially between agencies) is about consent. There can be rules around sealed envelopes, but these may need to be very sensitive to handle information sharing problems. It is doubtful whether any information can be guaranteed to be shared automatically (i.e. there will always be a stage when information sharing is considered before information is sent, and editing considered – although this will only be needed in a small minority of instances). So we may need to build this stage into our sharing of the CSR (except that the CSR is not a naturally occurring document – but something that we hope to have assembled by computer)

**Summary and detail**

Even if we did share the CSR (as defined in the dataset), there are times when its codifications will not be enough for decisions on care (and where it's "labelling" may be misleading). Having **access** to the material that lies behind the CSR may always be necessary, and our problem will be to decide how to handle such access (maybe by people communicating)

## **When to share**

The Current Summary Record has a major problem of when it should be shared. Transferring all information, when any element changes, is obviously a difficult overhead. It does have the real benefit of being something that can be sent when a new professional becomes involved.

## **An alternative approach**

Most of the material represented in the CSR obviously has relevance, but it needs to be seen in two contexts – where in the SAP care framework does it get created or changed; and when does it get shared with the person cared for. If the sharing is between two systems, it is best to disassemble the CSR and share material in pieces at different times.

**Factual information** (person demographics and their physical environment and main contacts)

Changes in a fairly ad-hoc manner, and may be reducible mainly to concrete things – and coded. This should be shared and changed on all systems as the information changes (we may have to document how much needs to be transferred)

## **Clinical/practice information**

What really matters is the care planned to be delivered (its purpose and the reasons for it) and a medical summary of current conditions and major history. With these items anybody working in a partial way will have enough information to do their main work, and if they have to go into more detail, they may need to look at more detailed documents, like the assessments, or talk to other individuals involved like GPs, social workers or consultants. (Mutual access to these items can be important)

## **Sharing the events and involvements**

Knowing that assessments have taken place, and the people responsible for them (so that they can be talked with) is important for multidisciplinary work, and sharing the existence of major events and current involvements seems valuable. This could be extended to items marked by individuals as significant events within their record.

## **Sharing the Care Plan**

Since delivered care is the prime thing that the person wants (assessment is but a step on the way to this), this is the prime thing to share with the individual (and such sharing is prescribed in the SAP guidance, and re-inforced in the White Paper).

It should be written in their terms, and should be a natural product of the process. This will also provide most professionals with the key information they need, and as a natural product of the process, should be available for sharing.

Before the sharing of the care plan, the key thing to share is where somebody is on the SAP process, and who is currently taking responsibility for them on that process. If there was an assessment and no care plan, it might also be worth share the conclusions on needs and risks that had been reached in the assessment process.

## **Sharing the medical summary**

This is a more difficult item. It is not really naturally occurring – but maybe, in essence, it is the GP summary which has started to be discussed in terms of the spine. It can cover the whole of medical care, which may make structuring it into a summary quite difficult, but for people with long term and complex conditions vital. Its content should however obviously consist of all current conditions and treatments/medications and major items of history.

It's sharing with social services needs to be subject to consent to share (and if this was obtained by a social worker, when starting on SAP, would the health service accept their assurance that it did exist, if they were doing an electronic look up?). It may need to contain items like prognosis, although sharing this with the person needs to be handled sensitively.

## **Moving from an artificial construct, to sharing during the natural process of a case**

The alternative suggested in this paper seems to be a move from sharing something created artificially, with no clear moment to share (and therefore potentially lacking currency) to sharing things naturally created as they happen, and especially the items (like the care plan) which are shared with the individual (and might typically be found in their person-held record).

### **Recommendation**

That we move from the concept of a current summary record to the sharing of the following items, as they happen or as they are compiled, and define the content (which may be free text in some circumstances):

- **Medical summary**, including problems, medications and major prevention indicators as compiled by the GP? (time of compilation and sharing to be defined). To be shared on initial multi-professional/agency work, and whenever it changes. This needs further CfH work, which should be allied to similar work on planned spine sharing, which also includes events like hospital spells (see Mike Pringle's paper: Clinical development of the NHS Care Record Service),
- **Basic Personal information** – demographics, contacts etc. - mainly coded and textual fields. Shared on initial multi-agency work, and as items change. Again this is information defined and held on the PDS part of the spine – access may be one way of sharing, but with prompts as items are changed.
- **Event details**: Contact assessment, overview assessment, specialist assessment, comprehensive assessment, review. (Current terms which may be revised by CAF) Shared as they happen, with individual details, date of event, type of event, person responsible, their role, team and organization, outcome of event, with a link (URL) to the actual material in the relevant system (or possibly the whole material to be shared as a document). For a specialist assessment, also send the type of assessment (e.g. OT, Physiotherapy, DN pressure sores, Waterlow, etc.). SAP events should be included as part of the general set of events that might happen to a person receiving health and social care, e.g. hospitalisation.
- **Allocated professional/team details**: Details of any allocated professional/team (separate data entities), changed as their allocation changes: Individual details, person allocated (if any), their role, team and organization allocated, contact telephone and e-mail, date of allocation (and when ending, date of end of allocation), care co-ordinator indication, role.
- **Integrated Care plan**: As it is initiated or changed (based on, and maybe as the integrated document shared with the individual): If split down, the following are the most important items: Individual details, date of implementation, need/risk (text, and if necessary for spine sharing, a high level code), service/intervention (text, and if necessary for spine sharing, a high level code), expected outcomes (text, and if necessary for spine sharing, a high level code), {each of these last three together representing a line in an array, and repeatable}, care co-ordinator (or other main responsible professional), their role, team and organization, contact telephone and e-mail, and possibly the timetable of care.
- **Referrals**: The other process that needs supporting is referral for action, which would need to transfer between systems, where care is being delivered across boundaries.
- **Consent**: all of the above to be shared (and edited before sharing if necessary), based on the individual's express consent.