



How information about you helps us to provide better care

A partnership between: Stockport Metropolitan Borough Council, NHS Stockport Clinical Commissioning Group, Stockport NHS Foundation Trust and Pennine Care NHS Foundation Trust

A free interpreting service is available if you need help with this information: **0161 477 9000** eds.admin@stockport.gov.uk 如果你需要幫助去了解這份文件的內容, 我們可以提供免費的傳譯服務。eds.admin@stockport.gov.uk 0161 477 9000 اگر در مورد این اطلاعات احتیاج به کمک داشتید سرویس خدمات مترجمی رایگان موجود است eds.admin@stockport.gov.uk 0161 477 9000 Jeśli potrzebujesz pomocy odnośnie tej informacji, dostępne są darmowe usługi tłumaczeniowe: eds.admin@stockport.gov.uk 0161 477 9000 Unit 477 9000 Dibi 1477 9000 نی مرت رسیلی و <u>ds.admin@stockport.gov.uk</u> 0161 477 9000 Dibi 1477 9000 نی مرت جاتی که نی مدر کی شرورت جاتو مخت ترینالی که ندمت در تایا جات ای کی از محمد الموانید تواصل معنا علی البرید الالکترونی : 000 eds.admin@stockport.gov.uk ولای مراح محمد الموانید الم Whenever you access health and care services a record will be kept about you. These records can be both electronic and paper and may be stored at places such as your GP practice, local hospital or social care services.

Often the professionals treating you need to share information in order to make the best decisions about your care. The Health and Social Care (Safety & Quality) Act 2015 means that by law health and care organisations must share information where this will help care for someone.

The information in this leaflet explains two ways in which we share your information electronically with other organisations involved in your care via the *Stockport Health and Care Record* and also the *Summary Care Record*.

Stockport Health and Care Record

The Stockport Health and Care Record is an electronic record that brings together information from health and care services within Stockport.

Everyone registered with a Stockport GP will automatically have a Stockport Health and Care Record which contains your name, address, date of birth, NHS number and relevant sections of your GP record, social care record (if you have one) and End of Life Care Portal for Anticipatory Care (EPAC) record (if you have one).

What does it mean for me?

You can be confident that the person treating you has all the information they need in order to quickly make the best decisions about your care.

Other benefits include:

- Safer and better care as health and care professionals can access information quickly to help them manage conditions more effectively
- Safer care as up to date information on things like medication and allergies is available when needed
- Reduces the amount of information you need to tell the person treating you
- Reduces the duplication of tests and investigations as professionals will have access to details of tests you have already had done and their results
- Quicker and safer discharge from hospital

Who can access my information?

Only authorised professionals involved in your care will have access to your information. This may include your GP, Practice Nurse, Hospital Consultant, Out of Hours GP or Social Care Worker.

It is important to understand that these professionals will only have access to the information *they need* in order to treat you effectively. The amount of information that can be viewed varies depending on the person's job role.

How is my information kept safe?

Your information is protected under the Data Protection Act 1998. Health and care staff receive training and understand that they have a duty of confidentiality.

The records are kept on a secure database to prevent unauthorised access in line with current legislation. Your information will never be shared with anyone who is not directly involved in your care.

Also, professionals should only access this information with your permission. If they cannot ask you, for example if you are unconscious, they may look at your information but if they do this, they have to make a note on your record to say why they have done so.

Every time someone tries to access your information the system logs this so we can easily audit who is accessing your information and when. They will also have to log whether they have accessed the information with your permission.

What if I don't want my information to be shared?

At any point, you can say 'no' to any professional who asks for permission to view your information.

You are also able to opt out completely of having a Stockport Health and Care Record. However, this will mean that in an emergency the professionals helping you may not have all the information they need to make the best decisions about your care. If you would like to opt out you should contact your GP practice who can arrange this for you.

Summary Care Record

The NHS in England introduced Summary Care Records to improve the safety and quality of patient care. Like the Stockport Health and Care Record it gives healthcare staff faster, easier access to reliable information about you to help with your treatment.

This record is not as detailed as the Stockport Health and Care Record and only contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you may have. It also includes your name, address, date of birth and NHS number to help identify you correctly.

The purpose of this is to make important information readily available anywhere that you need health treatment within England, for example if you are staying away from Stockport on holiday. The information in the Stockport Health and Care Record is only accessible by staff based within the Stockport area.

What does it mean for me?

Having a Summary Care Record gives authorised healthcare staff a quicker way to get important information about you. This can reduce the risk of medical errors occurring when caring for you in an emergency or out-of-hours when your GP practice is closed. Only healthcare staff involved in supporting or providing your care can see your Summary Care Record. Healthcare staff will ask your permission every time they need to look at your Summary Care Record. If they cannot ask you, for example if you are unconscious, they may look at your Summary Care Record, but if they do this, they will make a note on your record to say why they have done so.

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