What is the Summary Care Record?

A **Summary Care Record** is an electronic record used nationally across England and available to authorised healthcare professionals who care for you in urgent or emergency situations . This might be if you are ill when you are away from home or when your GP surgery is closed. It is based on your GP record and contains key information to support emergency care such as:

- Medicines you take
- Any allergies you have
- Any bad reactions you have had to medicines

You may want to add other details about your care to your Summary Care Record. This will only happen if you ask for the information to be included. You should discuss your wishes with your GP.

For more information, about the national Summary Care Record please use the details provided on the back of the leaflet

Do I have an Oxfordshire Care Summary and a Summary Care Record ?

You can choose whether or not to have an Oxfordshire Care Summary or Summary Care Record. If you were registered at an Oxfordshire GP practice in 2012, you will have received a letter asking if you want these records created; otherwise you will have been asked when you registered at the practice.

If you are unsure about whether you have an Oxfordshire Care Summary or a Summary Care Record, please ask your GP practice. You can change your mind at any time.

Where can I find more information?

For the Oxfordshire Care Summary

Visit: www.oxfordshireccg.nhs.uk/your-health/oxfordshire-care-summary
Call: 0300 1232061
E-mail: oxfordshire.caresummary@nhs.net

For the Summary Care Record

Visit: www.nhscarerecords.nhs.uk or www.oxfordshireccg.nhs.uk/your-health/summary-care-record
Phone: 0300 3035678
Email: enquiries@hscic.gov.uk

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NHS

Providing quicker access to essential information to support the best and safest treatment for patients in Oxfordshire

Working in partnership with:

- Oxfordshire Clinical Commissioning Group
- Oxford Health NHS Foundation Trust
- Oxford University Hospitals NHS Trust
- South, Central and West Commissioning Support Unit

What is the Oxfordshire Care Summary?

The **Oxfordshire Care Summary** is an electronic view of more detailed clinical information from your GP record and other local records kept to support your care. It is available locally to authorised health and social care professionals who provide care for you.

It is being developed all the time to best meet the needs of patients and the professionals who care for them. It provides a view of information such as:

- Medicines you take
- Any allergies you have
- Any bad reactions you have had to medicines
- Your medical history and diagnoses
- Test results and X-ray reports
- Your vaccination history
- General health readings e.g. blood pressure
- Your appointments, hospital admissions, GP out-of-hours attendances and ambulance calls
- Care / management plans
- Correspondence such as discharge summaries.

For a complete list of all the information available on the Oxfordshire Care Summary, please refer to the website (provided on the bottom of this page)

Who can access my information?

Access is strictly controlled.

Only authorised health and social care staff that are **directly involved** in supporting or providing your care can access this information and they will only see the information they need to do their job.

Healthcare staff will ask your permission when they need to look at your Oxfordshire Care Summary.

If they cannot ask your permission, for example if you are unconscious or if you are not present, they may look at your health record without asking you so that they can quickly provide you with the most appropriate care and treatment. The record will indicate that they have done so and what they looked at. If necessary, they will be required to justify their actions.

Oxfordshire Care Summary

How will this support my care and treatment?

- It allows faster and easier access to essential, up-to-date and accurate information about you.
- Health care professionals who provide care to you will be able to use the information about you to help them make decisions and to prevent mistakes.
- In an emergency, health care staff will have access to your medications and allergies to ensure the treatment they give you is safe and appropriate.
- In outpatient departments, specialists will have access to detailed medical history and will be able to make better decisions about your care.
- In hospital, nurses and discharge planners will have information about care you already receive at home to ensure you don't stay in any longer than you need to.
- In the community, district nurses will have access to information about care you received in hospital.
- Better access to more detailed information about your health makes your care quicker, safer and more personal; improving the quality of your care.

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www.oxfordshireccg.nhs.uk/your-health/oxfordshire-care-summary