

What is the Yorkshire & Humber Care Record?

The Yorkshire & Humber Care Record is a secure computer system that brings together certain important information about patients who have used services provided by their GP, at a local hospital, community healthcare, social services or mental health teams. It enables clinical and care staff to view real-time health and care information across care providers and between different systems.

All health records are strictly confidential and can only be accessed by clinical and care staff who are directly involved in a patient's care. The Yorkshire & Humber Care Record holds certain information about a patient or service user, for example:

- Address and telephone numbers
- A list of diagnosed conditions - to make sure your clinical and care staff have an accurate record of your care
- Medication - so everyone treating you can see what medicines you have been prescribed
- Allergies - to make sure you're not prescribed or given any medicines you can have an adverse reaction to
- Test results - to speed up treatment and care
- Referrals, clinical letters and discharge information - to make sure the people caring for you have all the information they need about other treatment you are having elsewhere
- Care plans - for clinical and care staff involved in your care to view a joined-up plan of care and the wishes you've asked for in relation to your care

What are the benefits of the Yorkshire & Humber Care Record?

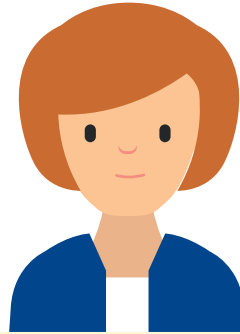
- Joined-up and safer care
- More time to spend on your care
- Less paperwork
- Your information in one place
- Don't have to repeat details to different clinical and care staff

Who can see my Yorkshire & Humber Care Record?

Only clinical and care staff directly involved in your care will see your Yorkshire & Humber Care Record. We won't share it with anyone who isn't providing your treatment, care or support. Your details won't be made public, or passed on to anyone not directly involved in your care, neither will it be used for advertising.

How do I know my Yorkshire & Humber Care Record is secure?

Data is pulled from secure clinical systems across the region which is displayed in the Yorkshire & Humber Care Record and remains confidential.



Can I object to my Yorkshire & Humber Care Record being shared?

Yes. You have the right to object to your Yorkshire & Humber Care Record being shared by calling 0113 20 64102. However, if staff require access to the information shared on the Yorkshire & Humber Care Record to provide safe individual care they are legally allowed access.

Any questions?

If you have any queries or would like to object to your Yorkshire & Humber Care Record being shared, please contact:

0113 20 64102

Or you can write to:
Yorkshire & Humber Care Record,
Leeds Teaching Hospitals NHS Trust,
St James University Hospital,
Lincoln Wing/Chancellor Wing Link Corridor,
Beckett Street, Leeds, LS9 7TF

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hullccg.stpcontactus@nhs.net



Yorkshire & Humber Care Record

Working together to improve your care



The Yorkshire & Humber Care Record provides clinical and care staff directly involved in your care access to the most up to date information about you.

It does this by sharing appropriate information from your health and care records between health and social care services in Yorkshire & Humber.



Examples of what's included in my Yorkshire & Humber Care Record:

- Diagnosed conditions
- Medications
- Allergies and adverse reactions
- Test results
- Referrals, clinical letters and discharge information
- Care plans
- Contact details

What's in it for me?



Joined-up and safer care



Information in one place



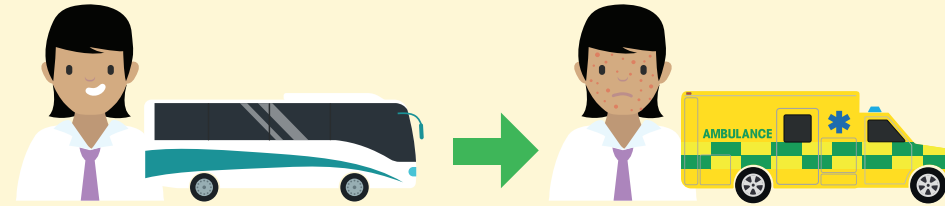
More time to spend on your care



Secure and confidential

Scenario 1

So, how does it work?



Jamie is on a school trip in York and has an allergic reaction.

Parents can't be reached, Jamie is taken to hospital by ambulance.

The hospital care staff can access the Yorkshire & Humber Care Record to see Jamie's medication and allergy history.



Yorkshire & Humber Care Record

Medications and list of allergies

Supplied by Jamie's GP

A&E summary

Supplied by Hospital Care Staff



Benefit

Enables clinical and care staff to provide the emergency care to treat Jamie immediately and safely.

Scenario 2



Gladys regularly visits her local GP and receives home visits from a Community Nurse.

Gladys visits her GP stating she is feeling unwell.

Her GP is concerned and calls for an ambulance to take her to the hospital.

Arriving at A&E, the care staff review Gladys's Yorkshire & Humber Care Record and investigate the cause of illness by taking some routine blood tests. Following the diagnosis, Gladys is transferred to a hospital ward. After spending a few days in hospital Gladys is discharged to recover at home.



Yorkshire & Humber Care Record

GP history

Supplied by Gladys's GP

A&E summary discharge letter blood results

Supplied by Hospital Specialists

Community contacts

Supplied by Community Nurse



Benefit

Sharing Gladys's information allows her GP and Community Nurse to be more informed, allowing them to provide better and safer care.