

The Single Patient Record

A report by the Primary Health Care Specialist Group of BCS from its Clinical Special Interest (CLICSIG) meeting on April 17th 2026

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Executive Summary

The document evaluates NHS England's plan for a **Single Patient Record (SPR)** and captures consensus from a multi-disciplinary expert forum. The group is **supportive but cautious**, stressing that the SPR must be built **incrementally**, using **existing regional shared care records**, not replacing them.

Core message: A national SPR is achievable and valuable, but only if it is **open, federated, clinically safe, workflow-integrated, and governed transparently**.

What the group agreed on (in one breath)

The SPR should **connect—not replace—regional systems**, use **open FHIR APIs**, avoid **vendor lock-in**, reduce **manual data re-entry**, ensure **high data quality**, and provide **clear governance and opt-out rules**. Delivery must be **phased over 5–10 years** with **annual milestones**.

Major risks identified

- Regions may **stop investing** in working shared care records.
- Clinicians could face **extra workload** if systems don't interoperate.
- Poor data quality and “**shoeboxes of PDFs**” could create safety issues.
- **Medico-legal liability** unclear for unviewed central data.
- Public trust threatened by **complex opt-outs** and fears of **commercial access**.
- National leadership fragmented; secondary care lacks unified digital representation.

Patient & public concerns

Patients want **granular control**, transparency, and protection for vulnerable groups. They fear data expansion without consent and misuse by commercial entities. They also highlight unsafe issues like **unclear medication dates** and **uncurated central stores**.

Technical insights

The group compared UK models with Scotland's NDP and Australia's My Health Record. Key lessons include:

- Build **foundational infrastructure first** (IDs, authentication, terminology).
- Automate data flows; clinician-curated summaries add limited value.
- Federated systems tend to **drift toward centralisation**.
- Over-regulation and unclear incentives can stall adoption.

Functional priorities

1. **Fix secondary–primary care data gaps** (stop manual retyping).
2. **Evolve shared care records** into unified views without unsafe duplication.
3. Clarify the role of the **Patient Data Manager** (transport vs store).
4. Address **clinical safety and liability** for centralised alerts.
5. Strengthen **cross-specialty leadership**.
6. Improve **data quality, metadata, and usability**.

Overall sentiment

“Supportive—but only if done pragmatically.” The SPR must be a **hybrid integration layer**, not a big-bang national system. Success depends on **open standards, automated data flows, clear governance**, and **clinical safety** driving every decision.

PHCSG CLICSIG on the Single Patient Record

April 2026

Section 1: Background, Logistics, and Meeting Framework

Event Context & Governance

- To conduct an in-depth, candid evaluation of the SPR's pros, cons, feasibility, and real-world problem-solving capacity.
- Conducted strictly under the Chatham House Rule to facilitate open exploration among members and invited experts.
- Discussions were recorded and processed using AI tools to assist in generating synthesis reports.

Participant Roles Represented

- General Practitioners and primary care informaticists from multiple English regions and South Wales.
- NHS England clinical advisors, policy strategists, and program leads.
- Hospital specialists, including representatives from anaesthetics and acute care.
- International health system delegates with expertise in Australian national record systems.
- Patient advocates and digital health privacy specialists.
- Academic researchers specializing in health data standards and semantic interoperability.

Section 2: NHS England Strategic Direction & Policy Context

Strategic Drivers and Policy Context

The SPR initiative is a core component of the NHS 10-Year Plan and aligns with broader national policy priorities.

- **Neighbourhood Health Concept:** Reorients services around patient-centred delivery pathways rather than organizational silos.
- **Life Sciences & Investment:** Driven by national policy imperatives to strengthen UK research capabilities and attract technology investment.
- **Capacity & Demand Management:** Aims to leverage digital infrastructure to bridge the growing gap between healthcare demand and clinical workforce capacity.

NHS England's Hybrid Architecture Model

NHS England has outlined an emerging logical technical framework that avoids rigid, top-down software mandates.

- It will start by connecting and querying existing shared patient records. Gradually it will determine what data should be centrally stored such as Vaccination and Pathology data. It will only evolve toward more centralisation only where beneficial. Service transformation areas such as maternity and frailty are being used to test the model.
- Future capabilities may include de-duplication, AI summarisation, care planning and sensitive access controls.

Clinician and patient involvement

- There is a deliberate shift from past national programmes. The intention is to actively involve healthcare professionals, patients, and the public in shaping its development.

Business Case, Funding, and Timelines

- **Approvals:** The formal business case has secured approval from NHS England and HM Treasury.
- **Delivery Horizon:** Implementation is framed as a 5-to-10-year evolutionary program, with team establishment following formal sign-offs. NHSE gives timelines 2026-2028. [NHS England » Single Patient Record – your health at your fingertips](#)
- **Near-Term Pressure:** Treasury and policy stakeholders expect demonstrable core functionality within the initial 3 to 4 years.

Concerns Raised by the Group

1. Timescale and deliverability

- No formal timeline; risk of **no measurable deliverables for 3–4 years**.
- Pressure for early wins.
- Recognition that this is a **5–10 year programme**.

2. Risk of de-investment in existing shared care records

- Some counties are already pausing development because “the SPR is coming.”
- Concern that this will **undermine current benefits**.

3. Front-line clinician understanding and education

- Concern was expressed about the need for education and training for all Health Care Professionals in using a Single Patient Record
- Clinicians may not understand what the SPR is, how redaction will work or how they will access it.
- Tools are currently “clunky”; education and usability need improvement.

4. Policy and political context

SPR is tied to the **10-year plan**, modern service frameworks, and wider political drivers (e.g., life sciences investment, digital transformation).

- Tension between patient-centred care, and national ambitions for data aggregation and research.

5. Organisational instability

- NHS England’s abolition and large-scale redundancies raise concerns about continuity, capability and who will run SPR in future.
- DHSC merger creates uncertainty around **data controllership** and governance.

6. Opt-outs and information governance

- Confusion around type 1 and type 2 opt-outs.
- Assurance that national data opt-out remains policy, but **all opt-out mechanisms are under review**.

- Architecture and legislation not yet defined.

7. Lack of clarity about the fundamental purpose

What is the SPR *really* for? Is it for improving individual patient care or making the system more affordable or enabling research. There was concern that the narrative is not yet coherent.

8. Patient-centred benefits need to be clearer

Examples raised:

- GPs need reliable access to hospital prescribing (e.g., chemotherapy).
- Population health discrepancies (e.g., immunosuppressed vaccination lists differing by 16,000 between primary and secondary care).

🔗 Proposals and Suggestions from the Group

- **Set milestones** to avoid drift and ensure early deliverables.
- **Protect and continue investing in shared care records** during SPR development.
- **Improve clinician education** and simplify tools.
- **Clarify governance and succession planning** given organisational changes.
- **Refresh and simplify opt-out frameworks.**
- **Strengthen the patient-centred narrative**—make clear how SPR improves individual care.
- **Ensure population health benefits are realised** through better data linkage.

Section 3: Patient & Public Perspectives

Patient Concerns & Data Curation Risks

Patient advocacy representatives highlighted several areas of friction regarding comprehensive shared records:

- **Unclear Record Scope:** Patients express uncertainty over what data types are included and fear unannounced expansion of data collection.
- **Granular Control:** Patients desire clear mechanisms to control sensitive information without compromising emergency care data availability.
- **Dynamic vs. Static Records:** Primary care records are continually refined over time, whereas hospital records are episode-based. Treating an uncured central store as a single "source of truth" risks perpetuating outdated clinical errors.
- **Medication Data Precision:** Current shared systems frequently lack accurate date metadata, making it difficult for clinicians to distinguish active prescriptions from historical treatments.
- **Secondary Use Misgivings:** Strong public apprehension remains regarding data access by commercial third parties, such as insurance providers.

Section 4: Technical Architecture & System Models

Participants reviewed several operational and theoretical architectures used across the UK and internationally.

AI Triage Integration

A service has used a probabilistic inference engine for triage since 2022, incorporating chronic conditions, lifestyle factors, travel history, and multiple symptoms. It halved Emergency Department referrals and doubled digital-channel completion rates. The team now plans to shift to a conversational Generative AI layer to match evolving user expectations.

Regional Data Federation & The Great North Care Record

A presenter described a £16 million regional data-sharing initiative in the North of England.

- Enterprise vs Federated Architecture: Enterprise models are unsuitable for the NHS's 250+ autonomous organisations. A federated model—shared membership infrastructure and agreed standards—is required.
- Implementation & Document Sharing: The approach centred on document-based sharing (referrals, discharges, MDT notes, immunisations) with clinician-signed documents for provenance. It used a real-time pull model via an XDS registry/hub rather than a central repository.

Regional Dynamics & Evolution

Progress initially stalled due to funding and inter-trust tensions. During COVID-19, Newcastle Upon Tyne Hospitals Trust took ownership of the regional hub and enforced XDS standards across all 14 trusts, enabling functional cross-system document viewing for direct care.

Co-Produced Personal Health Records (coPHR)

The [CoPHR model from the Apperta Foundation](#) was outlined:

- Core Principles: Patients act as equal partners. Data is separated from applications using open standards (OpenEHR, FHIR) and open APIs.
- Data Rules: Non-revocation of professional entries (with patient annotation), strict provenance, legally valid audit trails, portability, and granular patient-controlled permissions.

Scotland's Single Patient Record Framework

An update covered Scotland's legislative and technical developments:

- Legislative Mandate: The Care Reform Act Scotland 2025 requires a shared digital record for all receiving health and social care and empowers ministers to set data standards.
- National Digital Platform (NDP): Delivered by NHS Education for Scotland, providing reusable components (CHI demographics, ScottAccount authentication, FHIR layers, audit, Ontoserver terminology).
- Data Stores & MyCare.scot: Centralised stores include vaccines, dermatology images, ReSPECT plans, implantable devices, and diabetes data. Citizen access is via mycare.scot. The next phase adds a patient-controlled "About Me" record for preferences, interpreter needs, and housing/mobility details.

Concerns Raised by the Group

- 1. Data Governance, Usability, and Clinical Safety**
 - Fragmented, document-heavy records make navigation difficult; tab-based interfaces risk missed information.
 - Questions about how static PDF stores support curation, evolving diagnoses, or legally mandated deletions (e.g., child-at-risk reports).
 - Tension between unstructured “filing cabinet” models and structured data warehouses when creating a single patient view.
 - If the SPR is to be used as a single source of truth, incompatible or unobtainable records create a clinical safety risk.
 - Public Trust, Consent, and System Misuse
- 2. Patient advocates raised concerns:**
 - Unclear Scope: Uncertainty about what data is included and fear of unannounced expansion.
 - Granular Control: Desire for sensitive-data controls without harming emergency access.
 - Dynamic vs Static Records: GP records evolve; hospital records are episodic. A central “source of truth” risks perpetuating outdated errors.
 - Medication Precision: Shared systems often lack accurate date metadata, making active vs historical prescriptions unclear.
- 3. Secondary Use Misgivings**
 - Strong apprehension about commercial third-party access (e.g., insurers).
 - Concerns that trust is eroding due to central mandates and poor communication.
 - Specific groups (Travellers, domestic abuse survivors, LGBTQ+ communities, refugees) face heightened risks from record visibility.
 - Internal privacy breaches by staff or acquaintances were also discussed.

What the Group Was Happy / Positive About

1. Impact of Shared Emergency and Care Plans

Members praised structured plans like ReSPECT and London’s Universal Care Plan. A major success was rapid rollout of escalation plans for 80% of sickle-cell patients, enabling paramedics and unscheduled care staff to access clear directives quickly.

2. Integration into Existing Clinical Workflows

Systems that surface shared data directly within clinicians’ existing software—without separate portals—were viewed very positively. Background data-sharing that prompts clinicians within their workflow was seen as a major improvement.

3. Granular Patient Control and Deliberation

Members supported public deliberation findings showing citizens favour shared records when safeguards, audits, and access logs are clear. Empowering patients to view, annotate, and control their longitudinal data alongside clinicians was seen as essential for long-term sustainability.

Section 5: International Insights — Australian Experience

Australia's single patient record formed part of a national digital health strategy begun around 2009, built on core infrastructure: healthcare identifiers, authentication, credentialing, terminology, data structures, and standards. Unique identifiers for individuals, services, and providers were legislated due to privacy concerns.

My Health Record became a national repository receiving prescription and dispensing data via national prescribing systems, plus immunisations, discharge summaries, and (in principle) diagnostic reports. Immunisation data expanded from childhood to all vaccines, including pharmacy and school delivery, later supporting COVID vaccination records.

Two GP-curated documents were included: the shared health summary and event summary. Despite early design focus, these proved less important than automatically flowing data such as prescriptions and immunisations.

The system depended on standards, implementation guides, technical working groups, and vendor conformance. It used HL7 (V2, CDA) and was moving to FHIR, with SNOMED and medicines codes. Vendors were supported through test rigs and a conformance scheme ranging from basic document transfer to structured ingestible data.

A major feature was the consent engine and audit trail. Consumers could hide documents and receive alerts when organisations accessed their record. Permitted uses centred on health services; prohibited uses included employment and insurance decisions.

Legislation required all data to remain onshore. Three acts governed the system: Healthcare Identifiers Act, My Health Records Act, and Privacy Act, with high penalties for misuse. The initial opt-in model left the system underused for years.

Professional guidelines shaped clinical use and indemnity expectations. The record launched in 2012 (opt-in) and moved to opt-out in 2018. In hindsight, opt-in was seen as a mistake because it delayed benefits and limited uptake.

The original business case emphasised medicines safety, reducing duplicate tests, and future consumer engagement. Over time, the most valuable data was the automatically flowing data, especially medicines and immunisations. Diagnostics were a major gap due to limited private-sector incentives; legislation later mandated their inclusion.

Other issues included a seven-day delay before consumers could view test results, reduced to two days during COVID, and criticism that the system was a "shoebox of PDFs" due to low-level vendor conformance—though AI may mitigate this.

Secondary use remained tightly constrained by legislation. The speaker questioned whether the primary/secondary distinction still fits personalised medicine. Future opportunities included greater patient access, AI-generated insights, integration with lifestyle data, and attention to sovereignty, autonomy, safeguards, and equity.

Australian law treats data not as owned property but as a set of rights and responsibilities distributed across different actors.

Lessons Learned from the Australian My Health Record

1. **Build Foundations First — Identifiers, Authentication, Standards** Robust identity, terminology, standards, and vendor conformance are essential.
2. **Central Repository Emerges Even When Not Intended** National-scale ingestion tends to centralise systems.

3. **Automate Data Flows** Automatically generated data (prescriptions, immunisations, discharge summaries, diagnostics) proved most valuable; clinician-curated summaries were peripheral.
4. **Incentives Matter** Private providers will not share diagnostics without legislation or strong incentives.
5. **Excessive Penalties Suppress Use** Very high fines discouraged some users.
6. **Opt-In Was a Strategic Mistake** Opt-in delayed benefits and limited participation.
7. **Over-Focusing on Outliers Distracted from Value** Concerns about patients seeing results first led to delays that later proved unnecessary.
8. **PDF “Shoebox” Problem** Low-effort PDF uploads limited usefulness; structured data must be enforced early.
9. **Secondary Use Locked Down Too Hard** Legislative constraints limited long-term value.
10. **Direct Care vs Secondary Use Became Outdated** Personalised medicine blurs these boundaries.
11. **Consumer Control Is Essential but Complex** Document hiding, access alerts, and audit trails build trust but require balance.
12. **Patients Will Extract Data if System Falls Short** Lack of analytics/APIs drives consumers to external tools.
13. **Data Sovereignty Rules Can Constrain Future Use** Onshore-only rules conflict with global tools.
14. **Clinician-Curated Summaries Are Not the Future** Automated summarisation may replace manual curation.
15. **Value Emerges Over Time** Benefits appeared only once automated data flows matured.

Section 6: Further highlights

Connecting Secondary Care to Primary Care Data

There can be severe operational hurdles secondary care clinicians face when trying to access patient records from primary care or neighbouring trust systems. Secondary care currently lacks visibility across systems like EMIS, SystmOne, and military systems, relying instead on fragmented options like local integrated care records or basic summaries. Major frustration was expressed over new hospital Electronic Patient Record (EPR) implementations, such as replacing Lorenzo with Oracle/Cerner Millennium, which lack automatic integration with GP Connect, forcing clinicians to manually re-type primary care data into hospital systems. The group supported using lessons and blueprints from the Frontline Digitisation programme, fostering cross-specialty clinical networks, and building better data-sharing links, while expressing deep concern over manual duplication, system lockdowns by vendors, and the loss of patient data visibility.

Shared Care Records vs. Single Patient Record Architecture

The meeting explored how to transition from traditional shared care records—which rely primarily on read-only extracts—to a coherent single patient record architecture. Discussion focused on whether to utilize a centralized cache/repository or adopt a hybrid model where specific lifelong primary records (such as pharmacogenomics, end-of-life care plans, or advance decisions) sit in patient-centric data stores accessible to all providers. Members strongly supported creating a seamless, unified view of patient records across clinicians and citizens, as well as taking an agile, pragmatic approach that builds on existing shared care infrastructure. However, there was significant concern over supplier resistance, commercial vendors locking down data models to protect their business models, the technical and

semantic complexity of linking non-standardized systems, and the potential risks of duplicating data.

NHS Patient Data Manager (PDM) and Messaging Infrastructure

The technical mechanism for routing and storing data was evaluated, focusing on the evolution of NHS infrastructure and the role of the NHS Patient Data Manager (PDM). The group discussed how PDM is intended to consolidate FHIR APIs and manage data flows to and from the national Spine, alongside discussions around national repositories for lab and pathology results. The group supported moving toward modern FHIR standards and establishing direct feed caches or repositories (e.g., for labs and e-prescribing) to remove the need for hundreds of point-to-point integrations. Conversely, concerns were raised regarding confusion over PDM's true scope, whether it is merely a transport layer or a patient store, as well as the high ongoing costs of paying intermediary middleware companies and the historic mistake of turning off useful legacy messaging systems before replacements are fully operational.

Clinical Safety, Governance, and Medico-Legal Risks

Participants discussed the governance, legal accountability, and patient safety implications surrounding a shared or centralized patient record. Concerns were highlighted around "coronial/regulation 28" risks, where coroners might hold clinicians legally accountable for information (such as prescription dispensing statuses or centrally held alerts) that exists in a repository but is not directly pushed into the clinician's immediate workflow. The group strongly supported the establishment of a transparent trust framework, clear audit trails, robust cybersecurity, and strict access controls so clinicians only consume data they trust. Beyond legal liability, concerns were expressed about potential patient safety incidents during system migrations, as well as the unreliability of AI-generated document summaries or unverified historical entries.

Professional Representation and Leadership

The group addressed the absence of unified clinical representation across the medical profession when shaping digital health strategy and single patient record requirements. While general practice has well-established IT representation through bodies like the BMA and RCGP, secondary care lacks a single, equivalent cross-specialty digital working group. The group supported bringing together the BMA, Royal Colleges, and the Chief Medical Information Officer (CCIO) forum to establish genuine professional leadership for digital medical records. However, concerns were raised that without a unified voice representing all medical specialties, major national IT programs risk pushback or failure, alongside concerns over structural disconnects between trade unions (focused on pay/contracts) and royal colleges (focused on standards).

Patient Perspective, Usability, and Data Quality

The discussion concluded by evaluating how a single patient record serves citizens and the importance of underlying data integrity. Attendees noted that for patients, the core value lies in breaking down organizational silos so their critical health information, such as allergies, vaccinations, or genetic profile, follows them safely throughout their lives. The group supported clear, transparent communication to build public trust, explicit rules around direct-care consent, and prioritizing high-value, lifelong clinical use cases like pharmacogenomics. On the other hand, members expressed deep concern over poor baseline data quality, including misattributed records, coding errors overridden by free text, and missing information, warning that without dedicated investment in data curation, a single patient record risks presenting incorrect or unsafe clinical information.

Appendix

Acronym Reference List

- **BCS**: British Computer Society
- **BMA**: British Medical Association
- **CCIO**: Chief Clinical Information Officer
- **CliCSIG**: Clinical Computing Special Interest Group
- **CoPHR**: Co-Produced Personal Health Record
- **EPR**: Electronic Patient Record
- **FHIR**: Fast Healthcare Interoperability Resources
- **GNCR**: Great North Care Record
- **GP**: General Practitioner
- **ICB**: Integrated Care Board
- **NHS / NHSE**: National Health Service / NHS England
- **PHCSG**: Primary Health Care Specialist Group
- **SNOMED CT**: Systematized Nomenclature of Medicine -- Clinical Terms
- **SPR**: Single Patient Record
- **UCP**: Universal Care Plan