# The Single Patient Record: what Parliament should test

## Second Reading Briefing

The Health Bill would create the legal foundation for a Single Patient Record (SPR), bringing health and social care information together through national technical infrastructure.

Done well, the SPR could support safer, more joined-up clinical care by giving professionals timely access to the information they need, while also giving patients far better access to – and greater control over – their own information. Public appetite is clear: 9 in 10 Britons want better access to their medical records, many people already assume a single patient record exists, and recent national deliberative engagement shows strong support for making it a reality. This is a rare opportunity to meet an existing public expectation while improving the conditions for safer direct care – if the legislation is robust enough to earn and keep trust.

The concept of a Single Patient Record is not new, but the Bill would move patient information sharing for direct care towards a more routine, more consistent and more nationally coordinated model. Parliament's role is therefore not simply to welcome the ambition, but to satisfy itself that the case for this national shift is clear – and that the safeguards, responsibilities and limits are strong enough to sustain public confidence. This includes future-proofing to enable potential secondary uses, including research, with appropriate guardrails.

## Five key messages for Parliamentarians

### 1. SPR proposals move data sharing from local discretion towards national coordination

The SPR builds on the foundations of Shared Care Records (regional), Summary Care Records (national), electronic patient records (local) and years of interoperability programmes. It is not a plan to replace every local record with a single database. It is a plan to connect existing systems more consistently *at national level*. The Bill creates powers to require organisations, including GP practices, to share information with the SPR. Ministers argue this is needed to reduce longstanding variation, uncertainty and risk aversion around information sharing.

At the same time, the Bill transfers NHS England functions into DHSC, including responsibility for data infrastructure and policy. Together, those changes represent a significant shift towards a more central model for managing patient information across the NHS.

### 2. The SPR is being introduced for direct care, but there is a need to future-proof wider use

The Government has framed the SPR as a tool for direct patient care. The Bill does not itself create new powers for research or commercial access. But the infrastructure it enables could, over time, support other lawful uses, including research, planning, service improvement, population health management and AI development.

The SPR is also being introduced alongside wider reforms to NHS data governance and infrastructure, including a new Health Data Research Service, roll out of the Federated Data Platform, a review of the National Data Opt-Out and possible reform of Control of Patient Information Regulations 2002 ("COPI") to speed up access to data for research. Parliament should therefore look not only at the SPR's initial purpose, but at how any future interactions or expansions of the SPR infrastructure would be authorised, explained and scrutinised over time.

Taking this even further, while the Bill does not create a cross-sector data system or a link to a digital ID or National Data Library scheme, these are precisely the kinds of future connections many people fear when national infrastructure is built without sufficiently clear public-facing limits.

Understanding Patient Data, National Voices and the Association of Medical Research Charities support secondary uses of health data where they deliver clear public benefit, and where the rules are future-proofed with robust guardrails, meaningful checks and balances, and a level of transparency the public can genuinely understand.

Parliament should therefore test not only what ministers intend now, but what legal, technical and governance barriers would allow responsible additional uses while preventing inappropriate expansion later.

### 3. The Bill doesn’t change existing law — but it shifts the dynamics of control

Existing law already permits substantial sharing of patient information for direct care, approved research and emergencies. In practice, clinicians already share information for direct care, many patients can already see much of their GP record digitally through the NHS App, and COVID-19 showed how existing COPI powers could be used to enable rapid NHS-wide sharing.

What this Bill changes is how routinely, how consistently and under whose authority data sharing happens. Current arrangements still rely heavily on local governance, separate data controllers and case-by-case decisions. The SPR would move the NHS towards more standardised, nationally coordinated sharing.

The question, then, is not simply whether data sharing is lawful in principle. It is who decides, on what basis, with what scrutiny, and with what enforceable limits when sharing becomes routine at national scale. That matters all the more when some of the most sensitive data involved sits in GP-held records, where accountability and public trust are already finely balanced.

### 4. The legislation seeks to address longstanding tensions around national access to GP-held records

GP records are among the NHS’s richest data assets, and GP practices remain independent data controllers. The SPR therefore depends on GPs that may be asked to share more routinely while still carrying legal and professional risk – and who, as UPD research shows, remain the people patients expect to explain how their records are used.

If ministers want general practice to support the programme, they will need to show not only that the model is lawful, but that it is workable in practice; protecting both the first principle of medical confidentiality and GP personal liability. It will come down to who decides, what safeguards apply, and how associated burdens on practices will be managed.

Recent experience shows that these issues are practical as well as legal. The 2022 rollout of automatic prospective GP record access through the NHS App was paused after concerns about patient safety, safeguarding and the burden on practices of reviewing records in advance.

Recent reports that the British Medical Association may consider collective action around GP data sharing underline how sensitive this area remains. There is also a risk here that ongoing disputes about workload, contracts - and the future role of general practice - become folded into debates about the Single Patient Record itself.

### 5. Legislation alone will not settle this

Public engagement evidence shows that people are broadly supportive of data use where there is clear benefit, clear limits and a clear explanation. But programmes such as care.data and GPDPR show that reforms can fail, even when lawful, if people feel poorly informed or shut out.

Questions remain about how patient choice will operate within the SPR. The National Data Opt Out does not apply to direct care – it covers research and planning. But ministers have not yet fully resolved whether, and to what extent, patients will be able to opt out of the Single Patient Record being used for direct care or whether there will be a 'public veto' mechanism to safeguard in case future SPR use cases step beyond public acceptability. It also needs to be absolutely clear where the red lines are – including enshrining previous commitments on not using non-consented identifiable data for marketing or insurance purposes. This would provide the public with reassurance that their concerns on this had been heard and it starts to provide a clearer scope on what patient data might be used for in the future.

The parliamentary test is not just whether a joined-up record is desirable, but whether ministers can explain it clearly enough to sustain confidence in practice. The timetable is ambitious. Clinicians could begin to see improved access to records from 2027 in areas such as maternity and frailty care, with patients expected to start viewing SPR information through the NHS App from 2028. Parliament should therefore seek confidence that the model is robust enough to command the confidence of general practice as well as the wider public.

## Four tests for Parliament

### 1. Is the purpose clear?

Parliament should be clear what the Bill itself does, what it leaves to later regulation or guidance, and what uses of data it is meant to support. The most important safeguards should not be left entirely to later implementation.

### 2. Are responsibilities clear?

The Bill should say more clearly who is responsible for decisions about access, sharing, liability and redress, especially as decision-making becomes more centralised.

### 3. Will the public be involved?

Public involvement should be ongoing, visible and tied to real implementation decisions, not treated as a one-off communications exercise. Past NHS data reforms show that support depends on people feeling informed, heard and able to challenge decisions.

### 4. Are the limits on use clear?

The Bill and its implementation should distinguish between direct care and wider secondary uses such as research, planning or AI development, with different safeguards for different kinds of access. It should also be absolutely clear where the red lines sit – including that there should be no non-consented use for marketing or insurance purposes, and limits to wider cross-sector linkage without explicit public co-production and parliamentary scrutiny.

## Questions for Ministers

- *What exactly is the SPR provision intended to do in the Bill, what is left to later regulation or guidance, and which uses of data is the Government asking Parliament to endorse at this stage?*
- *How will responsibilities for access, sharing, liability, redress and public communication be allocated as decision-making becomes more nationally coordinated?*
- *How will patient involvement, choice and opt-out work in practice within and beyond the SPR, and what mechanisms will exist if future uses move beyond current public expectations?*
- *How will the Government distinguish between direct care and wider secondary uses such as research, planning or AI development, and where will the safeguards to prevent inappropriate expansion be set out?*
- *How will new statutory powers fit alongside existing law, planned reforms to the COPI framework and the wider reshaping of health data governance and infrastructure?*

## Authors

**Understanding Patient Data** is an independent initiative hosted by the NHS Alliance and funded by Wellcome, the Medical Research Council, the National Institute for Health and Care Research, NHS England, the Department of Health and Social Care, and the Office for Life Sciences. We exist to make the use of patient data more visible, understandable and trustworthy, so it can be used well, responsibly and for public benefit.

**National Voices** is England's largest VCSE membership body for health and care charities. We have 200+ member charities, who work with us to advocate for more equitable and person-centred health and care. We believe that health and care services are at their best when they are designed with the people who use and need them the most.

**The Association of Medical Research Charities (AMRC)** champions, supports and connects UK medical research charities, helping them fund the best research and improve health for everyone. Our 150 members include household names such as Cancer Research UK and the British Heart Foundation, as well as smaller charities who invest in rare diseases and areas of unmet need. We have a laser focus on their disease areas and a deep understanding of their patient communities. We fund where there's an opportunity to accelerate progress – their research improves lives and offers hope.