PCRS Position Statement

Single Patient Record

June 2026

Summary of PCRS position

A Single Patient Record, which is available to patients and healthcare professionals from different care settings alike, and includes information on investigations, care records, results, medical notes by clinicians and coding information, would optimise resources and improve patient care and outcomes by facilitating timely and accurate transfer of medical information. The Primary Care Respiratory Society (PCRS) believes that the continued reliance on written patient records, multiple non interoperable computer systems which result in poor information flow between care settings, is neither acceptable nor aligned with the NHS's analogue to digital ambition.

Introduction

The PCRS recognises that many of our members across primary, community and secondary/tertiary care face significant barriers to effective patient management due to limited or delayed access to patient notes, investigation results, clinical letters and care records.

PCRS supports the ambitions set out in the NHS 10 Year Plan: Fit for the Future[1] and believes that a core element of the analogue to digital transition must be the creation of a Single Patient Record. Such a system would reduce delays in communication, ensure timely availability of results and enable clinicians to access essential information at the point of care—improving patient outcomes and reducing unnecessary duplication.

We also support giving patients access to this information to enhance their understanding and engagement in their own care. A unified record would further enable more meaningful, integrated use of data across the NHS, strengthening service planning, evaluation and development.

Primary Care Respiratory Society 483 Green Lanes, London, N13 4BS
Registered Charity 1098117 Company No 4298947 VAT Registration Number 866 1543 09
Telephone +44 (0)1675 477600 Email info@pcrs-uk.org Website http://www.pcrs-uk.org

The Primary Care Respiratory Society is grateful to its corporate supporters including AstraZeneca UK Ltd, Chiesi Ltd, GlaxoSmithKline (GSK) plc, Lupin Healthcare Limited, and Trudell Medical for their financial support which supports the core activities of the Charity and allows PCRS to make its services either freely available or at greatly reduced rates to its members. Corporate sponsors have no input into the content of PCRS resources.

Background

In some parts of the NHS, clinicians have used a computerised patient record since the 1990s and many in primary care converted to paperless (computerised records) at the introduction of the Quality and Outcomes Framework (QOF) in 2002.[2] However, there are still some parts of the NHS where paper records are the norm.[3]

It is of concern that, although so many facets of our lives such as online purchasing, banking, etc are now carefully managed by electronic/single systems, this is not yet considered a priority in the NHS.

Many clinicians in areas of the NHS are writing paper records and needing to access multiple different computerised systems (eg, x-ray/imaging, investigations, clinical, national spine, NEWS system, prescription system) within their Trust to deliver care, and these may not communicate with each other, nor with the core patient record in primary care.[3]

There has been considerable research indicating that delays in diagnosis, care and treatment, discussions, advice and duplication of tests are due to delayed or non-existent communication, and research has suggested that repeated work accounts for at least 25–30% of clinical activity.[4,5] The benefits of neighbourhood care and continuity with a single lead clinician are undeniable, but much of the patient's care is shared amongst a variety of healthcare professionals requiring timely access to the patient record to ensure such continuity of care.[6,7] The patient safety concerns about documentation in a variety of non-retrievable sources is clear when we consider drug allergy, prescription and potential interactions, and access to tests. PCRS believes that access to a single computerised record by all healthcare professionals involved in a patient's care that is easily available, comprehensive and simple to code (for research and clinical searching) should be essential in the NHS. PCRS further believes it will improve safety, reduce duplication, support prevention and will more easily support innovation and, with patient access to the record, should enhance patient empowerment.[2]

Perhaps one of the most fundamental concerns with the NHS 10-year plan: Fit for the Future[1] is a drive from analogue to digital without a clear commitment to address the fundamental issue of a Single Patient Record as a requisite.

Conclusion and PCRS position

A Single Patient Record, which is available to patients and healthcare professionals from different care settings alike, would improve patient care and outcomes by supporting the secure, efficient and accurate transfer of medical information to all who require it. The record would include information on and access to investigations, care records, results and medical notes by clinicians, as well as coding for research and system development, which will help the NHS optimise resources. PCRS believes that the continued reliance on written patient records, alongside hospitals using multiple non interoperable computer systems resulting in poor information flow between community, primary and secondary care, is neither acceptable nor aligned with the NHS's analogue to digital ambition.

References

1. UK Government. 10-year Health Plan for England: Fit for the Future. July 2025. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future. Accessed March 2026.
2. Majeed A, Molokhia M. The future role of the GP Quality and Outcomes Framework in England. BJGP Open 2023;7(3):BJGPO.2023.0054. https://doi.org/10.3399/BJGPO.2023.0054
3. Best J. NHS still reliant on paper patient notes and drug charts despite electronic upgrades, The BMJ finds. BMJ 2023;382:2050. https://doi.org/10.1136/bmj.p2050
4. Vrijsen BE, Ten Berg MJ, van Solinge WW, Westerink J. Redundant laboratory testing on referral from general practice to the outpatient clinic: a post-hoc analysis. BJGP Open 2022;6(1):BJGPO.2021.0134. https://doi.org/10.3399/BJGPO.2021.0134
5. De Swart ME, Zonderhuis BM, Hellingman T, et al. Incomplete patient information exchange and unnecessary repeat diagnostics during oncological referrals in the Netherlands: exploring the role of information exchange. Health Informatics J 2023;29(1):14604582231153795. https://doi.org/10.1177/14604582231153795
6. Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018;8(6):e021161. https://doi.org/10.1136/bmjopen-2017-021161
7. Pereira Gray D, Sidaway-Lee K, Johns C, Rickenbach M, Evans PH. Can general practice still provide meaningful continuity of care? BMJ 2023;383:e074584. https://doi.org/10.1136/bmj-2022-074584

Author: Steve Holmes, GP, Somerset

Reviewers: Reviewed by members of the policy committee which includes Helen Ashdown, Chloe Bloom, Dhiren Dayal, Daryl Freeman, Sharon Hall, Steve Holmes, Robert Horne, Aleksandra (Ola) Howell, Sian Jones-Barry, Vincent Mak, Marieke Strange, Rachel Voller

Approved by PCRS Executive policy lead on committee: June 2026