Final stage impact assessment

Title:	Health Bill: single patient record and information sharing
Type of measure:	Primary legislation
Department or agency:	Department of Health and Social Care
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1. Summary of the proposal

Making effective use of data is essential to delivering high quality health and social care, and to provide an evidence base that supports improvements in treatment and outcomes. England has a unique set of datasets, across primary, secondary, and social care, but these are not fully utilised. This is partly due to the incremental way IT infrastructure has been developed, partly due to the diversity of organisations delivering care, and partly because rules governing the use of data have not kept pace with technological improvements that now allow greater security.

The objective of this policy is to improve data sharing through a single patient record to enable patients and health care professionals to access a comprehensive medical record throughout England. This will be supported by a new legal framework, enabled through the Health Bill.

As announced by Secretary of State for Health and Social Care (Secretary of State), in October 2024, the ambition for direct care is to create a Single Patient Record (SPR), which is owned by the patient, and shared across the system, so that every part of the NHS has a full picture of the patient.

The SPR is positioned as a central element of the 10 Year Health Plan for England (10 Year Health Plan) and will be a significant step in creating a more responsive and efficient healthcare system.

The SPR will be available to every person who has visited an NHS health professional in England and will initially cover data from primary and secondary care, expanding over time to include services such as adult social care. It will contain medical history from birth, including diagnoses, physiological data (such as blood pressure), imaging, lab results, treatments, prescriptions and personal care plans.

The core vision for the SPR programme is to:

- Give patients visibility and greater control of their data, enabling them to read, write, share care plans and offer corrections to data, as well as to manage sharing preferences and see who has accessed their record.
- Remove the need for patients to repeat their medical history at each appointment, by giving staff access to a complete and consistent record.
- Provide a single version of the truth that is accessible across care settings.
- Lay the foundations for patient information to flow safely, securely and seamlessly between care providers, benefiting clinicians and social care staff, improving outcomes, making decision-making more informed and speeding up care.

At present, while there are powers to require individual health and care providers to share information with NHS England and/or Secretary of State, they are not considered comprehensive enough to enable the full range of the SPR's expected functionality (such as enabling access to a record by patients). Further, drawing on the recent experiences of *care data*, and GP Data for Planning and Research, the use of public data in a centralised way is likely to be high profile and attract some controversy. It is therefore both necessary and prudent to create specific legislative powers to establish the SPR. Clear statutory provisions

would support public confidence, ensure appropriate parliamentary scrutiny and provide the flexibility needed to adapt to future developments in data use and technology.

The Department of Health and Social Care (DHSC) has conducted public deliberations[1] to inform policy thinking alongside the development of the SPR programme. Patients described it as a 'long overdue fix to fragmented care'.

The aim is to provide a power to establish the SPR (that would be added to the NHS Act 2006) to address 2 problems with the current system – (i) inability of patients to see their entire record and (ii) inability of practitioners to see information provided about their patient by others. Regulations made under the new power will enable the Secretary of State, to:

- Authorise or require patient data to be processed (which could include sharing, ingesting etc), for the purpose of establishing the system.
- Authorise or require data held in the system to be made available to patients and those involved in the delivery of their care.
- Delegate powers to establish the system to a public authority
- Create an offence or other civil sanctions to enforce the regulations

This assessment focuses on the legislative impact of requiring public and private health and social care providers and their IT suppliers to share health and adult social care information with the SPR. It does not assess the wider programme of work, for example the SPR technical solution or NHS App development. The wider programme of work will be scrutinised separately through a dedicated internal business case process.

2. Strategic case for intervention

The NHS has reached a critical juncture in delivering a data-informed, evidence-based health service. At present, there are barriers to effective information flows across the health and care sector.

From a care delivery perspective, better coordination between providers is needed to support electronic discharge summaries, build neighbourhood health systems and run national vaccination and other direct care programmes. These require health care professionals from different providers, as well as NHS England (and the body responsible for NHS data following the planned transition of functions to DHSC), to have read and write access to a shared, comprehensive record built from multiple provider systems. At present, these activities are held back by the absence of a cohesive record.

The merger of NHS England into DHSC provides an opportunity to make provision to ensure the flow of health and care data to support improved clinical care.

Current state

Data sharing varies in the health and care system, but currently neither patients nor their health care professionals can see a complete record, creating risks of errors, duplication,

[1] NHS England (2025), National engagement on data: cohort 2 report (viewed August 2025)

patient safety incidents and limiting patient empowerment. Today, electronic health records for an individual are spread across multiple provider organisations, including GPs, and are controlled and owned by those providers.

Significant progress has already been made in digitisation. NHS trusts are responsible for securing an appropriate Electronic Patient Record (EPR), guided by the What Good Looks Like framework and supported by NHS England's Frontline Digitisation programme. Since 2022, £1.9 billion has been invested in laying the foundations for digital transformation across the health and care system, including rolling-out EPRs to NHS trusts without them and to improve existing systems. As of September 2025, 93% of secondary care trusts had an EPR in place, with 13 in procurement or implementation.[2]

Although EPRs are well established, there is no single source of information for clinicians in delivering care, and the essential information is not always available in a care setting and/or at the time it is needed. This is partly because each individual provider is responsible for facilitating the data flows, which creates administrative burdens each time a data collection is issued (particularly for smaller providers such as GP practices). The large number of providers (for example, over 6,200 GP practices)[3] also means data requests to individual providers are inefficient, and in some cases, providers refuse to share data despite existing duties.

Digital social care records (DSCR) are also expanding. A DSCR, also known as an electronic care plan, allows care information to be recorded digitally and shared in real-time with authorised individuals across the health and care sector. As of July 2025, 80.0% of Care Quality Commission (CQC) registered adult social care provider locations in England are estimated to have a DSCR[4].

As of March 2022, all integrated care boards (ICBs) in England had at least a Connecting Care Records (ConCR)[5,6], providing connected views of an individual's patient data across multiple health and care organisations. While these represent progress in record sharing, their implementation varies between ICBs due to the legacy investments and differing levels of local digital maturity. ConCR are read only (clinicians cannot update or edit them), operate at a regional level and are not shared with patients. They also rely on local agreements for the sharing of data, which limits consistency and scope.

Evidence to support problem statement

Patient data is currently held by and requested from individual providers. With over 6,200 GP practices[7], over 6,100 (brand adjusted) care home providers[8] and hundreds of acute and

[2] DHSC (2025), DHSC letter response to HM Area Coroner Chris Morris (viewed September 2025)
[3] NHS England (2025), General Practice Workforce, 30 June 2025 (viewed August 2025)
[4] DHSC (2025), Adult social care in England monthly statistics (viewed August 2025)
[5] The Connecting Care Records programme is the successor to the Shared Care Record programme.
[6] DHSC (2022), Data saves lives: reshaping health and social care with data (viewed September 2025)
[7] NHS England (2025), General Practice Workforce, 30 June 2025 (viewed August 2025)
[8] DHSC analysis of CQC (2026), CQC Care Directory with filters (viewed August 2025)

community providers in England, the process is highly inefficient. Independent reviews and studies consistently highlight the risks and inefficiencies caused by fragmented information systems and barriers to data access in the NHS.

Lord Darzi's independent investigation of the NHS in England (the Darzi review) highlighted the problems associated with fragmented information systems. The review found a lack of information systems that function seamlessly across different care settings and stressed that despite holding some of the most comprehensive health data in the world, the NHS has yet to fully unlock its value, whether improving day-to-day clinical care, planning services more effectively, or enabling cutting-edge research.

Ipsos asked 1,888 English adults (aged 18 to 75) about their experience with NHS administration.[9] It found that nearly 2 in 3 patients and carers have experienced at least one problem over the last year such as having to chase for test results, attending an appointment but the right information was not available, or inability to change or cancel appointments. They report that this is leading to patient frustration, with 4 in 10 of people who faced administration problems less likely to seek care in the future. They found that this is also fuelling a negative public perception of NHS efficiency, with 56% saying their time was being wasted and 55% felt that NHS staff time was being wasted.

In summary, the status quo does not consistently enable the secure and timely flow of data between health and care organisations throughout England. This represents both market and government failure. Market failure as public and private providers, without government intervention have not created a system whereby data flows optimally across all care settings, resulting in fragmented information systems. This is because the burden to implement the necessary changes are borne at a local level while the benefits, such as the reduction in duplicate tests, time saved reporting and improved health outcomes, could be realised in other settings across the health and social care system (a positive externality resulting in under-provision of data sharing relative to the social optimum). Internationally, countries such as Estonia[10] and Northern Ireland[11], have shown government regulation to be the most effective means to address the issue of achieving compliance with the conditions required for interoperability in health and social care.

Current government intervention has failed to fully coordinate and regulate data sharing across a mixed market of providers. While successive initiatives have sought to improve interoperability and develop local approaches to shared care records, these measures have not been sufficient to deliver system-wide, national patient record sharing. Fragmented information systems continue to create barriers to integrated care, duplication of effort, and missed opportunities to improve safety, efficiency, and population health outcomes. Further government intervention is required to bring together these different sources of information which are obtained and processed under powers set out in existing legislation. While existing legislation contains some powers for the Secretary of State to establish, commission and oversee systems collating health information from different sources, it is not considered

[9] Ipsos (2025), Patients struggling with NHS admin (viewed August 2025)
[10] Willis and others (2018), National Digital Infrastructures for Healthcare: A comparative case of Estonian and British Healthcare Infrastructure page X (viewed August 2025)
[11] Norther Ireland Department of Health (2016), eHealth and Care Strategy, (viewed August 2025)

comprehensive enough to ensure that information can flow safely, and in a timely manner across health and care organisations in England.

3. SMART objectives for intervention

Policy objective for intervention:

The objective of this policy is to improve data sharing through a single patient record to enable patients and health care professionals to access a comprehensive medical record throughout England.

Intended outcomes of intervention:

Patients will no longer need to repeat their medical history at every appointment and healthcare staff will have access to one source of the truth — enabling more informed decision making and saving vital clinical time. The Theory of Change (Figure 1) sets out the intended outcomes in more detail.

This will have consequential benefits across the 10 Year Health Plan:

- **Enabling proactive and preventive care**: support continuous monitoring and proactive management of patients, allowing clinicians to intervene early if a patient's condition deteriorates, potentially preventing hospital admissions.
- **Supporting the shift from hospital to community care**: providing comprehensive patient data in community settings.
- **Driving digital transformation**: assuming a suitable digital patient and professional interface.
- **Improving staff efficiency:** seamless data sharing could save NHS staff time allowing more time for direct patient care.
- **Enabling personalised medicine:** integration of data, will support more tailored, individualised care approaches.

4. Description of proposed intervention and explanation of the logical change process whereby this achieves SMART objectives

The proposed legislation, including regulation making powers, is intended to improve access to health and social care data for direct care.

The proposed legislation will:

1. Allow the Secretary of State the ability to design, establish, develop, operate and maintain the SPR.
2. Enable Secretary of State to require or authorise organisations holding health and adult social care information such as health and care providers and their IT suppliers to be shared into the SPR

3. Require or allow providers to receive data from SPR (including patient uploaded data) back into source clinical systems
4. Require providers to make use of SPR themselves
5. Provide a patient right to access to information in the SPR, subject to necessary exceptions (such as third party data and data that would cause harm)

The intention is not to build a new single IT system, but to harmonise with existing data systems being used by healthcare professionals. The SPR will unify patient data from multiple sources into one accessible platform for patients and clinicians. Clinicians will be able to access the SPR through their existing clinical systems. Patients will access the SPR through the NHS App.

The SPR will integrate with current EPR systems, meaning the impact on medical professionals and staff will be minimised.

Alongside patient contributed data, the requirement to input data to the SPR (which will be set out in regulations) is expected to apply to people involved in the provision to patients of health services or adult social care in England ('providers') examples of the types of providers include but are not limited to:

- **Public health and care providers,** such as primary care providers (such as GP practices) and NHS trusts and foundation trusts.
- **Independent and private sector providers,** such as independent community care providers (such as private home care agencies, hospices), independent hospitals and clinics and adult social care providers.

These provisions will enable Secretary of State to require or authorise health and social care providers and their IT suppliers to process data for SPR purposes, and in turn to update other clinical systems to reflect changes to the SPR. They will also ensure that patients can access the SPR, by enabling access to the SPR by patients (or their proxies).

This is in effect bringing together existing analogous requirements for record keeping and data sharing already in place across the sector.

The SPR will encompass a patient's medical history from birth, including (but not limited to):

- Diagnoses
- Physiological data (such as blood pressure, heart rate)
- Medical imaging
- Laboratory results
- Treatments and procedures
- Prescriptions and medications
- Personal care plans
- Key primary and secondary care NHS interactions

The SPR will be available to every person who has visited an NHS health professional in England. This comprehensive approach ensures that all patients within the NHS system can benefit from having their complete health information in one accessible location.

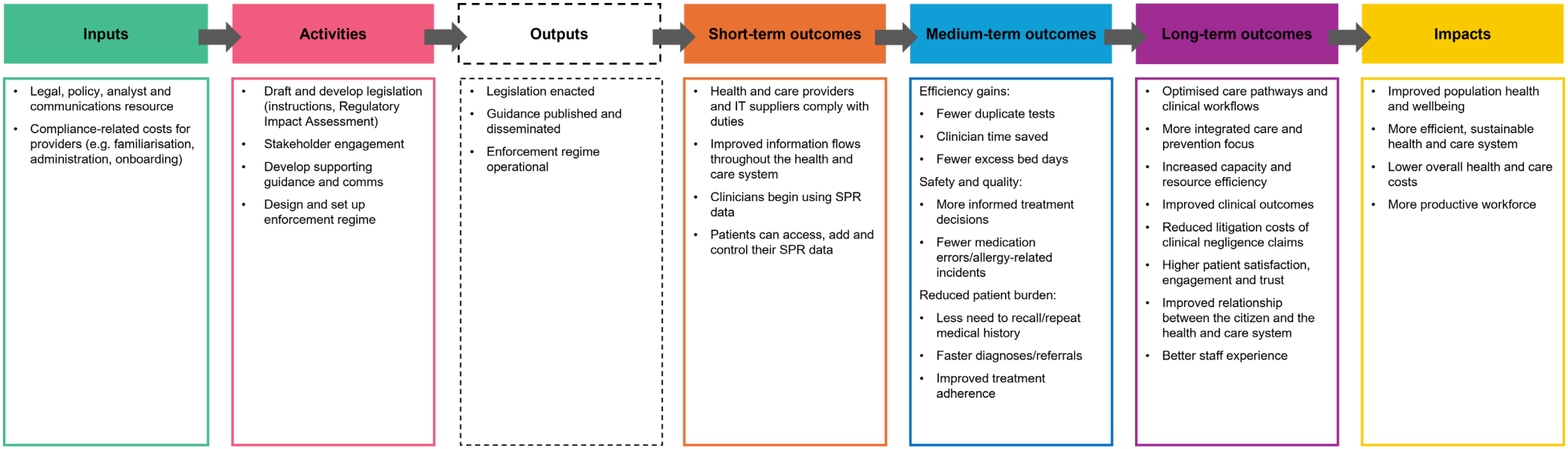
Burden of implementation on providers will be minimised through the platform design. Whichever technical solution is progressed, the intent is to minimise disruption to the clinical source systems of individual providers by ensuring that the provider-system interface is unchanged.

Theory of Change

Figure 1 is a high-level Theory of Change outlining how the preferred option is expected to work, setting out the steps involved in achieving the intended outcomes, the assumptions made, and wider contextual factors.

This Theory of Change has been used to inform the monitoring and evaluation plan.

Figure 1: Theory of Change for preferred option



5. Summary of long-list and alternatives

The steps below outline the process taken to identify and appraise alternative policy options to achieve improved data sharing through a single patient record.

Much of this work was carried out during the development of the 10 Year Health Plan, which started with the Darzi review to understand the true scale of the challenge facing the health service. This was followed by 'Change NHS: help build a health service fit for the future'[12] a national conversation seeking views from the public, staff and patients, and finally the publication of the 10 Year Health Plan.

1. **Identify a long list of options**: Identifying a range of options through public engagement and international comparisons to achieve the policy objective.
2. **Define critical success factors (CSFs) and associated weights**: Defining and agreeing CSFs for the options appraisal provides a consistent and objective framework to analyse each option.
3. **Shortlist viable option(s)**: Objectively score each option against each CSF to determine whether they should progress to the short-list for further assessment or be discounted.
4. **Carry out qualitative and quantitative appraisal**: Qualitative and quantitative appraisal will be carried out on the short-listed options including a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis and cost benefit analysis

Summary of long-list and alternatives

In line with HM Treasury's (HMT) Green Book guidance on best practice for options appraisal, the longlist of policy interventions was generated through a structured process designed to ensure comprehensive consideration of feasible approaches to improving data sharing via a single patient record. Stakeholder engagement, through a series of workshops with DHSC and NHS England (ICB and frontline colleagues), helped refine the options to ensure they were realistic. This systematic approach ensured that the longlist captured both incremental and transformative solutions.

Table 1: Longlist options

Option	Description	Legislative Basis
Option 1: Business As Usual	Continue to rely on a fragmented existing infrastructure, which does not deliver the sharing of records beyond institutional or ICB boundaries (EPR's, ConCR and DSCR). All ICBs have a ConCR, most trusts have an EPR, but maturity and capabilities vary. Progress in record sharing is significant but does not unify patient data nationally for patients and professionals.	None (status quo)
Option 2: Use existing Control of Patient	Use existing legislative powers (such as regulations under	Secondary legislation (New

[12] DHSC (2025), Change NHS: help build a health service fit for the future - initial surveys (viewed August 2025)

Option	Description	Legislative Basis
Information (COPI) legislation and contractual requirements	Section 251 NHS Act 2006) to compel sharing of patient data for a single patient record.	regulations under section 251 of the NHS Act 2006).
Option 3: Use existing legislation (information standards)	Publish information standards under Section 250 Health and Social Care Act 2012 to require systems to meet certain standards and support interoperability.	Secondary legislation (Health and Social Care Act 2012; Data (Use and Access) Act 2025)
Option 4: Legislation to establish the SPR	Use new primary legislation to provide powers for Secretary of State to design, establish, and operate a single patient record.	New primary legislation

Critical Success Factors (CSFs)

In determining what to shortlist for further evaluation, the long list of options have been assessed against a set of CSFs. The CSFs are the attributes that any successful proposal must have if it is to achieve successful delivery of its objectives and are based on HM Treasury Green Book guidance. They have been selected to provide a consistent and objective framework to analyse each option. The set of CSFs used to assess each option are summarised below:

- **Strategic fit and business needs:** To what extent does the option align with national health and care strategies and objectives for integrated records and digital transformation? Consideration is given to the ability to unify patient data and support both patients and health and care professionals.
- **Potential value for money (VFM):** What is the relative scale of benefits achieved by the option, in terms of improved data sharing, patient outcomes, and operational efficiency, balanced against the scale of costs and risks?
- **Capacity and capability:** Can the health and care sector, including IT suppliers, deliver the required service under the option? Is the option attractive and feasible for both providers and suppliers?
- **Potential affordability:** What are the relative costs of each option compared to available budgets and resources?
- **Potential achievability:** How likely is the option to be delivered successfully, considering the complexity of implementation, stakeholder engagement, and the time required for transition?

Appraisal of long-list options

Table 2 presents an options scoring matrix, where all options were assessed and scored using a scale of 4 intervals. To arrive at a final score, equal weighting was applied to all criteria. The options assessment process was undertaken as part of the development of the 10 Year Health Plan. Strategic fit was based on alignment with the policy objective. The policy objective was developed using evidence, input from subject matter experts and the views of stakeholders. Scores generally reflect how well each options performs relative to each other.

Table 2: Appraisal of options against CSFs

Option	Strategic Fit & Business Needs [13]	Value for Money[14]	Supplier Capacity & Capability[15]	Affordability[16]	Achievability [17]
Option 1: Business As Usual	Not aligned	No change	High capacity & capability	Within budget	Highly achievable
Option 2: Use existing legislation (COPI) and contractual requirements	Moderately aligned	Medium VfM	High capacity & capability	Within budget	Moderately achievable
Option 3: Use existing legislation (information standards)	Low alignment	Low VfM	High capacity & capability	Within budget	Moderately achievable
Option 4: Legislation to establish th e SPR	Highly aligned	High VfM	High capacity & capability	Within budget	Moderately achievable

Option rankings

Based on the scoring assessment, the options were ranked from 1 to 4, as set out in the table 3.

Table 3: Option ranking

Rank	Score	Option	Rationale
1	19	Option 4: Legislation to establish the SPR	This option is highly aligned with achieving improved data sharing through a single patient record as it enables the powers needed to achieve it in full. The analysis estimates high value for money (central Net Present Social Value (NPSV) estimate is £76.8million over a ten-year). IT suppliers are likely to have high capacity and capability to deliver this option and it scores strongly in relation to affordability and achievability.
2	17	Option 2: Use existing legislation (COPI) and contractual requirements	This option is moderately aligned with achieving improved data sharing through a single patient record as it will not enable all the powers needed such as rights of patients and types of information. Given the lower

[13] For Strategic Fit & Business Needs the scale was 'Not aligned, low alignment, moderately aligned, strongly aligned'.
[14] For Value for Money (VfM) the scale was 'No VfM, low VfM, medium VfM, high VfM'
[15] For Supplier Capacity & Capability the scale was 'No capacity & capability, low capacity & capability, moderate capacity & capability, high capacity & capability'
[16] For Affordability the scale was 'Significantly over budget, moderately over budget, just over budget, within budget'
[17] For achievability the scale was 'Not achievable, low achievability, moderately achievable, highly achievable'

Rank	Score	Option	Rationale
			benefits and the associated costs, it represents medium value for money. IT suppliers are likely to have high capacity and capability to deliver this option and it scores strongly in relation to affordability and achievability
3	15	Option 3: Use existing legislation (information standards)	This option is weakly aligned with achieving improved data sharing through a single patient record as it will not enable data to be required to be shared with the SPR, making data sharing voluntary. Previous experience suggests voluntary compliance will not achieve a high enough compliance rate, undermining the policy objective. Given the lower benefits and associated costs, it represents low value for money. IT suppliers are likely to have high capacity and capability to deliver this option and it scores strongly in relation to affordability and achievability.
4	14	Option 1: Business as usual	This option is not aligned with achieving improved data sharing through a single patient record as it will not meet the strategic aims or business needs. Given this, it represents no change in relation to value for money. IT suppliers are likely to have high capacity and capability to deliver this option as it doesn't require change and so it scores strongly in relation to affordability and very strongly in relation to achievability.

6. Description of shortlisted policy options carried forward

Following the assessment against the CSFs, only 2 options: Business as Usual and Option 4 were taken forward into the shortlist for full analysis.

While other options demonstrated technical feasibility and fell within indicative budget constraints, they failed to adequately meet the criteria for strategic fit and business needs and were therefore discounted as viable options to carry forward to the shortlist. There were concerns these intermediate options would only deliver marginal improvements and risked perpetuating fragmented data flows, potentially undermining the overarching policy objective of improving data sharing through a single patient record.

Option 2 would enable data to be required for the purposes of the SPR but would not have the flexibility needed to meet all the strategic aims of the business (such as rights of patients or types of information). Option 3 would not enable Secretary of State to require data be shared, so lower compliance levels would be expected. Similar costs across these options are expected and therefore Option 2 and Option 3 with lower benefits than Option 4, would most likely lead to a lower value for money.

Business as Usual was retained as a baseline comparator in line with HM Treasury Green Book guidance, and Option 4 was selected as the highest scoring option.

The SPR was announced by the Secretary of State and is a key deliverable in the 10 Year Health Plan, which committed to using legislation to support its delivery.

Rationale for Primary Legislation (Preferred Option)

Primary legislation is preferred for the following reasons:

- **Greater clarity and certainty:** Provides clear, robust powers with fewer potential gaps, ensuring all necessary aspects of the SPR can be delivered.
- **Effective enforcement mechanisms:** Enables a full compliance and enforcement system to be developed
- **Increased longevity:** Establishes enduring powers in primary legislation, supporting the SPR's sustainability and adaptability over time.

SWOT Analysis of Shortlisted Options

To get a better understanding of the 2 shortlisted options, a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis was conducted. This provided a structured framework for understanding the pros and cons of each option, helping to inform future decision making.

Option 1: Business as Usual

Strengths:

- There will likely be some incremental improvements to the current fragmented service offered to patients built on utilising the existing NHS architecture but not the wholesale changes required.
- No additional costs will be incurred as current plans are being implemented and delivered.

Weaknesses:

- The fragmentation of patient data can make it difficult for clinicians to access up to date medical history, and can lead to redundant testing, misdiagnoses, and adverse medical outcomes. Therefore, unlikely to enable full functionality envisioned by SPR.
- Information often has to be manually shared and entered into multiple systems, giving rise to duplicate records, increased likelihood of error or missing information, repeated testing and delay in diagnosis and treatment, as well as creating a data burden on front line clinicians
- Ensuring compliance with data protection regulation, such as General Data Protection Regulaion (GDPR), becomes more complex when patient data must be shared across disconnected systems. Hence, the risks relating to patient privacy and security should be taken into consideration
- Does not provide a separate legal basis for sharing and accessing data for the SPR.

Opportunities:

- Has the potential to enable a SPR type solution earlier and within existing budgets by utilising existing infrastructure.
- Has the potential to position the existing system in readiness for future innovation, as there are multiple products and services operating at a national, regional, and local levels across health and social care, though none provide the full set of capabilities expected from the SPR in one complete, end-to-end solution.

Threats:

- There is a risk of non-compliance due to the differences in the health and social care provider and IT supplier markets. Providers and IT suppliers may resist the change if not properly consulted and their views considered in the end-to-end SPR design.
- There is a potential risk to any future implementation if the existing transformation programmes are not adequately resourced or managed due to a siloed approach to delivery.
- Carrying on with the same approach will not deliver on the desired outcomes and fail to enable full functionality.

Option 4: Primary Legislation (preferred option)

Strengths:

- A bespoke legislative framework for the establishment and operation of the SPR which would ensure greater clarity, transparency and public confidence, and, from a legal perspective, a more robust basis on which to ensure compliance with Article 8 of the European Convention of Human Rights (ECHR), the UK GDPR and the common law duty of confidence.
- Legislation requiring the sharing of information will allow a comprehensive view of health and care information across care settings. It will give both patients and professionals secure access to a single, accurate and up-to-date record.
- New legislation will introduce new powers that supports the robust enforcement and compliance of the SPR system by imposing financial penalties on any person or organisation, who without reasonable excuse, fails to comply with a requirement imposed.

Weaknesses:

- Loss of public trust and concerns around data security, impacting adoption if failure to implement data security measures that comply with all relevant regulations and best practices, including clear parameters for data processing and legal basis.
- Proactive engagement with the public will be required to address concerns and build support for the legislation.

Opportunities:

- New primary legislation underpins the SPR which will:
  - Drive digital transformation and integration across health and care by providing a comprehensive view of patient health and care information, giving both patients and professionals secure access to a single, accurate and up-to-date record.
  - Give patients more ownership and control. No more being a passive recipient of care, but an active partner with their health information literally at their fingertips. The ability to read, write, share, and manage their own health story.
  - Reimagining how care is delivered, putting patients truly at the centre, and creating a digital backbone that will enable innovation across the entire health and care system for decades to come.

Threats:

- Potential resistance from stakeholders such as a loss of professional trust due to inadequate clinical leadership and engagement and unclear relevant use cases
- There is a risk that ICBs and trusts continue to make strategic investment decisions that do not align to the direction of the SPR due to a lack of clarity around the future role of the SPR.
- Implementation risks if not adequately resourced or managed.

Conclusion:
The options assessment demonstrates that while existing infrastructure and legislation offer partial solutions, only new primary legislation (Option 4) provides all 3 of the clarity, enforceability, and longevity required to deliver a truly unified SPR, as committed to in the 10 Year Health Plan.

Small and Micro Business Assessment (SaMBA) and medium-sized business impact of Option 4

Micro businesses are defined in the better regulation framework guidance as those with under 10 employees. Small businesses have between 10 and 49 employees. Medium businesses have in the range of 50 to 499 employees. For consistency with the Department for Business, Energy & Industrial Strategy (BEIS) small and medium enterprises (SMEs) action plan: 2022 to 2025[18], medium businesses have been classified as having between 50 and 249 employees.

A number of factors mean that regulatory changes may fall disproportionately on micro, small and medium size businesses.

Government has committed to considering whether the impacts of the legislative changes will fall disproportionately on them, and whether such businesses could be exempted from

[18] BEIS (2023), BEIS small and medium enterprises (SMEs) action plan: 2022 to 2025 (viewed August 2025)

the legislation, or the impacts mitigated in some way without compromising the policy objectives.

The impact on the following groups of private business has been assessed, as they provide a good representation of those in scope of the preferred option:

- Independent hospitals
- GP practices not funded by the NHS
- Community pharmacies not contracted by the NHS
- Private community care providers
- Dental practices not supplying any NHS dental care
- Private care home providers (including charities)
- Private home care providers (including charities)
- IT suppliers of health and care providers.

Table 4 summarises the number of private businesses in scope of the legislation by size. Table 15 shows the number of organisations in scope of the legislation by organisation type and size.

Table 4: Private businesses in scope of the legislation, by size

Business size	Number of businesses	Proportion of total businesses affected
Micro businesses	5,505	28%
Small businesses	9,021	46%
Medium businesses	4,096	21%
Large businesses	870	4%
Total businesses	19,492	100%

Note: (i) Totals may not sum due to rounding (ii) The costs of this legislation are expected to be felt at the provider level, meaning a provider with 3 care home locations would experience costs once. Where possible, organisation numbers have been brand adjusted to account for companies that have multiple locations. In many instances it was not possible to make this adjustment. So, for example, individual GP practices and dental practices have been counted, overstating the aggregate costs.

Of all businesses assessed to be in scope of the preferred option, this analysis estimates 75% are small or micro businesses (compared with approximately 99% of all UK businesses that are small and micro) and 21% are medium businesses. This is composed of 5,505 micro businesses, 9,021 small businesses and 4,096 medium businesses that are in scope of this legislation.

Businesses have been categorised into size according to headcount. A range of data and methods have been used including organisation level headcount data, Office for National

Statistics (ONS) statistics on size for specific organisation types, such as Dental Practices[19], and in limited cases where no better data is available, business population estimates published by the Department for Business and Trade (DBT)[20].

While the number of micro, small and medium businesses affected by this legislation is large, the cost per organisation is limited.

All micro, small and medium health and care providers and IT suppliers are expected to incur direct familiarisation costs because of this legislation.

Micro, small and medium health and care providers and IT suppliers are expected to incur direct administration costs where they are not compliant prior to the introduction the legislation.

Micro, small and medium IT suppliers are expected to incur direct onboarding costs where they are not compliant prior to the introduction of the legislation. These costs apply directly to IT suppliers and are expected to be passed on to health and care providers. This is because while the legislation targets both health and care providers and IT suppliers, it is the IT suppliers that must make any technical onboarding changes. The passing on of these costs to health and care providers is discussed in the distributional impacts section.

Further descriptions of the costs and how they have been calculated can be found in section 6.

Table 5: Costs type incurred by private organisation grouping

Cost	Health care and providers	IT suppliers
Familiarisation costs	✓	✓
Administration costs	✓	✓
Onboarding costs	*Not incurred directly*	✓

Note: Onboarding costs apply directly to IT suppliers where they are not compliant prior to the introduction of the legislation and are expected to be passed on to health and care providers. This is because while the legislation targets both health and care providers and IT suppliers, it is the IT suppliers that must make any technical onboarding changes. The impact of this is discussed in the distributional impacts section.

To address the risk that costs have been understated due to assumptions around timing, complexity or achievability, an optimism bias uplift of 54% has been applied to all cost estimates. This follows HMT Green Book guidance[21] on the upper bound optimism bias for 'Equipment or Development' projects in the absence of a more suitable project type.

Including optimism bias of 54%, familiarisation costs for micro and small business are estimated to be £250 (with a range of £130 to £380 given the uncertainty of implementation details and availability of evidence). Administration costs for micro and small business that are not compliant prior to the introduction of legislation are estimated to be £550 (with a

[19] ONS (2024), Dental practices by size and location (viewed August 2025)
[20] DBT (2024), Business population estimates for the UK and regions 2024: statistical release, (viewed August 2025)
[21] HM Treasury (2013), Green Book Optimism Bias Guidance (viewed August 2025)

range of £270 to £820). Onboarding costs for small and micro IT suppliers that are not compliant prior to the introduction of legislation are estimated to be £43,870 (with a range of £21,930 to £65,800).

Table 6: Estimated cost per affected small and micro business

Cost	Central	Low	High
Familiarisation cost	£250	£130	£380
Administration cost	£550	£270	£820
Onboarding cost	£43,870	£21,930	£65,800

Including optimism bias of 54%, familiarisation costs for medium business are estimated to be £500 (with a range of £250 to £760 given the uncertainty of implementation details and availability of evidence). Administration costs for medium business that are not compliant prior to the introduction of legislation are estimated to be £1,100 (with a range of £550 to £1,650). Onboarding costs for medium IT suppliers that are not compliant prior to the introduction of legislation are estimated to be £43,870 (with a range of £21,930 to £65,800).

Table 7: Estimated cost per affected medium business

Cost	Central	Low	High
Familiarisation cost	£500	£250	£760
Administration cost	£1,100	£550	£1,650
Onboarding cost	£43,870	£21,930	£65,800

Achieving a successful SPR will require all constituent parts of the health and care system and IT suppliers to integrate. Exemptions for micro, small and medium size businesses have been considered, but ruled out on the basis that exemption of any size business would undermine the policy objective of a single source of truth for patient records.

The costs of this legislation on micro, small and medium businesses are recognised. The burden of familiarisation costs will be mitigated by the issuance of guidance notes. These notes will provide tailored information and advice which will be adequate to support compliance with legislation. This is particularly helpful for smaller businesses, reducing the time required to understand the legislation and navigate the changes needed.

More widely, the NHS has experience of programmes like this, the lessons of which can be drawn upon to improve the experience for business. For example, the proof-of-concept work is considering how the SPR technical solution can be delivered in a way that supports all sizes of business, including health and care providers and IT suppliers to keep technical onboarding costs to a minimum.

7. Costs and benefits

Summary of Net Present Social Value

The central Net Present Social Value (NPSV) estimate is £76.8 million over a 10–year appraisal period (2026 to 2027 prices). To reflect uncertainty in evidence and assumptions used a range has been modelled: a low NPSV of -£23.0 million and a high NPSV of £124.0 million.

Summary of cost benefit analysis methodology

The methodology for calculating the costs and benefits of the SPR legislation involves estimating direct transitionary costs such as familiarisation, administration, and onboarding (the latter 2 are incurred by health and care providers and IT suppliers who would otherwise be non-compliant without the legislation). Benefits were assessed by monetising the additional national-level interoperability gains such as reduced duplicate testing, time savings, and fewer medication errors that are attributable to the legislation from increased compliance, while also incorporating non-monetised qualitative benefits.

For this analysis, non-compliance refers to the proportion of health and care providers and IT suppliers not sharing data with and receiving data from the SPR prior to the introduction of this legislation and does not refer to a failure to meet any existing legislative requirements.

As this is primary legislation and the SPR programme is still in development, the costs and benefits of the SPR legislation reported in this impact assessment (IA) are largely illustrative. With limited information available, evidence and assumptions from analogous measures have been used to provide reasonable estimates. To reflect uncertainty, low, central and high scenarios have been developed. Where quantitative evidence is not available, qualitative analysis of impacts has been undertaken. Although an NPSV figure is presented, it does not provide a complete assessment of the costs and benefits. Both quantitative and qualitative impacts have been thoroughly considered, supporting the conclusion that the preferred option is expected to deliver a net positive outcome for society.

The cost benefit analysis assumes that a SPR technical solution is in place. SPR technical solution refers to the architecture to enable transfer of information between health and care providers at a national level, which is a key dependency for realising the benefits of the legislation. The impact of the SPR solution not being delivered effectively has been explored in the sensitivity analysis section.

The wider programme costs of the technical solution and the NHS App development do not form part of this assessment as they are not considered part of the legislative changes but will form part of the cost benefit analysis for the wider programme business case that is subject to internal government scrutiny.

Equivalent Annual Net Direct Cost to Business (EANDCB)

This section estimates the Equivalent Annual Net Direct Cost to Business (EANDCB).

The estimated EANDCB is £1.8 million. To reflect uncertainty in evidence and assumptions used, a range has been modelled: a low EANDCB of £0.5 million and a high EANDCB of £3.0 million.

The impact on the following groups of private business has been assessed:

- Independent hospitals
- GP practices not funded by the NHS
- Community pharmacies not contracted by the NHS
- Private community care providers
- Dental practices not supplying any NHS dental care
- Private care home providers (including charities)

- Private home care providers (including charities)
- IT suppliers of health and care providers.

The direct monetised costs include:

- Familiarisation
- Administration
- Onboarding

No direct benefits of this legislation to business have been monetised.

Table 8: Direct costs to private business (contributing to the EANDCB), present value over the 10-year appraisal period, 2026 to 2027 prices

Cost type	Direct costs to private businesses, present value over 10-year appraisal period, 2026 to 2027 prices
Familiarisation cost	£6.4m
Administration cost	£8.1m
Onboarding cost	£1.0m

Further detail on the basis for the costs reported in the EANDCB is given in the following section.

Summary of costs

This IA estimates the costs of introducing the legislation. These costs are closely linked to the eventual SPR technical solution, since the legislation will require integration with that solution. As potential SPR solutions are still at proof-of-concept stage, cost estimates are largely illustrative. With limited information available, evidence and assumptions from analogous measures have been used to provide reasonable estimates. To reflect uncertainty, low, central and high scenarios have been developed.

The impact on the following organisations has been assessed:

- NHS trusts
- GP practices funded by the NHS
- Community pharmacies contracted by the NHS
- Community care providers (NHS and local authority funded)
- Dental practices supplying some NHS dental care
- Public care homes providers
- Public home care providers
- Local authorities
- Independent hospitals
- GP practices not funded by the NHS
- Community pharmacies not contracted by the NHS
- Private community care providers
- Dental practices not supplying any NHS dental care
- Private care home providers (including charities)
- Private home care providers (including charities)

- IT suppliers of health and care providers.

The total number of organisations judged to be affected is 43,857.

The main legislative costs are expected to be:

- Familiarisation
- Administration
- Onboarding
- Enforcement

The wider programme costs of the technical solution and the NHS App development do not form part of this assessment as they are not considered part of the legislative changes but will form part of the cost benefit analysis for the wider programme business case that is subject to internal government scrutiny.

Only organisations that transition from non-compliance to compliance as a result of the legislation will incur administration and onboarding costs as they represent the changes required to meet the legislation. Familiarisation costs are incurred by all organisations in scope of the legislation because even those who are compliant will need to understand the new obligations.

Given the limited applicable evidence on data sharing compliance across health and social care settings, compliance with information standards has been used as a proxy:

- Low scenario: Non-compliance rate of 17% based on the proportion of health and care providers that were non-compliant with the NHS number information standard[22] prior to the introduction of information standards legislation.

- Central scenario: Non-compliance rate of 58% based on the average non-compliance of health and care providers with information standards[23] excluding NHS number[24] prior to the introduction of information standards legislation.

- High scenario: Non-compliance rate of 71% based on proportion of health and care providers that were non-compliant with the Dictionary of Medicines and Devices information standard[25] prior to the introduction of information standards legislation.

At the level of individual providers, costs are expected to be minimal. The type of information required is already routinely collected and recorded by health and care providers during patient interactions, and the structure of data for integration will be defined through information standards. Providers and suppliers are already obliged to comply with these

[22] DHSC (2024), Data (Use and Access) Bill: open data architecture information standards impact assessment, based on Information Standards and Interoperability Survey, NHS, Feb 2024 – available in Table 3, and DHSC (2025) Health and Care Act 2022, section 95: open information standards and private provider enforcement measures impact assessment

[23] Including only the standards measured in the Information Standards and Interoperability Survey, NHS, Feb 2024.

[24] DHSC (2024), Data (Use and Access) Bill: open data architecture information standards impact assessment, based on Information Standards and Interoperability Survey, NHS, Feb 2024 – available in Table 3, and DHSC (2025) Health and Care Act 2022, section 95: open information standards and private provider enforcement measures impact assessment

[25] DHSC (2025), Health and Care Act (HCA) 2022 Section 95 Open Information Standards Impact Assessment (viewed August 2025)

standards under existing legislation, with the impacts of that requirement assessed in previously published Regulatory Impact Assessments.[26,27]

Without known implementation details it has been assumed affected organisations face costs in year 1 of the legislation. In reality, implementation is likely to be phased.

To address the risk that costs have been understated due to assumptions around timing, complexity or achievability, an optimism bias uplift of 54% has been applied to all cost estimates. This follows HMT Green Book guidance[28] on the upper bound optimism bias for 'Equipment or Development' projects in the absence of a more suitable project type.

Monetised costs

The total direct cost of the introduction of legislation is estimated to be £32.8 million, with a range of £10.2 million to £55.1 million. This includes familiarisation costs, administration costs and onboarding costs, which all occur in year 1 only (transition costs).

These costs are broken down by organisation type and cost type below.

Table 9: Monetised costs of SPR legislation (including optimism bias) by organisation type, undiscounted, 2026 to 2027 prices

Organisation Type	Public or Private*	Number of providers (brand adjusted) or practices**	Familiarisation costs	Administration costs	Onboarding costs
NHS trusts	Public	205	£185,000	£160,000	*Not incurred directly*
GP practices (funded by NHS)	Public	5,837	£2,745,000	£2,367,000	*Not incurred directly*
Community Pharmacies (contracted by NHS)	Public	10,399	£3,248,000	£2,802,000	*Not incurred directly*
Community Care Providers (NHS and local authority funded)	Public	257	£80,000	£69,000	*Not incurred directly*
Dental practices (supplying some NHS dental care)	Public	7,350	£2,261,000	£2,848,000	*Not incurred directly*
Public Sector Care Home Providers	Public	*Small proportion*	£0	£0	*Not incurred directly*
Public Sector Home Care Providers	Public	*Small proportion*	£0	£0	*Not incurred directly*

[26]DHSC (2025), Health and Care Act (HCA) 2022 Section 95 Open Information Standards Impact Assessment (viewed August 2025)
[27] DHSC (2024), Data (Use and Access) Bill: Open Data Architecture Information Standards Impact Assessment (viewed August 2025)
[28] HM Treasury (2013), Green Book Optimism Bias Guidance (viewed August 2025)

Organisation Type	Public or Private*	Number of providers (brand adjusted) or practices**	Familiarisation costs	Administration costs	Onboarding costs
Local authorities	Public	317	£240,000	£302,000	*Not incurred directly*
Independent Hospitals	Private	172	£87,000	£109,000	*Not incurred directly*
GP practices (not funded by the NHS)	Private	373	£147,000	£185,000	*Not incurred directly*
Community Pharmacies (not contracted by NHS)	Private	*Small proportion*	£0	£0	*Not incurred directly*
Private Community Care Providers	Private	557	£146,000	£184,000	*Not incurred directly*
Dental practices (not supplying any NHS dental care)	Private	3,150	£969,000	£1,221,000	*Not incurred directly*
Private Care Homes Providers including charities (brand adjusted)	Private	6,145	£2,130,000	£2,683,000	*Not incurred directly*
Private Home Care Providers including charities (brand adjusted)	Private	9,055	£2,896,000	£3,649,000	*Not incurred directly*
Private IT suppliers	Private	40	£19,000	£24,000	£1,018,000
Total	**Mix**	**43,857**	**£15,153,000**	**£16,604,000**	**£1,018,000**

Notes: (i) Totals may not sum due to rounding (ii) Impacts related to activities of private sector bodies in the delivery of public services such as pharmacists or dentists providing NHS funded services have been classified as public for this IA. (iii) The costs of this legislation are expected to be felt at the provider level, meaning a provider with 3 care home locations would experience costs once. Where possible, organisation numbers have been brand adjusted to account for companies that have multiple locations. In many instances it was not possible to make this adjustment. So, for example, individual GP practices and dental practices have been counted, overstating the aggregate costs. (iv) Onboarding costs apply directly to IT suppliers where they are not compliant prior to the introduction of the legislation and will be passed on to health and care providers. This is because while the legislation targets both health and care providers and IT suppliers, it is the IT suppliers that must make any technical onboarding changes.

Familiarisation costs

As with any new legislation, staff time will be required for organisations to understand the new obligations and how they apply. These costs apply directly to all health and care providers and IT suppliers. This cost is transitionary, occurring in year 1 only.

DHSC expect familiarisation requirements to be relatively limited. Data sharing processes already exist between NHS England, health and care providers and their IT suppliers, and the burden of data collections on providers are often assessed by NHS England as being minimal.

Data Provision Notices (DPNs) are currently used by NHS England to request data from health and care providers[29]. In instances where the data can be automatically extracted and the information required is routinely collected and recorded by health and care provider systems, the cost on health and care providers is minimal. A sample of DPNs where collections can be automatically extracted and the information is routinely collected is shown in table 10. Alongside this is NHS England's assessment of the associated time burden on providers, ranging from 4 minutes to 30 minutes per provider.

Table 10: NHS England time burden assessment of Data Provision Notices

Data Provision Notice	Date	Time burden on providers
GP Appointments Data[30]	November 2023	30 minutes per provider
General Practice to Diabetic Retinopathy Screening (GP2DRS)[31]	September 2021	4 minutes per General practice manager
Physical Health Checks for people with Severe Mental Illness (PHSMI)[32]	November 2020	4 minutes per General practice manager. 15 minutes for fair processing of patient information.
Learning Disabilities Data[33]	August 2020	4 minutes per General practice manager.
Individual GP Level Data[34]	August 2017	4 minutes per General practice manager. 15 minutes for fair processing of patient information

Given uncertainty around the implementation details and that the SPR would likely equate to multiple data collections at the outset, the following assumptions for the central estimate have been made:

- Micro and small organisations: 4 hours familiarisation time for senior managers
- Medium organisations: 8 hours familiarisation time for senior managers

[29] NHS England (2023), Data Provision Notices (viewed August 2025)
[30] NHS England (2023), GP Appointments Data DPN Version 3.0 (viewed August 2025)
[31] NHS England (2021), General Practice to Diabetic Retinopathy Screening (GP2DRS) Data Provision Notice (viewed August 2025)
[32] NHS England (2020), Physical Health Checks for people with Severe Mental Illness (PHSMI) (viewed August 2025)
[33] NHS England (2020), Learning Disabilities Data (viewed August 2025)
[34] NHS England (2020), Individual GP Level Data DPN (viewed August 2025)

- Large organisations: 12 hours familiarisation time for senior managers

To reflect uncertainty, a range of ±50% in the high and low scenarios has been modelled.

For organisations using Agenda for Change[35] pay rates, it is assumed the person is Band 8b (for example Strategic Management) with 2 to 5 years' experience. For other organisations, the median wage of a corporate manager and director is assumed[36]. To account for the full cost of employment, wages have been uplifted by 35% for Agenda for Change pay rates and 30% for other organisations.

All organisations, regardless of their compliance rate prior to the introduction of the legislation will incur familiarisation costs because even those who are compliant will need to understand the new obligations.

The ten-year present value of familiarisation costs is estimated to be £15.2 million, with a range of £7.6 million to £22.7 million.

Administration costs

Staff time will also be required to oversee and support successful completion of new obligations. These costs cover organisational activities such as updating best practices, communication and training material needed to bring the organisation in line with the legislation. These costs apply directly to health and care providers and IT suppliers where they are not compliant prior to the introduction of the legislation. This cost is transitionary, occurring in year 1 only.

Given uncertainty around the implementation details of SPR, evidence from an analogous measure outside of health has been used: the National Underground Asset Register (NUAR)[37]. NUAR legislation requires underground asset owners (like gas pipes, water mains and telecommunications cables) to share their data digitally with a central platform. Engagement with underground asset owners indicated administration costs of 10 hours of a STEM (Science, Technology, Engineering and Mathematics) professional's time per organisation. Given the similarities between NUAR and the SPR legislation, following assumptions for the central estimate have been made:

- Micro and small organisations: 10 hours administration time for STEM professionals
- Medium organisations: 20 hours administration time for STEM professionals
- Large organisations: 30 hours administration time for STEM professionals

To reflect uncertainty, a range of ±50% in the high and low scenarios has been modelled.

For organisations using Agenda for Change[38] pay rates, it is assumed the person is Band 6 (for example Health Records Manager) with 2 to 5 years' experience. For other organisations, the median wage of a science, research, engineering and technology

[35] NHS (2026), Agenda for Change pay rates (viewed August 2025)
[36] ONS (2025), Earnings and hours worked (ASHE Table 1) (viewed December 2025)
[37] Department for Science, Innovation and Technology (2024), Data (Use and Access): Legislation to deliver the National Underground Asset Register (viewed August 2025)
[38]NHS (2026), Agenda for Change pay rates (viewed August 2025)

professional is assumed[39]. To account for the full cost of employment, wages have been uplifted by 35% for Agenda for Change pay rates and 30% for other organisations.

Only organisations that transition from non-compliance to compliance as a result of the legislation will incur administration costs as they represent the changes required to meet the legislation. 3 baseline compliance rates (representing conditions prior to the introduction the legislation) have been considered as central, low and high scenarios (details provided in the summary of costs section).

The ten-year present value of administration costs is estimated to be £16.6 million, with a range of £2.4 million to £30.5 million.

Onboarding costs

The SPR technical solution will be designed to integrate with existing architecture with minimal additional resource needed and will not make additional demands on providers to digitise. The structure of data required for integration will be defined through mandatory information standards, which health and care providers and IT suppliers are already obliged to comply with through existing legislation.

However, as the SPR technical solution has not been confirmed, it is not possible to be certain that there will be zero costs of integrating with the SPR. It has therefore been assumed some technical onboarding costs are incurred by IT suppliers of health and care providers to ensure smooth integration. These costs apply directly to IT suppliers where they are not compliant prior to the introduction of the legislation and will be passed on to health and care providers. This is because while the legislation targets both health and care providers and IT suppliers, it is the IT suppliers that must make any technical onboarding changes. These costs are transitionary, occurring in year 1 only.

With exact implementation details unavailable and limited evidence, NUAR legislation has again been used as an analogous measure (see explanation of NUAR in administration cost section). The NUAR IA[40] assumed initial transformation costs based on a team of 10 science, research, engineering and technology professionals working 8 hours per working day across 10 working days. Given the in-house capability of the IT suppliers, it has been assumed they would not contract an external transformation team. While a need for data transformation is not envisaged, these costs have been used as indicative estimates for IT suppliers to ensure smooth onboarding with the SPR.

The following assumptions for the central estimate have been made:

- All size IT suppliers: 800 hours of onboarding time for science, research, engineering and technology professionals.

To reflect uncertainty a range of ±50% in the high and low scenarios has been modelled.

[39]ONS (2025), Earnings and hours worked (ASHE Table 1) (viewed December 2025)
[40] Department for Science, Innovation and Technology (2024), Data (Use and Access): Legislation to deliver the National Underground Asset Register (viewed August 2025)

It is assumed that the people have a median wage of a science, research, engineering and technology professionals[41]. To account for the full cost of employment, wages have been uplifted by 30%.

Only organisations that transition from non-compliance to compliance as a result of the legislation will incur onboarding costs as they represent the changes required to meet the legislation. 3 baseline compliance rates (representing conditions prior to the introduction the legislation) have been considered as central, low and high scenarios (details provided in the summary of costs section).

The ten-year present value of familiarisation costs is estimated to be £1.0 million, with a range of £0.1 million to £1.9 million.

Unmonetised costs

Enforcement

The bill will extend enforcement powers with respect to anyone who does not comply with the relevant activity.

The SPR programme is at an early stage, and no decision has been made on the approach to enforcement; therefore, this provision has not been monetised. More detail will be provided at secondary legislation stage.

Distributional impacts

The onboarding costs are expected to be incurred by IT suppliers and passed on to health and care providers through higher fees in contracts or one-off charges.

Cost recovery is standard business practice and given many IT suppliers are rooted in clinical workflows, they may have confidence that they can pass on costs to health and care providers without losing customers.

This has not been included as an indirect cost to avoid double counting in line with the Better Regulation Framework.

It is unclear exactly how much of the cost will be passed on to health and care providers by IT suppliers. Assuming 100% of the onboarding costs are passed on, this would be £1.0 million across health and care providers. To estimate how much cost is passed on to which organisations CQC fee income has been used as a proxy for activity across sectors. CQC fees are calculated by reference to turnover, others by the number of locations, chairs or persons supported with regulated activities depending on services provided. Using this, it is estimated that roughly half of those costs would be passed on to public health and care providers and half to private health and care providers.

[41] ONS (2025), Earnings and hours worked (ASHE Table 1) (viewed December 2025)

Benefits

Summary

The SPR legislation together with the SPR technical solution is expected to enable the successful delivery of a unified patient record, accessible across health and care providers and patients. The benefits presented in this assessment are those attributable specifically to the legislative requirement to share data via the SPR and are distinct from the benefits of the technical solution, which will be scrutinised separately through a dedicated internal business case process.

As SPR legislation is enabling, all the benefits included in this assessment are indirect and while several have been quantified, some have not due to various dependencies, uncertainty and a lack of data. As a result, many of the benefits have been qualitatively assessed, so although a NPSV figure is presented, this does not represent a complete assessment of the costs and benefits. A comprehensive consideration of both the monetised and non-monetised benefits has been made for a thorough assessment, demonstrating that the benefits of the preferred option will likely offset the costs, leading to a net positive outcome for society.

The total direct and indirect benefits of the legislation are estimated to be £109.6 million over 10 years, discounted and in 2026 to 2027 prices, with a range of £32.1 million to £134.1 million.

Assumptions and methodology for benefit calculations

Interoperable data that seamlessly flows between different IT systems across organisations results in important benefits for health and social care delivery. To achieve this, 3 conditions must be in place:

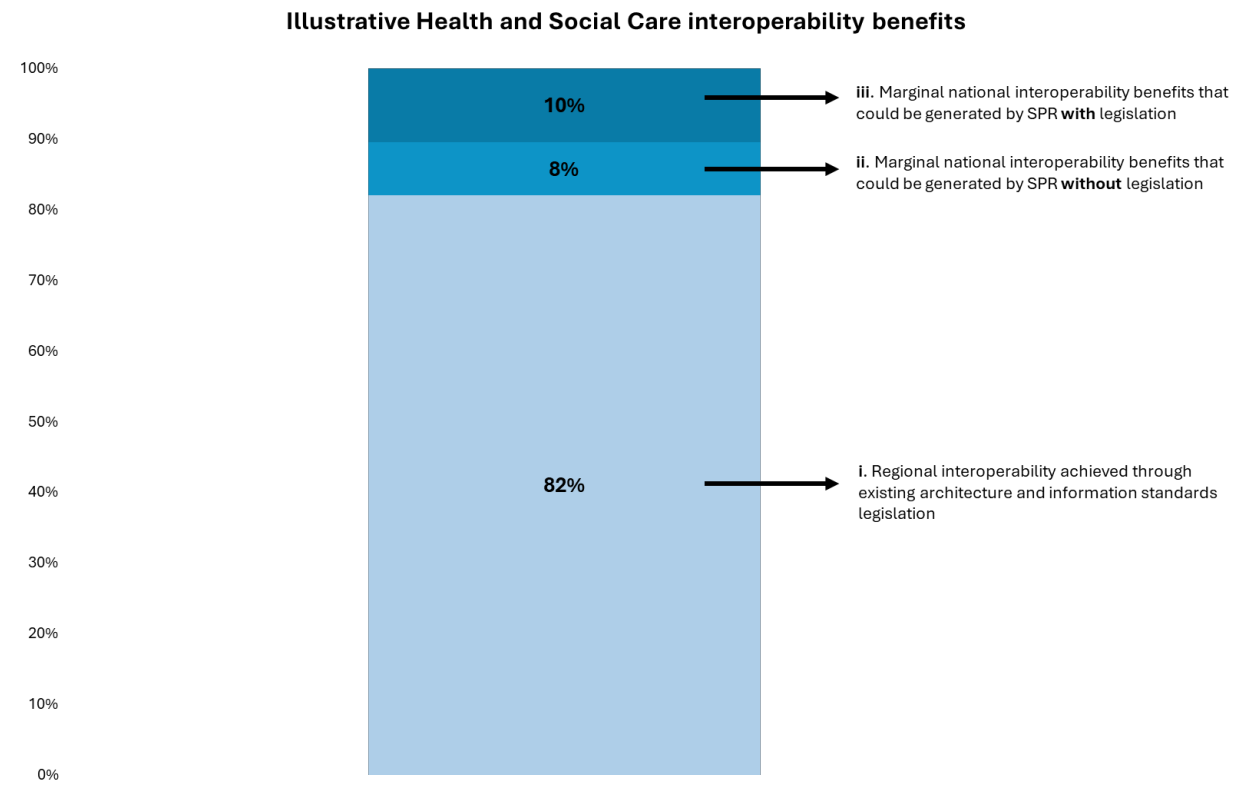
- Fit-for purpose architecture to enable timely transfer of information between providers across public and private systems. Existing NHS England programmes, such as ConCR, are building the clinical architecture necessary to deliver regional interoperability.
- Information standards that define the format for storing and processing data. The powers to mandate all health and social care providers (both public and private) and their IT suppliers were strengthened with the Health and Care Act 2022 (HCA22) and the Data (Use and Access) Act 2025 (DUA) legislation.
- Compliance with sharing of health and care data between health and care providers and patients.

The SPR will unify patient data from multiple sources into one accessible platform for patients and clinicians, creating the conditions for national-level interoperability benefits. This legislation is intended to unlock those benefits by requiring compliance with data sharing through the SPR.

To avoid double counting, the analytical approach focuses on identifying the marginal benefits, which is those that arise specifically from the intervention at the national level, over and above the regional impacts already in place. Taking a proportionate approach, it uses

the benefit estimates for HCA22[42] and DUA[43] as a baseline to convert regional interoperability benefits to a national level, all benefits already claimed through information standard legislation and regional clinical architecture are removed and the residual is the additional benefit that can be unlocked by SPR. To isolate the benefits attributable to the legislation it has been considered how mandating data sharing with the SPR would increase compliance to enable all SPR benefits to be generated, as shown by area **iii** in Figure 2. This approach assumes that a SPR technical solution is in place, which is a key dependency for realising the benefits of the legislation. The impacts of the SPR technical solution not being delivered effectively have been explored in the sensitivity analysis section.

Figure 2: Illustrative diagram of SPR benefit calculation



Note: Areas ii and iii are based on the non-compliance rate in the central scenario (58%) outlined below.

3 baseline non-compliance rates (representing conditions prior to the introduction of the legislation) have been considered to assess the benefits that could be achieved through achieving full compliance (100%). Given the limited applicable evidence on data sharing compliance across health and social care settings, compliance with information standards has been used as a proxy.

[42] DHSC (2025) Health and Care Act (HCA) 2022 Section 95 Open Information Standards Impact Assessment, page X (viewed August 2025)
[43] DHSC (2024) Data (Use and Access) Bill: Open Data Architecture Information Standards (viewed August 2025)

- Low scenario: Non-compliance rate of 17% based on the proportion of health and care provider who were non-compliant with the NHS number information standard[44] prior to the introduction of information standards legislation.
- Central scenario: Non-compliance rate of 58% based on the average non-compliance of health and care providers with information standards[45] excluding NHS number[46] prior to the introduction of information standards legislation.
- High scenario: Non-compliance rate of 71% based on proportion of health and care providers that were non-compliant with the Dictionary of Medicines and Devices information standard[47] prior to the introduction of information standards legislation.

As with the HCA22 and DUA Regulatory Impact Assessments, there is considerable uncertainty in both evidence and assumptions. To address the risk that benefits have been overstated due to assumptions around timing, complexity or achievability, an optimism bias reduction of 54% has been applied to all benefit estimates. This follows HMT Green Book guidance[48] on the upper bound optimism bias for 'Equipment or Development' projects in the absence of a more suitable project type.

Interoperability might look different in different contexts, and there is continual potential for further development and progression. It is not a concrete, fixed state, which can be simply achieved. For this reason, the monetised benefits presented here should be viewed as illustrative estimates of the national-level interoperability benefits SPR legislation could achieve, rather than a comprehensive quantification of all possible benefits. Other SPR-enabled benefits could be identified in the future that haven't been quantified at this time.

Monetised benefits:

Table 11: Option 4 benefits estimates over a ten-year period – at point of national interoperability attributed to SPR legislation (£million, present value, discounted)

Benefit type	Measure	Direct or indirect benefit	Cash or non-cash releasing	Estimated benefit
B. Reduced duplicate tests and procedures	Cost savings from reduction in duplicate tests (diagnostic and lab tests)	Indirect	Cash releasing	£22.2 million

[44] DHSC (2024), Data (Use and Access) Bill: open data architecture information standards impact assessment, based on Information Standards and Interoperability Survey, NHS, Feb 2024 – available in Table 3, and DHSC (2025) Health and Care Act 2022, section 95: open information standards and private provider enforcement measures impact assessment

[45] Including only the standards measured in the Information Standards and Interoperability Survey, NHS, Feb 2024.

[46] DHSC (2024), Data (Use and Access) Bill: open data architecture information standards impact assessment, based on Information Standards and Interoperability Survey, NHS, Feb 2024 – available in Table 3, and DHSC (2025), Health and Care Act 2022, section 95: open information standards and private provider enforcement measures impact assessment

[47] DHSC (2025), Health and Care Act 2022, section 95: open information standards and private provider enforcement measures impact assessment

[48] HM Treasury (2013), Green Book Optimism Bias Guidance (viewed August 2025)

Benefit type	Measure	Direct or indirect benefit	Cash or non-cash releasing	Estimated benefit
C. Time saved accessing information	Value of time saving (patient record access)	Indirect	Non-cash releasing	£10.8 million
D. Reduced medication errors and patient safety incidents (PSIs)	DI. Reduction in cost of excess bed days (transition medication error reduction)	Indirect	Non-cash releasing	£5.5 million
D. Reduced medication errors and PSIs	D2. (Non-Cash Releasing) Quality-Adjusted-Life Years (QALY) value of prevented fatalities (transition medication error reduction)	Indirect	Non-cash releasing	£4.1 million
D. Reduced medication errors and PSIs	D3. (Non-Cash Releasing) Reduction in cost of excess bed days (non transition medication error reduction	Indirect	Non-cash releasing	£2.0 million
D. Reduced medication errors and PSIs	D4. (Non-Cash Releasing) QALY Value of prevented fatalities (non-transition medication error reduction)	Indirect	Non-cash releasing	£7.6 million
D. Reduced medication errors and PSIs	D5. (Non-Cash Releasing) Value of time saved reporting medication errors	Indirect	Non-cash releasing	£3.9 million
D. Reduced medication errors and PSIs	D6. (Non-Cash Releasing) Reduction in reporting costs for PSIs	Indirect	Non-cash releasing	£53.6 million
All	All	Direct and indirect	Cash releasing and non-cash releasing	£109.6 million

Note: (i) Total may not sum due to rounding (ii) The list of benefits starts from B to maintain comparability with the benefits outlined in the HCA22 and DUA IAs. Benefit A (Mapping and Standardisation) is not relevant to SPR and has been excluded.

B. Cost savings from reduction in duplicate tests (diagnostic and lab tests):

Studies show that up to 30%[49] of medical tests are duplicated. The increase in interoperable systems enabled by the SPR with integrated decision support could assist in minimising unnecessary tests due to a lack of, or poor patient data. A cost benefit analysis of electronic medical records in primary care suggests an average reduction in duplicate laboratory test

[49]Airedale NHS Foundation Trust (2023), A new EPR can help stop unnecessary medical tests, (viewed August 2025)

costs of 8.8%[50] can occur as a result of the implementation of decision support within the electronic health record, while a European Commission impact assessment on the European Health Data Space estimated interoperability at a national level could contribute to reduced duplicate medical imaging of 10% in the EU[51].

Improved access to comprehensive and up-to date patient data is expected to minimise unnecessary duplicate tests, procedures and prescriptions, leading to a reduction in health and social care costs.

This is calculated based on the total cost of diagnostic (£1.4 billion) and lab tests (£0.9 billion)[52]. It is also based on calculating the proportion of duplicate tests (30% for diagnostic tests, 20% for lab tests, as outlined above) and calculating the cost saving based on a reduction in these duplicate tests (10% reduction in duplicate diagnostic tests and 8.8% reduction in duplicate lab tests, as outlined above).

Based on the evidence available and approach outlined that factors in the additional impact of SPR, the ten-year present value cost saving expected from the reduction in laboratory and diagnostic imaging tests, from national interoperability attributable to the SPR legislation is estimated to be £22.2 million, with a range of £6.5 million to £27.2 million.

C. Value of time saving (patient record access):

Working with standardised data and interoperable systems could save staff time due to quicker and more efficient access to patient data. It is expected this would remove the need for manually retrieving physical notes or accessing multiple records as well as reduce the time spent on information gathering or reviewing data. It may result in time saving for health and social care workers, which could be refocused on more value-add activities to the benefit of patients. It was estimated that the joining up of direct care within the OneLondon programme had a time saving per system access of at least 0.5 minutes, with potential for up to a 20-minute time saving on more complex cases[53]. Scaling this time saving for the estimated number of patient accesses across England[54,55], it is estimated that the ten-year present value of staff time saved attributable to national interoperability from SPR legislation is £10.8 million, based on the average NHS staff salary per minute of £0.37[56], with a range of £3.2 million to £13.2 million.

D1 and D3. Reduction in cost of excess bed days, from reduction in transition and non-transition medication errors:

[50] Wang, S. and others (2003), A cost-benefit analysis of electronic medical records in primary care (viewed August 2025)
[51]European Commission (2022), Impact Assessment Report: Proposal for a regulation of the European Parliament and of The Council on the European Health Data Space (viewed April 2026)
[52] NHS England (2023), 2021/22 National Cost Collection Data Publication (viewed August 2025)
[53] McFerran, E. and others (2023), Economic Analysis of Digital Health Infrastructure: The Case of OneLondon's Impact on Time Efficiency and Safety in Healthcare Services (viewed August 2025)
[54] NHS England (2024), Hospital Outpatient activity (viewed August 2025)
[55] NHS England (2024), A&E Attendances and Emergency Admission (viewed August 2025)
[56] NHS England (2024), NHS Staff Earnings Estimates, September 2023, Provisional Statistics, (viewed August 2025)

Improved patient safety is expected from a reduction in errors resulting from re-entering information across systems and care settings. It also ensures clinicians and carers have the data they need on patients during transfers, discharges and referrals. Also, enhancing patient safety can mitigate adverse drug reactions by minimising the risk of medication errors and overprescribing. This could reduce the resources that the NHS dedicates to medication errors and thus lead to a reduction in the number of excess bed days.

A study by the University of Manchester highlighted the potential benefits of implementing the DAPB4013 information standard for Medicine and Allergy or Intolerance Data Transfer. The adoption of this standard could lead to a 40% reduction in medication errors during patient transitions, such as when care is transferred between settings or healthcare professionals. The standardisation of data transfer ensures that accurate medication information is consistently communicated, minimising the risk of errors that can occur due to misinterpretation or missing information.[57]

The impact of reducing these medication errors is two-fold: it is estimated to result in 14,275 fewer inpatient care days and save approximately £6.59 million annually. These savings stem from avoiding the additional treatments and extended hospital stays that often follow medication errors. Beyond the economic benefits, the most significant outcome is the potential to prevent 20 deaths per year caused by such errors[58]. This underscores the critical role that standardised information transfer plays in enhancing patient safety and healthcare efficiency.

The benefits of interoperability go beyond just transition errors. Health and social care providers and patients could also benefit from the reduction in other prescription, administration and monitoring errors. The cost saving from prevented excess bed days from non-transition medication errors is estimated to be £5.1 million each year, with an assumed reduction in 80 deaths. This is based on a reduction in number of severe and avoidable non-transition medication errors.

Based on the evidence available and approach outlined that factors in the additional impact of SPR, the estimated ten-year present value cost saving from reduction in excess bed days from reductions in transition medication errors, attributable to SPR legislation is £5.5 million, with a range of £1.6 million to £6.7 million (D1).

Based on the evidence available and approach outlined that factors in the additional impact of SPR, the estimated ten-year present value cost saving from reduction in excess bed days from reductions in non-transition medication errors, attributable to SPR legislation is £2.0 million, with a range of £0.6 million to £2.4 million (D3).

D2, D4, D5 and D6. QALY value of prevented fatalities from medication errors, value of time saved reporting errors, and reduction in reporting costs for patient safety incidents (PSIs):

The value of prevented fatalities from transition and non-transition medication errors has also been quantified in terms of the additional Quality-Adjusted-Life-Years (QALYs) gained.

[57]Elliott, R. and others (2023), Estimating the impact of enabling NHS information systems to share patients' medicines information digitally (viewed August 2025)
[58] Elliott, R. and others (2023), Estimating the impact of enabling NHS information systems to share patients' medicines information digitally (viewed August 2025)

This is calculated based on the number of estimated deaths prevented from a reduction in medication errors[59], DHSC data on fatalities by age due to adverse drug reactions (ADRs), average life expectancy[60], and using the HMT Green Book 2022 estimates of a QALY (£70,000) which is adjusted for each age group. The benefit is further apportioned based on assumptions outlined above to attribute it to national interoperability enabled by SPR.

As described above, SPR and interoperability are expected to reduce the prevalence of avoidable medication errors. In addition, access to real-time patient data can support providers making better informed decisions. Interoperable systems and information standards can reduce the risk of miscommunication or misunderstandings which can compromise patient safety and hence prevent patient safety incidents. This reduction in medication errors and patient safety incidents can reduce the time spent reporting and investigating such errors for staff, as well as the consequences for patient health and fatalities.

Based on the evidence available and approach outlined that factors in the additional impact of SPR, the ten-year present value of QALYs gained due to the reduction in transition and non-transition medication errors attributable to national interoperability from SPR legislation is estimated to be £11.7 million, with a range of £3.4 million to £14.4 million (D2 and D4). This benefit is discounted at a 1.5% discount rate in-line with HMT Green Book guidance for QALY health effects. [61]

Studies show that the average time spent reporting a medication error is 4 minutes per error[62]. This creates the opportunity for significant time savings from the reduction of medication errors. Based on the value of staff time per minute and a 6.8 million reduction in the number of medication errors (this is calculated based on applying a 6% reduction in non-transition medication errors per annum (in line with evidence from Estonia[63]) to the total number of prescribing, administration and monitoring non-transition errors per year for primary and secondary care (approximately 100 million[64]), and also adding a 0.7 million reduction in transition errors) [65], the estimated value of time saving is £10.1 million nationally each year.

Based on the evidence available and approach outlined that factors in the additional impact of SPR, the ten-year present value benefit attributable to SPR legislation is estimated to be £3.9 million, with a range of £1.1 million to £4.7 million (D5).

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[59] Elliott, R. and others (2023), Estimating the impact of enabling NHS information systems to share patients' medicines information digitally, calculated based on 20 deaths prevented due to a reduction in transition medication errors (viewed August 2025)

[60] ONS (2021), National life tables – life expectancy in the UK (viewed August 2025)
[61] HM Treasury (2026), The Green Book
[62] Bullen, K. and others (2020), Prescribing error reporting in primary care: a narrative synthesis systematic review (viewed August 2025)
[63] European Commission (2022), Impact Assessment on the European Health Data Space, page 21 (viewed August 2025)
[64] Elliott R. and others (2021), Economic analysis of the prevalence and clinical and economic burden of medication error in England (viewed August 2025)
[65] Elliott, R. and others (2023), Estimating the impact of enabling NHS information systems to share patients' medicines information digitally, page 9 (viewed August 2025)

In 2022, there were 2.2 million patient safety incidents reported in the NHS[66]. It was reported in a study by Adams and others that 7.9% of patient safety incidents were related to problems with Electronic Health Record interoperability[67]. In addition, the average cost per incident form is £337.16 – hence there is a potential cost saving of up to £6.76 million per year from the reduction in patient safety incidents from improved interoperability.

Based on this evidence and approach outlined that factors in the additional impact of SPR, the ten-year present value benefit attributable to national interoperability from SPR legislation is estimated to be £53.6 million, with a range of £15.7 million to £65.6 million (D6).

Benefits profile

The implementation of SPR is uncertain, so this assessment assumes that there is an interaction between the national interoperability benefits generated by SPR and the full adoption of information standards mandated by HCA22 and DUA.

- It is assumed that no benefits are generated in the first year of implementation (2026 to 2027) as systems plan, develop and distribute the technical solution required to deliver the SPR.

- Year 2 of this appraisal (2027 to 2028) is the first year that benefits are estimated. The fourth-year benefits profiles from the HCA22 and DUA IAs are extrapolated as it is assumed that once the solution is in place, the benefits from SPR will be realised relatively quickly through its positive interaction with information standards compliance achieved through the previous legislation.

- The SPR benefits profile, as is the case with the HCA22 and DUA assessments, assumes full implementation by the start of 2027 to 2028, with benefits also fully achieved and recurring each year.

Table 12: Annual benefits of Option 4 – preferred option (£m, present value terms)

Benefit Type	2026 to 2027	2027 to 2028	2028 to 2029	2029 to 2030	2030 to 2031	2031 to 2032	2032 to 2033	2033 to 2034	2034 to 2035	2035 to 2036	Benefit over 10 Years
Reduction in cost of excess bed days (non-transition medication error reduction)	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	**2.0**

[66] DHSC (2025), Review of patient safety across the health and care landscape (viewed August 2025 year)
[67]Li, E. and others (2022), The Impact of Electronic Health Record Interoperability on Safety and Quality of Care in High-Income Countries: Systematic Review (viewed August 2025)

Benefit Type	2026 to 2027	2027 to 2028	2028 to 2029	2029 to 2030	2030 to 2031	2031 to 2032	2032 to 2033	2033 to 2034	2034 to 2035	2035 to 2036	Benefit over 10 Years
Reduced duplicate tests and procedures	0.0	2.8	2.7	2.6	2.5	2.5	2.4	2.3	2.2	2.1	**22.2**
Time saved accessing information	0.0	1.4	1.3	1.3	1.2	1.2	1.2	1.1	1.1	1.0	**10.8**
QALY gained (transition medication error)	0.0	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.5	**4.1**
QALY gained (non-transition medication error)	0.0	0.5	0.7	0.8	0.8	0.9	0.9	1.0	1.0	1.0	**7.6**
Value of time saved reporting medication errors	0.0	0.5	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.4	**3.9**
Reduction in reporting costs for PSI's	0.0	6.8	6.6	6.4	6.1	5.9	5.7	5.5	5.3	5.2	**53.6**
Reduction in cost of excess bed days (transition medication error reduction)	0.0	0.7	0.7	0.6	0.6	0.6	0.6	0.6	0.5	0.5	**5.5**
Total	**0.0**	**13.3**	**13.0**	**12.8**	**12.5**	**12.2**	**11.9**	**11.6**	**11.3**	**10.9**	**109.6**

Non-monetised benefits:

In addition to the quantified benefits above, SPR could also generate a range of benefits in the form of efficiency savings, improving health outcomes and enhancing patient satisfaction and engagement. The decision has been taken within this assessment to discuss these

benefits qualitatively as even though they are plausible outcomes attributable to SPR, the currently available data and evidence base is too limited to make a reasonable quantification. Consequently, these benefits will not factor into the quantified NPSV, but should be considered when making an overall assessment of the costs and benefits of SPR.

Efficiency savings:

Reduced clinical negligence claims

NHS Resolution reported that the cost of Clinical Negligence Scheme for Trusts (CNST) clinical negligence claims incurred as a result of incidents in 2020 to 2021 was £7.9 billion, with 60% of this cost related to maternity services (£4.8 billion as at 31 March 2021).[68] The unified view of patient information and maintenance of data quality enabled through SPR could reduce errors, such as the medication errors discussed above, which could lead to fewer clinical negligence claims providing a cost saving to the NHS. Given the limited evidence on the number of clinical negligence claims resulting from data errors and the lack of an appropriate counterfactual to estimate the impact of SPR against, it is not possible to quantify this benefit at this stage.

Improve health care utilisation by patients

Improved patient access to their medical records could improve health care utilisation outcomes as individuals are better equipped to manage their own care and utilise the appropriate health and care resources. Brands and others (2022), in a systematic review observed that patient-centred digital health record use may be associated with an increased use of recommended care services[69]. Additionally, Fitton and others (2014) concluded that if 30% of patients accessed their electronic general practice record online at least twice a year, a 10,000-patient practice is likely to save around 5,000 appointments each year[70].Through enabling patients to make more informed decisions about their care facilitated via the implementation of patient access to the SPR, health and care resources could be better utilised, reducing unnecessary appointments and freeing up resources for other patients.

Health outcomes:

The SPR will unify patient data from multiple sources into a single platform for patients and clinicians offering an improved level of detail and clarity. This will enable a more effective use of health data for care delivery, improving health outcomes.

Improved patient adherence to treatment and medication plans

There is some evidence that access to medical information can improve patient adherence to prescribed treatment and medication plans, which in turn could improve health outcomes. Alomar and others (2024) in a systematic review across various international databases found a positive relationship between patient access to Electronic Health Records (EHRs) and health care engagement[71]. Similarly, Walker and others (2019) surveyed on patient

[68] NHS Resolution (2021), NHS Resolutions Annual Report 2021, page 60 (viewed August 2025)
[69] Brands, M. and others (2022), Patient-Centered Digital Health Records and Their Effects on Health Outcomes: Systematic Review (viewed August 2025)
[70] Fitton, C. and others (2014), The impact of patient record access on appointments and telephone calls in two English general practices: a population-based study (viewed August 2025)
[71] Alomar, D. and others (2024), The Impact of Patient Access to Electronic Health Records on Health Care Engagement: Systematic Review (viewed August 2025)

experiences with ongoing access to their clinicians' outpatient visit notes across 3 large health systems in the US and found that note reading was very important for their health management and patients frequently shared their notes with others[72]. The medical information that SPR will give patients access to could enable them to better engage with the outcomes of their appointments, supporting their treatment and improving their overall health.

Patient engagement and satisfaction:

Public engagement to support the delivery of the 10 Year Health Plan highlighted the frustration patients have with repeating their information and clinicians not knowing what happened at a previous appointment.

A Healthwatch survey found that nearly one in four (23%) of adults have noticed inaccuracies or missing details in their medical records before and over one in seven (16%) of those who reported an inaccurate record said that it was related to inaccurate information about what medication they have taken[73].

The SPR will enable patients to securely view and interact with their health data. This could improve patient satisfaction as they can ensure that their medical information is correct, preventing the need to repeat or correct information at appointments, improving their experience and increasing trust in providers. It may also support medical professionals to offer an improved quality of care as they will have access to all the necessary information, also increasing patient satisfaction.

Business environment and household impact

The discussion around benefits in the impact assessment focuses on the health and care system. Private health and care providers and IT suppliers are an integral part of this system and therefore it is important to consider the impact of this legislation on them. While private health and care providers and IT suppliers will face direct costs associated with compliance, these may be offset over time by efficiency gains from reduced duplication and improved data flows. Small and micro businesses, which make up a significant proportion of affected organisations, will receive tailored guidance to minimise the administrative burden. The impact on market competition is uncertain, as while an increased compliance burden could deter entry into the market, improved data sharing processes and an increase in clarity on the management of patient data might encourage entry and investment into the sector.

The SPR legislation aims to support improved information sharing across all individuals involved in a person's care in England. This is especially important for people who are more likely to require health and care services across a range of health and care settings. The SPR legislation is expected to have an indirect positive impact on all patients, with people who require a higher use of health and care services across a range of health and care settings likely to disproportionately experience the benefits.

Sensitivity analysis

[72]Walker, J. and others (2019), OpenNotes After 7 Years: Patient Experiences With Ongoing Access to Their Clinicians' Outpatient Visit Notes, (viewed August 2025)
[73] Healthwatch (2025), The extent and impact of inaccurate NHS patient records (viewed August 2025)

To assess the key dependency of the technical solution on the benefits of legislation, a sensitivity analysis was conducted to examine how uncertainty in the delivery and effectiveness of SPR would influence the NPSV and Benefit Cost Ratio (BCR) for the preferred option. International comparisons have been drawn to understand the range of potential interoperability outcomes.

International research by Black Book evaluates interoperability across 18 high-income countries in 2025, using quantitative data and stakeholder surveys. It gives countries an interoperability rate by comparing the percentage of healthcare providers actively exchanging patient data through standardised digital systems. The UK's interoperability rating was 80.5%, below leading countries such as Estonia (99.1%), Finland (98.9%) and Denmark (98.2%), but above countries such as Canada (74.6%), Germany (70.2%) and the United States (59.8%)[74].

The following scenarios have been modelled to consider different levels of effectiveness of the SPR technical solution and its impact on the NPSV and BCR for the preferred option:

- No effective SPR technical solution is delivered so no additional interoperability benefits are realised.
- Only one-third of the additional national interoperability benefits are realised, comparable to the Netherlands at 88.9% and Norway at 87.3%[75].
- Two-thirds of additional national interoperability benefits are realised, comparable to Sweden at 95.4%
- All the additional national interoperability benefits are achieved[76], taking UK interoperability to a level comparable with Estonia, Finland and Denmark.

Achieving full national interoperability remains an ambitious goal, and the scenarios provide a range to account for this.

To isolate the impact of adjusting the SPR effectiveness assumption, the non-compliance assumption has been fixed at the level used in the central scenario (58%). Table 13 summarises the impacts on the overall NPSV and CBR when compared to the central cost scenario.

Table 13: NPSV and Benefit Cost Ratio (BCR) SPR effectiveness and compliance sensitivity

Effectiveness of SPR technical solution	Legislative benefits (present value over 10-year appraisal)	Legislative costs (present value over 10-year appraisal)	NPSV	BCR
0.0%	£0.0m	£32.8m[77]	-£32.8m	0.0

[74] Black Book Research (2025), Global Interoperability Gaps Revealed in 2025 Healthcare Connectivity Rankings - Black Book (viewed August 2025)
[75] Black Book Research (2025), Global Interoperability Gaps Revealed in 2025 Healthcare Connectivity Rankings - Black Book (viewed August 2025)
[76] Equivalent to the central scenario.
[77] If no SPR technical solution was delivered the costs of legislation could be lower as some costs (such as onboarding costs) would not be incurred.

Effectiveness of SPR technical solution	Legislative benefits (present value over 10-year appraisal)	Legislative costs (present value over 10-year appraisal)	NPSV	BCR
33.3%	£36.5m	£32.8m	£3.8m	1.1
66.7%	£73.0m	£32.8m	£40.3m	2.2
100.0%	£109.6m	£32.8m	£76.8m	3.3

To achieve a net present social value of zero, thus reaching the break-even point, assuming a non-compliance rate in line with the central scenario (58%), the SPR technical solution would need to be effective enough to deliver 29.9% of the additional national interoperability benefits. As mentioned above, the exact compliance rate is uncertain and will vary across health and social care providers, influencing the break-even point.

8. Risks and assumptions

Delivery of SPR Technical Solution

The benefits of this legislation are highly dependent on the successful implementation of the SPR technical solution. Any obstacle that delays or fails to implement the technical solution successfully will have an impact on the benefits presented in this impact assessment, which is explored in the sensitivity analysis section.

A business case is being developed to fully explore and scrutinise the costs and benefits of the SPR technical solution. These figures will differ from this Regulatory Impact Assessment as they are based on the costs and benefits of the SPR programme, rather than the impact of the legislation.

Data privacy and security concerns

There is a risk that public concerns about data privacy and security cause reduced trust in the SPR, resulting in limited adoption that results in diminished effectiveness or impact of the programme.

To mitigate this, data security measures that comply with all relevant regulations and best practices will be implemented, including clear parameters for data processing and legal basis. Design principles centred around security and privacy will also be used, and the public will be engaged with to address concerns and build support for the programme. The engagement exercises in 2024 to 2025 revealed significant public support for the SPR and an awareness that rules-based access, cyber security and other protections would keep data safe. Implementation of the SPR will include extensive public communications to keep people fully informed about the security arrangements in place and to build on the existing awareness that NHS systems have strong protections in place.

The risk of non-compliance

There is a risk, of high impact, but low likelihood, that health and social care providers will refuse to comply with the requirements of an SPR, despite legal obligations, and the undoubted operational benefits to the delivery of health and care services.

The history of digitisation in the NHS and social care does not suggest an appetite for deliberate non-cooperation with such an endeavour: all ICBs have a local ConCR in place, and 93% of NHS trusts have an EPR[78]. Challenges to digitisation are logistical, and accordingly, the implementation of the SPR will mitigate this through ensuring appropriate resourcing and support; comms, clinical champions, and engagement of professions and organisations using the SPR, will mitigate antipathy towards the concept, or providers involved in delivery.

Stakeholder engagement and public perception

DHSC and NHS England undertook public engagement in late 2024 to understand people's views on creating a single patient record, as part of a programme of large-scale public engagement, to build and maintain trust in how data is used across health and social care. A full report of the findings has been published[79].

The public were overwhelmingly in favour of a single patient record, regarded as a long-overdue solution to many of the frustrations the public feel across multiple health and care settings. They could immediately see the benefits of this (especially more frequent users of healthcare) through:

- better experiences using healthcare systems
- improved efficiency of care
- (ultimately) better health outcomes

Participants also highlighted key elements of delivery which would make the single patient record system trustworthy to them, including: tiered access for health and care professionals, staff training as well as technical measures to ensure security, transparency and accountability, and ensuring that patients are informed and have a say on how data they consider sensitive is shared, all of which will be fundamental to the design.

This engagement also considered the public's views on the current system for how data in GP records is used for secondary purposes and whether this should change. This found that they understood the benefits of using this data for things like planning and research, although they emphasised the need for security and privacy.

When they considered the topic in detail, participants in the engagement concluded that new arrangements should be put in place so that decisions about the use of data in GP records does not sit with individual practices, and that decision making should move to a new model. Survey respondents, who were unable to discuss the issue in detail, were more uncertain but even here there was no significant opposition to moving to a new model.

There is a risk that external resistance from professions or lobby groups, or public distrust due to data security concerns could reduce support, increase opt-out rates, and harm programme reputation.

[78] DHSC (2025), DHSC letter response to HM Area Coroner Chris Morris (viewed September 2025)
[79] NHS England (2025), National engagement on data: cohort 2 report (viewed August 2025)

The likelihood of this risk has increased with the recent motion opposing the SPR[80]. The motion will be taken to the main British Medical Association (BMA) council.

The motion proposes “using the media and any other appropriate means to ensure that the public and clinicians are made aware of this threat to patient confidentiality.”

The Parliamentary process will allow a public forum for making the case for the benefits to public and professionals of the SPR and engaging with specific BMA concerns of security and confidentiality, not least by referring to the several decades of existing practice in sharing EPRs, and the current participation of doctors in ConCR. As above, high-profile champions will also be important in providing an authoritative voice.

The requirement to provide data direct from IT providers, will also need defending, drawing on existing precedents (of no-action Data Provision Notices), and the convenience of a system which would save significant admin time for services.

Mitigating actions include continued active stakeholder engagement, transparent communication on data security, and proactive media strategies to manage public and stakeholder perceptions.

Provider perception

If the SPR is seen as excessively complex, this may be viewed unfavourably by vendors in the supplier market, potentially leading to reduced involvement from suppliers and a decrease in market competition.

Devolved administration

Healthcare is a devolved matter. The SPR will be England only, but further consideration is required to ensure the existing cross border care arrangements with the Devolved Administrations will remain in place following the implementation of the SPR. This bill will not create this risk.

Analytical assumptions

Despite best endeavours to collect and draw upon strong evidence, cost and benefit assumptions remain uncertain and based on limited evidence availability in places. To mitigate this uncertainty, optimism bias has been applied, sensitivity analysis carried out, and monitoring and evaluation planned.

Monitoring and evaluation of preferred option

The business case for the SPR will set out an appropriate approach to monitoring and evaluating the outcomes of the overall programme, including the delivery of the technical solution.

[80] BMA (2025), Resolution report of the SRM (viewed December 2025)

A high-level monitoring framework has been developed to show how the impact of the SPR legislation could be tracked over time. This identifies potential indicators that would allow government to understand whether the legislation is being implemented as intended, whether health and care providers comply with new duties, and whether patients are able to exercise their new rights.

The SPR legislation will be a regulation-making power and so the question of whether a statutory review provision is included will need to be considered at the point of making the regulations, meaning if at that point the criteria in the Small Business, Enterprise and Employment Act 2015[81] are considered to be met, a review clause will be added. The high-level monitoring framework set out in this section would support an evaluation, or Post Implementation Review if required.

Monitoring will depend on the availability and quality of data. Some indicators, such as patient and clinician engagement, may require new surveys or data collections. Many of the longer-term outcomes (such as reduced waiting times and improved clinical outcomes) will also depend on the effective technical delivery of the SPR and broader NHS transformation initiatives. In practice, it may be difficult to isolate the specific effects of the legislation from other concurrent reforms. Monitoring data would therefore provide useful assurance and directional evidence, but not definitive attribution.

The effectiveness of the legislation will also depend on external factors beyond its direct control, including provider and supplier capacity to comply, the interoperability and quality of underlying data systems, levels of patient trust and digital inclusion and delivery of the wider NHS digital agenda.

While this framework is not a commitment to a full evaluation, there are steps that could enable more robust assessment in future if required. These include:

- Building monitoring requirements into compliance processes (for example providers and suppliers reporting against connection and usage duties).
- Making use of existing national datasets (such as Hospital Episode Statistics and patient safety incident data) to minimise new data collection burdens.
- Embedding survey questions for patients and clinicians into existing feedback mechanisms to capture experience and engagement.

Table 14: Illustrative monitoring framework

Stage	Metric or Measure	Data Required	Potential data sources
Outputs	Legislation enacted	Date of Royal Assent	Parliamentary records: Bills & legislation - UK Parliament
Outputs	Guidance issued to providers or supplies	Guidance document publication date	DHSC & NHS England websites (for example NHS England » Publication Containers)
Outputs	Enforcement regime set-up	Enforcement framework, operational	Internal DHSC & NHS England documentation of procedures and resources. Enforcement guidance may also be

[81] Department for Business and Trade (2023), Statutory Guidance under s.31 of the Small Business, Enterprise and Employment Act 2015 (viewed August 2025)

Stage	Metric or Measure	Data Required	Potential data sources
		procedures, staff assigned	published on www.gov.uk or NHS England » NHS enforcement guidance
Short-term Outcomes	Health and care providers comply with duties	Proportion of health and social care providers complying with the new duties set out by the legislation.	The compliance assumptions used in this impact assessment are based on the information standards and interoperability survey, NHS England, Feb 2024. To measure the impact of the legislation this survey could be adapted to reflect compliance with the new legislation and monitored on an ongoing basis.
Short-term Outcomes	Patients can access, add to, and control data	Number and proportion of patients with access, usage logs, feedback	Information about the number of users and usage for the NHS App, and for features that are available through the NHS App is published on a monthly basis (NHS App Management Information - NHS England Digital). It's possible that NHS App Management Information could be used to measure patient access to the SPR. The internal business case for the SPR will set out an appropriate approach to monitoring and evaluating patient access. On its own it's unlikely that this data would be used to disaggregate the impact of the legislation but other assumptions, such as compliance rates of providers, could be used to create a proxy measure of the legislative impact on patient access.
Assumptions	Clinicians and patients engage with SPR	Number and proportion of clinicians or patients using SPR, usage frequency	A survey commissioned to health and social care providers (in a similar form to the information standards and interoperability survey, NHS England, Feb 2024) could generate data on clinician SPR usage. NHS App patient SPR usage data could be available from NHS App Management Information - NHS England

Stage	Metric or Measure	Data Required	Potential data sources
			Digital. It's possible that this published data could be updated to specifically ask patients questions on SPR usage.
Medium-term Outcomes	Faster diagnoses and referrals	Waiting time statistics	A reduction in waiting lists could serve as an indicator of faster diagnoses and referrals.
Medium-term Outcomes	Clinician time saved	Time-use surveys, electronic health record system logs	One measure is to track the average time spent on administrative tasks versus direct patient care activities by clinical professionals. This can involve time-motion studies, electronic health record audits, and feedback from health and social care providers. Additionally, any changes in patient, waiting times, and overall efficiency of patient care time (from admission to discharge) could be monitored to evaluate how interoperability affects the allocation of time and resources towards delivering patient care.
Medium-term Outcomes	More informed treatment decisions	Clinical audit results, case reviews, decision support system logs	Pre- and post-implementation data on patient outcomes could be collected in line with the guidance set out in NHS Outcomes Framework (NHS OF) - NHS England Digital and The adult social care outcomes framework: handbook of definitions - GOV.UK. Patient reported outcome measures (such as Statistics » Patient Reported Outcome Measures (PROMs)) could also provide useful insight into the impact of the legislation.
Medium-term Outcomes	Fewer duplicate tests	Duplicate test rates	Data could be collected on duplicate testing incidents during the implementation period. This may involve reviewing electronic health records, laboratory information systems, or other relevant sources to identify instances of

Stage	Metric or Measure	Data Required	Potential data sources
			duplicate testing. Another approach could involve modifying diagnostic test request forms to include factors such as "missing patient test results" as reasons for requesting diagnostic tests or procedures.
Medium-term Outcomes	Fewer medication errors and allergy-related incidents	Medication error reports, incident logs	Pre- and post-implementation data on total medication errors across relevant categories (transition, prescribing, administration, monitoring) and patient safety incidents could be monitored for any overall change in total errors or incidents. Additionally, it is important to attribute pre- and post-implementation errors to interoperability or data sharing-related issues (such as a lack of patient data on allergies). This may involve monitoring error reports, conducting audits, or analysing incident reports related to medication errors and patient safety incident to identify any changes in the frequency or nature of medication errors or safety incidents related to interoperability issues.
Long-term Outcomes	Higher patient satisfaction, engagement and trust	Patient satisfaction scores, complaints data	Patient and provider surveys such as Statistics » National Patient and Staff Surveys could be used to measure trends in health and social care satisfaction pre and post implementation of the SPR. It will be difficult to disaggregate the impact of the legislation on patient satisfaction but data points from compliant and non-compliant providers could be compared to give an indication of the impact. Complaints data (such as Data on Written Complaints in the NHS, 2024-25 - NHS England Digital) could be monitored to

Stage	Metric or Measure	Data Required	Potential data sources
			measure trends overtime and possibly compare compliant and non-compliant providers to disaggregate the impact of the SPR.
Long-term Outcomes	Improved clinical outcomes	Health outcome indicators (such as reduced errors, improved recovery rates)	Pre- and post-implementation data on patient outcomes could be collected in line with the guidance set out in NHS Outcomes Framework (NHS OF) - NHS England Digital and The adult social care outcomes framework: handbook of definitions - GOV.UK. Patient reported outcome measures (such as Statistics » Patient Reported Outcome Measures (PROMs)) could also provide useful insight into the impact of the legislation.
Long-term Outcomes	Optimised care pathways and clinical workflows	Admin time logs, cost savings, process mapping	The internal business case for the SPR will set out an appropriate approach to monitoring and evaluating efficiency savings and the reduced admin burden. This could be tracking the average time spent on administrative tasks pre and post SPR implementation. This can involve time-motion studies, electronic health record audits, and feedback from health and social care providers. To disaggregate the impact of the legislation, the compliance rates will need to be factored into any benefits calculations.

Annex A:

Minimising administrative and compliance costs for preferred option

Please state how you intend to minimise the administrative burdens of complying with the regulation. This should include burdens on businesses and people. It should include factors such as time taken for familiarisation, filling in forms, and reporting requirements.

Through the development of a technical solution, the platform design will aim to minimise disruption to clinical source systems by ensuring that the existing provider-system interface is unchanged, reducing the burden on providers.

As discussed in the SaMBA, to minimise the administrative and compliance costs for the preferred option there will be issuance of guidance notes. These notes will provide tailored information and advice which will be adequate to support compliance with legislation, reducing the time required to understand the regulation therefore reducing burden on businesses.

Regulatory scorecard for preferred option

Please provide quantitative estimates and qualitative descriptions of impacts under each heading in the following sections. The right-hand column for directional ratings should be based on the description of impact and the sign of the suggested indicator (net present value (NPV), net present social value (NPSV), all impacts): **Green** – positive impact, **red** – negative impact, **amber** – neutral, negligible, or no impact, **blue** – uncertain impact. Please use the colours in the examples shown below, as these are suitable accessible colours. Please see Better Regulation Framework (BRF) guidance technical annex for definitions.

Part A: Overall and stakeholder impacts

(1) Overall impacts on total welfare		**Directional rating**
Description of overall expected impact	The overall impact of this legislation on society is positive. While there are initial transition costs incurred by Health and Care Providers and IT Suppliers, the benefits it enables of saving clinician time, reducing duplicate testing, reducing medication errors and improved patient engagement are greater.	**Positive** **Based on all impacts (incl. non-monetised)**
Monetised impacts	Total £76.8 million NPSV. Low estimate: -£23.0 million. High estimate: £124.0 million. Largest benefits: reduction in reporting costs for patient safety incidents; cost savings from reduction in duplicate tests; value of time saving (patient record access).	**Positive** **Based on likely £NPSV**

(1) Overall impacts on total welfare		Directional rating
	Largest costs: familiarisation costs, administration costs, onboarding costs.	
Non-monetised impacts	Non-monetised indirect benefits: Reduced clinical negligence claims; improved healthcare utilisation by patients; improved patients' adherence to treatment and medication plans; improved patient engagement and satisfaction.	**Positive**
Any significant or adverse distributional impacts?	The SPR legislation is expected to have an indirect positive impact on all patients, with people who require a higher use of health and care services across a range of health and care settings likely to disproportionately experience the benefits. The distributional impact on business is uncertain.	**Uncertain**

(2) Expected impacts on businesses		
Description of overall business impact	Businesses (private health and care providers and IT suppliers) will incur direct costs of familiarisation, administration and onboarding. While the analysis attributes benefit to the overall health and care system, private health and care providers are part of this and so could expect to benefit from improved efficiency from quicker access to patient information and reduced duplicate testing. As the benefits are health and care focused, IT suppliers only incur the costs of this legislation and so the impact on them is negative overall.	**Uncertain**
Monetised impacts	Business NPV -£15.5 million EANDCB is £1.8 million of which £1.7 million is familiarisation and administration costs. Pass through to public health and care providers has not been deducted from these figures.	**Negative** **Based on likely business £NPV**
Non-monetised impacts	While the analysis attributes benefits to the overall health and care system, private health and care providers are part of this and so could expect to benefit from improved efficiency from quicker access to patient information and reduced duplicate testing. A proportion of the overall benefits would be experienced by business.	**Uncertain**

(2) Expected impacts on businesses		
Any significant or adverse distributional impacts?	The cost of regulation is felt disproportionately by small and micro businesses. While mitigation has been outlined in the Small and Micro Business Assessment, it is recognised this might not be comprehensive. Improved data sharing processes and increased clarity on requirements for private businesses might encourage entry and investment in the sector.	**Uncertain**

(3) Expected impacts on households		
Description of overall household impact	Households will not incur costs due to this legislation. Households may benefit indirectly from reduced medication errors, and improved patient engagement.	**Positive**
Monetised impacts	Direct costs or benefits to households because of this legislation have not been monetised.	**Uncertain** **Based on likely household £NPV**
Non-monetised impacts	Non-monetised indirect benefits to households: Improve health care utilisation by patients, improved patient adherence to treatment and medication plans, and improved patient engagement and satisfaction.	**Positive**
Any significant or adverse distributional impacts?	Adverse impacts on specific groups are not expected because of this legislation. On balance, the SPR legislation is expected to have an indirect positive impact on all patients, with people who require a higher use of health and care services across a range of health and care settings likely to disproportionately experience the benefits.	**Positive**

Part B: Impacts on wider government priorities

Category	Description of impact	Directional rating

Business environment: **Does the measure impact on the ease of doing business in the UK?**	This measure is a new requirement for private businesses and therefore may work against the ease of doing business in the UK. However, improved data sharing processes and increased clarity on requirements for private businesses might encourage entry and investment in the sector.	**Uncertain**
International Considerations: **Does the measure support international trade and investment?**	These requirements do not directly impact on trade. The UK has always protected its right to choose how NHS health and social services are delivered in trade agreements and will continue to do so. However, these measures are new requirements for private businesses and may therefore deter overseas businesses from entering the UK market.	**May work against**
Natural capital and Decarbonisation: **Does the measure support commitments to improve the environment and decarbonise?**	This legislation is not expected to have a significant impact on the UK's natural capital and decarbonisation of the economy.	**Neutral**

Annex B

Table 15: Number of organisations in England assessed to be in scope of the legislation, by type and size

Organisation type	Public or Private	Business size	Number of organisations
NHS trusts (All)	Public	All	205
NHS trusts (Micro)	Public	Micro	0
NHS trusts (Small)	Public	Small	0
NHS trusts (Medium)	Public	Medium	0
NHS trusts (Large)	Public	Large	205
Public GP practices (All)	Public	All	5,837
Public GP practices (Micro)	Public	Micro	54
Public GP practices (Small)	Public	Small	2,565
Public GP practices (Medium)	Public	Medium	3,155
Public GP practices (Large)	Public	Large	64
Community pharmacies, contracted by NHS (All)	Public	All	10,399
Community pharmacies, contracted by NHS (Micro)	Public	Micro	8,462
Community pharmacies, contracted by NHS (Small)	Public	Small	1,602
Community pharmacies, contracted by NHS (Medium)	Public	Medium	275
Community pharmacies, contracted by NHS (Large)	Public	Large	60
Public Community Care Providers, NHS and local authority (All)	Public	All	257
Public Community Care Providers, NHS and local authority (Micro)	Public	Micro	209
Public Community Care Providers, NHS and local authority (Small)	Public	Small	40
Public Community Care Providers, NHS and local authority (Medium)	Public	Medium	7
Public Community Care Providers, NHS and local authority (Large)	Public	Large	1
Dental practices, supplying some NHS dental care (All)	Public	All	7,350
Dental practices, supplying some NHS dental care (Micro)	Public	Micro	4,964
Dental practices, supplying some NHS dental care (Small)	Public	Small	1,520
Dental practices, supplying some NHS dental care (Medium)	Public	Medium	129
Dental practices, supplying some NHS dental care (Large)	Public	Large	738
Public Care Home Providers (All)	Public	All	Small proportion
Public Care Home Providers (Micro)	Public	Micro	Small proportion
Public Care Home Providers (Small)	Public	Small	Small proportion
Public Care Home Providers (Medium)	Public	Medium	Small proportion

Organisation type	Public or Private	Business size	Number of organisations
Public Care Home Providers (Large)	Public	Large	Small proportion
Public Home Care Providers (All)	Public	All	Small proportion
Public Home Care Providers (Micro)	Public	Micro	Small proportion
Public Home Care Providers (Small)	Public	Small	Small proportion
Public Home Care Providers (Medium)	Public	Medium	Small proportion
Public Home Care Providers (Large)	Public	Large	Small proportion
Local authorities (All)	Public	All	317
Local authorities (Micro)	Public	Micro	0
Local authorities (Small)	Public	Small	0
Local authorities (Medium)	Public	Medium	0
Local authorities (Large)	Public	Large	317
Private Hospitals (All)	Private	All	172
Private Hospitals (Micro)	Private	Micro	0
Private Hospitals (Small)	Private	Small	0
Private Hospitals (Medium)	Private	Medium	172
Private Hospitals (Large)	Private	Large	0
Private GPs (All)	Private	All	373
Private GPs (Micro)	Private	Micro	3
Private GPs (Small)	Private	Small	164
Private GPs (Medium)	Private	Medium	201
Private GPs (Large)	Private	Large	4
Community Pharmacies, not contracted by NHS (All)	Private	All	Small proportion
Community Pharmacies, not contracted by NHS (Micro)	Private	Micro	Small proportion
Community Pharmacies, not contracted by NHS (Small)	Private	Small	Small proportion
Community Pharmacies, not contracted by NHS (Medium)	Private	Medium	Small proportion
Community Pharmacies, not contracted by NHS (Large)	Private	Large	Small proportion
Private Community Care (All)	Private	All	557
Private Community Care (Micro)	Private	Micro	453
Private Community Care (Small)	Private	Small	86
Private Community Care (Medium)	Private	Medium	15
Private Community Care (Large)	Private	Large	3
Private Dentist (All)	Private	All	3,150
Private Dentist (Micro)	Private	Micro	2,127
Private Dentist (Small)	Private	Small	651
Private Dentist (Medium)	Private	Medium	55

Organisation type	Public or Private	Business size	Number of organisations
Private Dentist (Large)	Private	Large	316
Private Care Homes (All) – brand adjusted	Private	All	6,145
Private Care Homes (Micro)	Private	Micro	624
Private Care Homes (Small)	Private	Small	3,471
Private Care Homes (Medium)	Private	Medium	1,809
Private Care Homes (Large)	Private	Large	241
Private Home Care (All) – brand adjusted	Private	All	9,055
Private Home Care (Micro)	Private	Micro	2,285
Private Home Care (Small)	Private	Small	4,644
Private Home Care (Medium)	Private	Medium	1,835
Private Home Care (Large)	Private	Large	291
Private IT Suppliers (All)	Private	All	40
Private IT Suppliers (Micro)	Private	Micro	12
Private IT Suppliers (Small)	Private	Small	5
Private IT Suppliers (Medium)	Private	Medium	9
Private IT Suppliers (Large)	Private	Large	14
Total organisations			43,857
Total public organisations (All)			24,365
Total public organisations (Micro)			13,688
Total public organisations (Small)			5,727
Total public organisations (Medium)			3,565
Total public organisations (Large)			1,386
Total private organisations (All)			19,492
Total private organisations (Micro)			5,505
Total private organisations (Small)			9,021
Total private organisations (Medium)			4,096
Total private organisations (Large)			870

Notes: (i) Totals may not sum due to rounding (ii) Impacts related to activities of private sector bodies in the delivery of public services, such as pharmacists or dentists providing NHS funded services have been classified as public for the purposes of this IA. (iii) The costs of this legislation are expected to be felt at the provider level, meaning a provider with 3 care home locations would experience costs once. Where possible, organisation numbers have been brand adjusted to account for companies that have multiple locations. In many instances it was not possible to make this adjustment. So, for example, individual GP practices and dental practices have been counted, overstating the aggregate costs.