

Declaration of interest

The author is the founder of Digital Narrative Care Ltd (Company No. 17237182), which develops governance methodology and tools of the kind the recommendations in this submission would require. This submission is made in that context. The four recommendations are framed as requirements on the architecture of the Single Patient Record, not as a procurement route for any single provider. They could be met by a range of approaches and suppliers, and are offered to the Committee on that basis.

Summary

1. The Health Bill creates the legislative vehicle for a national Single Patient Record (SPR). This submission welcomes that ambition. It identifies a specific structural gap in the Bill as currently drafted and makes four targeted recommendations to close it before the technical architecture locks.
2. The gap is this. The Bill enables the Secretary of State to require that data be combined into a single patient record. It does not specify what must remain true of that record once AI has helped form it. It does not require that AI-generated and clinician-authored entries remain distinguishable as they travel. It does not require that corrections propagate to downstream copies held in social care, education and tribunal processes. It does not establish that the conditions under which an AI-shaped record was formed must remain recoverable.
3. These are not abstract governance questions. They are the conditions under which the Single Patient Record will be trustworthy, challengeable and correctable once it begins to travel — into GP practices, hospital trusts, community services, social care, education, SEND tribunals and beyond. They need to be built into the architecture now, before the contracts are live. They cannot be retrofitted once the record is in circulation.
4. The evidence base for this submission draws on independent evaluation of ambient voice technology in NHS settings, peer-reviewed research into AI-assisted record formation, and the governance methodology developed by Digital Narrative Care over 2025–26.

Background: The Travelling Account Problem

5. AI is already reshaping the records that drive care, justice, education and public accountability. Ambient scribing tools transcribe and summarise clinical consultations. AI assistants draft case notes. Classification models assign risk scores. In each case, the output is not simply a tool result — it is a record that will travel, acquire authority, and be relied on by people who were not present when it was formed.

6. NHS England's own guidance identifies the clinical hazards: missing critical information, incorrect information and context, and delayed outputs requiring review, approval and monitoring. Oxford University Hospitals and Royal Devon University Healthcare NHS Foundation Trust have both published results from ambient scribing pilots that confirm both the efficiency gains and the accuracy risks. A peer-reviewed study of ambient scribing in general practice (van Linschoten et al., npj Digital Medicine, 2026) found a documentation-time saving of roughly 43 seconds per consultation alongside unresolved questions about accuracy and professional responsibility — a modest, conditional gain, not an unqualified one.
7. The governance question is not whether the AI tool was accurate at the point of production. It is whether the record it produced remains trustworthy, challengeable and correctable as it moves through the system. That travelling record — not the original encounter, not the tool itself — is the real governance object.
8. Once a record enters a national infrastructure like the Single Patient Record, its authority compounds at every stage. It may be read by a GP who did not write it, relied on by a specialist who did not know it was AI-assisted, inherited by a social worker who cannot see what it compressed, and acted on by a SEND tribunal with no mechanism to challenge its formation. At each stage, the window for correction narrows.
9. Digital Narrative Care governs this problem through three integrity conditions that must hold wherever AI mediates high-stakes records: record integrity (was what entered the record accurately captured and attributable?), meaning integrity (does the record remain faithful to the person and situation it describes?), and temporal integrity (does the record remain current enough to act on, and can it be corrected when it is not?).

Evidence: Why This Matters for the Single Patient Record

Community Paediatrics

10. The most concrete current evidence for the governance gap comes from community paediatrics. Independent evaluation of ambient voice technology in this setting — covering children's developmental and neurodevelopmental assessments — has identified it as the highest-burden, lowest-fidelity clinical environment yet documented. In the February 2026 evaluation by TheHill and Oxford University Hospitals NHS Foundation Trust, community paediatrics recorded the highest editing burden of any setting studied: a majority of users reported that AI-generated documentation required substantial editing, and around 40% reported frequent confabulation or omission of key details. Reported error types, across this and the earlier Unity Insights evaluation of July 2025, include fabricated growth measurements, people recorded as present who were not in the room, omitted clinical caveats, and diagnostic inferences unsupported by the consultation.

11. This evidence must be read with one important qualification — which strengthens rather than weakens the case. Neither evaluation was designed as a systematic error-tracking study; both state that their focus was the documentation process and staff experience rather than direct patient outcomes or systematic error tracking. The confabulation and omission figures therefore describe errors that clinicians happened to notice and report. They are a floor, not a ceiling. That no systematic error-tracking regime exists for AI-generated entries in the highest-consequence paediatric setting is not a gap in the evidence. It is the gap this submission asks the Committee to close.
12. These records do not stay in community paediatrics. They travel to Education, Health and Care Plans, to safeguarding processes, and to SEND tribunals. Under the SPR, they would travel further still — to every NHS provider with access to the record, and potentially to any researcher or service approved for secondary use.
13. Critically, the audio source material from these consultations is often deleted within minutes of the session ending, making later correction of AI-generated errors impossible. The correction mechanism fails at the formation stage. Once the error has hardened into the record, it is available to every downstream service that relies on it.
14. Community paediatrics does not currently meet the conditions for safe travel of AI-assisted records into the NHS Single Patient Record. That is not an argument against AI in this setting. It is an argument for what must be in place — source-material retention, AI-origin tagging, correction propagation — before AI-assisted records from this setting are allowed to enter national infrastructure.

The Correction Propagation Gap

15. The Health Bill creates a record that will be held in one place but relied on across many services. Social care, education and tribunal processes will inherit from it. When an error is identified in the SPR — whether AI-generated or otherwise — the correction must reach every downstream copy and every downstream decision-maker that has relied on the uncorrected version.
16. The published Bill materials and the Single Patient Record fact sheet set out safeguards covering access levels, audit trails and patient choice over data use. These are necessary, and welcome. But they govern who may see the record and how its use is logged. They do not establish whether a correction made in the NHS record will reach social care, education or tribunal copies. In a genuinely interconnected national record, the answer to that question must be yes — and it must be built into the technical architecture, not assumed to follow from general data-protection principles. Access governance is not account integrity.
17. The same gap applies to AI-generated errors specifically. If an AI tool fabricates a clinical detail that enters the SPR, and that detail is then relied on in an EHCP or a safeguarding assessment, correcting the SPR entry does not automatically correct the downstream

document. An explicit correction-propagation obligation — with defined reach — is needed.

18. This gap extends beyond NHS records. The Ada Lovelace Institute’s Scribe and Prejudice? research (2026) found that AI transcription tools were already in active use across at least 85 local authorities in England, with inconsistent safeguards, uncertain human review practices, and evidence of AI-generated misrepresentations entering statutory social care records. The SPR will connect health and social care data; its correction and provenance architecture must therefore be designed to anticipate records travelling into precisely those settings where AI-assisted documentation governance remains uneven.

AI-Origin Distinguishability

19. As AI tools become more capable and more widely deployed, the practical ability to distinguish AI-generated content from clinician-authored content will become progressively harder without explicit technical requirements. A record that does not distinguish AI-generated summary from clinician observation, AI-inferred diagnosis from confirmed diagnosis, or AI-drafted letter from reviewed and signed letter is not a trustworthy foundation for a national record infrastructure.
20. The current Bill does not require that AI-generated, AI-assisted and clinician-authored entries remain distinguishable within the SPR. That requirement needs to be established before the architecture locks. If it is not built in, it cannot be added to records already in circulation.
21. This is not a demand for AI-scepticism. It is a demand for transparency about what was known, how it was produced, and who is accountable for it. A clinician who reviews and confirms an AI-generated entry is accountable for that confirmation — but that accountability requires that the entry's origin be visible.

The Deployment Window Is Now Measured in Months

22. The Government has committed that, by March 2027, clinicians in England will benefit from improved access to records for at least 80% of patients, through the connection of existing shared care records, with maternity and frailty as the first priority pathways. From 2028, the ambition is that all patients in England will have access to a core set of their data through the Single Patient Record. That timetable is welcome. It also means the design window for building governance conditions into the SPR architecture is now measured in months, not years.
23. The urgency of these requirements became concrete on 8 June 2026, when NHS England announced the deployment of Microsoft 365 Copilot to 505,000 clinical and support staff across the health service — following the largest AI trial of its kind globally, across 30,000 NHS workers in 90 organisations. The deployment is expected to produce AI-mediated administrative and clinical documentation at very significant scale. The Health Bill

contains no provision governing the integrity of those accounts once they enter the Single Patient Record and travel to downstream services. The correction propagation gap this submission identifies is not theoretical. As of this week, it is operational at national scale.

24. The medico-legal consequences are already being recognised by professional bodies. In June 2026, Medical Protection warned that AI scribes, automated documentation assistants, triage algorithms and clinical decision-support tools share a common feature: they shape clinical reasoning, records and workflows without taking autonomous responsibility for outcomes. It warned that clinicians risk becoming the “liability sink” — the obvious target for a damages claim — despite having limited control over how the AI system reaches its conclusions. That risk compounds directly where the records those systems produce cannot be traced to their origin, corrected once errors are identified, or distinguished from clinician-authored content. Formation-state retention and AI-origin distinguishability are not only governance requirements. They are the preconditions for fair accountability.
25. The governance requirements set out in this submission are not post-deployment safeguards. They are formation-stage requirements. They must be specified in the Bill, or in subordinate legislation, before the technical architecture is finalised. Once the architecture locks — once the systems are procured, the contracts are live, and the records are in circulation — these requirements cannot be retrofitted.

Recommendations

The Committee is invited to consider the following four recommendations, either as amendments to the Bill or as matters for specific provision in the subordinate legislation and technical standards that will govern the SPR.

Recommendation 1: Require AI-origin distinguishability in the Single Patient Record

The Bill should require — or empower the Secretary of State to require by regulation — that AI-generated, AI-assisted and clinician-authored entries in the Single Patient Record remain distinguishable from one another in every version of the record accessed by any authorised user or downstream service. This requirement should survive transmission, formatting and inheritance. A record that loses its AI-origin information as it moves between systems, or is accessed by a new service, no longer supports meaningful accountability.

Recommendation 2: Establish a correction-propagation obligation with defined downstream reach

The Bill should establish — or empower the Secretary of State to establish by regulation — that corrections to entries in the Single Patient Record must propagate to all downstream copies and all downstream services that have inherited from the corrected entry, including social care, education and tribunal processes that have relied on the uncorrected entry. The correction is not complete until it has reached every reliance point. This is especially critical for AI-generated entries, where errors may be systematic rather than individual. The technical architecture for the SPR should be required to include a correction-propagation mechanism before deployment, not as a future enhancement.

Recommendation 3: Require that formation conditions for AI-assisted records are retained and recoverable

The Bill should require — or empower the Secretary of State to require by regulation — that for any AI-assisted entry in the Single Patient Record, the conditions under which that entry was formed are retained and recoverable for the duration of the record's active use. This includes: the source material from which the AI generated its output (where this is audio or other primary material, it must not be deleted before a defined minimum retention period has elapsed); the human review and sign-off status of the AI-generated entry; and the date and context of formation. The specific case of community paediatrics — where audio source material is currently deleted within minutes of a session, making correction of AI-generated errors impossible — demonstrates why this requirement cannot be left to local practice or vendor discretion.

Recommendation 4: Define minimum integrity conditions before AI-assisted records may enter the SPR from high-consequence settings

The Secretary of State should be required to define, by regulation or technical standard, the minimum integrity conditions that AI-assisted records must satisfy before they may enter the Single Patient Record from high-consequence settings. These settings should include at minimum: community paediatrics and children's developmental assessment (where records travel to EHCPs, safeguarding processes and SEND tribunals); children's social care (where records travel to looked-after-children processes, family courts and independent reviewing officers); and any setting where AI-assisted records will directly inform dosage, surgical or other safety-critical clinical decisions. The conditions should include: AI-origin tagging present and verified; source material retained for a minimum period; human review completed and signed; and a defined correction pathway.

Conclusion

26. The Health Bill creates an important and welcome foundation for national health record infrastructure. The recommendations in this submission do not oppose that ambition. They ask the Committee to ensure that the infrastructure being built is equal to what the records it will carry will do.
27. A national Single Patient Record will travel further, be relied on by more services, and be harder to correct than any local record that preceded it. If the account it carries is wrong, interoperability does not help — it accelerates. The governance conditions must match that scale. AI-origin distinguishability, correction propagation, formation-state retention, and minimum integrity conditions before entry are not optional enhancements. They are the conditions under which the SPR can be trustworthy.
28. These requirements need to be in the architecture before it locks. By March 2027 — nine months from now — connected records are intended to reach 80% of patients in England. The Committee has the opportunity to ensure the governance conditions are built in from the start, before the first failures expose how difficult, costly and incomplete retrofit would be.
29. That urgency is sharpened by what is currently absent from the professional infrastructure being built for AI assurance. The AI Assurance Stakeholder Consortium — convened by the Department for Science, Innovation and Technology and led by the British Computer Society — is constructing a code of ethics, a skills and competencies framework, and the route to a formally recognised AI assurance profession. Its scope covers how AI systems are designed, developed and deployed. It does not cover what must remain true of the AI-mediated record once it leaves the room and enters institutional memory. The account-integrity layer is not in scope. Not because it has been considered and deferred. Because it has not yet been named.
30. The Science, Innovation and Technology Committee's report *Rewiring the State: Delivering Digital Government* (HC 61, June 2026) examined NHS digital infrastructure, vendor lock-in, and the governance of AI systems including those being deployed across the Single Patient Record. The Committee made significant findings about procurement and supplier sovereignty. It made no recommendations about what must remain true of the AI-mediated accounts those systems produce once they enter NHS institutional memory. The absence is not an oversight in the report — it reflects the fact that account integrity governance has not yet entered the parliamentary conversation. This submission invites the Public Bill Committee to be the first place it does.

About Digital Narrative Care

Digital Narrative Care (Company No. 17237182) is a governance methodology for AI in high-trust, high-consequence institutional settings. It has developed practical frameworks and instruments for governing AI-mediated records across healthcare, children's social care, policing and justice, and education, drawing on engagement with NHS trusts, the Department for Education, the Department of Health and Social Care, and the Information Commissioner's Office. The founder holds a guest lectureship at the University of Nottingham.

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