PUBLIC POLICY PROJECTS

INSIGHT • ANALYSIS • INTELLIGENCE

INSIGHTS

Designing the future health and care digital architecture

CHAIRED BY MATTHEW DOUGLAS

quantexa

ubh UB HEALTHCARE

ORACLE Health

ORION HEALTH

Optum

GREAT WEST ROAD PCN
TOWARDS A HEALTHIER FUTURE

Contents

Key Information

ABOUT PPP

Public Policy Projects (PPP) is an organisation operating at the heart of health and life sciences policy delivery. We bring together senior leaders and practitioners in the public and private health and life sciences sectors to find realistic solutions to the most pressing issues relating to health and care delivery.

ABOUT THE DDT PROGRAMME

The Digital and Data Transformation (DDT) Programme from Public Policy Projects (PPP) is a multi-stakeholder coalition that generates practical recommendations for transforming health and care services through digital and data. The programme brings together leaders from the NHS, integrated care systems (ICSs), social care, local government, academia, and industry to examine priority topics through targeted roundtables and produce actionable, concise reports that support the transformation of the health and care sector.

This report synthesises insights from the third roundtable in the DDT series. The session explored the future health and care digital architecture, including the pathway toward a single patient record (SPR), standards, governance, operating models, and how to realise value for patients, staff and taxpayers.

This programme of work is supported by a coalition of sponsor organisations, including Orion Health, Quantexa, Oracle Health, UB Healthcare, Optum and Great West Road PCN. PPP has retained editorial control of all outputs.

Quotations have been anonymised in line with the Chatham House Rule and lightly edited for clarity. PPP has supplemented the findings of the roundtable with further analysis to produce this report.

Foreword

MATTHEW DOUGLAS
Former Director of Digital and Infrastructure, NHS Cambridge & Peterborough ICB

Current health reform points firmly toward a digitally enabled, neighbourhood model of health and care – one where services are designed around people and communities, rather than the institutions that treat them. This ambition is right, however as this report makes clear, there remain long-standing barriers that continue to prevent us from translating this 'North Star' vision into a practical, everyday reality for patients and staff.

The infrastructure supporting digital technology within the NHS—the core of how systems connect, how data flows, and how trust is maintained—has long been limited by fragmented guidance and a lack of common direction amongst the many providers. Central to this discussion is a familiar dilemma: how do we balance local independence with national consistency? Health policy has often struggled to strike a balance between local innovation and the national standards needed for interoperability and safety.

What is different now is the opportunity presented through the 10-Year Health Plan. If we choose to grasp it, we can transform this historic friction into a virtue – building an architecture that is both flexible and consistent, rooted in local delivery but underpinned by national clarity. This is not a question of technology alone, but of redesigning the foundations and governance of the system so that digital tools work with – not around – the pathways of care.

It was my pleasure to chair this roundtable, which brought together stakeholders from system and provider level to interrogate these challenges openly and constructively. The breadth of insight shared here reflects both the ambition of those leading digital transformation across health and care, and their realism about the cultural, technical and architectural change required.

This report does not pretend to offer definitive answers. Instead, it sets out a set of practical recommendations that can help shape a modern and effective digital architecture – one capable of supporting the aims and objectives of the 10-Year Health Plan, and of enabling a health and care service that is integrated, future-focused, and ultimately designed around the needs of the citizen.

Key Insights

- Current NHS digital architecture models are largely organisation-bound. There is a need to pivot the health system towards citizen/patient-centred architecture, underpinned by shared workflows and services that follow the citizen/patient across pathways and places. Further, shifting toward an events-driven, real-time architecture model will better support proactive care and automation.

- The development of a single patient record (SPR) could 'liberate' data from individual applications, and allow for tailored data presentations to different users, whether it be a clinician, social worker or citizen/patient, etc. However, the SPR must be designed to surface the correct data at the right moment, rendered in a way that is appropriate for different users. Over-exposure of unnecessary data risks confusion and misinterpretation from users. Conversely, under-exposure risks harm and may lead to missed opportunities to develop actionable insight and address health challenges.

- The Federated Data Platform (FDP) and SPR should develop as complementary platforms. While both platforms have distinct use cases (FDP typically operational and SPR more clinical), lessons from FDP development so far suggest that openness, interoperability, and actionability, rather than vendor lock-in, are crucial factors for successful digital development and developing national systems. A hybrid approach containing national standards with local flexibility remains essential in the development of digital architecture.

- Modern digital architecture requires a nationally agreed 'base', such as ISO-based data models, openEHR, Observational Medical Outcomes Partnership (OMOP) or Fast Healthcare Interoperability Resources (FHIR). This base must maintain alignment with international norms to avoid 'anglicising' digital services.

- Data must flow directly into workflows in order to inform care choices. Shared care records have helped close information gaps, but they require more integrated processes to improve clinical decision-making further. While shared care records are widely recognised as critical infrastructure for digital transformation, they face significant funding uncertainty, requiring sustainable investment and clearer national leadership to realise their full potential.

- There remains a pressing need to simplify information governance to build modern digital architecture and encourage safe and effective data sharing. Delegates emphasised the duty to share data to enable direct care, with consistent, system-wide agreements that avoid repeated, bilateral negotiations.

- Providers and systems must pursue a simplified digital estate, disinvest where solutions no longer deliver, and prioritise capabilities with the most significant system-wide impact.

Recommendations

RECOMMENDATIONS TO CREATE A MODERN HEALTH AND CARE DIGITAL AND DATA ARCHITECTURE

1. **Adopt a patient-centred reference architecture that organises data, systems and workflows around the citizen/patient.**

1a Publish a national target architecture that models how NHS digital services fit together across three states of care: personalised/digital self-service, neighbourhood/integrated, and site-based – each with common, reusable services (identity, consent, tasking, notifications) that span them.

1b Create a national event taxonomy for the three states of care. Provide worked examples for typical journeys (such as frailty, maternity and mental health crisis) and specify how events, data and tasks move between settings.

2. **Mandate a core data model and open standards to eliminate one-off integrations, allowing suppliers to plug into systems more easily and make patient data portable across the NHS.**

2a Set and enforce one national data model and API standard for clinical information. Publish the mappings between International Organisation for Standardisation (ISO) 13606 and Fast Healthcare Interoperability Resources (FIHR) and require agreed openEHR archetypes where openEHR is used.

2b Supply reference artefacts (schemas, profiles, test suites) and a migration guide for legacy systems.

2c 'Liberate' data from apps and require that all clinical systems implement export/import and APIs aligned with the national model, ensuring a 'write once, read many' approach across settings and vendors.

3. **Prioritise an event-driven backbone to digital architecture that ensures that key changes (events) in citizen/patient status drive workflows. This will allow systems to react in real time.**

3a Introduce an NHS 'event bus' pattern for state changes that require action, starting with high-value events, such as diagnosis change, discharge readiness or medication changes. This shared service would then deliver key event updates to subscribed systems across health and care.

3b Before the delivery of updates, the bus should check the purpose of the use as well as consent/opt-outs, roles and data minimisation so each recipient only gets the information they need/are allowed to see.

3c Track a core benefits set: time-to-share for critical data, time-to-task from insight, avoided duplication, pathway cycle time, staff experience, patient-reported confidence/understanding, and equity metrics (such as access by language group).

4. **Design digital systems for 'decision intelligence', not just to produce insight. To help enable this, analytics should be directly tied to workflow by default.**

4a Require analytics platforms (including FDP use cases) to emit actionable 'insight objects' that create tasks in operational systems with clear ownership and due dates; verify completion via closed-loop telemetry.

4b Insight objects should trigger tasks in EPRs, PAS/ED systems, primary care systems and community platforms, with closed-loop feedback.

5. **Simplify information governance to enable lawful sharing.**

5a Provide national templates and system-wide sharing agreements (with a strong "duty to share" framing) to reduce delays and duplication.

5b Publish model IG frameworks, DPIAs, DSAs and a standard consent framework that recognises the duty to share. Offer a 'common controls catalogue' to expedite approvals.

6. **Codify the "done once nationally" vs "done locally" split.**

6a Centralise standards, identity, consent and reference data, federate pathway design, UI templates and local analytics nuances. Measure and publish benefits.

6b Classify shared care records as critical national infrastructure, guaranteeing recurrent funding and supporting integration with tools like the NHS App to enhance patient access.

7. **Create a national library of user interface, actionable visualisations and pathway models.**

7a Share reusable, AI-enabled UI components and reference pathway models to ensure consistent quality while allowing local adaptation.

7b Curate reusable UI templates and pathway models (forms, summaries, care plans), including AI-assisted variants. Allow local adaptation but maintain versioned, shared assets to drive quality and reduce unwarranted variation.

8. **Ensure architecture embeds wider determinants by design.**

8a Plan for privacy-preserving linkage with cross-government datasets through the National Data Exchange. Use robust entity resolution and transparent minimisation to unlock preventative and targeting benefits safely.

8b Align with cross-government data initiatives. Architect for linkage with the National Data Exchange and wider determinants (education, welfare, housing, justice) using privacy-preserving approaches and robust entity resolution.

9. **Protect openness and competition.**

9a Ensure commercial frameworks avoid vendor lock-in; enable a genuine marketplace of interoperable components for both FDP and SPR-related capabilities.

9b Set commercial guardrails that prevent lock-in, enable competition and allow modular substitution. Publish conformance status for suppliers; fund transition for high-value legacy migrations.

10. **Finally, equality and social justice must be treated as architectural requirements,** embedded through consistent data fields and federated approaches to balance local autonomy and national needs.

Roundtable findings

INTRODUCTION

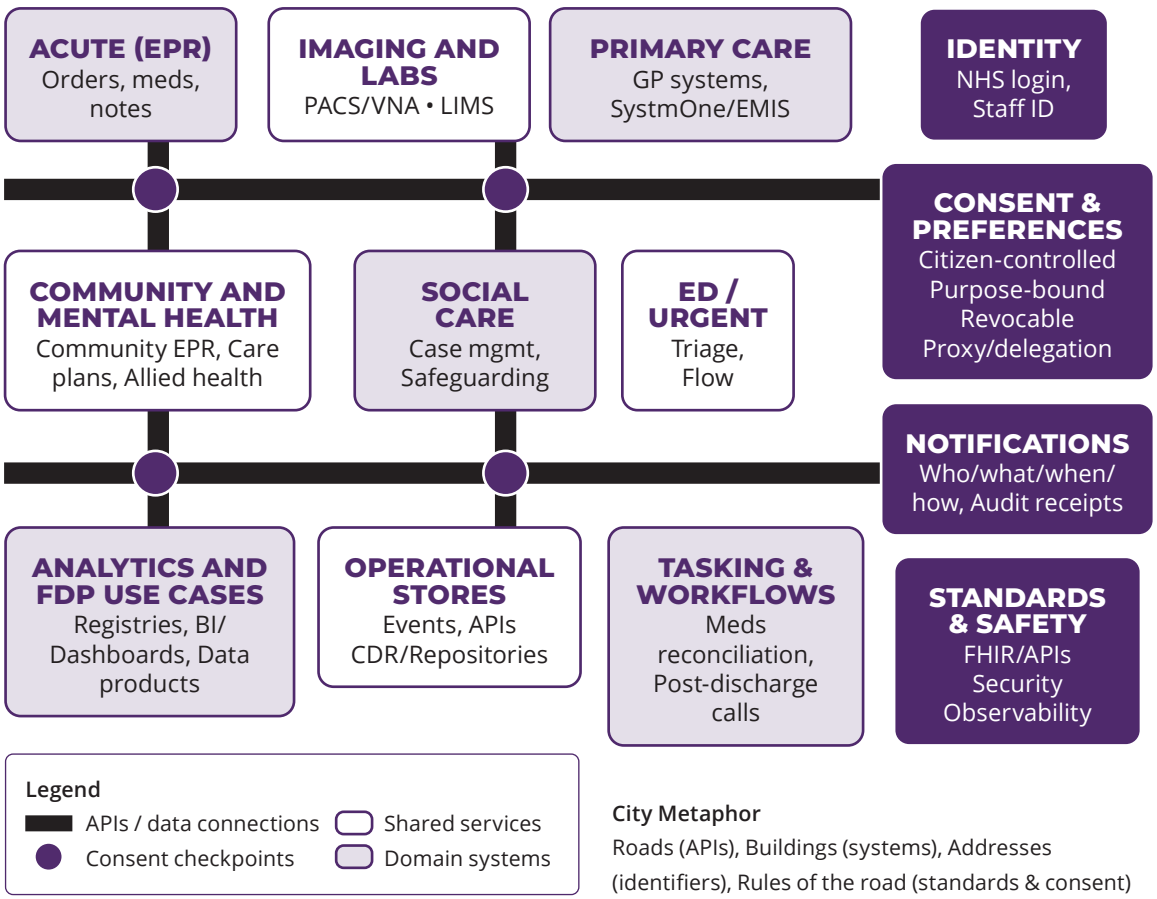
The commitment to move "from analogue to digital" requires more than new tools and software. Our group of experts and digital leads argued that it demands a shift in architecture, as well as culture and incentives.

Digital architecture is the plan for how digital services, data, and tools work together to ensure that the correct information reaches the right people safely, quickly, and reliably. Much like a city plan, which consists of roads (connections), buildings (systems), addresses (identifiers), and the rules of the road (standards), health and care must have an effective digital architecture to ensure that systems and providers work together effectively.

Examples of the different components of digital architecture:

- Clinical systems, apps, data stores, analytics, and user interfaces
- Standards, APIs and event signals
- Data sharing agreements, including security considerations, privacy, access controls, and audit tools
- Governance, reusable components, and ways to add/replace parts without disruption

DIGITAL ARCHITECTURE 'CITY MAP'



City Metaphor

Roads (APIs), Buildings (systems), Addresses (identifiers), Rules of the road (standards & consent)

What effective digital architecture leads to in healthcare:

- Fewer logins and clicks for patients and staff, which creates a more effective workflow
- Information shows up where work happens, and staff spend less time sifting through portals and dashboards
- Trustworthy data that provides a single source of truth with clear ownership
- Systems can be changed, swapped or added without disruption

To enable a substantial shift from analogue to digital, the 10–Year Health Plan promotes a range of devices and technologies, including AI, genomic, and wearable technologies, as well as positioning the NHS App as a central component of future health and care delivery.[1]

Delegates present at this roundtable recognised both the ambition and the friction inherent in the 10–Year Health Plan's ambitions: the need to move from organisationally bound systems to patient-centred, event-driven (i.e. real-time reaction to patient state changes) services, from duplicated point solutions to a simpler, standards-based estate, and from data locked inside applications to data that is 'liquid', trustworthy and designed for action. The NHS must develop a digital architecture that shifts from a 'store then report' mentality towards a 'signal then act' approach, supporting proactive care and automation – not just information sharing.

In the context of significant flux in the structure of UK health and care, there remain debates as to how these objectives are best achieved, standardised, and able to deliver local autonomy and flexibility. While falling short of providing definitive answers to these longstanding challenges, this paper articulates some of the complexities inherent in modernising digital architecture in the NHS.

> *The way we deliver care needs to be more patient-centric… that's a real calling for a different architecture than we've ever had before.*

The task for services across the NHS is to translate a 'North Star', as described in the 10-Year Plan, into a practical roadmap or blueprint for change – one that defines what should be done once, what should be adapted locally, which standards to mandate, and how to measure 'value' within digital health architecture. Roundtable delegates sought to address these challenges and present a blueprint for future digital architecture.

From organisational to patient-centred architecture

There were calls throughout the discussion to embed patient agency into digital architecture. Delegates agreed that existing digital capability models are still mapped around organisations, rather than citizens/patients. This approach fails to follow individuals through their pathways as they interact with various components of health and care. The system must pivot towards patient-centred and adaptive architecture, defining capabilities that are stable regardless of organisational form or scale and then specifying what is 'best done once' on a national level versus what can be configured locally and flexibly.

Delegates outlined three operating 'states' that need to be balanced to inform the design of this architecture:

- Personalisation and digital self-service, which includes services surfaced primarily through the NHS App and companion services
- Neighbourhood integrated care to allow for shared tasking, workflow and context across primary, community, mental health, social care and Voluntary, Community and Social Enterprise (VCSE) partners
- Site-based care with digitally mature sites in acute and community settings that interoperate seamlessly with the other states

Delegates also called for the NHS to define a small set of shared services that operate uniformly across all three states to encourage greater continuity, speed and safety in digital tools and workflows:

- Identity services: who a patient or staff member is (such as an NHS login and staff identity) across all settings
- Consent and preference services: what a person has agreed to share and for what purpose, the NHS App could be developed to introduce citizen controlled consent
- Tasking/orchestration services: to create/assign/track tasks (such as "meds reconciliation", "post-discharge call") regardless of which system triggers it
- Notification services: consistent rules for alerts/messages – who gets what, when, and how across apps, community teams, and hospitals

> *We'll have to create integrated services behind the patient channel… it's a change of culture more than technology in some cases.*

Delegates urged realism on sequencing. Legacy complexity and heterogeneous estates require ruthless prioritisation – addressing the foundations, retiring duplicative tools, and focusing investment on capabilities that unlock value across pathways. "*We're going to have to make some hard decisions… tidy up legacy… [and] be ruthless about what we can and can't do now.*"

The single patient record: liberate data, tailor presentation

There was a strong consensus among roundtable delegates that the SPR should be a durable, application-independent longitudinal record. One contributor made the case plainly: *"No computer system lasts as long as a record… the data has to be liberated from the computer system that generated it."*

However, the means through which the record is rendered must vary. *"Write once, present in many different ways,"* stressed one participant, cautioning that citizens, social workers and clinicians hold different mental models and information needs. Clinicians do not need every granular data point at decision time; they need salient summaries with the option to drill down: *"You don't need all that data to go to ED…you want the summary that lets you make the decision."* Integration with the NHS App will be a crucial means through which the SPR can 'liberate' patient data. However, this integration must also be broader than NHS acute services, encompassing community services, social care and mental health. A single health record (or personal health record) will support at liberation, providing patients with more control.

Crucially, the SPR should not be reduced to a single use case or vendor format. A pragmatic stance emerged of aiming for a generic base record (one that is durable and medico-legally reliable) with mappings to multiple standards and presentation layers, avoiding use-case-specific lock-in.

Centralised vs distributed single patient record

> *Do we mean a single, centralised dataset, or interoperable systems that assemble a patient view in real time? The PHM implications differ.*

A more centralised SPR with a single longitudinal store can be more effective for population health management (PHM), as well as for research and secondary uses that benefit from stable schemas and whole-system linkage. A more centralised approach also simplifies analytics and risk adjustment, but concentrates cyber/operational risk, can increase data latency, and risks supplier lock-in without strong openness/exit safeguards.

A more local or distributed SPR approach would benefit direct care, particularly where data 'freshness', and the need for data to remain close to source systems, matter. This also reduces duplication and some IG friction, but demands robust interoperability, identity/consent brokering, metadata/catalogues, and "compute-to-data" patterns for secondary use.

Delegates called for a pragmatic, hybrid SPR approach. The SPR should centralise what must be durable and shared at scale (master data, registries, entity resolution, curated PHM layer), while assembling patient views in real time for care via standards-based APIs. This keeps operational pathways fast and flexible, while still enabling high-quality secondary use.

Landing on clear standards

> *We need to start with a universal standard and an international-by-default mindset.*

Delegates urged the system to "land" on a clear standards baseline and mandate conformance. Options referenced included ISO 13606, openEHR, OMOP, and FHIR, with a strong steer towards international alignment to reduce costs and enable domestic vendors to compete globally.

> *Keep it as international as possible as 'anglicising' standards is just a cost to us.*

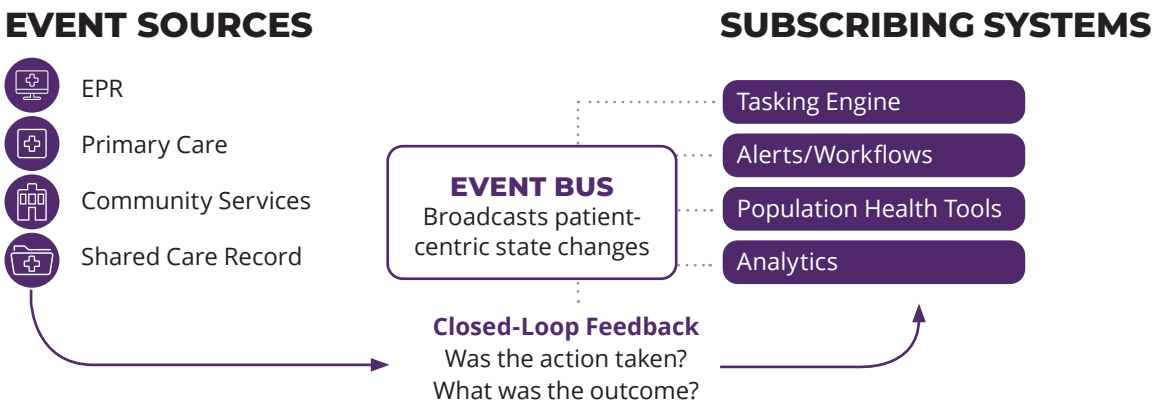
Potentially useful examples cited by participants include the European Health Data Space – regulation which aims to establish a common framework for the use and exchange of electronic health data across the EU, the International Patient Summary, and comparable work overseas, as useful models to watch – even if political realities limit formal participation.[2]

Event-driven services and "architecture for action"

A recurring theme was the need to shift from static data stores and retrospective reports to event-driven patterns that trigger timely action. *"Some things are best served by events… we're moving into a much more events-based architecture."*

Delegates contrasted the success of shared care records in closing information gaps with their more limited impact on decision-making where process integration is missing. Actionability requires:

- An event bus for state changes, (state changes could be new diagnosis, discharge ready, deterioration alert)
- Tasking and workflow hooks into EPRs, primary and community systems
- Closed-loop feedback to measure whether an action or intervention happened and with what outcome



Delegates called for the development of an event bus (a software architecture component that facilitates communication between different parts of an application or between different applications, using a publish-subscribe model) – this could be aligned to the National Events Management Service (NEMS), to broadcast patient-centric state changes to subscribing systems.[3]

Information governance: enable the duty to share

Persistent IG friction slows integration and data sharing within and across health and care. Participants called for simplification that recognises the duty to share for direct care, supported by standardised, reusable data sharing agreements and clear national positions to reduce repeated negotiations. This aligns with the Caldicott Principles for the safe and effective sharing of data in health and social care, as well as existing NHS IG guidance.[4, 5]

"Done once nationally" vs "done locally"

The roundtable endorsed a practical division of labour within digital architecture, between elements that are better being "done once nationally" (i.e. build/decide it once for all systems and providers, so all regions and suppliers reuse the same architecture), or "done locally", which allows for flexible configuration between regions, and tailoring for local pathways, teams, and priorities.

- Done once (national/system): identity, consent, core data model and terminologies; standards, conformance testing; cybersecurity baselines; event taxonomy; reference services (notifications, audit, provenance)
- Done locally (with guardrails): pathway design and configuration; user interface (UI) templates adapted to local contexts; local analytics enrichment

To accelerate reuse, delegates proposed a national library of UI and process models (including AI-enabled components), enabling consistent quality while preserving necessary variation by speciality or setting.

Equity, usability and the correct exposure of data

Data presentation must be safe, comprehensible and context-aware to each individual user. As one attendee reflected on seeing pathology results in the App: *"I honestly have no idea what they are… I'm not a haematologist."* The SPR should therefore support layered views, progressive disclosure and multilingual accessibility – this will help ensure that the right person sees the correct data at the right time.

Delegates stressed that equity must be baked into digital architecture from the outset. There were calls to standardise a minimal set of equity-critical fields (such as ethnicity, disability, language/communication needs, reasonable adjustments, and postcode-based deprivation), enforced across APIs and validation, while maintaining a federated data model to allow local services to retain autonomy while contributing to a shared view. Disaggregation should be a protected characteristic in the default dashboards and in data quality checks. Architecture should be designed to capture Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) using common instruments and codes (such as FHIR questionnaire response with agreed-upon value sets) so that outcomes are comparable across settings and inequities are visible and actionable.

VCSE providers should be integrated, as first-class data publishers/consumers, into digital architecture via 'lightweight connectors' and standard templates. This will help ensure activity and outcomes for underserved groups are captured and used to close gaps.

The complementary levers of FDP and SPR

Insights from PPP's prior roundtable on the FDP remain pertinent: the need for clarity of purpose when designing national platforms as well as openness by design, and inclusion of primary, community, social care and wider determinants data.[6] A hybrid approach to data architecture that incorporates national standards while allowing for local flexibility was again endorsed, with explicit warnings against vendor lock-in and calls for transparent commercial frameworks that foster a genuine ecosystem.

> *Keep markets competitive and avoid monopolies. Full data separation is a must, so suppliers compete on features rather than lock-in.*

Delegates outlined how entity resolution and privacy-preserving linkage can be key enablers for operational decision making through the FDP and clinical decision making through the SPR, particularly as cross-government datasets mature via the National Data Exchange.

There were calls from software leads to establish a national metadata registry (covering provenance, permissible use and quality expectations) alongside entity resolution quality rules (match thresholds, stewardship and audit) so datasets can be safely linked across programmes, making FDP outputs immediately reusable in operational and PHM decision making.

> *One way to 'liberate the data' is to focus on metadata… Data quality is dynamic; we need to describe quality expectations so repurposing is safe.*

Conclusion

The future NHS digital architecture must be patient-centred, standards-led and event-driven, with data 'liberated' from applications, rendered safely for each user, and connected to actionable insight. Delegates present at this roundtable stressed that this journey is not a 'big bang' replacement but a cumulative transformation where reference architecture and standards are established, an event backbone is stood up, IG simplified, and actionability is driven into frontline workflows. Alongside this, there is a need to align with cross-government data initiatives and protect an open, competitive ecosystem.

If the NHS can combine clarity of design with discipline in execution, it can move from well-intentioned fragmentation to a simpler, trusted, high-value digital estate – one that truly follows the patient, supports staff, and delivers better outcomes for all patients and citizens.

Attendees

Adeniyi Akinyandenu
Business Manager
Provide CIC

Alex Cheung
Senior Manager, Community Engagement
NHS England

Andrew Pearson
Project Coordinator
NHS Suffolk and North East Essex ICB

Andrew Raynes
Director of Digital and Chief Information Officer
Royal Papworth NHS Trust

Angela Pinnock
Project Manager
NHS

Anna Porebna
Director of Sales
Oracle Health

Ben McAlister
Lead Product Regulatory Strategist
Oracle Health

Ben Wilson
Product Solution Director
Orion Health

Chris Love
Client Director
Oracle Corporation (UK) Limited

Clive Flashman
Chief Digital Officer
Patient Safety Learning

Diarmaid Crean
Advisor
DCDC

Harry Bourton
Director / Co Founder
UB Healthcare Ltd

Hassan Chaudhury
Commercial Director
GOSH

Ian Binks
Director of Business Development
Oracle Health

Jack Rodber
Chief Analyst
Nottingham and Nottinghamshire ICB

James Freed
Deputy Director, NHS Digital Academy
NHS England

Jane Johnston
Co-CEO
AphA

Janette Booth
BI Associate
West Yorkshire Integrated Care Board

Jason Bradley
Chief Digital and Data Officer
Countess of Chester Hospital

Jason Horton
Enterprise Architect
NHS Business Services Authority

Karen Bridgeman
Digital Lead
University Hospitals of Morecambe Bay

Kathryn Foskett
Head of Partnerships and Solutions
GE Healthcare

Laura Boyd
Director of Digital Partnerships
Health Innovation Yorkshire and Humber

Matthew Douglas
Former Director of Digital and Infrastructure
NHS Cambridge and Peterborough Integrated Care Board

Matthew Riley
Chief Information Officer
Here

Muhammed Ali
Managing Partner
GP Pathfinders Clinic

Mutahar Ali
Head of Data Management
NHS Blood and Transplant

Nathan Thomas
Data Solutions Architect
University Hospitals Plymouth NHS Trust

Neel Desai
Senior Consultant
Carnall Farrar

Nicholas Oughtibridge
Managing Partner
Oughtibrige

Rachel Wright
National Programme Manager
NHS England

Ram Rajaraman
Healthcare & Life Sciences Industry Lead
Quantexa

Sonia Patel
Chief Technology Officer
NHS England

Tal Mahmud
GP Partner
HIYOS

Tito Castillo
Principal Enterprise Architect & Data Management Consultant
Agile Health Informatics Ltd.

Tiza Nyimbili
Data Quality Analyst
University Hospitals Southampton NHS Foundation Trust

Vikesh Tailor
Head of Digital Transformation
NHS England - East

References

1. Department of Health and Social Care (2025). 10 Year Health Plan for England. Available from: https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf
2. European Health Data Space Regulation. What is the EHDS Regulation about. Available from: https://health.ec.europa.eu/ehealth-digital-health-and-care/european-health-data-space-regulation-ehds_en
3. NHS England (2025). National Event Management Service NHS England Digital. Available from: https://digital.nhs.uk/services/digital-child-health/digital-child-health-implementation-guides/nems-onboarding-guide/national-event-management-service?utm_source=chatgpt.com
4. National Data Guardian (2020). The Calicott Principles. Available from: https://www.gov.uk/government/publications/the-caldicott-principles?utm_source=chatgpt.com
5. NHS England (2022). Appendix 1: The Information Governance Review - To Share or Not to Share? - NHS England Digital. Available from: https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/a-guide-to-confidentiality-in-health-and-social-care/a-guide-to-confidentiality/appendix-1?utm_source=chatgpt.com
6. PPP (2025). Maximising the impact of the NHS Federated Data Platform. Available from: https://publicpolicyprojects.com/wp-content/uploads/2025/07/PPP_DDT-RT2-Report_0625-1.pdf