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A controversial new federated data platform for the NHS in England

Concerns include value for money and lack of public trust in the supplier

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On 21 November, NHS England announced the procurement of a federated data platform (FDP) for the NHS in England.[1] The FDP, which aims to join separate data sources from across the NHS, is now one of the largest and most ambitious health data infrastructure projects in the world. The £330m contract was awarded to the US software and analytics company Palantir.

That the NHS information infrastructure needs updating is undeniable; the new FDP hopes to deliver better care by making siloed data sources accessible to a wider range of users and providing a single platform for specific user groups to conduct analyses at local, regional, and national scale. In theory, this will enable system managers to gain deeper insight into health needs and provide more targeted, effective, and efficient services. Yet, despite great promise, the FDP has been controversial from the start.[2]

Much of the controversy can be attributed to lack of public trust in the procurement process and in the newly designated supplier. Palantir is controversial for several reasons,[3] including its work with the US Department of Homeland Security and US Immigration and Customs Enforcement. Despite reassurances from NHS England that the tender relates only to technology, justifiable concerns continue about privacy and perceived potential commercialisation of NHS data. These add to a pre-existing trust deficit between NHS England and the public about how patient data are used.

Two important concerns specific to the FDP are worth highlighting. First is the shifting scope of the contract: the original FDP contract specified its key functions as population health and planning, and patient cohorting or stratification[4]—indirect uses of data.[5] But FDP material released in the run-up to the announcement focused almost exclusively on the use of data for direct patient care, emphasising the need for joined up care and for patients to tell their stories only once.[6] Direct care was also mentioned explicitly on NHS England's Frequently Asked Questions web page before the announcement.[7] After the announcement, however, the reference to direct care was removed and the information now states that the FDP will enable "clinicians to plan and deliver care more efficiently to improve patient care." Despite this shift in emphasis, the national data opt-out—which allows patients to opt out of their confidential patient information being used for research and planning—will still not apply.[8]

How a national FDP will deliver the implied improvements to patient care remains unclear. As it stands, proposed uses of data are justified on the basis of case studies involving Foundry, Palantir's data and analytics platform, which is reported to have benefited trusts in local trials.[9][10] It is not clear whether all such trials have been successful,[11] or how the successful deployment of specific software by local trusts supports the case for a national federated infrastructure.

This lack of clarity has led some to question whether FDP use cases are based on a genuine system need that could be met by any potential supplier or whether they are instead based on services that Palantir is already—or could readily start—providing to the NHS through Foundry. Such concerns were recently exacerbated by a £25m contract awarded directly to Palantir, to "provide the smooth transition" of the existing platform to the FDP.[12]

Value for money?

The second concern is what additional value the £330m of public money being spent on the FDP will bring.[4] National data infrastructure already exists for many of the original FDP use-cases[13]: patient data for planning and benchmarking is available from all trusts through the NHS Secondary Use Services.[14] NHS integrated care boards use linked primary and secondary care data in population health and cohorting.[15] NHS shared care records enable direct data sharing between primary and secondary care for most of the population.[16] Secure software for GP data analysis already exists.[17]

The added value of the new FDP remains unclear, along with how (or whether) it will reduce friction and duplication of existing data flows. Furthermore, GP data will not be covered by the FDP,[18][19] greatly reducing its use for population health and anticipatory care.

Locking national infrastructure—including capabilities from data access to analytics—into a single vendor comes with both costs and risks. If the £330m includes buying data science and analytics services, this might be at the expense of upskilling the NHS workforce. Should problems occur or priorities change at the end of the contract, migrating infrastructure and skills could incur enormous costs.

The FDP risks repeating past mistakes such as the National Programme for IT[20] and Care.data,[21] where central vision, executed without sufficient engagement or technical understanding, led to costly failures and abandonment. Usage is not mandated, so trusts and integrated care boards might choose not to participate in the context of bad publicity and lack of trust. Longer term, the public may be more likely to opt-out of secondary data uses,[22] compromising numerous other data and research initiatives, and the overall value of NHS data.

To avoid such outcomes, questions around scope, value, and risk must be fully addressed. The FDP must be evaluated against specific performance targets related to added value, cost effectiveness, vendor lock-in, information exchange, usability and utility, and trustworthiness.

If targets are not being met, government support for the FDP must be removed. At a time when cost-cutting is the norm, and clinical frontlines are starved of resources, it is imperative that expenditure delivers demonstrable and sustainable benefits to patients and the NHS.

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