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Maximising the impact of the NHS Federated Data Platform

CHAired BY RACHEL DUNSCOMBE

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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

Public Policy Projects (PPP) is convening a coalition of stakeholders to advance practical recommendations for transforming health and care services. The coalition will gather leading experts from the sector, including the NHS, integrated care systems (ICSs), social care, local government, and leading industry figures.

This programme seeks to highlight opportunities and challenges in digital and data transformation across health and care services. A series of targeted roundtable discussions generates actionable insights and recommendations that support the government's longterm health policy goals and ensure digital technology is at the core of future health service delivery.

The findings of this report are based on a roundtable held on 26th April. The session was chaired by Rachel Dunscombe, CEO of openEHR International and former NHS CIO. PPP has supplemented the findings with independent research and analysis. This report was authored by David Duffy, Head of Content and Policy, Public Policy Projects.

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PPP has retained editorial control of the report and its findings.

Foreword



RACHEL DUNSCOMBE

CEO, openEHR International

It was my pleasure to chair the second roundtable in the PPP Digital and Data Transformation programme, which focused on the development of the NHS Federated Data Platform (FDP) and core national data infrastructure.

Data will power and inform the future target operating models for the NHS and beyond, and the FDP represents a pivotal shift in how we think about, manage, and act on health and care data. The platform has shown strong early momentum and there are powerful examples of where it is already making a difference, including reduced waiting times, expedited referrals and enhanced discharge planning. These are key achievements which hint at the vast potential of the platform.

For the platform to achieve this potential, it must be clear in its purpose, open in its design, and inclusive in its implementation. Today, there is confusion in the system. Stakeholders are unclear whether the FDP is a data integration tool, an AI platform, a business intelligence dashboard, or a population health engine. In truth, it has elements of each, and therein lies both the promise and the risk.

The report explores this tension. There is clearly a consensus that the FDP must prioritise interoperability and actionable insight over centralised control. A federated, hybrid approach, one that combines national standards with local flexibility, is essential. This platform must empower, not bypass,

local expertise. The most valuable data is often closest to the point of care, and the most meaningful analytics often come from those embedded in their communities, beyond the acute hospital. It is therefore vital that the FDP includes data from all care settings and social determinants, enabling a genuine ecosystem approach.

Critically, we must also address the data literacy and workforce readiness required to use the platform effectively. Too often, digital transformation is slowed not by a lack of tools, but by a lack of trust, training, or time. An ambitious educational programme and sustained engagement with local teams, including analysts, clinicians, and GPs, will be essential.

Finally, the FDP must be built on ethical, transparent foundations. As we expand its capabilities and consider new use cases and capabilities - from AI to predictive care - we must ensure governance structures are in place, commercial frameworks are clear, and the voice of the citizen is front and centre.

This report provides a valuable contribution to a vital, ongoing conversation. I hope it provides some clarity, provokes debate, and most importantly, informs action. The future of healthcare will be shaped by how we manage and use data. Let us ensure that the FDP becomes a platform for transformation, truly person-centred care and helps realise the 10-Year Health Plan.

Key Insights

- The FDP has so far demonstrated strong national uptake and early impact. The rapid adoption of the FDP, used by 41 of 42 integrated care boards (ICBs) and more than 100 hospital trusts, exceeds NHS England's targets, with early signs showing improved management of waiting lists and referral-to-treatment times. This momentum highlights the platform's potential to drive national improvements in healthcare delivery. The platform has the potential to support more preventative, personalised care by identifying unmet needs earlier and informing more coordinated interventions.
- There remains ongoing confusion as to the core purpose and scope of the FDP. While initially designed to improve NHS data integration and interoperability, the FDP has evolved into a multi-purpose tool seen by some as an AI platform, a population health management (PHM) tool, or a clinical aid. This has led to confusion, misaligned expectations, and concerns about scope creep. There is a need for clarification on the long-term objectives of the FDP.
- As the FDP expands its use cases and capabilities, such as with FDP development health strategy risks, and assurance become critical. ⁵
- A lack of data and digital literacy could restrict engagement with the FDP and, therefore, limit the scope of its potential. Without improvements in these areas, AI and analytics-driven insights could be flawed or mistrusted, undermining the platform's purpose.
- The FDP's potential is undermined by its current focus on acute data and business intelligence. Delegates urged broader integration of primary care, social care, and wider public sector data to address inequalities and support proactive care. Concerns included poor representation of diverse populations, fragmented analytics, and outdated data models. A hybrid approach, balancing national standardisation with local context, is needed, alongside better stakeholder engagement and investment in non-NHS data infrastructure to realise the FDP's full impact. Harnessing a broader set of contextually enriched data, which uses a wider set of sources beyond secondary care and even health, can help develop a real world view of connected data.
- Limited local engagement risks limiting effectiveness and trust in the FDP. Local analysts, GPs, and community voices feel excluded from FDP development. This lack of collaboration may not only diminish the platform's effectiveness but could also worsen health inequalities by ignoring local nuances and needs.
- Current FDP development health strategy risks vendor lock-in and lacks a clear commercial strategy. Despite original intentions to foster an open, competitive ecosystem, FDP development is increasingly associated with a single vendor, raising concerns about sustainability, innovation, and future procurement strategy.

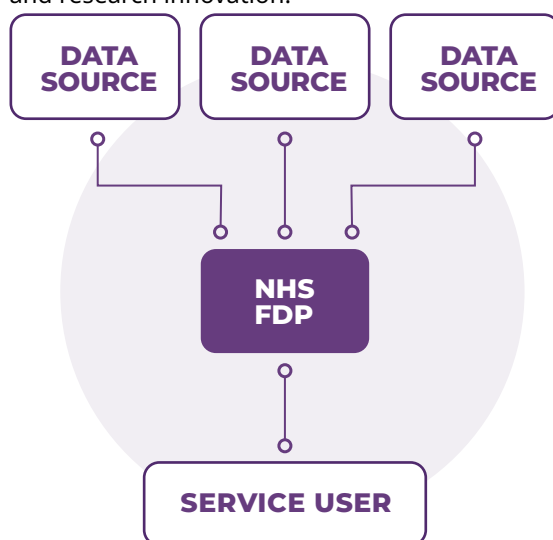
Recommendations

1. As implementation spreads, a clear educational component should accompany FDP development, ensuring users grasp how data feeds into NHS strategy. Workforce readiness, analytical maturity and data literacy are crucial as users need to understand the limitations of standardised data.
2. Communications surrounding the FDP must clearly articulate the platform's core purpose, scope, and intended use cases to reduce stakeholder confusion and align expectations across the system. Communications should differentiate core infrastructure goals from emerging capabilities and functions such as AI or population health management.
3. The platform must broaden data integration to realise its true potential, especially across primary care, social care, local authorities and wider public services such as education and housing. Harnessing more contextually enriched data will help enable a '360 degree' view of health data, eventually supporting personalised, preventative care.
4. A data quality strategy that improves the quality of data at the point of entry is needed. Such a strategy could provide a clearer framework for improving data provenance, ontologies, or definitions within FDP. Without such a structure, inconsistent or incomplete data could undermine insights, decision-making, and AI-driven tools.
5. FDP development must prioritise a hybrid approach of standardisation and local flexibility with a view to using federated data (data mesh concept). Such an approach would enable decentralised data ownership and federated analytics while supporting cross-sector integration.
6. NHS England/DHSC should publish clear commercial and technical frameworks to enable third party engagement and a competitive commercial environment. This would help ensure that multiple vendors can contribute to FDP development and establish long term procurement strategies that align with the vision of the NHS 10-Year Health Plan.

Roundtable findings

INTRODUCTION

The NHS Federated Data Platform (FDP) is a central initiative to unify healthcare data across England. Launched in 2023 following pilots in 2022, the platform aims to integrate (or federate) patient, operational, and research data from disparate systems into a single, secure ecosystem. In practical terms, the FDP is a software platform that provides NHS staff with access to data through online dashboards, which may utilise standard tools or custom-built interfaces, with permissions controlled by local data controllers, such as NHS England, trusts, or integrated care boards (ICBs). Built on advanced cloud infrastructure (using Palantir's Foundry platform), the FDP is designed to support critical applications, including patient flow, vaccine management, and research innovation.



As of March 2025, 41 of England's 42 ICBs had signed up to use the FDP, as well as 108 acute hospital trusts.^{1,2} NHS England's recent planning guidance sets out expectations for 85 per cent of all NHS trusts to have adopted the FDP by the end of March 2026.³ This so far exceeds NHS England targets for adoption, and many providers that have implemented the FDP have cited promising signs of expedited waiting lists and referral-to-treatment times. According to NHS England, trusts using the platform have treated

on average 114 more inpatients in theatres each month since introducing the tool, with South Tyneside and Sunderland NHS FT reporting a 37 per cent reduction in the number of days patients remained in hospital after they were ready to go home.⁴

The recent independent review of the NHS, led by Lord Ara Darzi, highlighted the platform as showing great promise and having already demonstrated positive local impact.⁵ The FDP has been highlighted as a central enabler of NHS digital strategy and realising the 'analogue to digital shift' in the upcoming 10-Year Health Plan. However, despite high adoption rates, systems and providers have cited challenges in using the platform's full functionality.⁶

Concerns have also been raised, particularly by senior figures in the analytics community, that the platform leaves little flexibility for local innovation, which often exceeds the capability of what the FDP is trying to do nationally. Concerns are compounded further by the absence of data from wider sources, including primary care and wider community data, limiting its impact on local communities. Finally, there are ongoing concerns as to the increasing scope and purpose of the FDP, with some stakeholders claiming that FDP development has deviated from its original core purpose of creating data connection capability, reducing data bottlenecks and improving decision making.⁷

CORE PURPOSE(S) OF THE FDP AND INCREASING SCOPE

For the purpose of this report, the core purposes of the FDP are categorised as follows:

Building infrastructure and enhancing interoperability

The FDP was initially conceived to address the fragmentation of national data assets, enabling integration across various datasets such as secondary uses service (SUS), model hospital,

and vaccination data.⁸ Fundamentally, the FDP is designed to make health data more accessible and this remains the foundational role of the platform, providing federated access to NHS data through a common architecture to query and connect data when needed – this is generally accepted as a core FDP purpose across the health sector.

Software platform with analytical tools

The FDP has also been described as a toolkit that embeds pluggable analytical capabilities, such as the NHS' surgery theatre optimisation tool, dashboards, data querying, visualisation, modelling, and other tools. These tools allow analysts, clinicians and operational staff to run real-time analytics without needing to extract data or build bespoke tools.

A product suite for solutions

The platform has also been viewed as having the potential to house pre-configured applications and populated tools to focus on areas such as:

- Elective recovery tools to stratify at-risk populations, target interventions and identify people who have been waiting for long periods of time
- Bed capacity or discharge planning tools for hospital flow optimisation
- Population health management tools to segment populations and target interventions

A driver of actionable insight

Ultimately, the FDP is designed to enhance patient care and increase efficiency; therefore, its effectiveness will be rooted in how clinical and operational professionals actually utilise the platform. It is vital that FDP development takes an outcome-oriented approach that not only enhances access to data but also leads to tangible improvements in healthcare delivery.

At its core, the FDP could and should be a mechanism for translating data into insight.

Strong potential and unrealistic expectations

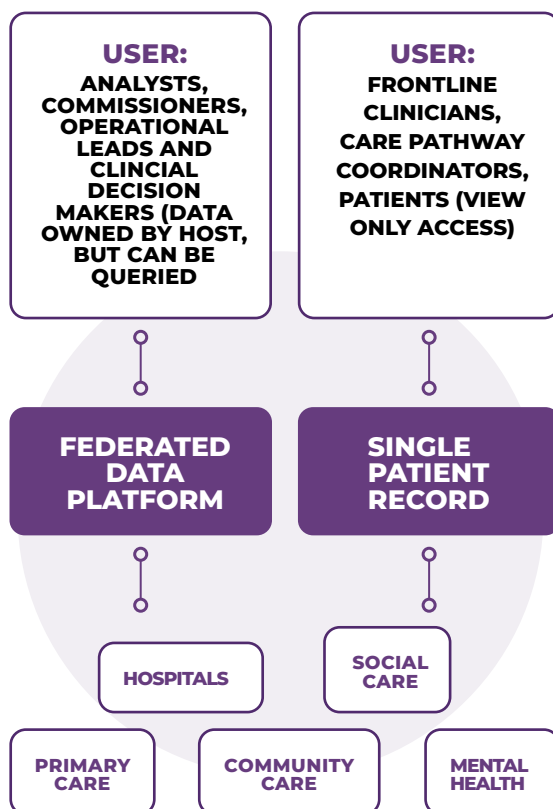
Beyond its initial design as a data integration platform, the FDP has shifted in perception and use. Delegates asserted that the expanding scope of the FDP has created confusion about the platform's core purpose, which has, in turn, led to unrealistic expectations of what the sector can expect the FDP to achieve. For example, delegates argued that if the FDP is to be increasingly seen as an AI platform and clinical support tool, then governance, ethical frameworks and appropriate regulatory requirements need to be prioritised to ensure responsible use.

Structural changes across health and the potential merger of some ICBs could alter the digital and analytical maturity level within individual systems, changing the role and reducing the need for the FDP in certain regions. Further, while it is vital that the FDP fulfils its core purpose of increasing interoperability, it has become strongly associated with a single technology stack and vendor – a fact that delegates argued does not align with locally tailored investments and solutions.

Delegates were keen to highlight the platform's vast potential, arguing that the FDP could serve as a real-time feedback mechanism, providing insights to organisations on how to improve their data inputs. This "give and get" approach could create organisations that contribute high-quality data and receive valuable insights in return.

There are also hopes that existing FDP infrastructure could help create the foundation for a single, unified patient record (SPR), leading to better coordination and insights.⁹ While they are both very different in concept and purpose (FDP informing PHM and broader decision-making, SPR informing real-time clinical decision-making), there is significant overlap between the clinical and operational use cases of the FDP and

the SPR. The digital infrastructure investment and information governance frameworks that come with the FDP will help enable a more effective SPR. However, without comprehensive integration into existing systems, concerns arise that the FDP could become another layer of software that extracts data but fails to enable timely action.



ENGAGEMENT AND COLLABORATION

The FDP represents a significant taxpayer investment, with £330 million invested over a seven-year contract.¹⁰ Delegates questioned the platform's long-term affordability, warning that its success and spending justification depend on openness, collaboration, and accountability.

Access to the platform and its contract terms is seen as restrictive in some circles, making the FDP feel like a “closed shop” rather than a collaborative initiative. There is frustration that efforts to engage constructively are not being met with openness, with delegates arguing that chief digital and analytical officers were not adequately involved in the FDP's development, despite being key future users of the platform. This lack of engagement, delegates argued, has contributed to a sense of confusion surrounding the platform's core purpose.

If we want FDP to succeed, it has to be built with and for the profession that will deliver its value.
NHS Data and Analytics Lead

Local analysts understand data quality, completeness, and inequalities within their systems. Without their input and collaboration, the FDP risks exacerbating existing health inequalities due to incomplete or biased data – particularly true if the platform develops comprehensive PHM and AI capabilities. Delegates stressed that a two-way conversation between local data experts and FDP architects is essential. These points link to broader concerns that national FDP outputs will overshadow locally developed analytics, reducing analysts' ability to influence decision-making with more contextually aware insights.

Following a recent letter sent from the Chief Data and Analytical Officers Network (CDAON) office to NHS England Chief Data and Analytics Officer, Ming Tang, the latter has responded to acknowledge these issues, confirming partial adoption models, standard tool support, and a commitment to transparency in AI and benchmarking. The CDAON has since raised further concerns, calling for a timeline on the partial adoption model.¹¹

We can all see the value in it, but we want to be able to offer our expertise... we need those local analysts engaged in this process, because they are the experts in the nuances of the data.

Beyond the analytics community, delegates also emphasised that GPs and communities, particularly those affected by past data-sharing controversies, require more transparent communication on the FDP's benefits and safeguards. Poorly executed communications from previous data initiatives have led to scepticism and resistance among GPs and professional bodies.

SKILLS GAP LIMITING IMPLEMENTATION

To maximise FDP's impact, we need stronger data literacy, workforce development, and a mature approach to AI-driven analytics.

Research shows that 70 per cent of digital transformation projects fail to deliver the intended benefits, and that this is primarily due to workforce challenges and skill deficits.¹² Even if the FDP provides the necessary capability to link data and inform each of its core purposes comprehensively, there is a pressing question about workforce capabilities, who will use the platform and whether they have the required skills to utilise the platform. Delegates argued that a lack of data literacy could prevent the FDP from reaching its full potential. If NHS staff and stakeholders do not trust or understand how the FDP translates data into decisions, there will be limited engagement with the platform beyond its core purpose of aggregating disparate data.

A clear educational component should accompany the FDP as its implementation spreads and development in each of its core purposes progresses, ensuring users understand

how data feeds into NHS strategy, as well as how the FDP works with other data initiatives, such as the SPR. Developing analytical maturity and data literacy is crucial, as users need to understand the limitations of standardised data. Delegates suggested the NHS invest in upskilling the analytics workforce separately from digital and IT teams to ensure data is interpreted accurately and responsibly.

BUILDING FOR ACTION

The success of the FDP depends not just on linking data but on transforming it into real-time, actionable insights that clinicians trust and can easily explain to patients. It must be intuitive, secure, and proactive – a tool that truly enhances care, rather than just another layer of complexity.

Fundamentally, the FDP is a data platform, meaning it stores, processes, and presents data, but it does not inherently improve data quality. There is no current NHS strategy that directly enhances data completeness, consistency, or accuracy at the point of entry. While playing data back to users might highlight gaps or errors, this alone is not a guaranteed fix.

A data quality strategy could provide a clearer framework for improving data provenance, ontologies, or definitions within the FDP. Without such a structure, there is a risk that inconsistent or incomplete data will undermine insights, decision-making, and the potential for harnessing AI-driven tools.

Data alone is not enough to improve the delivery of care; it must be developed into actionable insights. Currently, waiting list data in the FDP does not directly link to hospital scheduling systems, and clinicians must manually act on any insights provided. Primary care lacks an actionable workflow, and even if FDP identifies a care coordination need, there's no direct integration into GP systems or primary care team workflows.

If FDP is to be more than just a government analytics tool, it must be built for action, not just insight. Real change will come when data seamlessly translates into frontline decisions that improve patient care.

The FDP is considered a central tool in enabling the 10-Year Health Plan's digital shift and, therefore, is central to designing healthcare for future needs. Delegates argued that future healthcare systems will not rely on human data entry, instead suggesting that AI-driven anomaly detection will trigger actions for clinicians. As such, the FDP should be designed to support automated workflows, not just manual reporting. Delegates did acknowledge, however, that capturing the impact of social determinants cannot be fully automated, arguing that data alone does not tell the whole story – hospital readmission, for example, can occur due to poor housing conditions rather than failure of clinical care. It is often argued that the NHS is 'data rich, but insight poor' and the FDP must enable a holistic view, where data is federated from a broad range of contexts, and patient data can help develop actionable insights.

Delegates called for the FDP to develop a cohesive, user-centric experience. The platform, they argued, should not just be an extension of existing shared care records – it should be the enabler that makes them useful. A key challenge for the FDP will be integrating real-time updates, AI-powered suggestions, and an intuitive interface that makes insights immediately actionable. This more user-focused interface would help the FDP develop clarity on 'right data, right moment, right impact', ensuring data-driven insights are clinically meaningful and timely.

BEYOND NHS DATA

While the FDP is increasingly being viewed as an enabler of PHM tools, there is a risk that the FDP is being built around acute data and waiting lists rather than focusing on broader determinants

of health, which will be critical for long-term system sustainability and the platform's ability to derive meaningful insights from data.

Expanding the FDP to incorporate primary care data, as well as policing, education, social care and local authority data, would enhance its impact on population health and move towards a 'citizen 360' view, where a holistic profile of populations is built through connected health data. NHS Greater Manchester employs a linked dataset, which includes primary care data. Delegates familiar with the programme reflected that keeping GP engagement active across 430 practices has been a significant challenge, as staff changes (retirements, role changes, etc.) require ongoing effort to manage. By integrating primary care and acute hospital data, the FDP could identify uncoded health conditions in primary care that are evident in hospital data. Patients could receive earlier interventions if conditions were coded correctly within primary care, reducing unnecessary hospital admissions and costs.

Building population health management capability without primary care data cannot be the right way to really get at what needs to be done.

Population health expert

The absence of a broader dataset within the FDP risks reinforcing existing health inequalities, as it will lead to reliance on incomplete data that lacks key demographic information. For example, many NHS datasets overrepresent white, middle-class populations while missing critical primary care data that includes richer demographic insights.

The inequalities... are a worry for me. [The FDP is] going to take those inequalities, give you a list of people that need to be seen, and possibly miss the people that really, really do need that help.

This is particularly true in areas with richly diverse populations and data gaps. In areas like Brent in north London, where 150 languages are spoken and only 10 per cent of patients have English as a first language, the FDP must integrate multilingual accessibility and usability within the platform. Delegates urged FDP leaders to learn from past mistakes in major NHS IT implementations, where many previous health systems had not adequately accommodated language diversity, despite the availability of technology.

Delegates were keen to stress that the FDP has significant potential in addressing inequalities within access to health services, especially for marginalised populations. The standard '9-to-5' healthcare model fails to provide access for many patients, such as zero-hour workers who struggle to attend appointments. Through effective integration of health data and the development of an holistic, '360 degree' view of populations, the FDP could help highlight and address these disparities in healthcare access.

Some delegates argued that the FDP has shifted its focus away from supporting PHM and is now primarily functioning as a business intelligence tool, providing limited, surface-level insights. National-level dashboards may present incomplete or misleading data, which providers may trust over the more nuanced analyses provided by local analysts.

Current FDP data is transactional and event-based, lacking real-time or 'big data' elements such as live blood pressure monitoring, AI-driven analysis and large-scale computational simulations. This raises concerns that the FDP is solving past problems rather than preparing for future needs, such as AI, live data streams, and quantum computing.

I do worry that by the time we actually resolve some of these questions, we're solving the problems of yesterday rather than the problems that are going to hit us tomorrow.

Delegates highlighted current fragmentation in analytical approaches to the FDP. Many local systems, trusts and GP practices are independently developing cohort definitions, particularly with high-intensity users.

The result of this is that you have multiple versions of similar analyses being created across the country, leading to variability, duplication, and inefficiency.

Greater Manchester Combined Authority has developed a single public service dataset, the Greater Manchester Digital Platform, involving DWP, HMRC, and other key public sector organisations.¹³ The Platform also integrates a host of different products and solutions to provide comprehensive information for citizens and users and improve broader public service delivery.¹⁴ Delegates highlighted other examples of providers expanding data sources beyond the acute sector. Nottingham and Nottinghamshire ICB has made progress integrating children's special educational needs data and preventative public health services, such as smoking cessation and alcohol reduction.

Restricting the pool of data used by the FDP limits the ability for systems and providers to drive actionable interventions from data. It's not enough to know a population's deprivation level, delegates argued, and the FDP should help identify and target the right cohorts for specific interventions. Integrating social care data is essential for a holistic, linked, and longitudinal record that supports PHM tools. Delegates highlighted that data from preventative and proactive care services often sit outside traditional NHS datasets, underscoring the need for broader integration. However, there are inherent challenges in collecting data from non-NHS services, given that many preventive services, such as council-commissioned programmes and those from

the voluntary sector and social prescribing, lack robust digital infrastructure.

Data gaps also exist in community and mental health services. Existing NHS datasets like the Community Services Dataset (CSDS) and Mental Health Services Dataset (MHSDS) have limitations and may not be fit for purpose. Nottingham and Nottinghamshire ICB has achieved success in utilising SNOMED codes from GP records to derive useful data; however, this is not a comprehensive solution.

Delegates highlighted that systems that have successfully linked healthcare, primary, secondary, and social care data did so through multi-stakeholder boards. Delegates called for greater clarity on how central NHS teams are engaging with these external stakeholders to shape the FDP's future. A multi-stakeholder approach would help to address divergent priorities across the sector, with the NHS typically focused on patient care and operational efficiency, while DHSC is engaging in broader cross-government discussions on data infrastructure.

Integrating local data from multiple providers, sources, and systems is clearly complex, as a single ontology and data model can provide consistency, but it risks losing critical local context. The FDP must be designed to strike a balance between these needs. Delegates, as such, called for a hybrid approach to be prioritised, one which combines key approaches to standardisation with mechanisms that retain local context.

A key concept that should drive more effective integration of health and non-health data is entity resolution (ER), a process by which records referring to the same 'entity' (patient) are linked, to avoid duplication and improve efficiency.¹⁵ ER can help maximise the benefits of FDP data integration by improving data quality, enabling '360 degree' view of a patient's health data, particularly when federating data

from health and non-health sources. This is also relevant for the future development of an SPR. While operationally distinct and running in parallel, the FDP and SPR will be equally dependent upon each other's success, and the concept of ER will be a key enabler of both platforms.

With the government recently announcing a new market engagement phase for an SPR, it is increasingly vital that the FDP lays the foundation for an effective SPR by developing interoperability and data integration across the entire health and care ecosystem, not just the NHS acute sector.¹⁶

ENSURING INDUSTRY COLLABORATION

Achieving each purpose of the FDP, particularly developing the platform as a suite of products and solutions, will require an open ecosystem approach, with multiple collaborators used fostering local innovation. There was a strong desire from delegates to avoid 'vendor lock-in' with the FDP, where a single supplier dominates development, limiting competition. Delegates called for clearer commercial frameworks to expand the scope for innovation and competition within FDP development – FDP leaders should strive for a balance between standardisation and innovation that allows multiple vendors to contribute.

The original plans for the FDP included guarantees for a competitive ecosystem of vendors, but current implementation appears to be shifting towards a more closed, single-supplier model. Delegates called for an open marketplace within the FDP to be prioritised across future development.

We're very keen on ensuring it's an open ecosystem of collaborators... this is critical for driving local innovation and ultimately serving the population.
Industry Lead

There is currently a lack of defined commercial terms, which makes it unclear how suppliers can engage with or build on the platform. Greater certainty is needed regarding FDP product vehicles, as well as the exact integration of third-party solutions into the platform. Specifically, questions were raised about the roles of the solution exchange and the NHS Marketplace, and how these will coexist moving forward, as well as whether there will be a 'sub-marketplace' specific to the FDP.

While the FDP is positioned as a key enabler of the NHS 10-Year Health Plan, the commercial contract awarded for the current build and management of the FDP (such as to Palantir or any main supplier) is reportedly for a period of around five years or even less initially. This creates several risks:

- What happens if the supplier's contract ends or is not renewed?
- Will the NHS be locked into expensive extensions, or must it rebuild or reprocure major parts of the system midway through the 10-year vision?
- Could disruption or fragmentation occur if another vendor takes over partway through?

While the ambitions driving FDP development are long-term, the contractual arrangement is short-term, which could threaten continuity, stability, and sustainability of the FDP unless future transitions are carefully managed.

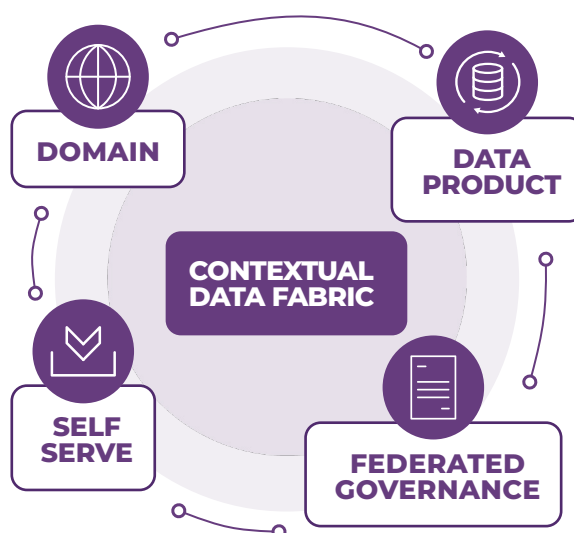
POTENTIAL FOR MODERN APPROACHES – FEDERATED ANALYTICS

There are inherent structural concerns with the FDP, which requires all data to be centralised for effective use – a potential barrier to adoption. Some stakeholders see this approach as less flexible and not aligned with modern, decentralised data-sharing strategies. There are also challenges of data movement

and control. Linking health, education, and social care data has traditionally required moving data between systems, raising concerns about security, governance, and accountability. This is both an information governance issue and a public trust issue, especially when dealing with sensitive data, such as criminal records and benefits data. Further, the FDP's current structure requires data to be placed in a local cloud-based system, which may feel outdated and potentially problematic for data custodians.

Delegates called for the FDP to develop a truly federated approach to analytics (described by some as a data mesh supported approach) that keeps data in its original location rather than moving it into a central repository. Instead of physically transferring data, delegates argued that organisations could share identities and insights while maintaining decentralised control. This approach could offer more flexibility in future for integrating wider determinants of health data, such as linking schools, social care, housing, and health.

I think things like data mesh, where the data stays where it is... feels like the future for managing particularly these sorts of wider determinants data.



The federated analytics model within a contextual data fabric (data mesh) architecture is rooted in four key principles

1. **Decentralisation:** Each team, such as hospital trusts, social care providers, or GP practices, keeps control of its own data. They are responsible for making their data available, high-quality, and easy to use by others
2. **Data as a product:** Data is treated like a product that has standards, and documentation. Teams providing data are responsible for its quality and are accountable for its use. Data is made understandable ¹⁵
3. **Self-serve data infrastructure:** There is a shared technical system (in the background) that makes it easy and safe to access data across different sources without needing technical experts to rebuild all components each time
4. **Federated governance:** Rules and standards for privacy, security, and data quality are agreed across the system and across organisations, but the data itself doesn't need to be centrally stored. This balances local control with central oversight

For the FDP, a contextual fabric approach would enable greater local control to be maintained as each organisation (such as GPs, councils and trusts) keeps ownership of its data, which is essential for governance and public trust. Data privacy is easier to protect in this context, as sensitive data doesn't need to be physically copied into a large central database. A fabric would support broader data integration, with different sectors (health, education, social care) working together without transferring all their data to one place. Finally, this approach would encourage ownership, flexibility for expected integration, as systems could connect and analyse data without being tied to a single platform which could become outdated. Delegates argued that this more federated approach to analytics would reduce fears of data misuse and enable more effective cross-sector data integration without requiring full data transfers. There would also be a renewed focus on real-world use cases rather than abstract infrastructure, enabling organisations to define their data needs accordingly. Finally, this federated approach would allow multiple vendors to contribute, avoiding reliance on a single supplier.

Federated analytics could enable secure, problem-driven insights across health and social care while preserving data sovereignty and trust. If the FDP is to be truly transformative, it must embrace models that go beyond simple data aggregation.

Conclusion

There is broad agreement that the FDP is valuable in principle and can be a cornerstone of the NHS digital transformation agenda. However, there is a need to clarify and refocus the platform's core purpose and reflect this in clear and transparent communication. The challenge also lies in building a platform that meets the needs of all parts of the health and care system, ensuring that the benefits of the FDP are felt by the most disadvantaged. The FDP must move from being a complex, overly centralised data tool towards a federated, user-focused platform that delivers real-time, clinically and operationally relevant action.

The full potential of the FDP can only be realised if GP data is effectively leveraged. However, even if primary data is incorporated, concerns remain about how the FDP will interact with existing GP systems and whether GPs themselves are being adequately engaged in the process. Further, many voluntary and community services lack data infrastructure, and a simple FDP-integrated solution could be transformational.

An ongoing, active and collaborative system-wide debate is needed to ensure the success of the platform. There are still many open

questions about how the FDP will be implemented and governed and future discussions should continue to bring in voices from across health, care, and voluntary sectors to ensure an inclusive approach.

Crucial to its future success will be how the FDP will encourage industry and third-party organisations to engage with the platform, especially in terms of technical integration. There is a clear need for the FDP to develop a competitive marketplace to drive innovation through the platform.

The NHS must now foster a genuinely open, inclusive, and co-designed future for the FDP, one where frontline professionals, analysts, and communities all play a defining role in shaping how data drives care.

FDP has huge potential for tackling social determinants, but its success depends on multi-agency collaboration, local intelligence, and ethical governance—not just automation. Analysts, public health teams, and frontline professionals must shape its development to ensure it drives real-world change.

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References

1. NHS England (2023). NHS Federated Data Platform. Available from: <https://www.england.nhs.uk/digitaltechnology/nhs-federated-data-platform/#:~:text=Contact%20us-,NHS%20Federated%20Data%20Platform, costs%2C%20and%20improve%20patient%20outcomes.>
2. Ibid
3. NHS England (2025) 2025/26 priorities and operational planning guidance. Available from: <https://www.england.nhs.uk/publication/2025-26-priorities-and-operational-planning-guidance/>
4. J Sollof, Digital Health (2024). Trusts using FDP treat 114 more patients a month on average. Available from: <https://www.digitalhealth.net/2024/11/trusts-using-fdp-treat-114-more-patients-a-month-on-average/>
5. Lord A Darzi, DHSC (2024), Independent Investigation of the National Health Service in England. Available from: <https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf>
6. M Taylor, NHS Confederation (2024). Available from: <https://www.nhsconfed.org/news-comment/confed-viewpoint/nhs-englands-federated-data-platform-one-year>
7. M Farr, Apha (2025). Chief Data and Analytical Officer Network position on the Federated Data Platform (FDP). Available from: <https://www.aphanalysts.org/apha-hub/cdao-network-news/chief-data-and-analytical-officer-network-position-on-the-federated-data-platform-fdp/>
8. NHS England (2023). Federated data platform – improving and connecting our health information. Available from: <https://www.england.nhs.uk/long-read/federated-data-platform-improving-and-connecting-our-health-information/>
9. Tony Blair Institute for Global Change (2024). Preparing the NHS for the AI Era: A Digital Health Record for Every Citizen. Available from: <https://institute.global/insights/public-services/preparing-the-nhs-for-the-ai-era-a-digital-health-record-for-every-citizen>
10. NHS England (2024). Federated Data Platform FAQs. Available at: [https://www.england.nhs.uk/digitaltechnology/nhs-federated-data-platform/fdp-faqs/#:~:text=NHS%20Federated%20Data%20Platform,-A%20consortium%20led&text=The%20contract%20is%20valued%20at, trusts%20and%20integrated%20care%20systems\).](https://www.england.nhs.uk/digitaltechnology/nhs-federated-data-platform/fdp-faqs/#:~:text=NHS%20Federated%20Data%20Platform,-A%20consortium%20led&text=The%20contract%20is%20valued%20at, trusts%20and%20integrated%20care%20systems).)
11. Health Service Journal (2025). Flagship NHSE tech policy creating ‘patient safety risks’. Available from: <https://www.hsj.co.uk/technology-and-innovation/flagship-nhse-tech-policy-creating-patient-safety-risks-claim-analysts/7039168.article>
12. NHS England (2025). The NHS Digital Academy's Contribution to the 'Analogue to Digital Shift'. <https://digitaltransformation.nhs.uk/news/the-nhs-digital-academy-s-contribution-to-the-analogue-to-digital-shift>
13. GMCA (2025) The Greater Manchester Digital Platform. Available from: <https://greatermanchester-ca.gov.uk/what-we-do/digital/digital-strategy/building-responsible-data-driven-public-services/the-greater-manchester-digital-platform>
14. Hospital Hub, Greater Manchester Digital Platform gathers pace. Available from: <https://hubpublishing.co.uk/greater-manches-ter-digital-platform-gathers-pace/>
15. R Rajaraman (2025). Harnessing Entity Resolution to Unlock Smarter Healthcare Data. Available from: <https://www.quantexa.com/de/blog/benefits-of-entity-resolution-in-healthcare/>
16. Health Service Journal (2025). Draft Single Patient Record (SPR) equi-ready for release. Available from: <https://www.hsj.co.uk/download?ac=3069337>



