Supplementary written evidence submitted by NHS England (DTN0074)

Thank you for a productive hearing on 14 March with yourself and the Committee on digital transformation of the NHS. During the hearing we discussed whether the UK (or in this specific instance, England) was ahead of the US in relation to interoperability in the healthcare system and I committed to writing back to you on this.

I would like to start by highlighting that the US and health system in England are very different. The US healthcare system receives funding through multiple channels compared to England (healthcare in the US being financed by a mix of private insurance and distinct federal government programs). The model for digital transformation in England is also not centralised. The US and England also have different regulatory frameworks, which is particularly important for interoperability:

- In both the US and England, access to an individual's clinical information by authorised clinicians is imperfect and is tied to the Electronic Patient Record ('EPR') system that the clinician is using.

- Patients in the US have greater digital access to their own medical records. This is typically provided by the EPR vendor and is required under US law.

- To enable authorised sharing of records, the US has the Trusted Exchange Framework and Common Agreement (TEFCA) which was developed under the 21st Century Cures Act to boost interoperability between Health Information Networks at a national level.

- In England, the obligations of data controllers towards each other and users of the care system are covered by a range of statutes and regulations such as the Health and Social Care Act, Data Protection Act, and common law, with statutory bodies such as the Department of Health and Social Care and NHS England ('NHSE') charged with setting and enforcing standards.

- The key challenge in England is to clarify and improve how these duties are to be discharged and to assure conformance to relevant standards. In addition, England has several existing partial solutions but has yet to settle on a target data architecture.

- The Health and Social Care Act imposes duties on care providers to conform to relevant information standards published by NHSE or the Secretary of State. Currently this duty requires providers to give “due regard” to standards.

Given that the US and English systems are not a like for like, my point around interoperability between the US and England was intended to highlight the differences between interoperability between institutions using the same system (e.g., anyone with Cerner or Epic looking at patient records from another institution also using that system) versus interoperability across local systems (i.e., between primary, acute, community, social care). It is this latter point I would like to emphasise and to demonstrate where the NHS is meeting national targets (and in some instances excelling).

Our ambition is for all trusts to meet our core digitisation standards, including an EPR, by March 2025. EPR coverage nationally is 88% and is expected to increase to 91% by December 2023. We are investing £2 billion in digitising and connecting the frontline for secondary care, which will be matched further by local systems. Where feasible, we’re encouraging systems to explore ICS-wide solutions to support integrated care (convergence). We are providing targeted funding and support to NHS trusts to help them “level up” to a core level of digitisation; trusts that are less digitally mature will get more funding and support than those that are more digitally mature.

More than 50% of care providers currently have a digital social care record, up from 40% in December 2021. Last year, we invested almost £50 million to support digitisation, including making more than £35 million available to Integrated Care Systems (ICSs) to support care providers to adopt digital social care records (DSCRs) and other care technologies that help improve the quality and safety of care, or support people to remain independent at home for longer. We will invest a further £100 million over the next two years to ensure people, providers and the wider health and social care system are able to realise the benefits of digitisation.

To further address potential variation between ICSs, as part of the What Good Looks Like programme, digital maturity assessments will give health and care organisations a baseline, so they know where they are. This will enable more targeted support for those organisations that need it. Digital maturity assessments will be updated yearly to track progress on their journey to achieving what good looks like.

As I mentioned during the hearing, the primary difference between the US and the delivery of healthcare in the NHS, is shared care records. Every Integrated Care Board in England has been supported to acquire and implement a basic shared care record, to address record sharing between general practice and NHS Trusts. In the most mature areas such as across London, 55,000 professionals access the multi-ICS shared care record 1.3 million times a month. Our priority for the coming year is to establish a national federated network of Shared Care Records so any authorised professional will be able to access the records of patients regardless of where they live in England. In parallel with the development of local shared care records, the long-standing Summary Care Record continues to be available for those who do not currently have access to their local shared care record – e.g., community pharmacists and some paramedic services. Around 90% of the registered practice population in England (58 million) have a summary care records with additional information.

In common with many other jurisdictions in Europe and Australia we are also increasingly moving towards open data architecture solutions using 'openEHR', a technology consisting of open specifications, clinical models and software that can be used to create standards and build information and interoperability solutions for healthcare. Use of open architectures facilitates the separation of data from application and enables greater interoperability by avoiding ‘lock in’ to proprietary vendor architectures.

We also have population health data at a national level, making patient data accessible for those who need it, to support a number of national initiatives. For example, the Health and Care Act 2022 has established ICSs as statutory bodies with a responsibility to improve population health, and it also introduces new duties for the NHS to tackle health inequalities Data to support analysis in identification of inequalities such as demographic data (ethnicity and index of multiple deprivation - IMD) has been made available for use both nationally and at local levels, underpinning the work in support of Core20PLUS5 programme. Significant emphasis has been placed by System Transformation Teams on supporting local systems to develop capability in use and adoption of data for ICSs to better understand the health of their local population and to apply population health.

The work of our NHS has also been commended globally. For example, the NHS East Berkshire CCG won the international Barbara Starfield Award in 2018[1] for their work on population health analytics (creating a new type of health care program that is delivered within a primary care setting).

However, we know there is also learning to take from the US. Leading trusts, such as Great Ormond Street Hospital, are using (and praising) systems such as Epic which have been spearheaded in the US and support interoperability between institutions. We are encouraging systems to explore ICS-wide solutions to support integrated care. As part of our Frontline Digitisation support offer, we are working to build an England-wide community to share lessons learnt, improvements and develop peer-to-peer networks so best practice, like that at Great Ormond Street can be shared with others.

Finally, you also queried the number of adults in the UK who had a smartphone. Different surveys and reports use different methodologies and definitions of smartphone ownership, which could result in slightly different percentages. However, all sources indicate that smartphone penetration in England (and the wider UK) is very high. According to a report by Statista,[2] as of January 2021, 88% of the UK population owned a smartphone, up from 79% in 2016.

I hope this assists you and the Committee in the final stages of your inquiry, and I look forward to reading your findings in the final report.

Yours sincerely,

Dr. Timothy Ferris
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[1] The Starfield Award recognises the best use of the John Hopkins ACG System. The system analyses health care data, the results of which improve accuracy and fairness in evaluating provider performance, identifies patients at high risk, forecasts health care utilisation and sets equitable payment rates. It has been used in commercial, government and research settings worldwide, longer and more extensively than any other health care data analytics system, impacting close to 200 million lives in 30 countries. See: https://www.johnshopkinssolutions.com/article/johns-hopkins-acg-system-team-honors-nhs-east-berkshire- ccg-with-2018-starfield-award/

[2] https://www.statista.com/statistics/271851/smartphone-owners-in-the-united-kingdom-uk-by-age/