



Health Connect Global – Written Evidence Submission

Health Bill Public Bill Committee

About Health Connect Global

Health Connect Global is a British health technology company building the infrastructure that will pull a patient's health information into a single, usable record that is owned by them, accessible to the professionals who care for them, and intelligent enough to make sense of itself. We work with over 1,000 care providers, specialist clinics, and local authorities across the UK, including digitising years of social care records that would otherwise remain inaccessible.

Our founder, Dr Devan Moodley, spent 25 years as a doctor in the NHS. He built Health Connect because he had been on the other side of the problem, running care services and watching staff drown in admin, duplicate records, and disconnected systems. He is the customer he is now trying to serve.

We put trust at the heart of everything we do, and work with health and care experts every step of the way to make sure our products are as effective as possible. We hold a UK patent for combining AI with structured health records and are progressing towards medical device registration for our AI care planning tool, a level of clinical validation almost no other health AI company in this country is pursuing, and one that matters because it means our technology is built to be safe in clinical settings, not just technically capable.

We welcome the opportunity to submit evidence to the Committee on clause 47 and the new sections 250E and 250F that it inserts into the NHS Act 2006.

Introduction

We don't have a data problem in healthcare. We have a coordination problem. The single patient record is the right response.

During the Bill's second reading debate, the Secretary of State put the problem plainly: information in the NHS currently 'tends to follow the institution, not the individual,' with the result that neither patients nor the professionals caring for them can see a complete picture in one place.

That is the exact problem that Health Connect was built to fix. The ambition behind this Bill of patient information that is owned by and follows the patient and is accessible to those who need it is one we share entirely, and we welcome it as a vital step in the right direction.

We have two concerns that we believe will prevent the Bill from truly delivering on that ambition.

Our first concern is usability. Making patient data available is not the same as making it useful. The Bill, as drafted, creates a legal gateway for data to be shared. But it does not address whether that data, once shared, can be understood and acted on at the point of care. That distinction between access and usability is where, in our experience, data-sharing initiatives most commonly fail.

Our second concern is scope. The usability problem exists across the whole health and care system, but it is most acute at the boundaries, the largest and most important of which is between the NHS and social care. That is where records are most fragmented, formats most incompatible, and patients most at risk of falling through the gap. The Bill's own impact assessment acknowledges that social care inclusion is deferred, with no mechanism or timeline for when it will happen. A framework designed for NHS settings alone, with social care retrofitted later, will not deliver the solution the Secretary of State has described.

These two concerns are linked: without designing for the hardest cases at the NHS/social care boundary at the outset, the potential of the SPR can not be reached.

We therefore recommend:

- That the Bill should ensure regulations made under section 250E address usability across all care settings, and that social care is brought within scope within a defined timeframe rather than left to indefinite future discretion.
- That secondary legislation under section 250E should establish standards for how shared data must be structured and presented to be actionable at the point of care, not just technically available.

The problem: access without usability is not enough

Information in healthcare doesn't follow the patient. A GP, a hospital consultant, and a care home manager can all be looking after the same person without seeing the same information, let alone having the time to make sense of it. Records don't cross the boundary between NHS and social care. A patient's history is spread across systems that were never designed to speak to each other, and the people responsible for their care are left to piece it together from memory, phone calls, and paper.

The single patient record addresses that structural failure by creating a legal requirement to share. But making data available is only half the problem. The more important half is what happens once data is shared.

A clinician seeing a patient has minutes, not hours. A care worker doing a handover needs the relevant information surfaced, not buried in a hundred-page history assembled from a dozen disconnected systems. Access to a collection of documents is not the same as access to a coherent clinical picture. A data dump is not a patient record, and without the infrastructure to synthesise, structure, and surface information at the point of care, that is what the SPR risks becoming for many of the clinicians and care workers it is designed to serve.

This is not a theoretical risk. It is what happens when data-sharing initiatives stop at access and do not address usability. The Bill's own impact assessment identifies, among its key assumptions, that 'clinicians will actively use SPR data once it is available.' That assumption is listed without any mechanism to ensure that this problem is tackled. The Secretary of State was right that information must follow the individual, but following the individual is not enough if, when it arrives, it cannot be understood.

The usability problem is most acute where data is most fragmented, and that is at the boundary between the NHS and social care. A patient's NHS record and their social care record are rarely held in the same system, rarely in compatible formats, and rarely seen together by any single professional involved in their care. The SPR, as currently scoped, does not address that boundary. It creates a framework for NHS primary and secondary care, with social care deferred. Patients with multiple long-term conditions, those in and out of hospital and care settings, and those whose lives span both sides of that boundary, are those who would benefit most from a truly joined-up record. But they are precisely the patients the current framework leaves out.

Until the architecture is set for the whole system, including social care, the usability problem cannot be truly solved and the impact realised. And once the architecture is set, retrofitting social care becomes harder, more expensive, and less effective than designing for it from the outset.

What we see in practice

Through our work with over 1,000 care providers, specialist facilities, and local authorities, we encounter this usability gap daily. Three specific problems underpin it, and they are worth distinguishing because they require different solutions.

1. **Volume and fragmentation.** The patients with the most complex needs, those moving between NHS and social care, those with multiple long-term conditions, those requiring support from multiple agencies, tend to have the most fragmented records. They are the patients for whom a complete picture matters most, but it is hardest to assemble. The more data there is, the greater the need for infrastructure that can read across it intelligently rather than simply aggregating it.

2. **Format incompatibility.** Social care records frequently exist in formats that NHS systems cannot read, whether that is unstructured case notes, paper-based care plans, spreadsheets, or PDFs generated by legacy systems. Even where the SPR creates a legal right to share, it creates no mechanism to make that data readable. A record that is technically in scope of the SPR but practically illegible to the system receiving it is not a shared record.
3. **Point-of-care usability.** Even a well-structured, complete record is not useful if it cannot be understood quickly at the point of care. Access without synthesis is not usability. Clinicians and care workers need the right information, structured and surfaced at the moment they need it, not just a longer list of documents.

What we have learned from working in these settings is that closing the usability gap requires infrastructure that goes beyond data sharing. It requires the ability to read across fragmented, unstructured records, synthesise them into something coherent, and surface the right information at the right time. And this needs to be done safely, flagging uncertainty rather than filling gaps with guesswork.

The population where this challenge is most acute, and where the consequences of getting it wrong are most serious, is people with learning disabilities. Their care typically spans the NHS, social care, housing, education, and the voluntary sector, with no single professional ever seeing the full picture. A GP may not know what a care home manager knows. A specialist clinic may not have the social care history. An annual health check, which should be the moment the whole person is seen, is often conducted without access to the full record.

This is where the SPR, designed well and extended to social care with usability built in from the outset, could make the biggest difference. And it points to what the longer-term ambition should look like: not just a system that aggregates records, but one that synthesises them into something clinicians and care workers can actually use, tested first where the complexity is greatest, so that what works there can work anywhere.

Why the Bill, as drafted, does not solve this

On usability

Clause 47 inserts new section 250E into the NHS Act 2006, giving the Secretary of State power to make regulations for the purpose of making patient information 'readily available' to patients and those involved in their care. Yet the phrase 'readily available' is not defined. The Bill does not require that information be structured, synthesised, or presented in a useful way. It does not establish any standard for what usability looks like in practice. It simply creates a legal gateway and assumes the rest will follow.

The Bill's impact assessment is explicit that net social value benefits of £76.8m over ten years are 'highly dependent on the successful implementation of the SPR technical solution', but the technical solution is still at the proof-of-concept stage, without consideration of data usability. The usability layer is not a detail to be resolved later, as without it, the SPR's stated benefits cannot be realised, and the Secretary of State's ambition that information follows the individual cannot be delivered.

On social care scope

Section 250E(1) is broad in principle: it covers those involved in the provision of 'health care or social care in England.' But the implementation tells a different story. The Bill's impact assessment states the SPR will 'initially cover data from primary and secondary care, expanding over time to include services such as adult social care.' Social care is acknowledged as part of the long-term vision, but is outside what the legislation currently delivers, with no mechanism, conditions, or timeline for when inclusion will happen.

This matters because the architecture being legislated now will shape what is possible later. A framework built around NHS primary and secondary care is not automatically extensible to social care, where data formats, governance structures, provider markets, and workforce digital capability are fundamentally different. The LGA has called explicitly for the SPR to be interoperable across the whole health and care system, including social care. We agree and believe the case for it is inseparable from the usability argument. You cannot design for usability if you are only designing for the easiest cases. Social care is where the data is most fragmented, the formats most incompatible, and the need most acute. Building a framework that defers social care indefinitely is simply deferring the hardest usability problems indefinitely.

The Bill's impact assessment also identifies that over 15,000 private care homes and home care providers are in scope of the legislation and will incur compliance costs as a result. They are being asked to participate in a framework that is not currently designed to deliver them meaningful benefits in return. That imbalance should be addressed in the Bill.

What the Bill should do

What we are asking is that the Bill, in whatever form is appropriate, ensures two things:

- **The Bill should ensure that regulations made under section 250E address usability, not just access.** 'Readily available' should mean actionable. The Bill should ensure that secondary legislation sets standards for how shared data is structured and presented, so that it can be understood and acted on at the point of care. Without this, the SPR risks delivering a legal right to a data dump rather than a patient record.

- **The Bill should include a mechanism for bringing social care within scope within a defined timeframe, with a framework that reflects its distinct operating environment rather than treating it as a variant of the NHS model.** The current deferral should be replaced with a commitment and a mechanism. Designing for social care from the outset is not harder than retrofitting it later. It is the only way to ensure the SPR delivers on the ambition the Secretary of State has set out.

Contact

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