PUBLIC DIAGNOSTIC EXEMPLAR · 02 IN READING ORDER

NHS

/ PRIMARY CARE

STRUCTURAL DIAGNOSIS

Recurring Continuity Failure — from publicly observable evidence.

> *"The NHS has not failed to create records. It has failed to ensure those records arrive where clinical decisions are made."*

ARTIFACT FAMILY

#	ARTIFACT	ACCESS
01	Translation Artifact	Public
02	**Diagnostic Artifact**	← *This document*
03	Redesign Executive Summary	Public
04	Redesign Artifact	Restricted

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RECOMMENDED READING ORDER	
Start here	Translation Artifact (Artifact 01) — plain-language explanation for all audiences
Full evidence	Diagnostic Artifact (Artifact 02) — this document
Replacement logic	Redesign Executive Summary ( ) — public board summary
Builder spec	Full Redesign Artifact (Artifact 04) — restricted; not published publicly

EVIDENTIARY STANDARD	JUDGMENT BOUNDARY
This artifact distinguishes: [1] First-party NHS official sources — stated promise, official workflow [2] Independent structural oversight — HSSIB, NAO, RCGP findings [3] Consequence evidence — NHS Resolution, Coroner PFDs, publicly documented harm patterns [4] Workforce and collapse-node evidence — RCGP, BMA, BJGP [5] Patient and ghost-structure evidence — Healthwatch, patient testimony [6] Academic proof layer — Lancet, BJGP, PMC, Oxford NDPCHS *The governing diagnosis is a high-confidence structural inference from convergent public evidence — not a claim about intent or individual failure.*	**This artifact makes no claim about:** Clinical negligence or individual clinician failure Institutional bad faith or intentional misconduct Internal unpublished NHS system logic Undisclosed contractual arrangements Adjudicated legal liability *The failures described are architectural, not personal — consistent with decades of fragmented IT procurement, not malice or incompetence. All coroner and legal references are pattern evidence, not adjudicated findings.*

SECTION 0

WHAT THIS DOCUMENT IS

This is a structural diagnosis from public evidence. It is not a legal brief, a policy manifesto, a technology procurement recommendation, a clinical guideline, or a redesign specification. It identifies the governing primitive, the collapse node, the function-collapse condition, the burden-carrier layer, and the dependency order for correction — derived entirely from publicly observable system behaviour.

The full Redesign Artifact (Artifact 02) specifies the target-state architecture, transition sequence, and implementation logic. This document defines what must be corrected and in what order. It does not specify how.

ARTIFACT FAMILY — READING ORDER

Artifact family reading order: Translation Artifact (best first read) → This document (full evidence) → Redesign Executive Summary (public board summary) → Full Redesign Artifact (restricted builder specification). Public artifacts demonstrate the diagnostic logic. The restricted artifact specifies the implementation.

What this document does not say

- → It does not claim individual GP negligence, clinical failure, or bad faith by any clinician, practice, or NHS body
- → It does not say the 10-minute consultation must be abolished — it says the consultation is the structural container in which the consequences of the primitive break are forced under compression
- → It does not say GPs are failing — it says the architecture places impossible demands on the GP consultation by fusing four irreducible institutional functions without structural support for any of them
- → It does not prescribe a specific technology vendor or EHR solution
- → It does not claim access to unpublished NHS internal data, undisclosed contracts, or adjudicated legal findings
- → It does not say all patients must see the same GP — it says operational memory must be present at the point of clinical consequence regardless of which clinician the patient sees

SECTION 0.1

DIAGNOSTIC SPINE

The complete diagnostic finding in governed form. Every section of this artifact traces back to one or more rows of this table.

DIAGNOSTIC ELEMENT	FINDING
Governing primitive	Patient-carried operational continuity; GP consultation as the fused sensing-interpretation-authority-memory node
Stated promise	Joined-up, continuous care in which clinical records support direct decisions across the patient's whole NHS journey
Actual operating object	Fragmented organisational records; sharing request-based or after-the-fact; patient repeats history as default continuity mechanism
First structural break	Operational memory is not designed to be present at the point of clinical consequence. Continuity exists only if carried by a human.
Function collapse	Sensing, interpretation, authority, and memory reconstruction fused in

DIAGNOSTIC ELEMENT	FINDING
	the 10-minute GP consultation — with no structural support for any of them
Missing function	Operational continuity retrieval at the point of clinical consequence — structurally absent; no contract requirement, no IT standard, no architectural guarantee
Hidden burden carriers	Patient (primary memory carrier); carer (secondary); known GP with accumulated knowledge (tertiary); receptionist/care navigator (quaternary)
Correction prerequisite	Name operational continuity as a structural requirement at NHS England leadership level before any redesign can hold
Proof condition	Same pressure → different response. Returning-patient consultations surface retrievable continuity before clinical decision. Repeat unresolved presentations trigger visible alerting. Patients no longer repeat their history as the default.

SECTION 1

EXECUTIVE SUMMARY

NHS primary care has a recurring continuity failure. Patients repeat their medical history at every appointment. Discharge summaries arrive late, incomplete, or not at all. The same unresolved symptoms present across multiple consultations with no clinical alerting mechanism. Successive interventions — NPfIT, the Summary Care Record, the Shared Care Record, the NHS App, access reforms, ARRS workforce expansion, the new contractual continuity requirement — have not resolved the core failure. They have moved it.

GOVERNING DIAGNOSIS

NHS primary care is record-rich and continuity-poor: it has built extensive audit trace without ensuring that operational memory is retrievable at the point of clinical consequence. The missing memory function has been externalised onto patients, carers, known GPs, and informal practice staff — while the GP consultation carries sensing, interpretation, authority, and memory reconstruction compressed into a ten-minute window with no structural support for any of them.

This failure is produced by a single structural condition: operational memory is not available at the point of clinical consequence. The patient repeats their history because the system cannot retrieve it. Because memory is absent, the GP must simultaneously sense, interpret, decide, and reconstruct prior state in a ten-minute window under full clinical consequence — with no structural support for any of these functions.

Every prior fix has addressed this at the wrong layer. Each programme has improved documentation density or audit visibility without restoring operational memory to the point of care [2]. HSSIB confirmed in 2023 that there is no GP contract requirement to deliver continuity of care and no GP IT standard requiring relevant information to be surfaced when patients return with unresolved symptoms [2]. The system has constructed audit visibility but not operational continuity.

Relational continuity was the human patch: for decades, the structural absence of operational memory was masked by patients seeing the same GP consistently. The relational GP carried memory personally — social context, prior episodes, the symptom mentioned once. As the workforce has contracted and practices have grown, that

workaround has failed. The human patch cannot be scaled. The system memory must now be built into the architecture.

The consequence: Coroner Prevention of Future Deaths reports are a recurring presence in NHS patient safety literature, with 713 PFD reports issued in 2024 alone (Ministry of Justice Coroners Statistics 2024), many citing information-sharing and care handoff failure as contributing factors [3]. Clinical negligence costs the NHS £2.8 billion annually, with failure or delay in diagnosis accounting for 43.5% of all GP indemnity notifications in the first year of the CNSGP scheme [3]. Over 40% of GPs doubt they will still be practising in five years [4].

BOARD VERDICT

The NHS has built the audit layer and left the operational layer with the patient. The GP consultation is the collapse node. Until operational memory is structurally present before clinical consequence, every new programme will relocate the same failure under a new name.

PROOF CONDITION

Proof standard: Same pressure → different response. The redesign is real only when, under the same workload and patient complexity, retrievable continuity is present at the point of clinical consequence, repeat unresolved presentations trigger visible alerting, and patients no longer repeat their history as the default.

SECTION 2

ENGAGEMENT SCOPE

System under analysis: NHS primary care continuity failure at the GP-led front door and across the GP → referral → secondary care → discharge → GP return pathway.

Included in scope: GP consultation (first contact and repeat presentation); referral generation and receipt; specialist handoff; discharge back to GP; record retrieval at the point of consultation; patient and carer continuity burden; NHS information architecture (Summary Care Record, Shared Care Record, GP Connect, NHS App).

Excluded unless directly relevant: broad NHS finance reform; hospital management generally; unrelated digital health policy; international health systems (referenced only as structural comparators after the governing diagnosis is formed).

Evidence basis: This diagnosis is based entirely on publicly available materials [1][2][3][4][5][6]. Primary sources include: NHS England official materials; HSSIB investigation reports (2023, 2025 ×2); NHS Resolution annual data; NAO digital transformation analysis; RCGP continuity and workforce reports; BMA pressures analysis; Healthwatch England national survey (n=1,800, March 2025); Coroner Prevention of Future Deaths reports (2024); peer-reviewed literature from BJGP, BMJ, Lancet, and PMC.

Known fixed constraints: the GP contractor model; demand-driven appointment availability; the 10-minute standard consultation unit; the multi-vendor EHR landscape; and the governance, privacy, and commercial environment surrounding NHS health data.

SECTION 3

FAILURE PATTERN RECONSTRUCTED FROM PUBLIC EVIDENCE

The following is synthesised from NHS England official materials, RCGP workforce and continuity reports, BMA pressures analysis, HSSIB investigation findings, and patient experience surveys [1][2][4][5]. It represents the operating problem before structural translation. These statements are derived from convergent public sources, not from undisclosed internal communications.

- → **Access and workload:** GP practices are under unsustainable workload pressure. Significant time is spent on administrative tasks rather than clinical care. The workforce is shrinking. Patients struggle to access appointments and often cannot see a familiar GP [1][4][5].
- → **Record fragmentation:** GPs do not reliably have the information they need — especially following hospital discharge. Discharge summaries are routinely delayed or incomplete. Different parts of the system use different IT systems that do not reliably communicate across organisations [2].
- → **Digital progress and persistent failure:** Significant investment has been made in the NHS App, the Shared Care Record, GP Connect, and the Summary Care Record. Progress has been made on documentation. The continuity failure persists [1][2].
- → **Unresolved presentations:** Patients with long-term conditions have multiple appointments without their care being properly coordinated. The same issues keep returning. Referrals are delayed. Diagnoses are missed [2][3].
- → **Contractual aspirations without structural mechanism:** The 2024/25 contract introduced a continuity requirement. It is difficult to deliver when the workforce is stretched, practices are large, and the digital infrastructure does not structurally support continuity retrieval at the point of care [1][2].

These are not isolated complaints. The pattern is identical across record access, clinical handoff, workforce sustainability, and patient experience [1][2][4][5]. That is the first structural signal that this is not a capacity problem or a digital investment problem in isolation.

SECTION 4

EARLY STRUCTURAL SIGNALS

Four structural signals are visible from the public record before the formal diagnosis is applied.

4.1 The system promises continuity but has no structural mechanism to guarantee it

HSSIB's 2023 investigation found no GP contract requirement for practices to deliver continuity of care, no standard national framework for doing so, and no GP IT requirement to surface relevant information when patients repeatedly present with unresolved symptoms [2]. The 2024/25 contract introduced the first contractual continuity requirement since 1948 — at the moment when patient-reported continuity was at its historical nadir [1] [2]. Continuity is treated as a desirable outcome rather than a structural requirement with a defined delivery mechanism.

4.2 Every correction has addressed the documentation layer, not the retrieval layer

NPfIT created records without interoperability [6]. The SCR created minimal cross-organisational access without the clinical picture required for judgment [1]. The Shared Care Record created professional read-access without real-time retrieval [1][2]. Each intervention improved the audit trace — the institution's ability to record what happened — without

improving retrieval: the clinician's ability to access what they need at the moment a decision must be made [2][6].

4.3 The patient is formally carrying the memory function

NHS England's health and care passport guidance actively encourages patients to maintain a personal summary of the information professionals need to care for them safely [1][5].

> **SHARPEST STRUCTURAL SIGNAL**
>
> ***This is not patient empowerment. It is the institution formally acknowledging that it cannot surface its own operational memory — and asking the patient to carry it instead. NHS England has named the structural failure and asked the patient to fill it.***

Healthwatch England's 2025 national survey found 26% of patients with record errors must repeat their full medical history at every appointment [5].

4.4 The consequence layer is patterned, not random

Coroners issued 36 Prevention of Future Deaths warnings in 2024 involving information-sharing failures linked to patient harm [3]. NHS Resolution receives clinical negligence claims at one every 40 minutes [3]. A Lancet study found that lower GP continuity is associated with a 30% increase in emergency hospital admissions [6]. These consequences cluster around the same structural origin. They are not coincidental.

SECTION 4.1

COMMON MISDIAGNOSES

The following explanations are frequently proposed for the NHS primary care continuity failure. Each is downstream of the actual break and will not resolve it.

MISDIAGNOSIS	WHY IT IS INSUFFICIENT
GP workforce shortage	Capacity addresses throughput, not memory retrieval. Adding more GPs without changing the record architecture still leaves every clinician without reliable prior patient history at the point of care.
IT interoperability problem	Interoperability is a necessary condition but not sufficient. The NHS has multiple interoperable systems (SCR, GP Connect) yet continuity still fails at the consultation. Interoperability transports data. Continuity retrieval determines whether the right clinical memory appears before consequence. The missing layer is operational retrieval, not data transport.
Discharge summary delay	Treating this as a communication delay ignores that the structural handoff has no guaranteed retrieval step. Faster summaries without guaranteed surfacing at the next consultation do not correct the break.
Patient empowerment through record access	Giving patients read access to records does not place operational memory in the clinician's workflow. It shifts the burden of retrieval to the patient — formalising the externalisation rather than correcting it.
ARRS workforce expansion	Adding more clinical role types to the pooled appointment list further fragments relational continuity. Capacity and continuity are not the same structural requirement.
Contractual continuity requirement (2024/25)	A contract clause without an IT standard or enforcement mechanism at the record layer does not guarantee that usable history appears in the consultation view when a returning patient presents to any clinician.

SECTION 5

SYSTEM BOUNDARY MAP

The system operates as a distributed record field with no central continuity node. Records exist across multiple organisational silos. Access is conditional, delayed, and request-based rather than native. Continuity is reconstructed at the consultation boundary by whoever is present.

Primary actors

ACTOR	ROLE	POSITION IN SYSTEM
Patient	Carries own continuity history; repeats at each encounter; fills the memory gap the architecture produces	De facto primary memory carrier — undesigned, uncompensated
Carer / family member	Maintains medication logs, appointment diaries, care histories across transitions	Secondary memory carrier — load-bearing, structurally invisible
GP (known / relational)	Clinical judgment with accumulated patient knowledge; carries social context and prior episode memory personally	Collapse node with relational continuity available
GP (pooled / unknown)	Clinical judgment without prior patient knowledge; must reconstruct history from fragments and patient account	Collapse node — full memory reconstruction required
Receptionist / care navigator	Informal triage, complexity flagging, routing returning patients toward known clinicians where possible	Informal sensing and continuity brokering layer — undesigned
NHS 111	Remote triage and urgent referral — limited record access	Parallel sensing node with minimal operational continuity access
Secondary care / specialist	Specialist assessment and treatment in separate EHR with no automatic GP record update	Separate record silo
Discharge summary	Information transfer mechanism from secondary to primary care	Handoff mechanism — routinely delayed, incomplete, or not sent [2]
Summary Care Record (SCR)	Medications, allergies, adverse reactions — national minimal record	Audit-grade memory layer [1]
Shared Care Record / ConCR (Connecting Care Records)	Cross-organisational professional read-access	Partial operational layer — programme closed March 2026 [1]
NHS App	Patient-facing GP record access from November 2023 (GP summary only)	Partial patient visibility layer [1]

Decision points where structural failure concentrates

- → Whether usable clinical history is present when the GP opens a returning patient's record [2][5]
- → **Whether a repeat unresolved presentation triggers any clinical alerting — currently: no IT standard exists [2]**

- → Whether a discharge summary has arrived and been uploaded before the follow-up appointment [2]
- → Whether the consulting clinician has any prior knowledge of the patient [4][5]

SECTION 6

WORKFLOW AND PIPELINE TRACE

The documented operating sequence:

1. Patient develops symptom; contacts practice by phone or online system [1][4]
2. Receptionist or care navigator routes to available appointment — not necessarily the patient's usual GP [1][4]
3. GP opens consultation; record displays GP notes, SCR summary, any uploaded correspondence [1][2]
4. GP reconstructs clinical history from partial record and patient verbal account — the patient is the primary continuity source [2][5]
5. GP senses presenting symptoms, interprets against reconstructed history, makes consequential clinical decision [2][4]
6. GP documents encounter — written for audit defensibility as much as clinical handoff [4][6]
7. If referral generated: secondary care episode occurs in a separate EHR with no automatic GP record update [2]
8. Secondary care produces discharge summary — standard target 24 hours; actual: routinely delayed, incomplete, or not sent [2]
9. Summary received at GP practice; reviewed and uploaded by administrative staff — not automatically available in consultation view [2]
10. Patient returns for follow-up; cycle repeats from step 3 with no structural guarantee the discharge summary is present [2][5]

Critical structural observations

- → **No step guarantees operational memory before clinical decision:** There is no step where operational memory is structurally guaranteed to be present before the clinical decision must be made [2][6]. The workflow assumes the clinician will reconstruct what the system cannot retrieve.
- → **The discharge summary arrives after the patient:** HSSIB's 2025 investigation confirmed that discharge summaries routinely arrive late, incomplete, or not at all — and in the gap, the GP relies entirely on the patient or carer's verbal account. HSSIB documented cases where summaries had not been sent for approximately a year, producing near-misses and confirmed patient harm [2].
- → **The pooled list model eliminates relational continuity by structural default:** A patient presenting five times in six months — the pattern most likely to indicate an unresolved diagnostic need — is statistically unlikely to have seen the same GP twice [1][4].
- → **No alerting mechanism exists for repeat unresolved presentations:** The same symptom coded differently across multiple consultations with different clinicians does not trigger a clinical flag. No IT standard requires it [2].

SECTION 7

FUNCTIONAL DIAGNOSIS

Applying the Four-Function Law [6]: institutions fail under scale when sensing, interpretation, authority, and memory remain fused or misaligned at the point of consequence.

FUNCTION	FORMAL LOCATION	ACTUAL LOCATION IN EXECUTION	CONDITION	CONSEQUENCE
Sensing	NHS 111, digital triage, practice receptionists	GP in consultation — absorbing signals from patient verbal account, record fragments, and presenting symptoms	Misaligned — sensing occurs at the collapse node after the pre-consultation opportunity is gone	Signal quality depends on patient recall and record availability. Weak signals — the unresolved pattern across five encounters with different GPs — are structurally invisible [2][5]
Interpretation	Clinical frameworks, NICE guidelines, specialist input	GP in 10-minute consultation, reconstructing history while forming clinical judgment	Fused with authority — interpretation and decision occur simultaneously with no structural separation	Judgment is formed from incomplete information. HSSIB confirmed: where continuity systems exist, GPs have more time to process information [2] [4]
Authority	GP as registered clinician	GP in 10-minute consultation — decides, prescribes, refers, or discharges	Fused with sensing and interpretation — no structural separation between signal reception and consequential action	43.5% of GP indemnity notifications in year one of the CNSGP scheme (2019/20) cite failure or delay in diagnosis [3]. This is not primarily a clinician failure. It is an authority node receiving degraded inputs.
Memory	NHS EHR, SCR, GP record, Shared Care Record	Patient (verbal history at each encounter); carer (medication logs); GP (accumulated knowledge for known patients only)	Structurally absent at point of need — externalised to patient without design, recognition, or compensation	The memory function is performed by the person least structurally equipped to carry it. When that person cannot, the system has no fallback [2][3][5]

CRITICAL FUSION AND ABSENCE

The critical fusion: sensing, interpretation, and authority are collapsed into the GP consultation. The 10-minute time unit eliminates any structural space in which they could be separated. The critical absence: operational memory is not reliably present at the point of clinical consequence. The critical inversion: the NHS has instrumented itself heavily for audit and compliance while the operational continuity function has migrated outward. Every documentation investment has deepened this inversion.

AUDIT TRACE vs OPERATIONAL MEMORY — NAMED DISTINCTION

Audit trace records what happened — produced for compliance and defensibility. Operational memory surfaces what must be known before the next decision — produced for clinical use. The NHS has built the first. It has not built the second. These are structurally different objects requiring different architecture, different custody, and different incentives.

SECTION 8

STRUCTURAL FAILURE POINT

DIAGNOSTIC LAW

A health system fails at the consultation when the information required for clinical judgment is not present at the point of clinical consequence. NHS primary care is a direct instance of this law.

The first structural break: the system is not designed to deliver operational memory to the point where clinical decisions are made. Continuity exists only if carried by a human.

This is not the delayed discharge summary — that is a downstream consequence. This is not the ten-minute appointment — that is the structural container in which the consequences of the break are forced under compression. This is not GP burnout or workforce shortage — each is a further downstream effect. The break accumulated through decades of fragmented IT procurement, organisational record ownership, and digital reform that prioritised documentation over retrieval [2][6].

Data without context: The GP record is a stack of facts, not a narrative of clinical state. The system may expose fragments, but it does not construct the clinical state the decision requires. Operational-grade retrieval is not having access to a PDF of a discharge summary. It is the system surfacing the relevant clinical delta since the last visit — outstanding investigations, unresolved presentations, medications changed in A&E — in retrievable form before clinical consequence begins.

Data gravity: Clinical data is trapped at the point of recording — in the silo where it was created. The system lacks a retrieval engine to pull relevant data toward the point of clinical consequence. The information exists. The force is absent. Data gravity keeps it anchored to its organisational origin rather than surfacing it at the moment of decision.

The three capability modes

MODE	DESCRIPTION	HOW THE NHS HANDLES IT
Execution reliability	Consistent appointment delivery, prescription processing, routine referral	Actively managed and measured. This is what access and throughput metrics capture. [1][4]
Diagnostic capability	Pattern recognition across encounters; escalation of unresolved presentations; detection of weak signals over time	Present for patients with relational continuity to a known GP. Structurally absent across the pooled list model and care transitions. [2][4]
Continuity retrieval	Surfacing usable clinical history at the point of consequential decision	No contract requirement, no IT standard, no architectural guarantee. Structurally absent by default. [2][6]

SHARPEST STRUCTURAL CLAIM — PUBLICLY SUPPORTED

The third capability — the one that would connect five appointments, surface the medication prescribed in A&E that the GP does not know about, and flag the symptom coded differently three times — is absent not because the data does not exist. It is absent because no structural mechanism surfaces it at the moment it is needed.

Evidence of the break

- → **HSSIB (2023) [2]:** no GP contract requirement for continuity; no IT standard to surface repeat unresolved presentations.
- → **HSSIB (2025) [2]:** when discharge information has not arrived, the GP relies on the patient or carer's verbal account to make care decisions. Cases documented where summaries had not been sent for approximately a year.
- → **Healthwatch England (2025) [5]:** 26% of patients with record errors repeat their full history at every appointment; 20% cannot convince clinical staff about their own history because it does not appear on the system.
- → **PMC EHR analysis (2024) [6]:** 9.1% of all acute presentations — over 11 million occasions per year — where the treating clinician had no access to the patient's prior record.

Publicly documented death cases involving record-access or handoff failures

- → *Case 1 [3]:* A child with Down's Syndrome died after the NHS 111 adviser had no access to his diagnosis — information that would have triggered immediate clinical assessment.
- → *Case 2 [3]:* A child died when incompatible IT systems forced verbal-only clinical handover between ambulance and A&E; critical information was lost in the transfer.
- → *Case 3 [3]:* A mental health patient was discharged rather than detained because her digital record was unavailable to the receiving team; she died the following morning.

Coroners have issued repeated Prevention of Future Deaths warnings to the same organisations without producing structural correction — which is itself evidence that the correction loop, not the individual failure, is the problem [3].

SECTION 9

COMPENSATION AND HIDDEN BURDEN

The NHS primary care system appears to function. Appointments are booked. Prescriptions are issued. Referrals are made. The strongest structural reading is that it functions because a set of informal human carriers performs the continuity functions the architecture does not formally support [2][5][6].

Primary carrier — the patient

The patient is the de facto memory function of NHS primary care [1][5]. They repeat their history at every appointment because the system cannot retrieve it. NHS England has formalised this with the health and care passport — officially encouraging patients to carry what the system has not been built to surface [1]. Healthwatch England's 2025 survey: 26% of patients with record errors must repeat their full medical history at every appointment [5]. When the patient cannot carry this burden — because they are unconscious, acutely unwell, cognitively impaired, or simply unaware of their own clinical history — the system has no structural fallback. The three publicly documented death cases in Section 8 are what that looks like [3].

Secondary carrier — the carer

Where the patient cannot carry the burden alone, the carer does. They maintain medication logs across multiple prescribers, bring appointment diaries to consultations, and hold context across transitions that the formal record does not reliably bridge [2][5]. HSSIB's 2025 investigation confirmed: where discharge information has not arrived, the GP relies on the patient or carer's verbal history to make care decisions [2]. This labour is unpaid, unrecognised, and structurally load-bearing.

Tertiary carrier — the GP with accumulated knowledge

For patients with a consistent relationship with a named GP, that GP carries the memory function personally — social context not in the record, family history mentioned once, a previous episode coded under a different symptom [4][6]. This accumulated knowledge is clinically valuable, irreplaceable, and structurally precarious. It exists only for patients with relational continuity. It disappears when the GP retires, moves practices, or is unavailable. It does not survive care transitions [4].

Quaternary carrier — the receptionist and care navigator

The receptionist performs informal triage: identifying complex patients, routing returning patients toward known clinicians where possible, flagging concerns to clinical staff [4]. This is undesigned, uncompensated as clinical work, and structurally load-bearing. It operates entirely outside the clinical record.

STRUCTURAL CONSEQUENCE

When any carrier layer withdraws — when the carer can no longer maintain the log, when the patient cannot recall their history, when the known GP is unavailable — the structural failure becomes visible as a clinical event. The system appears functional because these carriers absorb the ambiguity it produces. Their labour does not appear in any NHS budget, productivity calculation, or reform proposal.

SECTION 10

GOVERNING DIAGNOSIS

The NHS primary care system's recurring failure is not best explained as a GP capacity problem, a digital investment shortfall, or a workforce crisis. The structural reading — derived from convergent public evidence across the record architecture, the clinical workflow, the consequence layer, and the patient experience pattern [1][2][3][4][5][6] — is this:

THE GOVERNING DIAGNOSIS — COMPLETE STATEMENT

The NHS has not failed to create records; it has failed to ensure those records are retrievable as usable clinical continuity at the moment a consequential decision must be made. Every digital reform has addressed this at the wrong layer — improving documentation density and audit visibility without restoring the operational memory function to the point of care. The result is a system that is record-rich and continuity-poor: it generates more data about patients than at any prior point, and less of it arrives in usable form where it is needed. Because no reform has addressed the structural externalisation of the memory function — because the primitive has never been corrected — every downstream fix relocates the same failure: from NPfIT to the SCR, from the SCR to the Shared Care Record, from the Shared Care Record to the NHS App, from the NHS App to a contractual continuity requirement that covers fewer than one in ten patients and has no enforcement mechanism at the record layer.

EVENT-BASED vs STATE-BASED — THE ARCHITECTURAL MISMATCH

The NHS architecture is optimised for Events — the appointment, the referral, the discharge. It is blind to State — the patient's longitudinal clinical condition across encounters and transitions. Continuity failure is the inevitable result of trying to manage a State-bearing person using an Event-based ledger. The patient exists between appointments. The system does not.

SECTION 10.1

PRIMITIVE MISMATCH MAP

DIMENSION	STATED	ACTUAL
Primitive	Joined-up care in which records support direct clinical decisions across the patient's whole NHS journey	Each organisation holds its own records; sharing is request-based or after-the-fact; patient repeats history as default continuity mechanism
What is promised	Continuity of care at the point of need	Audit-grade trace of what happened; operational continuity reconstructed by the patient at each encounter
What is purchased	Clinical judgment supported by retrievable patient history	Clinical judgment formed from whatever the patient can remember, overlaid on a fragmented record
Who succeeds	Patients with relational continuity to a known GP; patients with a carer who maintains logs	Only those who can reconstruct and assert their own clinical history
Who bears the structural cost	—	The informal carrier layer: patient, carer, known GP, care navigator — unrecognised, uncompensated, load-bearing
What is measured	Appointment volumes, access times,	Output metrics that capture

DIMENSION	STATED	ACTUAL
	digital adoption rates, documentation compliance	documentation compliance without touching the operational continuity layer
What is not measured	—	Whether usable clinical continuity was present at the point of the consequential decision — the only metric that would reveal the structural failure
Commercial incentive (hidden)	Open, interoperable data flow supporting joined-up care	Vendor lock-in through API restrictions. GP system vendors control API access and have structural incentives to resist the openness that operational continuity would require. This makes retrieval structurally unreachable within the current commercial architecture, not merely technically difficult.

SECTION 10.2

WHY THE MISMATCH IS STRUCTURAL, NOT INCIDENTAL

The mismatch is produced by the collision between forces that have never been reconciled: fragmented NHS IT procurement that created an estate of incompatible EHR systems; organisational record ownership in which each NHS body holds its own records and sharing is an after-the-fact join rather than a native structural feature; and the commercial environment in which GP system vendors control API access and have structural incentives to resist the openness that operational continuity would require [2][6]. These forces have made operational continuity structurally unreachable within the current architecture — not merely difficult, but unreachable without a change at the primitive level.

Incentive misalignment: The current commercial model for EHR vendors rewards documentation density — useful for billing, legal defence, and audit — but provides no structural incentive for cross-platform retrieval, which would reduce the value of the individual silo. The architecture that fails patients is also the architecture that protects vendor market position. This is not a conspiracy; it is a structural alignment between commercial incentives and audit-grade record-keeping that has never been counterbalanced by a requirement to deliver operational-grade retrieval.

This is not a transitional state that will resolve itself. The structural incentives that produced it are still present. Until the primitive is named and the record architecture is redesigned to place operational memory at the point of clinical consequence, the same failure will be regenerated by the same forces that created it.

SECTION 10.3

VALIDATION TEST

If NHS England were to implement the Vanish List in Section 12 and structurally require that returning-patient consultations surface retrievable continuity data — including outstanding discharge context and prior unresolved presentations — would the remaining friction pattern be explained by execution quality rather than structural memory absence? If yes, the diagnosis holds.

Measurable signals that would confirm the diagnosis without full redesign:

- → Expose discharge summary status to GPs in real time. If administrative burden falls materially but patient-reported repetition does not decline, the problem is continuity retrieval, not discharge communication speed.
- → Pilot a GP IT alerting standard for repeat unresolved presentations in one ICS region. If diagnostic delay for multi-presentation patients reduces, the alerting layer was the binding constraint and the diagnosis is confirmed.
- → Measure the percentage of returning-patient consultations where a discharge summary is present and surfaced at the moment the clinician opens the record. If below 80%, the retrieval failure is structural, not individual.

FALSIFICATION CONDITION

Falsification condition: If patients still repeat their history after retrievable operational memory is structurally guaranteed at the point of care, revisit whether vendor API constraints prevent full retrieval — but that would be a constraint on the fix, not a refutation of the diagnosis.

SECTION 11

COST OF CONTINUATION

The following is a directional assessment of costs generated by the unresolved structural failure. These are derived from public evidence, not internal NHS financial data. Each figure is the financial or human expression of decisions made without reliable memory at the point of care.

Class 1 — Directly evidenced institutional cost

COST CATEGORY	ANNUAL SCALE	SOURCE
Total clinical negligence	£2.8 billion	NHS Resolution 2023/24
GP indemnity claims (CNSGP)	13,784 new claims; +9.3% year-on-year; one every 40 minutes	NHS Resolution CNSGP 2023/24
Failure/delay in diagnosis (GP)	43.5% of CNSGP notifications in year one of the scheme (2019/20, 401 cases); NHS Resolution notes this is an indication, not a firm conclusion	NHS Resolution CNSGP year-one baseline (August 2022)
Preventable deaths — information sharing	713 PFD reports issued in 2024 (up 25% on 2023); recurring themes include information-sharing failure and care handoff breakdown across NHS settings (Ministry of Justice Coroners Statistics 2024)	Ministry of Justice, 2024
Failed digital reform — NPfIT alone	£12 billion+ without producing a unified continuity record	NAO, 2013

Class 2 — Structurally associated downstream burden

COST CATEGORY	SCALE	SOURCE
Emergency admissions associated with low GP continuity	+30% increase	Lancet Primary Care, 2025
Acute presentations without prior record access	9.1% of all acute presentations; over 11 million occasions per year	PMC EHR analysis, 2024

COST CATEGORY	SCALE	SOURCE
GP workforce exit	40%+ doubt they will be practising in 5 years; projected 1-in-2 shortfall by 2030/31. The exit is not primarily burnout in the ordinary sense: it is the psychological strain produced by architectural failure — the weight of making high-consequence clinical decisions on structurally degraded data without the memory infrastructure to make them safely.	RCGP; Health Foundation

Class 3 — Invisible patient and carer labour

COST CATEGORY	SCALE	SOURCE
Patients repeating full history at every appointment	26% of patients with record errors	Healthwatch England, 2025
Patients unable to convince clinical staff about their own history	20% of patients with record errors	Healthwatch England, 2025

The compounding dynamic — no internal exit

STAGE	MECHANISM	STRUCTURAL ORIGIN
1	Workforce decline increases function fusion per consultation	Each GP carries more sensing, interpretation, authority, and memory reconstruction per session
2	More function fusion → more clinical risk	Authority node operating on degraded inputs under greater time pressure
3	More clinical risk → more negligence claims	Failure or delay in diagnosis is the predictable output of the collapse node
4	More claims → more regulatory and administrative burden	Documentation and defensive practice increase; clinical time shrinks further
5	More burden → more workforce exit	The collapse node becomes unbearable
6	More workforce exit → return to Stage 1	No internal exit without structural change at the memory function level

Structural upside if corrected: a continuity architecture that places retrievable operational memory at the point of clinical consequence would reduce negligence claims in the failure-to-diagnose category, reduce emergency admissions, reduce GP administrative burden, and eliminate the structural justification for patient-carried continuity. Primitive correction should be understood as a recovery mechanism, not a discretionary improvement initiative.

SECTION 12

CORRECTION DEPENDENCY ORDER

This is a dependency order, not a redesign specification. Right fixes in the wrong sequence still fail. This section defines what must stop and the order in which correction must proceed. The full Redesign Artifact (Artifact 02) specifies the target-state architecture, transition sequence, refusal invariants, operating objects, and builder handoff.

Vanish List — Non-Negotiable Refusal Conditions

What stops before correction can hold. These are preconditions, not optimisation targets.

STOP	WHY	FAILURE IF NOT STOPPED
Measuring digital programme success by adoption metrics without measuring continuity retrieval at the point of clinical decision [1][2]	Adoption metrics reward the audit layer. The operational layer remains unaddressed.	Programmes appear successful while continuity failure persists and deepens
Treating discharge summary delays as a communication problem [2]	HSSIB confirmed it is a structural handoff failure. More guidance without enforcement has not resolved it.	Summaries improve in speed without guaranteed surfacing at the next consultation
Treating ARRS workforce expansion as a continuity improvement [1][4]	Every additional clinician in the pooled appointment pool further fragments relational continuity. Capacity and continuity are not the same metric.	More clinicians, less relational continuity; function fusion per consultation remains unchanged
Treating the NHS health and care passport as a patient empowerment feature [1][5]	It is a formal acknowledgment that the system cannot surface its own operational memory. Name it correctly before designing around it.	The structural externalisation is institutionally normalised rather than corrected
Layering digital access features onto the existing fragmented record architecture without first correcting the retrieval layer [1][2]	Each new layer adds documentation trace without restoring retrieval. Scale compounds the mismatch.	More data, no more usable continuity at the point of clinical consequence
Treating patient-facing apps as a substitute for clinical memory [1][2]	Patient-facing record access creates an illusion of connectivity while the underlying data remains fragmented and unretrievable by the clinician. It redistributes the continuity burden to the patient rather than correcting the architectural absence.	The structural externalisation is institutionally endorsed rather than corrected; a new digital layer formalises the old failure

Correction sequence

Move 1 — prerequisite for everything else

Name operational continuity as a structural requirement.

NHS England must define what operational continuity means structurally: which actor holds the patient's continuity at the point of care, under what conditions it is retrievable, who has authority to update it, and what is the minimum standard for its presence when a consequential clinical decision must be made. Without this declaration, every subsequent reform will be interpreted through the existing frame.

FIELD	DETAIL
Owner	NHS England CEO and Chief Clinical Information Officer
Risk if skipped	Every downstream change is interpreted through the audit frame and produces the same partial fix
Redesign reference	Redesign Artifact, Section 10, Move 1

Move 2 — follows from Move 1

Separate the audit record from the operational continuity record at the data architecture level.

The audit record is produced for compliance and defensibility. The operational continuity record must be produced for clinical use — retrievable at the next point of care, enabling the next clinician to act without reconstruction. These require different structures, different custody arrangements, and different incentives.

FIELD	DETAIL
Owner	NHS Digital / NHSE Tech and Integrated Care Systems
Risk if skipped	Continuity remains fragmented even when individual systems are better documented
Redesign reference	Redesign Artifact, Section 10, Move 2

Move 3 — follows from Move 2

Redesign the discharge handoff to guarantee continuity transfer before the patient returns.

Continuity must be structurally transferred in retrievable form before the patient's follow-up appointment — not left as a delayed communication. The handoff mechanism, format standard, and enforcement consequence are in the full Redesign Artifact.

FIELD	DETAIL
Owner	Integrated Care Systems and secondary care trusts
Risk if skipped	Discharge summaries improve in volume without guaranteed arrival before the next consultation
Redesign reference	Redesign Artifact, Section 10, Move 3

Move 4 — follows from Move 3

Mandate a GP IT standard to surface repeat unresolved presentations.

When a patient presents with an unresolved clinical picture that has appeared in previous consultations — regardless of which clinician saw them — the system must surface that pattern before the consultation begins. No such standard currently exists.

FIELD	DETAIL
Owner	NHS England Chief Digital and Information Officer
Risk if skipped	Diagnostic delay persists for multi-presentation patients despite better records
Redesign reference	Redesign Artifact, Section 10, Move 4

DEPENDENCY SUMMARY

Move 4 cannot precede Move 3. Move 3 cannot precede Move 2. Move 2 cannot precede Move 1. The current pattern of digital programme layering fails precisely because it attempts Move 3 and Move 4 interventions without Move 1 in place. That is why every prior programme has produced partial improvement and then stalled or been replaced.

SECTION 13

ROLE-LEVEL DIAGNOSTIC IMPLICATIONS

Structural translation of the diagnosis into diagnostic implications by role. These follow the dependency sequence in Section 12. For full system object model, interface specifications, and implementation sequence, see the Redesign Artifact (Artifact 02).

These are diagnostic implications, not implementation instructions. Full transition logic, system objects, and builder handoff are contained in the Redesign Artifact.

ROLE	DIAGNOSTIC IMPLICATION	REDESIGN REFERENCE
NHS England leadership and DHSC	The primitive must be named before any redesign can hold. Pause any new digital access programme that does not first define how continuity retrieval will be measured — not adoption, but retrieval at the point of clinical consequence. Communicate honestly that the current architecture externalises memory onto the patient.	Redesign Artifact § 16 — Leadership Move 1
NHS England Transformation Directorate / digital and technology leadership	Expose discharge summary status to GPs in real time — a low-effort, high-impact change that directly addresses the most documented patient harm pathway. Separate the audit record from the operational continuity record at the data architecture level. Do not launch further patient-facing access features without addressing the underlying interoperability constraints that prevent continuity retrieval.	Redesign Artifact § 16 — Engineering Moves 2, 4
GP practices and clinical safety leads	Identify patients carrying the highest continuity burden: repeat presenters, post-discharge patients, those with multiple long-term conditions. Define a practice-level continuity protocol for surfacing information when those patients present, regardless of which clinician they see. The informal work your receptionists and care navigators are already doing is load-bearing, not supplementary.	Redesign Artifact § 16 — Operations
Integrated Care Systems	Use population health data to detect where continuity failure is producing repeat emergency admissions. Close the loop between hospital discharge and GP follow-up. The discharge handoff redesign (Move 3) operates at ICS level.	Redesign Artifact § 16 — ICS Move 3

SECTION 14

PUBLIC EXEMPLAR NOTE

This document is a public exemplar derived from a full internal diagnostic artifact. It is shared to demonstrate method, structural capability, and the distinction between diagnosis and redesign.

The full internal artifact contains the deeper correction bridge, detailed transition logic, object-level builder handoff, and specification not disclosed here. Full redesign specifications are restricted and not publicly available.

This public exemplar demonstrates that a structural diagnosis can be produced from entirely public evidence, that the Four-Function Law applies precisely to the NHS primary care continuity failure, and that the correction dependency order can be named before any implementation specification is required.

The public artifact proves the diagnostic logic; the restricted artifact preserves the implementation method.

SECTION 15

APPENDIX — EVIDENCE MAP

This map traces each major diagnostic claim to its evidence tier and representative sources. It is designed to make the evidentiary basis of each structural claim impossible to dismiss as reliant on any single source class.

Evidence tier key

TIER	CLASS	DESCRIPTION
[1]	First-party NHS official sources	NHS England official materials — stated promise, official workflow, official architecture claims, guidance documents
[2]	Independent structural oversight	HSSIB, NAO, Nuffield Trust, RCGP structural findings — investigation reports, audit analyses, professional body findings
[3]	Consequence evidence	NHS Resolution, Coroner PFDs, publicly documented harm patterns — allegation-level and pattern evidence, not adjudicated findings of individual liability
[4]	Workforce and collapse-node evidence	RCGP surveys, BMA analysis, BJGP workload studies — GP workforce experience as evidence of collapse-node conditions
[5]	Patient and ghost-structure evidence	Healthwatch England, patient testimony — treated as pattern evidence, not individual anecdote
[6]	Academic proof layer	Lancet, BJGP, PMC, Oxford NDPCHS — peer-reviewed structural and outcomes research

Claim-to-source map

DIAGNOSTIC CLAIM	EVIDENCE TIER	REPRESENTATIVE SOURCES
The system has no structural requirement for continuity retrieval at the point of care	[1][2]	HSSIB (2023): no GP contract requirement; no IT standard. NHS England 2024/25 GP Contract: first continuity requirement since 1948, with no IT enforcement mechanism.
Every correction has addressed documentation, not retrieval	[1][2][6]	NHS England: SCR, Shared Care Record, NHS App programme documentation. NAO: digital transformation analysis. HSSIB: investigation findings on record fragmentation.
The patient is the de facto memory carrier by architectural default	[1][5]	NHS England health and care passport guidance. Healthwatch England (2025, n=1,800): 26% of patients with record errors repeat full history at every appointment.
Sensing, interpretation, and authority are fused in the 10-minute GP consultation	[2][4][6]	HSSIB (2023, 2025): confirmation that GPs reconstruct history from patient verbal account in the absence of prior record. RCGP GP Voice Survey. PMC task analysis (2024).
The discharge handoff is a structural failure, not a communication delay	[2][3]	HSSIB (2025): discharge summaries routinely delayed, incomplete, or not sent; cases of no summary for approximately a year. NHS Resolution CNSGP: failure-to-refer claims.
The consequence layer is patterned, not random	[3][6]	713 Coroner PFD reports issued in 2024 (Ministry of Justice Coroners Statistics 2024), with recurring information-sharing and care handoff themes. NHS Resolution: 43.5% of GP indemnity notifications in year one of CNSGP cite failure/delay in diagnosis (2019/20 data, 401 cases). Lancet (2025): 30%

DIAGNOSTIC CLAIM	EVIDENCE TIER	REPRESENTATIVE SOURCES
		emergency admission increase with lower continuity.
The governing diagnosis — patient-carried memory, GP consultation as collapse node	[1][2][3][4][5][6]	Convergent across all six tiers. No single tier is sufficient alone. The structural inference holds only if all five lower tiers are consistent with it — which they are.

Key sources (representative selection)

[1] First-party NHS official sources

- → NHS England: Shared Care Records programme documentation and closure (March 2026)
- → **NHS England: Summary Care Record — specification, coverage, and access conditions**
- → NHS England: NHS App — patient record access guidance (November 2023)
- → NHS England: Health and care passport guidance
- → NHS England: 2024/25 GP Contract and continuity requirement

[2] Independent structural oversight

- → HSSIB: Continuity of care — delayed diagnosis in GP practices (2023)
- → **HSSIB: Primary and community care coordination for people with long-term conditions (2025)**
- → HSSIB: Electronic communications on patient discharge from acute hospitals (2025)
- → NAO: Digital transformation in the NHS
- → RCGP: Continuity of care in modern day general practice (2025)
- → BMA: Pressures in general practice data analysis (2024)

[3] Consequence evidence

- → NHS Resolution: Clinical Negligence Scheme for General Practice (CNSGP) 2023/24. £2.8bn total; 13,784 new claims; one claim every 40 minutes. Note: 43.5% failure/delay in diagnosis figure is drawn from the CNSGP year-one baseline report (NHS Resolution, August 2022), covering 401 notifications in 2019/20. NHS Resolution notes no firm conclusions should be drawn from a single year's data.
- → **Ministry of Justice Coroners Statistics 2024: 713 PFD reports issued in 2024, up 25% on 2023; recurring themes include information-sharing failure and care handoff breakdown across NHS settings**

[4] Workforce and collapse-node evidence

- → RCGP GP Voice Survey (2024): 76% of GPs believe patient safety is compromised; 40%+ doubt they will be in practice in five years
- → **Health Foundation: projected one-in-two GP shortfall by 2030/31**
- → PMC: Great expectations? GP consultations task analysis (2024). Documentation adds 2 minutes 38 seconds to every encounter

[5] Patient and ghost-structure evidence

- → Healthwatch England: The extent and impact of inaccurate NHS patient records (May 2025, n=1,800). 26% must repeat full history at every appointment; 20% cannot convince clinical staff about their own history
- → **NHS England: Health and care passport guidance — institution formally recommending patients carry their own continuity summary**

[6] Academic proof layer

- → Lancet Primary Care: Continuity of care in general practice and patient outcomes (2025). 30% increase in emergency hospital admissions associated with lower GP continuity
- → **PMC: A call to reconsider a nationwide EHR system (2024). 9.1% of all acute presentations — over 11 million occasions per year — without prior record access**
- → Oxford NDPCHS: The human connection — why relational continuity matters in general practice (2025)

APPENDIX A

ILLUSTRATIVE ACCEPTANCE PROTOCOL

PUBLIC EXEMPLAR NOTE

This is the Diagnostic Acceptance Protocol used in live engagements. In this public exemplar, the client and organisation fields are unpopulated; the checklist, consequence clause, and structure are reproduced in full. This document was not commissioned by the NHS, NHSE, or DHSC.

A diagnostic is only operative if leadership formally accepts it. Without explicit acceptance, this document can be noted in a meeting and the existing reform cycle resumed. The following protocol is required before the Redesign Artifact engagement begins.

Acceptance checklist

☐ **Governing diagnosis acknowledged**

Leadership confirms: NHS primary care has externalised its operational memory function. The GP consultation is the collapse node. The failure is architectural, not a GP capacity or digital investment problem.

☐ **Vanish List agreed**

The five Non-Negotiable Refusal Conditions in Section 12 are stopped. No new digital access programme launches without first measuring continuity retrieval, not adoption.

☐ **Dependency order accepted**

The four-move sequence in Section 12 is accepted as the correction sequence. No move is attempted before the move that precedes it is complete.

☐ **Measurement baseline established**

Before Move 1: patient-reported history repetition rate; GP consultation time on record reconstruction; discharge summary arrival timeliness; emergency admission rate by continuity level.

☐ **Redesign Artifact commissioned**

Artifact 04 (Redesign Artifact) is formally commissioned as the next engagement.

Acceptance signatures

ROLE	NAME	SIGNATURE	DATE
NHS England Chief Executive			
Chief Digital & Information Officer			

ROLE	NAME	SIGNATURE	DATE
National Director of Primary Care			
Chief Clinical Information Officer			

CLOSING STATEMENT

This artifact names the structural condition that public evidence makes visible: a single architecture is being used to deliver continuity that it was never designed to provide. The NHS has built the audit layer. It has not built the operational layer. Until operational memory is placed at the point of clinical consequence — by design, not by patient recall — the same failure will continue to reappear under new programmes, new contracts, and new digital investments. The redesign is real only when the same pressure produces a different response. Not when the architecture has changed. When the patient no longer repeats their history.

This public diagnostic exemplar was produced by Jamie Forrester, Independent Systems Architect, Edinburgh, UK. It is based entirely on publicly available information and was produced independently — it was not commissioned by the NHS, NHS England, DHSC, or any associated body. The diagnostic logic, structural interpretation, and governing diagnosis are the author's own.

For the Redesign Artifact (Artifact 02) or the Translation Artifact (Artifact 03), contact:
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