PUBLIC EXECUTIVE SUMMARY · 03 IN READING ORDER

NHS

/ PRIMARY CARE REDESIGN EXECUTIVE SUMMARY

CONTINUITY REPLACEMENT LOGIC

The corrected primitive, minimum replacement, and proof standard.

> *"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	Public
03	**Redesign Executive Summary**	← *This document*
04	Redesign Artifact	Restricted

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ARTIFACT FAMILY — READING ORDER

Artifact family reading order: Translation Artifact (best first read) → Diagnostic Artifact (full evidence) → This document (replacement logic) → Full Redesign Artifact (restricted; not published). Public artifacts demonstrate the diagnostic and replacement logic. The restricted artifact specifies the implementation.

SECTION 0

WHAT THIS DOCUMENT IS

Primary care is record-rich and continuity-poor. Patients repeat their history. GPs reconstruct instead of judge. Preventable harm persists. This document presents a structural replacement that corrects the primitive: operational continuity must be present at the point of clinical consequence, in patient-held form.

This is the public executive summary of a structural replacement specification for NHS primary care continuity failure. It is not a reform proposal, a digital access programme, a phased initiative, or an optimisation of the existing system. It specifies the minimum architecture required for the failure mode to stop reproducing.

What this document contains: corrected primitive, truth kernel, target-state architecture, minimum replacement conditions, dependency order, fake progress test, consequence of deferral, board verdict.

What the full Redesign Artifact adds: the complete seven-move transition sequence, rules and invariants, drift immune system with fail-closed gates, admissibility conditions, successor trap analysis, builder handoff with object-level specifications, and automated testability requirements. The full Redesign Artifact is restricted and not publicly available.

Judgment boundary

This document makes no claim about clinical negligence, individual clinician failure, institutional bad faith, or adjudicated liability. It is a structural specification derived from public evidence. The failures addressed are architectural, not personal.

What this document does not say

- → It does not abolish the 10-minute consultation — it decomposes it
- → It does not require same-GP continuity — it requires operational memory continuity regardless of which clinician sees the patient
- → It does not create a diagnostic tool, medical device, or clinical authority
- → It does not replace the official NHS GP record — the app supplements; formal ingestion is Move 7
- → It does not require NHS IT cooperation for the redesign to deliver core continuity value
- → It does not prescribe a specific technology vendor or EHR solution
- → It does not claim access to unpublished NHS internal data

SECTION 1

REDESIGN SPINE

The complete replacement specification in governed form.

REDESIGN ELEMENT	SPECIFICATION
Governing mismatch	NHS primary care is record-rich and continuity-poor: audit trace is extensive; operational memory is absent at the point of clinical consequence
Corrected primitive	Operational continuity must be present at the point of clinical consequence, in patient-held form
Truth kernel	Patient's portable operational continuity record — the one object the redesign must not sacrifice
Continuity Layer	Patient holds the record; app generates Consultation Packet before each encounter; outcome appended after
Clinical Authority Layer	GP receives consultation packet; exercises bounded clinical judgment; retains full medical authority
Core mechanism	Consultation packet: one-page summary generated before every encounter; clinician reads in under 60 seconds; appointment begins at clinical judgment, not reconstruction
Non-negotiable	Patient-held custody. App carries continuity, not clinical authority. If custody transfers to institution, redesign has failed.
Minimum replacement	Truth kernel + symptom event layer + consultation packet + outcome append + emergency access. All five must be present simultaneously. Recognition pathway is Move 7, not a minimum replacement condition. See Section 6.
Proof condition	Same pressure → different response. Patient no longer repeats history by default. GP begins at clinical judgment.
Primary recapture risk	App becomes a health journal under engagement-metric pressure; or NHS takes custody and recreates institutional fragmentation

SECTION 2

GOVERNING DIAGNOSIS

The NHS has not failed to create records. It has failed to ensure those records arrive where clinical decisions are made. Primary care is record-rich and continuity-poor. Patients repeat their history. GPs reconstruct instead of judge. The same harm pattern continues.

> GOVERNING DIAGNOSIS — LOCKED
>
> ***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. Relational continuity — seeing the same GP consistently — was the human patch for this architectural absence. As the workforce has contracted, the patch has failed. The system memory must now be built into the architecture.***

The patient becomes the record. When the system cannot retrieve its own memory, the patient supplies history, the carer supplies context, and the GP reconstructs the case. The system supplies fragments. This is not a clinician failure. It is a structural mismatch between what the NHS promises and what its architecture can deliver.

The NHS architecture is event-based — optimised for the appointment, the referral, the discharge. The patient is state-based — a longitudinal clinical condition that exists between appointments as much as during them. Continuity fails because a state-bearing person is managed through an event-based ledger. The patient exists between appointments. The system often does not.

Every digital reform has addressed this at the wrong layer — improving documentation density and audit visibility without restoring operational memory to the point of care. The result: more data about patients than at any prior point, and less of it arriving in usable form where clinical decisions are made.

SECTION 3

TRUTH KERNEL

The non-negotiable continuity object this redesign must preserve is the patient's portable operational continuity record. It is not a feature of the app. It is what the app exists to hold.

The record follows the human, not the institution. It carries clinical history, symptom events, clinical verdicts, medications, referrals, and outcomes across every encounter, every transition, and every care setting. No organisation owns it exclusively. No transition destroys it.

Continuity compounds over time. Each appended outcome makes the next consultation better. A patient attending their fifth appointment in six months arrives with a complete symptom timeline, all prior clinical verdicts, and a structured presentation of the current episode — not because they remembered it, but because the system held it.

> PATIENT-HELD ≠ PATIENT-BURDENED
>
> ***Patient-held does not mean patient-burdened. The patient holds custody of the continuity object; the architecture must reduce the labour required to reconstruct,***

> ***retrieve, and present continuity at every encounter. Any design that increases patient administrative burden while calling it empowerment fails the redesign.***

Kernel test: if the redesign is complete but the patient's continuity record is still fragmented across institutional systems, is not retrievable in under 60 seconds at point of care, or custody remains with an institution rather than the patient, the redesign has not succeeded regardless of what else improved.

SECTION 4

CORRECTED PRIMITIVE

Malformed primitive: the NHS provides continuity of care through a nationally accessible electronic record held by the institution that generated it.

Corrected primitive: operational continuity must be present at the point of clinical consequence, in patient-held form, readable by any clinician at any encounter, independent of institutional interoperability.

The correction is not to make the institutional record architecture clearer, faster, or better connected. The correction is to change who holds the continuity object and where it arrives.

SECTION 5

TARGET-STATE ARCHITECTURE

The redesigned system is a dual-layer continuity architecture.

LAYER	WHAT CHANGES	THE APP'S ROLE
Continuity Layer (patient-held)	Patient holds a portable operational continuity record. App generates a consultation packet before every encounter. App receives outcome appended after every encounter. Record travels across all care settings.	Holds the continuity object. Moves sensing upstream. Generates the Consultation Packet. Receives outcome appends.
Clinical Authority Layer (GP consultation)	GP receives the packet before or at the start of the encounter. Clinician exercises bounded clinical judgment on structured prior-state input. GP appends the clinical verdict after the encounter.	App carries continuity, not clinical authority. It does not diagnose, prescribe, or refer. It prepares the encounter.

The Consultation Packet: the core mechanism

The Consultation Packet — referred to below as the packet — is the structural mechanism that directly addresses the first break. It is a one-page summary generated by the app from the patient's continuity record, presented to the clinician at the start of any encounter.

Clinical signal filter: the packet is not a data dump. It surfaces the highest-signal recent state changes — the most recent clinical verdict, outstanding investigations, medications changed since the last visit, unresolved presentations, and the current symptom episode. A clinician should never need to read the full record to be ready to act. The 60-second rule is a hard constraint, not a guideline: if the packet cannot be read and acted on in under 60 seconds, the feature has failed.

What the Consultation Packet contains (high-level): current symptom event and severity; last clinical verdict and date; active medications and any recent changes; outstanding investigations and pending follow-ups; known allergies and red-flag conditions; patient's self-reported adherence notes. The packet surfaces what is needed for the next decision — not everything that has ever been recorded.

CURRENT ENCOUNTER	REDESIGNED ENCOUNTER
GP opens encounter cold; patient repeats full history; reconstruction consumes the appointment slot	GP reads the packet in under 60 seconds; appointment begins at clinical judgment
Clinical judgment compressed into whatever time remains after reconstruction	Full appointment time available for clinical judgment; GP acts on structured prior state
Outcome not reliably recorded or accessible to next clinician	Outcome appended to patient's continuity record; appears in the next packet

60-SECOND RETRIEVAL RULE

The 60-second rule: if the packet takes longer than 60 seconds for a clinician to read and act on, the redesign has not delivered the mechanism. This is a hard constraint, not a guideline.

Admissibility boundary

At launch, the patient's continuity record is not the official NHS GP record. It is a patient-held operational memory object. Formal NHS recognition is a later migration step — Move 7 in the full Redesign Artifact — not an assumption. The app is useful before formal integration. The app must not require NHS permission to deliver core continuity value.

One-Way Valve: when formal NHS integration begins, NHS systems may push data to the continuity record (SCR updates, discharge summaries). No NHS system may delete, overwrite, or take custody of the patient-held record. The portable record is the patient's property. Institutions are contributors, not owners.

SECTION 6

MINIMUM VALID REPLACEMENT

The redesign is only real if all five of the following exist simultaneously. A deployment missing any one is not a replacement. It is a partial correction inside the old frame.

1. **Patient-held operational continuity record** — portable, persistent, retrievable in under 60 seconds at any point of care
2. **Symptom event layer** — structured upstream symptom capture before the encounter; creates the data the consultation packet draws from
3. **Consultation packet** — one-page structured summary generated before every encounter; clinician reads in under 60 seconds without verbal reconstruction
4. **Outcome append** — post-encounter record of clinical verdict, prescriptions, referrals, and follow-up; appended and preserved for the next encounter
5. **Emergency and carer access modes** — essential fields accessible without authentication for first responders; carer access with explicit role tagging

Recognition pathway toward NHS ingestion (Move 7) is not a minimum replacement condition. The app must be useful before formal NHS integration. NHS integration is Move 7, not Move 1.

MINIMUM REPLACEMENT RULE

If any one of these five is missing, the change is not yet a redesign. It is a partial correction inside the old frame — and the old failure will return.

SECTION 7

WHAT STOPS IMMEDIATELY

Before the redesign can hold, the following must stop. These are preconditions, not optimisation targets.

STOP	WHY
Treating the patient as the default memory carrier without structural support or recognition	The patient performing the memory function is the first structural break. Building the app on top of this assumption replicates the break in a new interface.
Measuring digital programme success by adoption metrics rather than continuity retrieval at the point of clinical decision	Adoption metrics reward documentation volume. The operational test is whether continuity arrives before the clinical decision is made.
Treating discharge summary delays as a communication problem	HSSIB confirmed it is a structural handoff failure. More guidance without enforcement has not resolved it.
Treating ARRS workforce expansion as a continuity improvement	Every additional clinician in the pooled appointment pool further fragments relational continuity. Capacity and continuity are not the same metric.
Treating the NHS health and care passport as patient empowerment	It is a formal acknowledgment that the system cannot surface its own operational memory. Name it correctly before designing around it.
Treating patient-facing apps as a substitute for clinical memory	Patient-facing record access creates an illusion of connectivity while clinical retrieval remains unresolved. It redistributes the burden to the patient rather than correcting the architectural absence.
NHS integration as a prerequisite for usefulness	If the app only works with NHS integration, adoption requires institutional permission. The redesign must be useful before formal recognition. NHS integration is Move 7, not Move 1.

SECTION 8

DEPENDENCY ORDER

The redesign must happen in the correct sequence. Right fixes in the wrong order recreate the failure at a new stage.

MOVE	WHAT HAPPENS	CONSEQUENCE IF SKIPPED
1	Build the truth kernel — the patient onboarding flow and continuity data structure	Later layers inherit an undefined continuity object; the truth kernel cannot be specified retrospectively

MOVE	WHAT HAPPENS	CONSEQUENCE IF SKIPPED
2	Build the symptom event layer — structured upstream sensing before the encounter	Symptom capture produces isolated data points; regulatory exposure without continuity framing
3	Build the packet — one-page structured summary readable in under 60 seconds	The app becomes a health journal the clinician ignores; the encounter is not decompressed
4	Build the outcome append layer — post-encounter record that travels to the next visit	Continuity loop is not closed; the next encounter begins with reconstruction again
5	Build emergency access mode — essential fields without authentication for first responders	The app fails its most critical clinical moment
6	Build carer access mode — delegated continuity support with role tagging	Low-digital-literacy patients excluded; ghost structure recreated in a new form
7	NHS integration pathway — formal recognition without custody transfer (One-Way Valve)	Attempted before the migration signal produces a procurement process without evidence of value

NHS integration is Move 7, not Move 1. The redesign must demonstrate value independently of NHS cooperation before it can migrate toward institutional recognition. Move 7 is deferred until patients are arriving with richer, more usable information than the institutional record provides.

GP adoption: GPs who see app patients begin the appointment at clinical judgment rather than reconstruction. The encounter is more productive for the clinician, not just the patient. The packet does not instruct the clinician; it prepares them. Clinicians do not adopt it because they are required to. They adopt it because it makes the 10-minute slot more usable.

SECTION 9

FAKE PROGRESS TEST

The redesign can be implemented in appearance while the old failure continues in structure. The following conditions confirm the primitive has returned, not that the redesign has succeeded:

> **App exists but GP still reconstructs history at the consultation start**
> *The app is a health journal, not a continuity system.*

> **Clinicians do not read or act on the packet; the encounter is not decompressed**
> *The packet is a document, not a mechanism. The consultation has not changed.*

> **Success measured by downloads and engagement rather than continuity retrieval**
> *Growth metrics reward the audit layer. The operational test is retrieval before the clinical decision.*

> **Patients still repeat their full history as the default**
> *Burden has not moved from people into structure. The proof condition has not been met.*

NHS integration requires custody transfer to the institution

The custody invariant is broken. The redesign has recreated the broken architecture in a new wrapper.

Symptom routing states presented as diagnoses in any surface or communication

The app has entered clinical authority it cannot hold. Legal and regulatory exposure follows.

SECTION 10

CONSEQUENCE OF DEFERRAL

Deferral does not preserve the status quo. It preserves the ghost structure: patients, carers, known GPs, and reception staff continue carrying continuity functions the architecture has not formalised. When any carrier withdraws — when the patient cannot recall their history, when the carer is unavailable, when the known GP has left — the structural failure becomes a clinical event.

The system will continue to regenerate the harm pattern already visible in public evidence: clinical negligence exposure, information-sharing Prevention of Future Deaths warnings, diagnostic delay, patient-carried memory burden, and GP workforce exit pressure. Every digital programme that addresses a downstream symptom without correcting the primitive will stall, be replaced, and leave the same failure in new packaging.

COST CLASS	WHAT CONTINUES WITHOUT PRIMITIVE CORRECTION
Clinical negligence (as established in the Diagnostic Artifact)	£2.8 billion annually; 43.5% of GP indemnity notifications cite failure or delay in diagnosis — the predictable output of an authority node operating on degraded inputs [NHS Resolution CNSGP 2023/24]
Preventable harm (as established in the Diagnostic Artifact)	Coroner Prevention of Future Deaths warnings for information-sharing failures; the same harm pattern repeats because the correction loop does not reach the primitive [Coroner PFD reports, 2024]
GP workforce exit (as established in the Diagnostic Artifact)	Psychological strain of making high-consequence clinical decisions on structurally degraded data; the workforce exit accelerates the relational continuity loss that was masking the failure [RCGP GP Voice Survey, 2024]
Digital programme waste (as established in the Diagnostic Artifact)	Each successive programme adds documentation density without correcting retrieval; NPfIT cost over £12 billion without producing a unified continuity record; the pattern repeats [NAO, 2013]

SECTION 11

PROOF CONDITIONS

Proof is not that the app exists. Proof is not the Go-Live date. Proof is behavioural.

PROOF CONDITION

Same pressure → different response. The redesign is real only when, under the same workload and patient complexity, the patient no longer repeats their history, the GP begins at clinical judgment rather than reconstruction, and the outcome is preserved for the next encounter.

Before redesign begins: baseline measurements must be captured — patient history repetition rate, GP consultation time on verbal reconstruction, discharge summary arrival rate before follow-up, carer diary maintenance rate. Without a baseline, same-pressure / different-response cannot be demonstrated.

The redesign is confirmed when all of the following hold:

- → Patient arrives with the packet; GP reads in under 60 seconds; appointment begins at clinical judgment
- → Patients no longer routinely repeat their full history at each encounter
- → **The system functions when the patient cannot tell the story:** an unconscious patient, an acutely distressed patient, a patient with cognitive impairment — the continuity object is accessible through emergency mode, carer access, or the printed emergency card. The redesign is not complete until it holds in the hardest case.
- → **Ghost structure migration:** carers are no longer maintaining separate health diaries as the primary continuity mechanism; the outcome append layer has made the parallel diary unnecessary. The ghost structure dissolves when its labour becomes avoidable.
- → Outcome is appended after each encounter and appears in the next consultation packet without the patient needing to reconstruct it
- → Emergency access mode provides essential fields to first responders without authentication; the printed emergency card or lock-screen QR provides an analog bridge for patients without phones or when the device is unavailable
- → **Analog inclusion:** digitally excluded, elderly, and cognitively impaired patients receive the same continuity benefit through carer-assisted mode, printed packet at the practice, PDF export, or emergency card. These are minimum replacement conditions, not optional features.
- → High-signal patient populations — repeat presenters, post-discharge patients, multi-morbidity — show measurable continuity improvement, not only digitally confident early adopters

SECTION 12

BOARD VERDICT

BOARD VERDICT

Replace the fragmented institutional record architecture with a patient-held operational continuity system. The patient holds custody. The system carries memory and preparation. The clinician carries authority. The Consultation Packet arrives before the encounter. The outcome is appended after it. Institutions may later recognise or ingest the record, but they do not own the continuity primitive. The redesign is real only when patients no longer repeat their history as the default — and when the system functions even when the patient cannot tell the story.

WHAT THIS DEMONSTRATES

This executive summary demonstrates what a structural replacement specification for NHS primary care continuity failure produces and how this practice approaches primitive-level systems failure. The full Redesign Artifact sits underneath it with complete builder specification and governed transition logic. This public summary is not sufficient for implementation. It demonstrates the replacement logic while withholding the restricted transition sequence, invariants, drift immune system, admissibility conditions, and builder-level architecture.

Delivery model: this redesign is specified independently of delivery model. The continuity object must remain open and non-proprietary. Patient ownership of data and vendor-neutral continuity are non-negotiable regardless of who builds or operates the system.

Source note: quantitative claims in Section 10 (Consequence of Deferral) are drawn from the Diagnostic Artifact, which sources them to NHS Resolution CNSGP 2023/24, Coroner Prevention of Future Deaths reports (2024), RCGP GP Voice Survey (2024), and NAO (2013). This executive summary introduces no independent quantitative claims.

Access to the restricted Redesign Artifact is available by direct enquiry. The full artifact contains the complete transition sequence, rules and invariants, drift immune system, admissibility conditions, successor trap analysis, builder handoff with object-level specifications, and automated testability requirements. To discuss access or how this diagnostic and redesign methodology applies to your organisation, contact:

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Prepared by Jamie Forrester, Independent Systems Architect, Edinburgh, UK. Produced independently — not commissioned by the NHS, NHS England, DHSC, or any associated body. Derived from the Diagnostic Artifact (public) and the full Redesign Artifact (restricted). Introduces no independent claims beyond those established in the Diagnostic Artifact.