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The Architectural Question

A Strategic Brief on the NHS Federated Data Platform Contract Review — Spring 2027

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Executive Summary

The NHS Federated Data Platform contract is scheduled for review at its three-year break clause in spring 2027. Between now and that decision, the coalition opposing the platform has reached a scale and substance the government cannot dismiss. The 16 April 2026 Hansard debate produced thirteen MPs across five parties calling for contract review. Greater Manchester ICB has now twice refused to adopt the platform. NHS Analysts Together's open letter of May 2026 placed the system's own data professionals in formal opposition. Over 50,000 patients have written to local trust boards. The Financial Times reported in April 2026 that government ministers had sought advice on triggering the break clause, with one senior figure stating "we are confident we could do it if we wanted to." Foxglove, Medact, the Good Law Project, Privacy International, Corporate Watch, Amnesty International, the BMA, the Doctors' Association UK, Just Treatment, and the National Pensioners Convention have built infrastructure of analysis, litigation, and political pressure that the coalition's adversaries cannot match.

This brief is not addressed to what the coalition already knows. It is addressed to the question of how the next twenty-one months unfold, and where the analytical ground may need to be held against the government's most likely counter-moves. Three arguments are developed.

The first argument is that the contract relationship is not bilateral. The conventional framing — NHS as buyer, Palantir as supplier, the question being whether the relationship serves the NHS well — misses the third party whose interests are most at stake and whose voice is structurally absent. Patients are the data subjects whose records, conditions, treatments, and outcomes constitute the resource the system processes. The NHS holds the formal authority of a data controller and accountable public institution, but it lacks the technical capacity to audit the platform on which it depends, and lacks the operational independence to exit it. The institution best positioned to defend patient interests is also the institution whose own dependency on the platform makes that defence structurally compromised. This is the institutional pathology that the procurement frame cannot reach. It is also why "the NHS should choose differently" is not, on its own, a sufficient demand.

The second argument is that the architectural lock-in is structural and not contingent. Liberal Democrat MP Martin Wrigley made the legal core of this argument in Parliament on 16 April: "The current contract delivers a subscription service that leaves no deliverables after the subscription — no software, no improvements and no intellectual property after spending more than £330 million. All the specially written software and intellectual property rights belong to the supplier, says the contract. All the rights to any know-how are explicitly retained by the supplier and not passed across on termination of the contract. The contract delivers no software — not one line — just a subscribed service; a permanent lock-in; a single point of failure." This brief develops the institutional consequence of that contractual structure. Clause 17 of the Services Agreement and Schedule 8.5's exit provisions are formally present but architecturally inoperable, because exit requires the technical cooperation of the entity from which exit is being attempted. The Foxglove report of June 2023, "The NHS Federated Data Platform and Palantir: 7 Key Risks," documented the empirical conditions — over 3,000 vacant NHS tech roles, Palantir consultants

embedded across the system, Foundry-specific expertise existing only inside Palantir. The lock-in is not procurement failure to be repaired by procurement reform. It is the operational signature of architectural capture.

The third argument is that the existing oversight mechanisms have produced the appearance of accountability without producing accountable outcomes, and that this pattern will repeat at the break clause unless the coalition pre-empts it. The Information Commissioner's Office investigated and NHS England missed the statutory disclosure deadline regardless. The Good Law Project litigated and a partially-unredacted contract was published while substantial sections remained hidden, and the platform rolled out on schedule. Parliament debated and the contract proceeded unchanged. The BMA passed motions of no confidence and by February 2026 was reduced to urging individual doctors to refuse non-direct-care usage — a tactical retreat that conceded the institutional channels had produced no structural change. Every oversight mechanism activated. None of them altered the outcome. The strategic implication is that the government's most likely response at the break clause will be additional oversight mechanisms designed to repeat this pattern: new advisory boards, new transparency commitments, new audit arrangements, presented as substantive concession. The distinction between oversight as performance and oversight as function is the analytical category by which the coalition can evaluate the government's announcement when it comes.

A forecasting framework follows the three arguments. It names the most probable trajectory the next twenty-one months will follow, the observable indicators by which the trajectory can be tracked, and the variables that move the system between trajectories. It does not assign numerical probabilities because the variables that matter most — a triggering data-protection incident, a court ruling that alters the legal landscape, the timing of NHS England's dissolution into DHSC and the contract-governance implications of that reorganisation — are not amenable to confident probabilistic estimation. Structured qualitative scenarios with explicit indicators are the honest analytical product. Tracked predictions with explicit falsifiers and resolution criteria are recorded at the brief's close.

How this brief sits alongside coalition work

The coalition has been building the case against the contract for three years. Foxglove's June 2023 report identified seven key risks (flawed procurement, growing scope, secrecy and failure to design for patient consent, over-centralisation, monopoly lock-in, Palantir's reputation, failed pilots) and proposed alternatives. Medact's March 2026 briefing extended this to broader institutional risks, including the role of vendor lock-in in undermining local decision-making, and the documented refusal of multiple trusts to comply with rollout. The Good Law Project forced partial unredaction of the contract and exposed the negotiations that continued after signing. Corporate Watch produced FOI-based research documenting trust-level resistance and the displacement of locally-built systems. Privacy International has worked the surveillance and cross-departmental data-sharing risks. Amnesty International has named Palantir as complicit in human rights abuses. The BMA, Doctors' Association UK, Just Treatment, the National Pensioners Convention, and No Palantir in the NHS have built clinical, patient, and grassroots opposition.

This brief is intended as analytical complement, not correction. The three arguments below build on, rather than around, the coalition's existing work. The triangular structure analysis extends Foxglove's lock-in risk by locating the institutional pathology that makes lock-in self-reinforcing. The architectural-capture analysis develops the specific contractual and technical mechanisms behind Wrigley's parliamentary framing, drawing on Foxglove's documentation of the NHS technical capacity gap. The oversight-as-performance analysis names a pattern the coalition has observed empirically — investigations producing no outcome change, litigation producing partial transparency without structural change — and gives it analytical form against which the government's likely break-clause response can be evaluated.

The forecasting framework that follows is intended as shared analytical infrastructure for the twenty-one months ahead, not as prescription for tactics. The coalition has tactical knowledge this brief does not. What the brief offers is a structured way to track which trajectory is materialising and to recognise the government's framing moves when they come.

The triangular structure

The most common framing of the FDP relationship treats it as bilateral: the NHS contracts with Palantir for software, and the question is whether the relationship serves the NHS well. This framing is conventional, and is the frame within which the junior health minister Ashley Dalton's 16 April parliamentary response operated. It is also incomplete. The actual relationship is triangular.

Palantir provides the platform infrastructure. The NHS mediates access to that infrastructure on behalf of patients whose data flows through it. Patients are the subjects whose records, conditions, treatments, and outcomes are processed. The NHS sits in the middle position. It holds the formal authority of a data controller and the legal accountability of a public institution. It lacks the technical capacity to audit the platform on which it depends, and lacks the operational independence to exit it.

This middle position generates a specific institutional pathology. The NHS has more agency than a passive subject — it signed the contract, retains formal data controllership, and could in principle terminate the arrangement. It has less oversight capacity than a regulator — it cannot audit the proprietary Foundry architecture, depends on Palantir personnel to operate the system, and faces an asymmetry of technical knowledge that grows with every month of operation. It is structurally trapped between formal authority and substantive dependence.

The strategic implication is that arguments addressed to the NHS as a sovereign institution presume an agency the NHS no longer possesses. Letters to trust boards and integrated care boards remain necessary tactical pressure, and Greater Manchester ICB's continued refusal demonstrates that local-level pressure can produce real institutional outcomes. But trust-level resistance addresses the symptoms of the dependency, not the architecture that produces it. The architecture has to be addressed at the level of contract structure, parliamentary scrutiny, and judicial review — the bodies that retain external agency over the platform decision.

The triangular framing also reframes patient consent. The conventional account treats consent as the relationship between patients and the NHS — patients consent to NHS data use, the NHS holds the data, patients can opt out via the National Data Opt Out. The triangular account makes visible that patients are not consenting to NHS data use in any recognisable sense. They are consenting to an arrangement in which the NHS mediates access to a platform whose operations the NHS itself cannot fully observe. The IG Framework's five approved use cases may be honoured. They may also constitute the visible surface of operations the NHS lacks the proprietary-Foundry expertise to verify. No external body possesses the technical capacity to determine which. The opt-out is formally available. The information against which a meaningful opt-out decision could be made is not.

A consequence follows for the campaign's strategic positioning. The conventional consent reform — better patient communication, granular choice, clearer language — addresses a problem that is real but secondary. The deeper consent problem is that patients are being asked to consent to an arrangement they cannot in principle verify, by an institution that itself cannot verify it. Improving the consent interface does not change this. The architectural opacity is the consent problem.

Architectural capture

The strongest defence of the FDP procurement is that competition operated. Oracle and IBM bid. A UK consortium — Voror Health Technologies, Eclipse, and Black Pear — developed an alternative bid. Regional NHS platforms (OpenSAFELY, DARE UK, London's existing data-sharing infrastructure) offered alternative architectures. The procurement process selected Palantir over competing options. From the perspective of conventional procurement reform, this is a system that worked, even if one disagrees with the selection.

The defence holds only if competition continues to operate after adoption. It does not. The platform architecture eliminates the conditions under which competing options can apply pressure on the incumbent.

Martin Wrigley named this in Parliament on 16 April. The contract, he told MPs, "delivers no software — not one line — just a subscribed service; a permanent lock-in; a single point of failure." The "no software" framing is contractually precise. The Services Agreement establishes (Clause 17) that Palantir retains intellectual property rights in Foundry. The NHS owns the Canonical Data Model — but the model is built on top of Foundry. After £330 million and seven years of contracted operation, the NHS will own the data inputs and a set of derived data structures, but it will not own the platform, the software, or the institutional knowledge required to operate them. The contract is a subscription to capability, not an acquisition of it.

The five anti-lock-in measures NHS England identified at contract signing — incremental three-year commitments with extension options, cloud-based architecture not integrated into core systems, data export at any time, in-house skills development through a Centre of Excellence, and a multi-vendor Solution Exchange — each addressed a real risk on paper. Each has been structurally undermined by the platform's actual operation.

The break-clause structure assumes that the moments at which the NHS can choose to leave are genuine decision points. They are not. The cost of invoking exit escalates with every month of operation. Wrigley's own data, presented in the April debate, illustrates the problem from the inside. The initial three-year Palantir contract called for thirteen core capabilities and has delivered three or four, partially. Approximately two hundred NHS trusts have announced plans to join the FDP; roughly half are live; only a quarter report benefits from the system. This is not the deployment pattern of a system that the NHS is on track to internalise and replace at the break clause. It is the deployment pattern of a system that is becoming load-bearing at the local level even as it underperforms at the national level. Each operational dependency that accumulates is a sunk investment that makes the next exit decision more expensive.

The junior health minister Ashley Dalton's parliamentary formulation in April 2026 — that the break clause would be activated "if we evaluate and we find that there are other providers that can do the job better" — concedes the trap. The question at the break clause is not whether the NHS wishes to leave. It is whether a superior alternative exists, which by spring 2027 will be structurally difficult to demonstrate

because the comparative infrastructure has not been maintained during the lock-in period. The minister's framing presumes the institutional choice still exists in a form the architecture has been steadily eliminating.

The claim that the platform is "not integrated into core systems" is technically accurate and analytically misleading. Patient record systems remain the primary clinical record. The FDP sits on top of those systems, drawing their data and producing the analytics that trusts use to make operational decisions. The clinical record describes what has happened to a patient. The platform decides what happens next. Integration into decision-making is more consequential than integration into recording. Palantir's own marketing makes the point. Foundry is presented as "the operating system for the modern enterprise" — the substrate within which the organisation operates, not a peripheral analytical tool. A system that operates as institutional infrastructure cannot be characterised as a peripheral application.

The technical mechanism that distinguishes the FDP from ordinary enterprise software dependency is the platform's proprietary data architecture. Foundry organises NHS data through a proprietary layer that maps raw datasets into the operational objects — patients, discharges, bed states, care pathways — through which clinical and administrative decisions are executed. Pipelines, access controls, analytical logic, and governance rules are all defined against this layer, which is itself defined within Foundry's own framework. The NHS owns the data. The architectural meaning the data acquires inside Foundry is proprietary to Palantir. Migrating data out of Foundry is therefore not equivalent to switching telecoms vendors or replacing a clinical system. The data exports. The operational meaning it has acquired inside the platform does not.

The contractual exit right confirms the dynamic. Clause 33 and Schedule 8.5 establish formal exit provisions. The right to exit the contract is present. The right to exit the architecture is not. Exit requires reconstructing within a replacement system the entire operational meaning the data has acquired inside Foundry. The NHS does not have the in-house technical capacity to execute that reconstruction. The Foxglove report documented over 3,000 vacant NHS tech roles while Palantir consultants are embedded across the system. Exit from the FDP requires the cooperation of the entity from which exit is being attempted, because only Palantir's own staff have the expertise to unwind the integration. Needing the incumbent in order to leave the incumbent is the operational signature of architectural capture.

This is not analogous to ordinary outsourcing dependency. In conventional vendor relationships — defence equipment procurement, payroll systems, infrastructure maintenance — a dissatisfied buyer can engage a third party to manage the switch. The replacement vendor has equivalent expertise and the incumbent's cooperation is not technically required. In the FDP case, no third party possesses Foundry-specific expertise because Foundry is proprietary. The architectural opacity that the existing campaign critique correctly identifies as a transparency problem is also the structural condition that makes exit impossible. The two issues are not separable.

The Solution Exchange — promoted as evidence of multi-vendor competition through third-party applications built on the platform — operationalises the opposite of competition. Each third-party application built on top of Foundry deepens the NHS's investment in the underlying platform architecture.

The logic mirrors the smartphone application ecosystem: the more applications built on the operating system, the more indispensable the operating system becomes. The language of multi-vendor competition conceals the reality of architectural consolidation around a single proprietary substrate.

The implication for the break-clause decision is structural. Any framing that treats the decision as a choice between renewal and termination assumes a binary that the architecture has been eliminating. The realistic options at spring 2027 are: continuation with cosmetic safeguards (the path of least administrative resistance, against an architecture that the government has explicitly framed as evaluable on vendor-comparison grounds), or staged exit with explicit reconstruction of UK sovereign capability (the only path that addresses the architectural capture). The Financial Times reported in April 2026 that ministers had sought advice on triggering the break clause, with one senior figure stating “we are confident we could do it if we wanted to.” Whether the political will materialises depends on variables outside the coalition’s direct control. What the coalition controls is the framing within which the decision is publicly evaluated. Naming the architectural capture explicitly, and distinguishing exit-as-vendor-swap from exit-as-architecture-reconstruction, is the precondition for the political will to translate into a decision that actually alters the structure rather than performing alteration.

Oversight as performance, oversight as function

A sceptical reading of the campaign against the FDP might note that the standard accountability mechanisms have activated. The Information Commissioner's Office investigated. The Good Law Project mounted legal challenges and forced partial unredaction of the contract. Parliamentary Select Committees took evidence. The BMA passed motions of no confidence. The 16 April 2026 Hansard debate produced thirteen MPs across five parties speaking against the contract. Greater Manchester ICB has twice formally refused to adopt the platform. The Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee considered formal questions about Palantir adoption in February 2026. Each mechanism has operated as designed.

The system has performed accountability. It has not produced accountable outcomes.

The ICO investigated and NHS England missed the statutory deadline for full disclosure regardless. Parliament debated and the contract proceeded unchanged. The Good Law Project litigated and a partially-unredacted contract was published with substantial sections still redacted, while the platform rolled out on schedule. The BMA's chair of council, by February 2026, was reduced to urging individual doctors to refuse non-direct-care usage — a tactical retreat that conceded the institutional channels had produced no structural change. Every oversight mechanism activated. None of them altered the outcome.

The pattern matters strategically because it allows the coalition to predict the government's most likely response to break-clause pressure. The response will not be straightforward contract termination. Even if ministers privately conclude that exit is technically feasible — as the FT reporting suggests some have — the public path of least resistance is additional oversight presented as substantive concession. New advisory boards. New transparency commitments. New audit arrangements. New public-facing dashboards. A revised information governance framework. Each will be presented as a substantive response to coalition concern.

Each can be evaluated against the baseline the existing oversight pattern establishes. A genuine concession alters the contract architecture. A performance of accountability leaves the architecture intact while creating new visible mechanisms that produce the appearance of substantive change. The distinction is not abstract. It is the basis for evaluating the government's break-clause position when it comes. The coalition's pre-positioning of language that names this distinction — before the government's announcement — gives the analysis the framework against which the announcement is read, rather than having to construct the framework reactively.

A second strategic implication follows. The opacity that the campaign correctly identifies as a transparency problem also functions as protection for the architecture. If Parliament could see the unredacted contract, it could assess whether exit is viable. If patients could see how the platform actually operates, the consent architecture could not function. If oversight bodies could audit Foundry's internal operations, the verification problem at the heart of the contextual breach would be soluble. The redactions are not implementation errors. They are constitutive of the system. Commercial confidentiality is not a bug

in the FOI regime as it applies to public-sector contracts. It is a feature that the architecture relies on. This is why partial unredaction under legal pressure does not solve the transparency problem. The architecture survives partial transparency. It would not survive full transparency, which is precisely why full transparency does not occur.

The institutional reorganisation underway adds a further dimension. NHS England is being absorbed into the Department of Health and Social Care over 2025–2027. The contract that was awarded by a quango will be administered by a department of state at the moment of its break-clause decision. The data-controller question that Medact's March 2026 briefing flagged — who controls the data, and with what protections, after the merger — is unresolved. The coalition's analytical work over the next twenty-one months will need to address the architectural question across a moving institutional landscape, in which the body that signed the contract no longer exists in the form that signed it.

What spring 2027 will look like

The framework below names three trajectories for the contract decision and the observable indicators by which each can be tracked. Probabilities are deliberately not assigned. The variables that matter most over the next twenty-one months — a triggering data-protection or operational incident, a court ruling that alters the legal landscape, the timing and politics of the NHS England absorption into DHSC, the broader political position on technology sovereignty, the relative strength of cross-departmental ministerial alliances — are not amenable to confident probabilistic estimation. What can be done usefully is to name what each trajectory looks like from the inside and to identify the indicators that distinguish them in real time.

Continuation with cosmetic safeguards

This is the path of least administrative resistance. The contract is renewed at the break-clause date, framed as a difficult but necessary continuation. Renewal is accompanied by new oversight mechanisms designed to perform accountability without altering the architecture: an expanded advisory board, new transparency commitments around use cases, a revised information governance framework, possibly an independent audit arrangement with limited Foundry access. The new mechanisms are presented as substantive concessions to public concern. The contract architecture continues unchanged.

Observable indicators that this trajectory is materialising: continued ministerial framing of the contract as essential to NHS operational performance; defence of the contract on conduct-of-Palantir grounds (denial of misuse) rather than architecture grounds; new oversight announcements positioned as responsive to coalition demands; absence of any explicit ministerial commitment to UK sovereign capability development; absence of any visible Cabinet Office work on retender preparation; continued pattern of partial transparency concessions under legal pressure; FOI responses that defer rather than disclose; trust-level adoption metrics presented as success indicators without independent verification.

What moves the system away from this trajectory: parliamentary committee evidence that names architectural capture rather than vendor conduct; a high-profile clinical or patient-trust incident that the existing oversight mechanisms cannot defuse; cross-departmental Cabinet Office work on UK sovereign capability that becomes visible before the break clause; substantial whistleblower disclosure from NHS England, DHSC, or trust-level analytical staff; a court ruling that compels full contract disclosure or finds the procurement procedurally unlawful; further successful trust-level refusals that demonstrate the architecture is not load-bearing.

Staged exit with retender for UK sovereign architecture

This trajectory involves activation of the break clause with explicit retender for a UK consortium or NHS-led architecture. The exit is structured over a multi-year transition, not an immediate termination, in recognition of the architectural reconstruction required. The retender explicitly addresses sovereign

capability development and proprietary architectural risk. Dawn Butler's parliamentary intervention in April 2026 — "we must ask ourselves whether Palantir allows us to have AI and data sovereignty; I think the answer to that will be no" — names the framing this trajectory requires. Patrick Vallance's parallel commitment to "do something very different in the future" places a senior cross-departmental figure in alignment with the sovereignty framing.

Observable indicators that this trajectory is materialising: ministerial language shifts from "alternative vendors" to "UK sovereign capability"; visible Cabinet Office or Department for Science, Innovation and Technology work on retender architecture; parliamentary cross-party motion (rather than party-political division) demanding structured exit; senior NHS England personnel changes consistent with architectural reconsideration; Treasury engagement with the long-term cost of architectural lock-in rather than the short-term cost of exit; explicit governmental commitment to building rather than buying sovereign data infrastructure; the FT-reported "we are confident we could do it if we wanted to" position consolidating into a stated policy direction rather than a private ministerial calculation.

What moves the system into this trajectory: continued operational failure of the FDP (the existing pattern of trust-level adoption resistance, the gap between the thirteen contracted capabilities and the three or four partially delivered); successful Good Law Project litigation that produces a court ruling on contract terms rather than further partial transparency; substantial Whitehall realignment on technology sovereignty post-2025; coordinated coalition pressure that maintains the political cost of renewal above the political cost of exit; the NHS England-to-DHSC reorganisation producing a moment of contract reconsideration as part of the broader institutional restructure.

Full contract termination

This trajectory involves activation of the break clause with immediate full termination, accompanied by UK consortium retender or NHS-led architecture development. The platform is wound down over a defined transition period. It requires either a triggering event of sufficient severity to make continuation politically untenable, or a sustained sovereignty framing that converts coalition pressure into a clear cross-party position.

Observable indicators: a major operational, data-protection, or cross-departmental access incident that the existing oversight mechanisms cannot contain; a court ruling that the contract is procedurally unlawful or that NHS data flows under the platform breach the lawful basis the IG Framework asserts; cross-party majority in both Commons and Lords explicitly demanding termination; a senior governmental figure (Cabinet Office minister, Secretary of State, Prime Minister) making termination a stated policy position; visible budget commitment to UK sovereign capability development as immediate replacement; sustained adverse coverage from the Financial Times, Guardian, and Economist that converts the political cost of continuation into electoral risk.

What moves the system into this trajectory: a documented case of cross-departmental data sharing through the platform that exceeds the IG Framework's stated use cases; a Reform-aligned political environment in which the cross-departmental data access risk Medact's briefing flagged becomes politically salient; sustained patient opt-out volume growth that materially degrades the dataset's value; whistleblower disclosure of contract-breach evidence.

Reading the indicators

The three trajectories share most indicators in inverse. What distinguishes them is direction of movement on a small number of variables: ministerial language (vendor-comparison versus sovereignty); Cabinet Office and DSIT activity (silent versus visible); judicial decisions (procedural-transparency versus architectural-substantive); cross-party position (party-political versus cross-party); incident salience (managed versus uncontained). The coalition's framing infrastructure determines, in real time, which of these variables the analytical conversation focuses on. An incident framed as Palantir misconduct fits the continuation trajectory's logic. An incident framed as architectural capture or sovereignty failure fits the exit trajectories. The framing the coalition consistently uses now will determine how the variables, when they crystallise, are received.

Tracked predictions

These predictions resolve in defined windows and carry explicit falsifiers, so the analytical framework can be evaluated against subsequent events rather than relying on impressionistic assessment.

ID	Prediction	Resolution	Falsifier
FDP-P1	The Palantir FDP contract is renewed at the spring 2027 break clause without explicit structured-exit framework	Spring 2027	Contract terminated, or staged-exit framework announced as government position
FDP-P2	Any continuation announcement is accompanied by new oversight mechanisms (advisory board, transparency commitments, governance framework revision, audit arrangement) presented as substantive concession	Spring 2027	No new oversight mechanisms, or oversight presented as continuation rather than concession
FDP-P3	Government framing in the lead-up to the decision references “alternative vendors” rather than “UK sovereign capability” in ministerial statements from the Department of Health and Social Care	Spring 2027	Ministerial framing from DHSC shifts to sovereign-capability language
FDP-P4	Greater Manchester ICB continues to refuse FDP adoption through the contract review period	Spring 2027	Greater Manchester ICB adopts the FDP or moves to formal negotiation toward adoption
FDP-P5	At least one additional ICB joins Greater Manchester in formal non-adoption position before contract review	Spring 2027	No additional ICB takes formal non-adoption position
FDP-P6	Patient opt-out volume continues to rise from the 3.3 million baseline of 2024, with rate of increase accelerating in the twelve months	Spring 2027	Opt-out volume plateaus or rate of increase slows

ID	Prediction	Resolution	Falsifier
	preceding the break clause		
FDP-P7	The NHS England-to-DHSC absorption is completed before the break-clause decision, and the contract-governance question (data controller status, contract administration responsibility) is resolved in DHSC’s favour without coalition input	Spring 2027	Reorganisation incomplete at break clause, or contract-governance question subject to formal coalition consultation
FDP-P8	At least one further court ruling (Good Law Project or successor litigation) produces additional partial disclosure of contract terms before the break clause	Spring 2027	No further judicial decision on FDP contract disclosure, or full unredaction achieved

Each prediction carries a defined resolution window and an explicit falsifier. The framework can be evaluated against subsequent events. The DAEPOLIS canonical-claim ledger records resolutions publicly with Brier-score aggregation, allowing the analytical infrastructure to be assessed for calibration over time rather than treated as a one-time output.

Sources

Parliamentary records: House of Commons Hansard, 16 April 2026, debate on NHS Federated Data Platform, including statements from Martin Wrigley MP, Seamus Logan MP, Dawn Butler MP, Jeremy Corbyn MP, and Ashley Dalton MP (Parliamentary Under-Secretary of State for Health and Social Care); written ministerial responses from Patrick Vallance, Minister of State for Science, Research and Innovation.

Contract documentation: NHS England Award Notice for Federated Data Platform and Associated Services contract (November 2023); partially-unredacted Services Agreement and Schedules (republished March 2024 under legal pressure from the Good Law Project); NHS England Federated Data Platform Contract Explainer (2023); NHS England Federated Data Platform Information Governance Framework (2024).

Coalition materials: Foxglove, *The NHS Federated Data Platform and Palantir: 7 Key Risks* (June 2023); Medact, *Concerns Regarding Palantir Technologies and NHS Data Systems* (March 2026); Good Law Project legal proceedings on FDP procurement (2024 onward, including pre-action correspondence and the secured partial unredaction); Corporate Watch FOI-based research on FDP rollout and trust-level resistance (August 2025); NHS Analysts Together open letter (May 2026); Joint statements from Just Treatment, Doctors' Association UK, BMA, National Pensioners Convention, Privacy International, and Amnesty International (2023–2026).

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