NHS England

Mr Andrew Cox
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1 July 2025

Dear Mr Cox,

Re: Regulation 28 Report to Prevent Future Deaths – John Stephen England who died on 15 March 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 9 May 2025 concerning the death of John Stephen England on 15 March 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to John's family and loved ones. NHS England are keen to assure the family and yourself that the concerns raised about John's care have been listened to and reflected upon.

Your Report raises concerns around whether the Advanced Medical Priority Dispatch System (AMPDS) is sufficiently nuanced to distinguish between different types of abdominal complaints and to ensure that those who need to be recognised as a surgical emergency receive a disposition resulting in a patient being conveyed to hospital within an appropriate timeframe.

My response to the Coroner has been supported by NHS England's National Ambulance Team.

NHS ambulance services are required to process 999 calls through an approved triage system. There are currently two systems approved in England for primary 999 assessments; NHS Pathways and the AMPDS. The systems are used to prioritise 999 calls received into the Ambulance Services' Emergency Operations Centres (EOCs). South Western Ambulance Service NHS Foundation Trust (SWASFT) uses the AMPDS system under licence from Priority Dispatch Corp (PDC).

The primary purpose of triage is to quickly identify priority symptoms (e.g. unconsciousness, difficulty breathing, chest pain) and assign a response priority. The outcome (disposition) reached following the initial assessment must be mapped to approved, contracted standards. There is a requirement to map these outcomes to the various categories (Categories 1 to 5) set out within the NHS Constitution and ambulance service 999 contracts. In the case of abdominal pain, the Abdominal Pain Protocol seeks signs, symptoms, and history that may be related to the conditions of aortic aneurysm, myocardial infarction, and ectopic pregnancy. Patients with signs or

symptoms of severe blood loss, such as a decreased level of consciousness, fainting or near fainting, or an ashen/grey colour, are prioritised. Moreover, patients within a common cardiac age range (patients aged 35 years and older) are further assessed and coded based on their age and the location of the pain. However, whilst the AMPDS system's Abdominal Pain Protocol is able to identify and prioritise based on priority symptoms, triage systems are not designed to make differential diagnoses that would require additional visual, historic and diagnostic information that cannot be provided via telephone triage.

In John's case, the call was determined as a Category 5 response following initial triage. This response category identifies patients who do not necessarily require an immediate emergency ambulance response and may be suitable for management via an alternative care pathway. In such cases, where the response required by the patient is not immediately clear from the triage outcome, ambulance services have other clinical approaches that they can initiate, including the use of clinical assessment, as a means of trying to elicit further clinical detail over the telephone than was initially the case at the point of initial triage. Category 5 therefore is not an inferior response, but rather an opportunity to identify any additional information that may allow for a better patient outcome than the rapid dispatch of an ambulance resource on scene.

Patients should receive a timely enhanced clinical assessment to determine the most appropriate outcome. There should be robust clinical oversight of patients awaiting enhanced clinical assessment to ensure allocation to a clinician in a timeframe appropriate to their clinical need. The clinical assessment may still result in the call being upgraded by the clinician to, for example, an ambulance response, and a resource dispatched accordingly. John's call was clinically navigated and assessed as being suitable for further assessment, which was carried out by a Clinical Advisory Service 2 hours and 17 minutes following the initial call and a Category 2 ambulance response was then requested.

During this clinical assessment, the patient's current condition should be explored as well as considering the past medical history to be able to determine if an ambulance response is required. At the conclusion of the clinical assessment, additional information can be provided by the clinician to the caller about what actions to take if the patient's condition appears to be worsening or there are any other concerns. Individual ambulance services should have appropriate processes in place to facilitate the timely clinical navigation and validation of all calls that require further clinical assessment. It is critical that services consider their clinical navigation and validation timescales and processes in full to prevent patients from experiencing delays in receiving clinical assessment to identify the appropriate outcome required to meet their clinical needs.

On review of the specific concerns in this case, there are two aligned triage system/clinical coding and oversight groups that are engaged by NHS England:

- Within NHS England, the mapping of triage outcomes to response categories is undertaken and reviewed by an expert group which makes recommendations to the NHS England Emergency Call Prioritisation Advisory Group (ECPAG) for implementation across all NHS ambulance service providers. This provides a governance framework to ensure appropriate prioritisation, equity of access

and uniformity of response across the English Ambulance Services. The production, maintenance, review and revision of the categorisation dataset is the responsibility of NHS England. However, engagement with the ambulance sector within England, including SWASFT, along with reviews triggered by Coroners and patient safety concerns more generally, have a vital role in providing information, robust clinical evidence, and expert advice to NHS England regarding the categorisation dataset and the prioritisation of emergency calls.

- As regards to SWASFT being users of the AMPDS system, the Priority Dispatch Corp (PDC) is responsible for and manages the commercial international AMPDS system, including making any changes to the protocols and questions asked. This may be on the basis of a recommendation from NHS England's ECPAG, or as part of PDC's own improvement and triage development work, which draws on its international user base.

To respond directly to the Coroner's concerns on abdominal pain, NHS England has obtained the specific details of this case from SWASFT, which will be discussed within the NHS England AMPDS clinical coding sub-group, in collaboration with PDC, to determine if there are opportunities to improve the assessment and differentiation of abdominal pain presentations within the AMPDS triage system. NHS England has additionally shared the Coroner's concerns with PDC, who have outlined that they welcome the opportunity to review any dispatch-specific, non-visual interrogation suggestions to further improve the discovery of surgical emergencies associated with the compliant of abdominal pain.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of John, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

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Co-National Medical Director
(Secondary Care)