

Ms. Victoria Davies

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National Medical Director

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15th September 2026

Dear Ms. Davies,

Re: Regulation 28 Report to Prevent Future Deaths – Sheila Bastedo who died on 13th February 2026.

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 24th June 2026 concerning the death of Sheila Bastedo on 13th February 2026. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Sheila’s family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Sheila’s care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to Sheila’s family or friends. I realise that responses to Coroners’ Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your Report raised the following concerns:

1. Advice given by the ambulance service, following NHS Pathways, is inconsistent with the NICE guidelines on management of neutropenic sepsis.
2. The NHS Pathways does not appear to take into account recent chemotherapy and the risk that this poses.
3. Advice to contact a GP within an hour does not take into account the availability of a GP, and does not provide advice about what to do if a GP could not be contacted within an hour, for example to go to hospital.
4. The NHS Pathways tool does not support giving advice for a patient to attend hospital themselves, if they are able.

In summary, you were concerned that advice given following use of NHS Pathways led to a delay in Sheila attending hospital.

NHS England has reviewed the chronology of Sheila's care contained within the disclosure bundle, the relevant NICE guidance, the clinical content and functionality of NHS Pathways, and the wider urgent and emergency care arrangements.

Our review did not identify a deficiency in NHS Pathways or an inconsistency between its clinical content and NICE guidance. It did, however, identify opportunities to improve continuity across the wider system, particularly how specialist advice and predetermined management plans are made visible between services.

This aligns with existing work on the Single Patient Record, including the unscheduled, urgent and emergency care use case for people with known conditions and risk factors.

Our response

1. Consistency of NHS Pathways with NICE guidelines on Neutropenic Sepsis

The NICE Clinical Guideline on Neutropenic Sepsis ([CG151](#)) recommends that patients receiving anticancer treatment who become unwell and are suspected of having neutropenic sepsis are referred immediately for assessment in secondary or tertiary care.

NICE provides evidence-based recommendations for clinical management but does not prescribe the operational route by which that assessment should be reached. The appropriate route will depend upon the patient's clinical presentation and any existing specialist arrangements for their care.

NHS Pathways supports this in two ways. It assesses whether the patient has symptoms requiring an emergency ambulance response. Where emergency ambulance transport is not indicated, it also allows a call handler to follow a predetermined management plan—for example, directing the patient to their specialist cancer hotline or reinforcing earlier advice to attend the Emergency Department—where that plan is communicated by the caller or otherwise visible to the service.

In this case, Sheila had contacted the Clatterbridge Cancer Centre hotline before the 999 call and had been advised to attend the Emergency Department. That advice was not communicated during the 999 call and was not otherwise visible to the call handler. The NHS Pathways system could not, therefore, enact or reinforce the predetermined management plan and, using the information available, generated a Dx11 disposition requiring urgent senior clinician assessment within one hour.

Our review has not identified an inconsistency between NHS Pathways and NICE guidance. Rather, it has identified a gap in the visibility of specialist advice and predetermined management plans across services.

NHS England will consider how such plans can be made more consistently visible across specialist services, general practice and urgent and emergency care. This use case will also be considered as work on the Single Patient Record progresses.

2. Recognition of recent chemotherapy within the NHS Pathways system

NHS Pathways includes specific clinical enquiries relating to recent chemotherapy, immunosuppression and the associated risk of infection.

The system is designed to identify the most urgent response required from the information provided. Once an urgent disposition has been reached, questions that could not generate a more urgent response are not necessarily asked. The absence of a chemotherapy-related question from an individual assessment does not therefore mean that this risk is absent from the system.

In Sheila's assessment, Dx11 was reached before the chemotherapy-specific line of enquiry. This required urgent assessment by a senior clinician within one hour and was a more urgent disposition than the outcome that would otherwise have been reached through the chemotherapy questions.

The risk associated with Sheila's recent chemotherapy had also been recognised by the Clatterbridge Cancer Centre hotline before the 999 call. However, neither her recent diagnosis of neutropenia nor the advice to attend the Emergency Department was communicated during that call or was otherwise visible to the call handler.

Our review has therefore found that NHS Pathways does take account of recent chemotherapy and the risks associated with it. As described above, the opportunity for improvement relates to the visibility of specialist information and predetermined management plans across services.

3. Access to a GP and fallback arrangements

NHS Pathways identifies the type of care required and the timeframe within which it should be provided. The local services available to meet that requirement are returned through the Directory of Services (DoS), based on information provided and maintained by those services and their commissioners.

Dx11 requires assessment by a senior clinician within one hour. It should not be interpreted or handled as a routine request for a GP appointment. The clinician undertaking that assessment can consider information outside the scope of the initial ambulance triage and determine the appropriate destination and mode of transport.

Where an individual service is unavailable, the DoS can return alternative services according to the local configuration. The order in which services return on a DoS search is determined locally. During the out of hours period, these cases are received by GPOOH service providers or Clinical Advisory Services (CAS). When none of these services are available, the fallback for this end point is the Emergency Department.

In Sheila's case, her GP practice was contacted and she was offered a face-to-face assessment. The specific circumstance anticipated in your Report—that a GP could not be contacted—did not therefore arise. However, the available chronology does not establish when the assessment took place and suggests that it may have been arranged for later in the day.

Your concern therefore identifies a matter that we wish to explore further: which services are best placed to receive Dx11 referrals, how reliable fallback

arrangements can be provided, and how clinicians working in receiving services can be supported to understand the urgency and clinical case mix associated with Dx11, which can include potential medical emergencies..

4. Advice to make one's own way to hospital

NHS Pathways supports advice for patients to make their own way to hospital where that is the appropriate outcome of the assessment.

Where the triage identifies that assessment at an emergency treatment centre is required, NHS Pathways can provide advice about making one's own way, including safety-netting information and advice not to drive. Where an ambulance response is recommended, decisions about ambulance dispatch or whether a patient can safely make their own way are managed by the ambulance service under its own clinical and operational governance arrangements.

Where NHS Pathways recommends further clinical assessment, as it did in Sheila's case, the assessing clinician determines the appropriate destination and mode of transport. Both the Clatterbridge Cancer Centre hotline and the GP subsequently advised Sheila to attend the Emergency Department, but neither advised that emergency ambulance transport was required.

The absence of direct advice during the 999 triage for Sheila to make her own way to hospital did not therefore arise from an inability within NHS Pathways to support that advice. It reflected the disposition reached using the information available and the lack of visibility of the advice already given by the specialist hotline.

The opportunities for improvement are consequently those identified above: making specialist advice and predetermined management plans visible across services, and ensuring that Dx11 assessments result in a timely decision about destination and transport, with clear fallback arrangements where the assessment cannot be provided.

Overall concern: whether advice following NHS Pathways led to a delay in Sheila attending hospital

At 08:45, the Clatterbridge Cancer Centre hotline advised Sheila to attend the Emergency Department. The Bastedos subsequently contacted the ambulance service and were later seen at the GP practice before attending the Emergency Department at 17:30. Our review considered how information and advice were carried across that journey and whether the NHS Pathways assessment contributed to the delay.

The advice already given by the hotline, and the information that Sheila had recently been identified as neutropenic, were not visible to the 999 call handler. NHS Pathways could not therefore reinforce the specialist advice or follow it as a predetermined management plan.

Using the information available during the call, the assessment did not identify features requiring a category 2 ambulance response. It generated a Dx11 disposition, requiring urgent assessment by a senior clinician within one hour. Sheila

was subsequently assessed by her GP, although the time of that assessment is not recorded, and later attended the Emergency Department.

On admission, almost eight hours after the 999 call, Sheila's observations did not meet the [Healthcare Professional Ambulance Responses Framework](#) threshold for a category 2 transfer. Although this later assessment cannot determine her condition at 09:38, it is consistent with the ambulance response reached during the call.

It is not possible from the chronology to attribute the interval between the hotline advice and Sheila's attendance at the Emergency Department to a single part of the pathway. The review does, however, demonstrate that the journey depended upon important clinical information and specialist advice being transferred manually between services. As that information was not visible, the most direct route to care already identified by the hotline was not reinforced during the 999 assessment.

Actions arising from our review:

The following actions are intended to improve continuity across the whole pathway and reduce reliance upon patients repeating or reconciling clinical information while they are unwell. NHS England will:

- take this use-case into existing work on how predetermined management plans and specialist advice can be made visible through the Single Patient Record, including within unscheduled, urgent and emergency care;
- investigate and review the handling of Dx11 dispositions, including the services to which these cases are directed and whether a neighbourhood clinical assessment service with triage expertise and access to relevant patient records could improve their assessment and onward routing;
- agree and implement arrangements for providing services receiving Dx11 referrals with information about the urgency and clinical case mix associated with this disposition; and
- investigate whether work with relevant cancer and urgent and emergency care teams, to consider how patients can be given clear, accessible information about their predetermined management plans as an additional safeguard, without the safe operation of the pathway depending upon patients communicating that information themselves, would support better care.

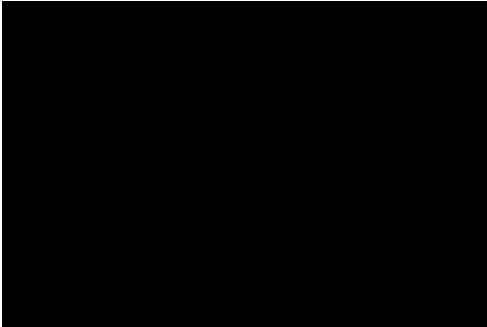
In light of this case, NHS England are also carrying out a review of NHS Pathways processes.

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 Sheila, 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.

I have included an Annex of relevant information regarding the NHS Pathways system for reference.

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,



National Director of Patient Safety
NHS England

ANNEX

Background information relating to NHS Pathways Clinical Decision Support System

NHS Pathways is the Clinical Decision Support System (CDSS) used for remote clinical assessment (triage) in urgent and emergency care. In use since 2005, it underpins all NHS 111 services and more than half of England's 999 telephony systems. The tool also supports online triage, in-person and enhanced clinical assessments via modules such as the NHS Pathways Clinical Consultation Support (PaCCS) system.

The safety of NHS Pathways triage outcomes, known as "dispositions", is overseen by the National Clinical Assurance Group (NCAG), an independent intercollegiate body hosted by the Academy of Medical Royal Colleges. Alongside this external scrutiny, NHS Pathways aligns its content with up-to-date national clinical guidance, including NICE (National Institute for Health and Care Excellence), UK Resuscitation Council and UK Sepsis Trust.

The system supports over 2.5 million triage assessments each month across telephone, digital, and face-to-face settings.

NHS Pathways follows a structured clinical hierarchy. Serious and potentially life-threatening symptoms are assessed first to ensure rapid escalation, such as dispatching an ambulance or involving a clinician. The assessment then progresses to less urgent symptoms, identifying the most appropriate level of care. The tool is not diagnostic. Instead, it works by systematically ruling out more serious causes of

symptoms to ensure safe, efficient triage. Relevant history is gathered where clinically necessary to minimise triage time while maintaining safety.

Principles of Health Advisor Training

In telephone settings (calls made to NHS 111 or 999), assessments are conducted by specially trained non-clinical health advisors. These advisors complete a comprehensive, structured training programme to ensure they can use the NHS Pathways algorithm safely and effectively. They are always supported by clinicians, as a condition of the NHS Pathways licence, which NHS 111 and 999 providers must enter into in order to use the system. If a case is complex or unclear, health advisors are required to escalate to clinical colleagues. As above, the NHS Pathways licence states that clinical supervision and escalation support must be available 24/7, and immediately accessible to health advisors during live calls. This clinical availability is a core system control.

Following initial core role training, both health advisors and clinicians are required to undertake mandatory training aligned to each new release of the NHS Pathways system, which typically occurs every 12 weeks. This ensures that staff remain up to date with any changes to clinical content, pathways, and system functionality. In addition, they have access to a comprehensive suite of ongoing learning resources, including 'Hot Topics', case studies and e-learning packages, which support continuous professional development and dissemination of learning.

Alongside this, providers are required to undertake regular quality assurance processes, including monthly audit of calls. These audits assess a range of core competencies, including the effective use of probing, and provide structured feedback to support ongoing development and safe practice.

Within NHS Pathways, health advisors are trained and expected to actively probe to clarify and refine the information provided by the caller. This is a fundamental component of the NHS Pathways model and forms an important part of its safety design.

Complex call process

Health advisors using the NHS Pathways system are trained to use probing questions to better understand caller responses. A fundamental component of training is learning how to manage complex calls. A complex call is any call which isn't straightforward and where the Health Advisor is working at or beyond the limits of their knowledge and experience.

The "complex call process" provides a clear protocol for health advisors to seek assistance or transfer a complex call to a clinician. This process should be followed in situations involving declared medications, medical procedures, terminology that complicates triage or any other situation when the advisor feels they have reached the limits of their knowledge or understanding. Additionally, it should be used if the call includes three "not sure" answers, or information is incomplete, ambiguous, or difficult to interpret. In such circumstances health advisors are expected to seek immediate clinical input from an experienced NHS Pathways trained clinician. This approach is reinforced by the principle: "if in doubt, shout."

Medical history

The NHS Pathways system is symptom-based. This means that the presenting clinical picture drives the assessment. Where some pre-existing conditions may alter the outcome of symptom assessment, these conditions are enquired after. Such enquiry is limited to these circumstances however, because detailed or unnecessary enquiry into past medical history may delay assessment, not only of the caller in question, but globally across the system by affecting average call lengths, when the information provided would not impact upon the disposition reached.

The aim of triage is to efficiently assess each call to determine the most appropriate skill set and time frame that is needed for each call. Details around the patients' medical history and treatments would be part of a more detailed clinical consultation rather than a triage.