

BRIEFING · OCTOBER 2026

# Artificial Intelligence in *NHS Acute Care: Patient Flow and Triage*

What the evidence says about the scores, algorithms and AI tools that decide who is seen first, what the regulators expect, and what an acute trust can safely do now. England only: health is devolved, and the NHS bodies, statistics and standards here are England's. The MHRA, the data protection law and the National Commission on AI in healthcare are UK-wide.

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Prepared as a market briefing. Every figure is traced to NHS England's official statistics or published record, a regulator, a safety investigator, a coroner, a government department or the statute book.

# A note on the numbers

*This briefing is built from what can be checked, and it names what was left out.*

Acute care is the part of the NHS where supplier claims about AI are loudest and evidence of outcomes is thinnest. Every figure here traces to NHS England's official statistics or its own published record, to the Care Quality Commission, the Health Services Safety Investigations Body, the Medicines and Healthcare products Regulatory Agency, a coroner's report, a government department, or the statute book. No supplier performance figure is used.

## NAMED AND EXCLUDED: THE MOST QUOTABLE NUMBERS IN THE SECTOR

A supplier of AI triage reports "94% triage accuracy", a 37% reduction in acute GP appointments and a 23% reduction in inbound practice calls, attributed in its own press release to "independent NHS evaluation data". No such evaluation has been published, an NIHR-funded evaluation at the same practice runs until August 2027, and the figures do not match NHS England's own account of the same trial. All three are excluded. So is NHS England's estimate that its £10bn technology programme will produce £41bn of benefits over a decade, which is published without a method.

## FLAGGED, NOT HIDDEN

NHS England publishes its Martha's Rule data as management information, and says it is released "rather than to conduct statistical comparisons of escalation tools, so caution should be taken when interpreting these figures". Its corridor care data is experimental, and its guidance "may not be consistently applied across Trusts". Both are used, because they are the best national evidence there is, and both are used with those words attached.

## WHAT THE CORONERS' CASES ARE, AND ARE NOT

Section four draws on four reports by coroners in 2026 about the triage systems used by NHS 111 and 999 services. Those systems are rule-based clinical decision support, not artificial intelligence. They appear because they are the baseline any AI triage tool will be compared with, and because their failures show where an AI tool's failures will surface. The people who died are described by age, place and date, not named.

Sources for each figure are given at the foot of the section in which it appears, and listed in full in section fourteen.

## The wider position

*More patients, more published data, and more ways for a patient or family to ask for a second look.*

### 2.44m

A&E attendances in September 2026, 5.8% more than a year earlier

### 65.2%

Of waiting-list pathways within 18 weeks, August 2026, up 4.2 points on a year

### 20,961

Martha's Rule escalation calls, September 2024 to August 2026

Emergency departments in England saw 2,444,743 attendances in September 2026, 5.8 per cent more than in September 2025, and admitted, transferred or discharged 1,817,992 people within four hours, 4.9 per cent more than a year before. The elective waiting list stood at 7.4 million pathways at the end of August, around 6.2 million people, and 65.2 per cent of them had waited up to 18 weeks, an improvement of 4.2 percentage points on a year earlier. More people are being seen. The standards are not yet being met, and section three returns to that.

The strength of the position is what the NHS now publishes about itself. Every month NHS England reports how many people waited more than 12 hours in an emergency department, how many were cared for in a corridor, how long patients stayed after they were ready to leave, and every call made under Martha's Rule — the right of a patient, family or member of staff to ask for an urgent review when they believe a patient is getting worse and is not being listened to. NHS Pathways, the clinical decision support system behind NHS 111 and more than half of England's 999 services, supports more than 2.5 million triage assessments a month. Few health systems anywhere publish this much about where they fall short.

#### WHY THIS MATTERS TO AN AI PROGRAMME

*The evidence an AI programme needs is already being collected. It is about where today's scores and algorithms miss.*

Most AI in patient flow is sold as a better score: a better early warning, a better triage, a better ranking of the waiting list. The NHS already records, every month, the cases where its existing scores were overruled by a person. That is the test any new score should be held to.

NHS England, *A&E Attendances and Emergency Admissions, September 2026, Statistical Commentary*, 8 October 2026 · NHS England, *RTT waiting times, August 2026, Statistical Press Notice*, 8 October 2026 · NHS England, response to a coroner's report, 1 July 2026 · NHS England, *Martha's Rule Programme August 2026*, 8 October 2026.

## The pressure point

*The early warning score misses many of the patients who are getting worse. The family catches them.*

Every adult inpatient in an English acute hospital is monitored against an early warning score: heart rate, breathing, oxygen, blood pressure, temperature and level of consciousness, combined into a number that tells staff when to escalate. Since June 2025, NHS England has recorded, for every Martha's Rule call about acute deterioration, whether an early warning score had been taken before the call and whether that score would have triggered escalation on its own.

### 83%

Of deterioration calls with a score recorded first, where the score would not have triggered escalation

### 69%

Of those patients who then needed a change in treatment or a transfer of care

### 72%

Of all Martha's Rule calls, made by families and carers

Between June 2025 and August 2026 a score was recorded before 3,841 of the 4,085 Martha's Rule calls about acute deterioration. In 3,173 of them, 83 per cent, the score would not have triggered escalation. Of those 3,173 patients, 423 were transferred to intensive care, a higher level of care or a specialist team, and 1,773 had another change in treatment: new tests, antibiotics, fluids, oxygen or a change in medical or nursing management. NHS England's own reading is that Martha's Rule "is identifying patients in need of further clinical interventions where this need would not have been identified via an early warning score".

#### READ WITH THE CAVEAT NHS ENGLAND ATTACHES

The data is management information. Calls are a selected group — patients someone was already worried about — and NHS England says the figures are not "statistical comparisons of escalation tools". What they show is not a failure rate for the score. They show that, in the cases where a person raised the alarm, the score usually had not.

That is the pressure point for anyone who owns an acute trust's AI programme. Most AI aimed at patient flow is a better score. The NHS has published evidence that its current score is regularly caught out by a family member at the bedside, and no published evidence about how an AI score would do in the same cases.

NHS England, *Martha's Rule Programme August 2026*, management information, published 8 October 2026, sections 3, 5 and 6.

# What the sector is facing

*Two queues, and triage systems that assume neither exists.*

## The emergency department

In September 2026, 157,574 people — 10.1 per cent of attendances at major and single-specialty emergency departments — spent more than 12 hours in the department from arrival. Of Type 1 and 2 attendances that ended in admission, 30.1 per cent were admitted within four hours. 50,582 patients waited more than 12 hours from the decision to admit them to their admission, 1,686 a day and 13.0 per cent more than a year earlier. "0 out of 120 reporting trusts with Type 1 departments achieved the 95% standard". In August, emergency departments recorded an average of 2,297 instances a day of corridor care lasting more than 45 minutes, and an average of 678 patients were receiving corridor care on general and acute wards at 8am.

## The back door

In August 2026, 335,591 patients were discharged from acute hospitals with acceptable data, and 306,740 bed days were spent by patients after the date they were ready to leave. One in seven, 14.3 per cent, left a day or more late, on average 6.4 days late, and 3,069 waited 21 days or more. Every one of those bed days is a bed an emergency patient cannot move into.

## The triage systems underneath

NHS Pathways has been in use since 2005 and is a Class 1 medical device. It "underpins all NHS 111 services and more than half of England's 999 telephony systems". It is "owned by the Secretary of State for Health and Social Care and is manufactured and managed by the Transformation Directorate of NHS England". In a letter to a coroner in July 2026, NHS England described the limit of its design: "NHS Pathways is not able to take account of these [operational delays] ... and thus NHS Pathway's expectations are based on what should happen in absence of such delays." The ranking assumes the queue is not there.

Four coroners' reports in 2026 set out where these rule-based systems fell short. None involved AI.

- **A three-year-old in Devon, 2022 (report January 2026).** His mother said his lips had turned "a little blue". The 999 provider's system, MPDS, produced a Category 1 response; NHS Pathways, used by 111, produced Category 2. NHS England told the coroner "the presence of cyanosis is not interrogated within NHS Pathways". It had said it would review the difference; the coroner reported because that "has not yet occurred".
- **A 17-year-old in Surrey, 2024 (report May 2026).** His parents called 999 describing a non-blanching rash. The call handler "was unable to prioritise any of the listed symptoms"; a call-back promised within 20 minutes came after 1 hour 41 minutes. His parents drove him to hospital, where he died of meningococcal septicaemia.
- **A woman of 53 in London, 2025 (report June 2026).** She was vomiting after surgery to remove a pituitary tumour. "Neurosurgery is not a specified Pathways category"; the call handler recorded "head injury", and a later clinical call reached "home management". She died of a seizure caused by low sodium.
- **A man of 32 in County Durham, 2019 (report July 2026).** He called 999 himself with a blocked airway from an abscess. Choking on a foreign object generates Category 1; an airway blocked by a natural cause generated Category 2. NHS England's response confirmed that in NHS Pathways "the term 'choking' generally refers to foreign-body airway obstruction".

NHS England: A&E statistical commentary and ECDS supplementary analysis, September 2026; Corridor Care, August 2026 (experimental), 8 October 2026; Discharge Ready Date, August 2026, 8 October 2026 · NHS England Digital, *NHS Pathways is a Class 1 medical device* · Prevention of Future Deaths reports 2026-0006 (6 January 2026), 2026-0326 (11 May 2026), 2026-0316 (17 June 2026), 2026-0383 (24 July 2026), and NHS England's responses of 1 July and 4 September 2026.

# The challenges of using AI here

*Where AI is arriving, what evidence comes with it, and four risks that have nothing to do with the technology failing.*

## Where AI actually is

**The front door.** On 4 July 2026 NHS England announced that a new AI triage tool in the NHS App "is due to reach more than 200,000 patients within the next 12 months and be available to all NHS App users by April 2028". It directs patients to a GP appointment, pharmacy, A&E, community service or self-care, or "provides clinicians with the information they need to prioritise care". The evidence given was "a 29% reduction in the number of people queuing on the phone" at a GP practice in Sussex. That practice, Wealden Ridge Medical Partnership, is also the evaluation site for an NIHR-funded study of an AI triage system accessed through the NHS App, which runs from March 2026 to August 2027. No supplier, device classification or evaluation report is given on any NHS England page searched for this briefing.

**The emergency department.** An AI tool that forecasts A&E demand from weather, admissions and day-of-week patterns is available to every trust through the NHS Federated Data Platform, and has "170 active users across 50 organisations each month". The evidence published: "Early feedback from staff has been positive."

**The waiting list.** AI risk-prioritisation of surgical waiting lists has been in use across the nine acute trusts of one integrated care system since 2023. The outcome figures announced with it are attributed to an NHS England assessment that could not be located, and are not used.

**The data underneath.** Any model that triages or predicts from emergency department records depends on what is recorded. In September 2026 the presenting complaint was recorded as "unknown" for 22.3 per cent of major A&E attendances, after a change of clinical coding, and no frailty score was recorded for 64.9 per cent of patients aged 65 and over. One teaching hospital trust has not submitted usable waiting-list data since its new electronic patient record went live in July 2025.

## Four risks specific to acute care

### 01 · A MODEL TRAINED ON WHAT THE SCORE SAW

In 83 per cent of the deterioration calls where a score had been taken, it had not flagged the patient. A model that learns to predict the score's flags learns its misses too. The question for any supplier is what the model was trained to predict.

### 02 · ROLLOUT BEFORE THE EVALUATION

The App's AI triage reaches 200,000 patients within a year and every user by April 2028. The NIHR evaluation at the practice NHS England cites reports in August 2027.

### 03 · INPUTS THAT ARE MISSING

Presenting complaint unknown for one major A&E attendance in five. Frailty unrecorded for nearly two-thirds of older patients. Waiting-list data missing after an electronic patient record go-live.

### 04 · AN ESCALATION ROUTE USED UNEVENLY

Martha's Rule deterioration calls are significantly less common, relative to admissions, for Black (3.4% against 4.0%), Mixed (1.4% against 1.8%) and other minority ethnic patients (1.8% against 3.0%). A tool validated on escalations inherits that gap.

The fourth risk deserves a board's attention for its own sake. The most deprived fifth of the population accounts for 25.6 per cent of deterioration calls against 21.1 per cent of admissions, so the route is reaching people in deprived areas. The ethnicity gap is a different matter. The families least likely to use the human check are the ones an AI tool will be least tested on.

NHS England, 4 July 2026 · University of Oxford, 11 June 2026 · DSIT and DHSC, 28 December 2025 · Cheshire and Merseyside ICS, 13 September 2023 · NHS England: ECDS analysis, September 2026; RTT press notice, August 2026; Martha's Rule, August 2026.

## The threat side

*In acute care the threat is not fraud. It is volume: a front door that is easier to use sets the size of the queue behind it.*

In insurance the threat from AI is fraud against the firm. In acute care no published source points that way. What the evidence does show is that the front door already routes a large share of people into emergency care, and that a new front door is being built.

### NHS 111 TODAY · AUGUST 2026

1,719,963 calls. Of the calls triaged, 11.4% were referred to the ambulance service and 14.7% recommended to attend an emergency treatment centre — roughly a quarter routed to emergency care. In September, 74,952 A&E attendances had been booked in advance.

### THE NHS APP TOMORROW

The App already takes around 3.5 million visits a month to online consultation services. Its AI triage can send people to A&E. How often it does, and how often those people are admitted, has not been published.

The National Audit Office names three forms of external AI-driven pressure on public services, and the first is "more legitimate demand as friction falls". That is people reaching a service that used to be hard to reach. It is not wrongdoing, and nothing here suggests that anyone is misusing the App or NHS 111. The risk is one of design and measurement: a small change in the share of App users directed to A&E, across every App user in England, moves a large number of people, and a trust that cannot see which arrivals came through the App will not know why its queue changed.

The other direction matters too. An App that sends fewer people to A&E will be counted a success on the measures published so far. Whether the people it sent elsewhere were the right people is the question section twelve turns into a measure.

NHS England, *Integrated Urgent Care Aggregate Data Collection, August 2026*, statistical note · NHS England, *A&E statistical commentary*, September 2026 · NHS England Digital, *NHS App Roadmap* · National Audit Office, *Good practice guide for organisations using AI*, May 2026.

# The UK legal position

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*The rules for AI in healthcare are being written now. Triage is not in them yet, and one change has already happened.*

## The National Commission and the government's response

The National Commission into the Regulation of AI in Healthcare, set up by the MHRA, reported on 10 September 2026 with 44 recommendations, drawing on evidence from more than 12,000 people. On 6 October 2026 the government accepted all 44, committed to "a full implementation roadmap ... by Spring 2027", and set out first steps: MHRA draft guidance by December 2026 on managing changes to AI-enabled devices, and a consultation next year on which AI products should be regulated as medical devices. The Commission asks the MHRA to consider whether "low risk clinical decision support" needs device regulation at all. It describes "perceived 'liability sinks', where responsibility for errors may be transferred onto healthcare professionals and providers without sufficiently recognising the influences of AI systems and wider system design". The government's response creates a working group "to ensure that responsibilities are clear across manufacturers, healthcare providers, professionals and regulators". Neither the report nor the response uses the word "triage", and neither mentions the NHS App.

## The regulator of care

The Care Quality Commission says: "We do not assess or approve specific technologies". It expects "AI to support, not to replace: AI can enhance, but not replace human decision making", and "clear mechanisms for addressing issues or harm caused by AI". "The absence or presence of AI does not predict a specific rating." The GMC tells doctors they "are responsible for the decisions they take when using new technologies like AI".

## Automated decisions using health data

Since 5 February 2026, UK GDPR Article 22A treats a decision as solely automated "if there is no meaningful human involvement in the taking of the decision". Article 22B then says that "a significant decision based entirely or partly on processing" of special category data, which includes health data, "may not be taken based solely on automated processing" unless the person has given explicit consent, or the decision is required or authorised by law and the substantial public interest condition applies. The condition a trust usually relies on for health care is not one of the routes. Whether an App directing a patient to self-care without a clinician is such a decision is a question for each trust's data protection officer before deployment. This briefing does not answer it.

## The equality duty

Every NHS trust is bound by the public sector equality duty in section 149 of the Equality Act 2010, including due regard to the need to "encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low". Martha's Rule is such an activity, and section five shows where participation is low.

National Commission into the Regulation of AI in Healthcare, *Recommendations for a future regulatory framework*, 10 September 2026 (text searched 15 October 2026) · Government response, 6 October 2026 · CQC, *Artificial intelligence in health and social care: CQC's role, expectations and plans*, last updated 21 May 2026 · GMC, *Artificial intelligence and innovative technologies* · UK GDPR Articles 22A–22D, as substituted by the Data (Use and Access) Act 2025 s.80 · Equality Act 2010 s.149.

# The change nobody has framed

*The clinical safety standards every trust works to have quietly become a duty to comply, and they do not yet cover AI.*

Every acute trust that deploys a clinical system works to two NHS standards. DCB0129 sets clinical risk management requirements for the manufacturers of health IT. DCB0160 sets them for the organisations that deploy and use it, including the appointment of a clinical safety officer. Both are information standards under section 250 of the Health and Social Care Act 2012, and section 250 has changed twice.

## SECTION 250, AS AMENDED

*Since 7 July 2025, anyone a standard applies to "must comply with the information standard". Since 5 February 2026, a standard can apply to "a relevant IT provider".* The first change came from section 95 of the Health and Care Act 2022. The second came from the Data (Use and Access) Act 2025, which brought suppliers of IT and IT services used in health and adult social care in England into scope.

The current versions of the two standards date from 2018. NHS England began a national review in June 2026. Its own supporting paper says that today "bodies exercising a health and care function must continue to have regard to the standards, but future revisions of the standards are likely to [use] these enhanced powers". Its focus groups found "critical missing areas including artificial intelligence governance", digital inclusion and post-implementation monitoring, and found current compliance mechanisms "insufficient".

- **For a trust**, the next revision of DCB0160 is likely to be a standard it must comply with, written with AI in mind. A trust that already runs its AI tools through DCB0160 as if compliance were mandatory will not be starting from nothing.
- **For a supplier**, DCB0129 can now be applied to it directly. The question of who carries clinical risk for an AI tool is moving from the contract to the statute.
- **For the system**, the Health Bill, now at committee stage in the House of Lords, would abolish NHS England and pass the operation of the NHS App to the Secretary of State, who already owns NHS Pathways and can publish information standards. If it passes, the same office will own the main triage tools and set the safety standards they meet.

Health and Social Care Act 2012 s.250, as amended by the Health and Care Act 2022 s.95 (in force 7 July 2025, SI 2025/807) and the Data (Use and Access) Act 2025 Sch. 15 (in force 5 February 2026, SI 2026/82) · NHS England, *National review of clinical risk management standards DCB0129 and DCB0160: supporting information*, 29 June 2026 · DHSC, *Health Bill: data and digital functions – fact sheet*, 19 May 2026 · UK Parliament, *Health Bill*, stage as at 15 October 2026.

## Beyond the UK

*The European Union names emergency triage AI as high-risk. The contrast is the point.*

The EU AI Act lists in Annex III the uses it treats as high-risk. Point 5(d) covers "AI systems intended to evaluate and classify emergency calls by natural persons or to be used to dispatch, or to establish priority in the dispatching of, emergency first response services, including by police, firefighters and medical aid, as well as of emergency healthcare patient triage systems". Point 5(a) covers AI used by public authorities to evaluate eligibility for essential public services, "including healthcare services".

The Digital Omnibus on AI, Regulation (EU) 2026/1744, was published on 24 July 2026 and came into force three days later. It moved the obligations for Annex III systems from August 2026 to 2 December 2027, and those for AI built into regulated products such as medical devices to 2 August 2028. It did not change the triage provision.

### THE CONTRAST

The EU names emergency healthcare triage AI as high-risk by default, and an NHS trust working with a supplier that also sells into the EU will meet those obligations through its supplier from December 2027. The UK's National Commission on regulating AI in healthcare does not mention triage at all. A trust deciding its own standard for AI triage has a ready-made benchmark in the EU text, and no UK one yet.

No court judgment or regulatory enforcement action on AI triage, in the EU or elsewhere, was located for this briefing.

For a trust, the useful part of the EU text is what high-risk status requires of a provider: a risk management system, data governance that addresses bias, logging, human oversight that can be exercised in practice, and post-market monitoring. Those are the questions to put to any supplier of AI triage now, whichever market it sells into, and they map closely to the DCB0129 and DCB0160 duties described in section eight.

Regulation (EU) 2024/1689, Annex III, points 5(a) and 5(d) · Regulation (EU) 2026/1744 of 8 July 2026, OJ L 24.7.2026 · National Commission report, 10 September 2026.

# Today

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*Seven things an acute trust can do now, none of which waits on new law, new money or a supplier.*

- **Review every Martha's Rule deterioration call where the early warning score did not trigger.** It is the trust's own measure of what its score misses, and it is already being collected.
- **Fix recording before prediction.** Presenting complaint and frailty score captured for every relevant attendance. A model built on "unknown" learns "unknown".
- **Ask any AI triage or flow supplier for its miss rate by group** — by age, ethnicity and deprivation — not its overall accuracy.
- **Compare Martha's Rule use by ethnicity and deprivation with the trust's own admissions,** and act on the gap under the equality duty.
- **Write down the Article 22B basis before any disposition is made without a clinician.**
- **Run every AI tool through DCB0160 as if compliance were already mandatory,** with the clinical safety officer's view of what the tool might miss on the record.
- **Mark App-routed arrivals at the front door from the first day,** so their effect on the queue can be seen and not guessed.

None of these needs a decision about whether to use more AI. They are the conditions under which AI already arriving can be defended. The first is the one that matters most, because it turns a trust's existing data into the test that any new score must pass.

Drawn from NHS England's Martha's Rule, ECDS, Integrated Urgent Care and DCB review publications, UK GDPR Article 22B and the Equality Act 2010 s.149.

# Tomorrow

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*Three levels defined by where accountability sits, and three horizons.*

## Three levels

### Assistive

It forecasts or prepares; people decide. A&E demand forecasting sits here: it informs rotas and beds, and no patient is ranked by it. Accountability is unchanged, and almost all defensible value sits here today.

### Augmentive

It ranks or recommends within bounds; a clinician confirms or overrides, and the override is recorded. Waiting-list risk scores and deterioration models used beside the early warning score sit here. The review has to be shown to catch what the tool misses, and Martha's Rule is the evidence that review by a person matters.

### Adaptive

It acts within a defined envelope, and oversight moves to whoever sets and monitors the envelope. App triage that sends someone to self-care without a clinician would sit here. A supplier involved in NHS App triage has said "this may open up the possibility of safely automating some clinical pathways for certain patient groups". For health data, Article 22B limits how it can be done. For acute care this is a reasoned projection, not an observation.

## Three horizons

### 0 to 12 months

MHRA draft guidance on changes to AI-enabled devices by December 2026. The government's implementation roadmap by spring 2027. DCB0129 and DCB0160 under review. App triage trialled across London, reaching 200,000 patients.

### 12 to 36 months

The NIHR evaluation at NHS England's trial practice reports in August 2027. EU obligations for triage AI from 2 December 2027. App triage for every user by April 2028. The Health Bill, if passed, moving the App to the Secretary of State.

### 36 months and beyond

Most urgent contact starting in the App, with clinicians reviewing by exception. Whether that review catches the patients the tool ranked too low is the question this briefing raises.

*The third band is a projection, not an observation. The Health Bill is still before Parliament, and the government's roadmap has not been published.*

DSIT and DHSC, 28 December 2025 · NHS England, 4 July 2026 · University of Oxford, 11 June 2026 · GOV.UK, government response, 6 October 2026 · NHS England, DCB review, 29 June 2026 · NHS England Digital, NHS App Roadmap · Regulation (EU) 2026/1744 · UK Parliament, 15 October 2026.

## Benefit realisation

*A shorter queue is a real benefit. It is not the whole answer, because it says nothing about who the tool missed.*

The worked example is on the public record. NHS England's evidence for the national rollout of AI triage in the NHS App is that an initial trial at one rural practice of 23,000 patients "resulted in a 29% reduction in the number of people queuing on the phone – helping to end the 8am rush while maintaining patient satisfaction levels". That is a real measure of access, and the practice's own GP put it well: "It hasn't replaced our judgement – it's given us back the time to use it."

It is a measure of the queue. The benefit claimed for triage rests on sending each person to the right place, and nothing in the published evidence measures that. A benefit case that counts calls avoided will report success whatever happens to the patients it routed.

### WHAT IS ALREADY COUNTED

Phone queues. Patient satisfaction. Time saved for clinicians. Staff feedback on forecasts. Waiting times against the 18-week and four-hour standards.

### WHAT WOULD SHOW THE TOOL WORKS

People sent to self-care or pharmacy who reached A&E within 72 hours. How often the tool sends people to A&E, and how often they are admitted. Misses by ethnicity, age and deprivation. Martha's Rule calls on patients the tool ranked low.

**The practical step is small.** Add one measure of the misses to every AI business case in the trust. It is the measure a coroner will ask about first.

NHS England, *NHS accelerates artificial intelligence rollout to cut waiting times and improve care for millions*, 4 July 2026.

# A way in

*Eight workstreams. The first three form a natural first step.*

|    |                                            |                                                                                                                                        |                   |
|----|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| 01 | <b>Readiness assessment</b>                | Every score, algorithm and AI tool that ranks a patient, including NHS Pathways and the early warning score, and who answers for each. | 4–6 weeks         |
| 02 | <b>Use case identification and triage</b>  | Sorted by where accountability sits on the three levels, not by expected saving.                                                       | 3–4 weeks         |
| 03 | <b>Regulatory and legal position paper</b> | Article 22B, section 250 and the DCB review, the equality duty and the EU triage provision, read together.                             | 3–4 weeks         |
| 04 | <b>Board and executive governance</b>      | What the board sees, and how often, including a measure of what the scores miss.                                                       | 4 weeks           |
| 05 | <b>Threat and integrity response</b>       | Front-door volume from the App, handled as a measurement problem, not a misuse problem.                                                | 4 weeks           |
| 06 | <b>Benefit realisation framework</b>       | Including the measures of misses in section twelve.                                                                                    | 3 weeks, parallel |
| 07 | <b>Build, buy or partner evaluation</b>    | Including what the supplier's model was trained to predict, and its miss rate by group.                                                | 4–6 weeks         |
| 08 | <b>Twelve-month mobilisation roadmap</b>   | Sequenced against the DCB review, the government's roadmap and the App's rollout.                                                      | 2 weeks           |

## THE FIRST STEP

*Workstreams one to three form a natural first engagement of six to eight weeks.*

The government's roadmap for regulating AI in healthcare is due by spring 2027, and the standards a trust must comply with are being rewritten now. Six to eight weeks is enough to know whether a trust can show who its scores and tools miss, before it is asked.

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## Sources

*Every figure in this briefing, traceable to a named publication and a date.*

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- NHS England, all published 8 October 2026: *Corridor Care, August 2026 (experimental)*; *Discharge Ready Date, August 2026*; *RTT waiting times, August 2026, Statistical Press Notice*; *Integrated Urgent Care Aggregate Data Collection, August 2026*.
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*Excluded on the record: a supplier's 94%, 37% and 23% figures for AI triage, attributed to an unpublished NHS evaluation; NHS England's £41bn benefits estimate, published without a method; waiting-list AI outcome figures attributed to an assessment that could not be located; a ten-scenario chatbot comparison, too small to carry a claim; projected gains from ambient voice technology; a link between pulse oximeter accuracy and the early warning score, which current evidence does not test; and secondary reports of AI-written complaints and of professional complaints about clinicians' AI use.*

# About the author

Neil Catton is an independent technology strategist with more than thirty-nine years of technology leadership across twenty-plus sectors — from central government, policing and national health systems to banking, manufacturing and insurance. He has held CTO and Director-level roles at BT, Wipro, Fujitsu, Sopra Steria and Capita, and works across a fractional portfolio spanning public safety, public sector, insurance, health technology and early-stage startups.

At Sopra Steria he was technical author of Lord Patel's *Breaking Barriers* report on transforming the NHS. At Wipro he was Chief Architect for a national health platform in India serving 400 million citizens across 11 medical cities and 6,500 clinics, and at Capita he led due diligence on CHKS, the health analytics business, and worked with NHS Business Services Authority on its shared services platform. He is the author of the technology ethics trilogy *The Next Evolution*, *The Cognitive Crucible* and *The Shadow System*, and writes at [neilcatton.substack.com](http://neilcatton.substack.com).

## How this briefing was produced

Only primary sources are used: NHS England's official statistics or its own published record, a regulator, a safety investigator, a coroner's report, a government department, or the statute book. Where this briefing reports an absence, the relevant source was searched for it and the claim is stated as what was searched. Figures that could not be traced to a named source are named as excluded rather than quietly dropped, because what a briefing leaves out is the better test of it.

In keeping with this report's own argument: this briefing was produced with AI assistance, used transparently and kept under direct human editorial control throughout. Every source was verified; every judgement was reviewed by Neil Catton before publication.

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## Version history

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