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15 June 2026

Dear Mr Thompson,

Re: Regulation 28 Report to Prevent Future Deaths – Theresa Lydon who died on 18th September 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 21st April 2026 concerning the death of Theresa Lydon on 18th September 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mrs Lydon's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mrs Lydon's care have been listened to and reflected upon.

Your Report raised the following concerns:

1. That there is no uniform format for use by consultants when they are informing a patient's GP what the treatment plan is and what action needs to be taken for the patient. This can mean that the treatment plan is not clearly communicated to those implementing it.
2. Current practice does not allow for a specialist in a secondary care setting to issue a prescription for the required drugs at the point of diagnosis and then instruct the patient's GP to continue the process.
3. There is a national issue with different trusts being able to promptly access medical records of patients in their care, for example, regarding recent admissions at other trusts.

Effective communication of treatment plans

It is indeed vital that secondary care clinicians communicate treatment plans as clearly as possible, both for patients and for the primary care team also involved in their care. Many trusts now have an electronic patient record, with locally agreed standardised clinic letter templates to facilitate this.

As that is not yet universal, nationally, the Getting it Right First Time (GIRFT) Team produced a Clinically Led Speciality Outpatient Guide document in July 2023 highlighting the importance of clear, concise clinic letters and offering guidance on the best ways to do this. This states that outpatient clinic letters have at least three different audiences, each of which will have different requirements for what they need to be able to take from the contents. In view of this, clinic letters must be clear, concise,

in plain English and be structured with headings to allow quick and easy reference for all concerned. It details a specific section for Primary Care which outlines:

"In view of the high volume of letters these are primarily dealt with by admin, coders and pharmacy. Need to easily understand and identify information on any changes to the patient's diagnosis or management and any actions required by primary care.

Summary of the key information that is structured and in plain English:

- *Diagnoses (highlight any new ones)*
- *Changes to medication*
- *Planned Investigations*
- *Management Plan (who is responsible)*
- *Actions for Primary Care to arrange*
- *Any follow up or escalation plan*
- *Contact details for queries / escalation"*

It is not clear from the Report whether or not the patient and GP had been told how to escalate any issues and whether they had been given contact details for any queries or escalation, for example for the local Inflammatory Bowel Disease (IBD) specialist nurse or the IBD helpline. Almost every hospital will or should have an IBD helpline or an IBD specialist nurse. Patients with known Ulcerative Colitis should be given these contact details when they are diagnosed.

More recently GIRFT have also recently produce an 'IBD handbook' to help to optimise care for patients with IBD, outlining these expectations in more detail. This was published in November 2025.

Specialists issuing prescriptions

When a diagnosis made by a specialist in secondary care, the specialist, assuming they are a registered medical practitioner, is permitted to prescribe medicines for the patient without having to ask a GP to do this on their behalf. This has been standard practice in the NHS since its inception, and was confirmed in guidance from NHS England in 2018.The North-East and North Cumbria Area Prescribing Committee formulary, lists balsalazide (the drug prescribed to Mrs Lydon to treat her ulcerative colitis) as a GREEN+ drug. The definition of a GREEN+ drug from the formulary is:

"GREEN+ DRUGS:

Drugs normally recommended or initiated by a hospital specialist who is a prescriber, a GP with an extended role [GPwER]), or a specialist within primary care which can be safely maintained in primary care and monitored in primary care. In some cases, a further restriction for use may be defined. The primary care prescriber must be familiar with the drug to take on prescribing responsibility or must obtain the required information from the specialist. Therefore, provision of additional information, or an

information leaflet, may be appropriate in some cases to facilitate continuing treatment by primary care prescriber or provide information re stopping criteria.

These are considered suitable for primary care prescribing following specialist assessment and recommendation of therapy, with ongoing communication between the primary care prescriber and specialist, if necessary.

In some case these drugs require specialist initiation and short to medium term monitoring of efficacy or toxicity until the patient's dose is stable. Following specialist review the patient may be transferred to primary care for ongoing prescribing. Ongoing prescribing by primary care can include, if required, additional dose titrations and assessment of efficacy, with ongoing communication between the primary care prescriber and specialist, if necessary.

If the drug requires urgent initiation, it is expected that the specialist provides the first prescription from the inpatient/outpatient setting, of sufficient supply for a patient's immediate needs. The quantity provided should cover at least up to the point where the discharge/clinic letter has reached the GP, plus reasonable time for the practice to manage the document and issue further supplies. A GREEN+ drug can only be recommended to primary care for initiation if it does not need to be initiated urgently, taking into account clinical need.

GREEN+ status will be assigned if the following conditions apply:

1. The medicine is being used for an established, licensed indication/dose. Alternatively, it is being used for an off-label indication that is considered to be standard therapy (i.e. supported by a consensus of recommended opinion or evidence base BNF / BNFc, reputable clinical guideline etc) and/or agreed by NENC Clinical Effectiveness and Governance (CEG) Subcommittee.

2. The medicine can be prescribed on FP10 and there are no issues around primary care procurement, or commissioning.

3. Primary care able to take full responsibility for prescribing after initiation or (after recommendation by a specialist and on-going prescribing. ICB prescribing guidelines or NICE guidance may apply.

4. Is considered safe, and can be safely maintained and monitored in primary care.

5. Dose adjustments can be undertaken with relative ease and are supported by readily available guidance (e.g. the product license / BNF).

6. The indication is non-specialist and is amenable to management in primary care.

7. There are no service, commissioning or restrictions on community pharmacy procurement (i.e. BNF states for hospital use only or wholesaler/manufacturer restricts supply to secondary care) associated with primary care prescribing or dispensing of the medicine.

8. Require no routine monitoring from the specialist but there is a route available to seek advice from specialist if needed.

9. The specialist will counsel the patient on the medication and its use."

This formulary shows that it is permissible for a secondary care specialist to prescribe a drug like balsalazide, before a GP is asked to take responsibility for ongoing prescribing. It also makes it clear that if the medication is required urgently, the secondary care clinician should issue the first prescription and then ask the GP to continue it, although if it is not urgent, then it is also possible for the secondary care specialist to recommend that the GP prescribed the medicine, provided that they have counselled the patient on the medicine and its use (point 9 in the list above). In light of this, we consider there may have been some misunderstanding about the suggestion that 'current practice does not allow for a specialist to issue a prescription for the required drugs at the point of diagnosis.'

While it is the case that if the GP had issued a prescription that Mrs Lydon would have ensured she received the clinically indicated drugs' promptly, it is also the case that if the specialist had issued the prescription Mrs Lydon would have received the medication even more quickly and would have avoided the risk of the prescription not being actioned by the GP.

Accessing medical records from other trusts

The Frontline Digitisation (FD) Programme, has reviewed the position at South Tyneside and Sunderland NHS Foundation Trust and Gateshead Health NHS Foundation Trust.

The South Tyneside and Sunderland NHS Foundation Trust uses the Meditech Electronic Patient Record (EPR) system and was the first hospital in the country to achieve Global Digital Exemplar (GDE) status, having been accredited at Level 7 by Healthcare Information and Management Systems Society (HIMSS). As part of the FD Programme, the Trust was assessed as already having an EPR that met the Programme's core standards against the Digital Capability Framework (DCF). The Trust has also secured limited FD Programme funding for hardware investment to support the extension and enhancement of future clinical ways of working.

Gateshead Health NHS Foundation Trust has the System C Electronic Patient Record (EPR) system in place. It was similarly assessed through the FD Programme as already having an EPR that met the Programme's core standards against the DCF. The Trust has secured limited FD Programme funding to invest in additional functionality to support its EPR.

The FD Programme has advised that both Trusts securely share electronic information with health and care partners through the Great North Care Record (GNCR). However, EPR systems are configured and managed locally, in line with contractual arrangements between individual Trusts and their technology suppliers. Accordingly, levels of interoperability may vary depending on local infrastructure and information governance arrangements.

Local EPR implementations should operate under the oversight of a Trust Clinical Safety Officer (CSO). The CSO is a registered healthcare professional responsible for overseeing the clinical safety and risk management of health IT systems and ensuring that such systems are safe for patient use. Digital safety is a critical component of patient safety.

Suppliers and Trusts are jointly accountable for compliance with the two mandatory Clinical Risk Management Standards defined under Section 250 of the Health and Social Care Act 2012:

- DCB0129: Clinical Risk Management: its Application in the Manufacture of Health IT Systems
- DCB0160: Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems

DCB0160 is an ongoing and iterative process rather than a one-time assessment. All modifications to the EPR, including system upgrades, configuration changes such as to change clinic letter templates, and incident management, must be proactively assessed for their potential impact on patient safety throughout the lifecycle of the system. Any identified hazards or foreseeable scenarios of patient harm, whether arising from system functionality, configuration or user interaction, must be recorded in a Hazard Log, which should be actively maintained and updated, together with associated controls or mitigations.

Trusts are also required to operate formal incident management systems to support the monitoring, reporting and investigation of clinical incidents or near misses associated with EPR systems. These arrangements should support organisational learning, continuous improvement and appropriate system changes in response to identified risks.

The FD Programme supports provider organisations to procure EPR systems and provides guidance on implementation to enhance local digital capability and interoperability, including improving the ability of different digital systems to communicate effectively.

Further investment in digital transformation has been confirmed through the Frontline Productivity (FP) Programme, a four-year initiative commencing in April 2026. This programme is intended to enable NHS organisations to realise the benefits of digitising patient data through further optimisation of EPR capability. Building on the experience and lessons from preceding programmes such as Frontline Digitisation, the FP Programme will also support analysis of digital health events to identify root causes and inform refinement of processes and systems to support future resilience and effectiveness.

The newly published Fit for the Future: 10 Year Plan for England sets out the government's plan for healthcare in England over the next 10 years, including a commitment to give patients 'a single patient record (SPR) – to enable more coordinated, personalised and predictive care.' However, rather than building an SPR from scratch, a likely solution may include improved interoperability between the many systems currently in operation, recognising the challenge of sharing medical records

and results within and between organisations, including social care and commissioned organisations, that use different technologies.

The interface between Primary and Secondary Care

An initiative called the 'Red Tape Challenge' was developed to improve the interface between primary and secondary care, such as how referrals are made and managed, patient discharge and how different parts of the health service communicate with each other. The Red Tape Challenge led to 10 recommendations, which were cascaded through Regional Medical Directors. The focus of the Red Tape Challenge is on reducing unnecessary bureaucracy, improving communication and understanding, strengthening culture and interface working between primary and secondary care, improving digital and estates infrastructure, streamlining healthcare delivery, enhancing patient experience, and freeing up clinical time. Those especially relating to this case include:

- Recommendation 3: Adoption of electronic prescribing (EPS) in secondary care, greater access to shared care records and greater interoperability of Electronic Patient Records (EPRs), starting with the sharing of structured medication information
- Recommendation 5: Greater standardisation of forms and process
- Recommendation 6: Prescriptions should be issued in outpatients for 28-days, unless clinically inappropriate – local guidance would also define expectations regarding supply of medicines during admissions and at discharge

Implementation of the Red Tape Challenge is being driven by ICBs and supported by national oversight from leads across primary and secondary care, pharmacy, medicines, estates, and transformation directorates.

The GIRFT Bridging the Gap guidance is now embedded in the regular national self-assessment tool to help providers identify barriers and enablers to better interface working. Analysis of the latest trust self-assessments shows encouraging progress, with many organisations having established local interface groups and interface liaison officers.

The Academy of Medical Royal Colleges has also published an 'Escape the Tape' document setting out practical quick wins to improve the primary-secondary care interface and raising the visibility of the Red Tape Challenge.

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 Mrs Lydon, 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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National Medical Director
NHS England