



Department
of Health &
Social Care

██████████
Minister of State for Health (Secondary Care)

39 Victoria Street
London
SW1H 0EU

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James Thompson
HM Assistant Coroner, Gateshead & South Tyneside

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15 June 2026

Dear Mr Thompson,

Thank you for the Regulation 28 report of 21 April 2026 sent to the Secretary of State about the death of Mrs Theresa Lydon. I am replying as the Minister with responsibility for Secondary Care.

Firstly, I would like to say how saddened I was to read of the circumstances of Mrs Lydon's death and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are very concerning, and your finding that Mrs Lydon's death was contributed to by neglect is particularly troubling. I am grateful to you for bringing these matters to my attention.

The report raises concerns across several issues: the formatting of letters sent from diagnosing consultants to GPs; the ability for secondary care specialists to issue a prescription at the point of diagnosis; and the sharing of medical records between NHS trusts.

In preparing this response, my officials have made enquiries with the Care Quality Commission (CQC). I understand that you have shared this report with NHS England who are responding separately. I hope this ensures that we are adequately addressing your concerns.

Whilst there is no national mandating of letter templates that diagnosing consultants should use when sharing a patient's treatment plan with GPs, I echo your concerns around the importance of clear formatting in ensuring that all necessary courses of action for a patient can be easily interpreted with no room for confusion. To support this, there should also be an open dialogue between primary and secondary care to enable swift resolution to any possible misunderstanding.

In July 2025, NHS England published the Getting It Right First Time (GIRFT) guidance 'Bridging the interface between primary and secondary care, mental health and community services'. This suggests that:

"ICBs should work with Trusts to design and use a standardised discharge letter template to enable consistency and aid GP practices to clearly see diagnosis and actions required".

<https://gettingitrightfirsttime.co.uk/wp-content/uploads/2025/07/GIRFT-Bridging-the-interface-July-2025-FINAL-1-1.pdf>

The department and the CQC generally expect registered providers to have awareness of and act in line with statutory and best practice guidance, and that registered providers take note of statutory and best practice guidance when providing care and treatment.

I am informed by the CQC that in their next planned engagement with both South Tyneside & Sunderland NHS Foundation Trust and Gateshead Health NHS Foundation Trust, they will discuss the concerns raised in your report.

With regard to the ability for secondary care specialists to issue a prescription at the point of diagnosis, when a patient is discharged from inpatient or day case care in hospital, sufficient medication must be supplied by the hospital pharmacy for a minimum period of 7 days after discharge. This is unless a shorter period is more clinically appropriate, or the patient has an adequate supply, or will receive such a supply through an existing repeat prescription. The minimum period of time covered by the prescription should take into account bank holidays and weekends, to allow patients sufficient time to contact staff at their general practice.

The GP to whose care the patient is being transferred should receive notification, via a Discharge Summary, within 24 hours of discharge of the patient's diagnosis and medication, so that any necessary ongoing treatment can be maintained.

Where a patient has an immediate clinical need for medication as a result of attending an outpatient clinic, the secondary care provider must supply medication sufficient to last at least until the point at which the outpatient clinic's letter can reasonably be expected to have reached the patient's GP, and when the GP can therefore accept responsibility for subsequent prescribing. Consideration should be given to providing a minimum of 7 days' supply to allow patients sufficient time to contact staff at their general practice (or shorter if medicines are not required for that length of time).

Prescribing of medicines can also be transferred from specialist to a GP through a process called shared care. Shared care within the NHS refers to an arrangement whereby a specialist doctor formally transfers responsibility for all or some aspects of their patient's care, such as prescription of medication, over to the patient's general practitioner (GP).

Shared care arrangements between a specialist service and the patient's GP can cover a number of clinical areas. In proposing shared care agreements, a specialist should advise which medicines to prescribe, what monitoring will need to take place in primary care, how often medicines should be reviewed, and what actions should be taken in the event of difficulties. The specialist clinician must follow General Medical Council (GMC) guidance that if continuation of the treatment is dependent on shared care, then an agreement with the GP must be in place before the treatment is started.

At an individual patient level, patients themselves and/or carers must be centrally involved in any decision-making process. They should be supported by good quality information that

helps them to both come to an informed decision about engagement in a shared care arrangement and sets out the practical arrangements for ongoing supplies of medicines. When clinical responsibility for prescribing is transferred to general practice, it is important that the GP, or other primary care prescriber, is confident to prescribe the necessary medicines. Shared care agreements play a key role in enabling primary care prescribers to prescribe medicines with which they may not initially be familiar.

Prescribers are responsible for the prescriptions they sign, and they must be prepared to explain and justify their decisions and actions.

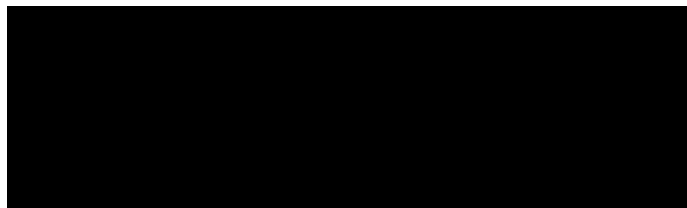
I would like to highlight action we are taking at a national level which will radically improve data sharing between NHS service providers, whether they are neighbouring hospitals as was in Mrs Lydon's case, or at opposite ends of the country.

There is a national programme of work to introduce a Single Patient Record across England from 2028. This will allow patient information to be shared with patients and their relevant health and social care providers (such as GPs, hospital doctors, social care workers and others involved in their direct care). Our aim is that for the first time, the NHS will have a single record of patient needs and history, consistently across health services and social care in England.

There are already some excellent local Shared Care Records which offer a similar service. The Single Patient Record will mean everyone across England gets the same benefits from having their data in the same place for professionals to see when delivering care.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

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MINISTER OF STATE FOR HEALTH