NHS
Greater Manchester
Integrated Care

E: [redacted]

Date: 24 June 2025

Private & Confidential

Ms Alison Mutch
Senior Coroner for the area of Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Sent by email to: [redacted]

Dear Ms. Mutch

Re: Regulation 28 Report to Prevent Future Deaths - Louise Danielle Rosendale

Thank you for your Regulation 28 Report dated 30 April 2025 regarding the sad death of Louise Danielle Rosendale. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Ms. Rosendale's family for their loss.

Thank you for highlighting your concerns during the inquest which concluded on the 17 March 2025. On behalf of NHS GM, we apologise that you have had to bring these matters of concern to our attention. We recognise it is very important to ensure we make the necessary improvements to the quality and safety of future services.

During the inquest you identified the following cause for concern:

> Louise Rosendale had been prescribed opiates for many years despite the risks associated with long term opiate prescribing. The evidence before the inquest was that there had been very limited attempts to review the long-term prescribing of opiates to her. The inquest was told that she had been identified as a patient on a long-term opiate prescription in 2022. The next action had been a pharmacy review in July 2024. There was no evidence of long-term detailed planning or oversight of these patients within the practice.

NHS GM has undertaken an investigation into the cause for concern. As the GP practice responsible for Ms. Rosendale's care, Flixton Road Medical Centre has provided a comprehensive response, and I understand that their response has been shared directly with you. The practice has shared their response with NHS GM, and I have included this and the associated documentation at Appendix 1 to this letter.

NHS GM (Trafford locality) Medicines Optimisation team have reviewed your report and the cause for concern and have provided information on the expectation of care for patients prescribed opioids, work underway in the locality to reduce harm from opioids and plans for improvements in the future.

GP practice expectation regarding review of patients prescribed opioids.

Since October 2020, there has been a requirement, as part of the PCN Direct Enhanced Service (DES) contract, for GP practices to proactively identify and prioritise for structured medication review (SMR) patients using one or more potentially addictive medications from the following groups: opioids; gabapentinoids; benzodiazepines; and z-drugs. However, the PCN DES also states that the number of SMRs that a PCN is required to offer will be determined and limited by their clinical pharmacist capacity.

Work undertaken in the NHS GM Trafford Locality

The Trafford locality Medicines Optimisation Team have undertaken several actions with the aim of reducing harm from opioids.

One of the pharmacists in the team leads on opioid risk reduction and pain management, collaborating with colleagues to share good practice and implement strategies for opioid risk reduction. This includes:

- Taking part, along with a pharmacy technician from the Trafford team, in the Medicines Safety Improvement Programme (MedSIP) breakthrough series collaborative which aims to implement a whole system approach to high-risk opioid prescribing. This has resulted in sharing of good practice and closer working with other secondary and primary care colleagues across Greater Manchester.
- Representing the Trafford Locality at the Greater Manchester Pain Collaborative which brings together stakeholders to identify and develop solutions to the challenges of prescribing pain medicines across Greater Manchester.
- Attending the local hospital trust's Opioid Safety Group to facilitate primary and secondary care colleagues working together to reduce the harm from opioids. One of the current areas of work for this group is the implementation of the GM Communication Standards for Opioids at Discharge.
- Attendance at trust-led case-based discussions regarding opioid prescribing to gain a better understanding of the challenges faced in secondary care and how these impact on primary care
- Working with colleagues from Manchester University to investigate and implement use of the new Safety Medication (SMASH) dashboard indicator which identifies patients prescribed opioids within 30 days of discharge from hospital. The aim of the indicator is to facilitate identification and review of patients to prevent harm from long term opioid use.
- Collaboration with a colleague from another locality to produce a communication for primary care to highlight the risks from opioids used in chronic pain, encourage review of these patients and signpost to resources available on the Greater Manchester Pain Management Resources Hub.
- Discussion at regular meetings held with PCN clinical pharmacists to highlight the need to identify and prioritise patients prescribed opioids for structured medication reviews and ensuring they are aware of resources available to facilitate review, including the Greater Manchester Pain Management Resources Hub.

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- Attendance at the Regional CD Local Intelligence Network meetings to ensure awareness of and learning from issues/incidents in other areas and share good practice.

As well as continuing with the work detailed above, the following actions are planned in Trafford locality this year:

- Work with GP practices to increase use of the safety medication (SMASH) dashboard, including the new opioid indicator.
- Review by a pharmacy technician and pharmacist from the team of patients flagged by the SMASH opioid indicator and identify improvements that can be made to primary care review processes as well as feeding back, via the trust Opioid Safety Group, potential improvements to secondary care processes.
- Work with colleagues in other GM localities to produce and implement standards for primary care review of patients discharged on opioids.
- Provide data to GP Practices regarding their opioid prescribing, including high dose opioids, and ensure they are aware of resources available to facilitate review of patients.
- Increase awareness, and ensure information is readily accessible to GP practice clinicians, regarding local services available to support the review of patients on opioids, including pain clinic referral pathways and non-pharmacological support for pain management.
- Collaborate with colleagues from other GM localities and secondary care pain clinics to explore the potential for multidisciplinary team review of complex patients on high dose opioids in primary care.

NHS GM works in partnership across all locality Medicines Management teams and all learning is shared through the ICB for GM wide system learning.

I hope that this responses assures you that NHS GM has responded to your report and will take positive steps to share learning. If you have any questions about this responses, please contact me.

Best wishes

[redacted]

[redacted]
Interim Deputy Chief Executive Officer and Chief Nursing Officer
NHS Greater Manchester

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