

**Regulation 28 Report to Prevent Future Deaths  
Derby and Derbyshire Integrated Care Board Response**

**Derby and Derbyshire Integrated Care Board (DDICB) would like to extend** our sympathies to the family and friends of Wendy Boddington. Please find below the ICBs response and future plans regarding the Regulation 28 Report to Prevent Future Deaths.

If there are any areas which you feel you would like more information or to discuss in person, this will be arranged.

Wendy was found deceased at home by friends who went to check on her on 24 March 2025 after she had not responded to texts and phone calls for several days. Wendy had [REDACTED] fentanyl patches on her body rather than the single patch prescribed.

Post-mortem examination with toxicology established that she had a high level of fentanyl in her system recognised to be in the fatal range and codeine would have added to that toxicity. Wendy had been prescribed those medications for chronic pain since 2011, following an accident and amputation of her arm.

The court heard that there is now awareness of the risks of long-term prescription of opiates and opioids and fentanyl in particular, concerning complications including tolerance and dependence, with guidance issued to medical practitioners over time as understanding has increased.

The fentanyl was prescribed by a GP at Wendy's GP practice in 2011 because Wendy complained that other pain relief had been ineffective. The dose was increased over a short period. At that time GP awareness of the complications of fentanyl was more limited, but in 2014 and 2015 GPs at the practice had attempted to address Wendy's level of opiate and opioid medication, although Wendy was not in agreement. However, Wendy had at least annual medication reviews, and on the evidence, there were no clear plans to address this after 2015 which were missed opportunities over a nine to ten year period. There was also a missed opportunity for the specialist hospital pain clinic to raise the fentanyl prescription with the GP practice in 2021. The court heard that it is often the case that opiate and opioid reduction or stoppage can be difficult, and Wendy had expressed objections.

There is no positive evidence that Wendy had placed two fentanyl patches on herself to deliberately harm herself, and it is noted that she had fallen and injured her ankle just days before her death and she was probably experiencing increased pain because of that.

**Coroner concerns**

**Context - The well-recognised situation of long-term prescription of opiate and opioid medications, often at high doses, for chronic pain.**

It is now recognised that such prescribing will usually cause other health problems, including dependence and tolerance, and over time becomes limited in controlling pain. Whilst current guidance is against such prescribing, there are many people who have been taking these

medications for a long time for whom stopping or reducing the medications is very challenging.

There are no specialist services for patients who have developed dependence on opiates and opioids, and that substance misuse services will only work with people with non-prescribed drug issues. The inquest did hear anecdotal evidence that NHS England may be pursuing some relevant initiatives but the details and extent of this was unclear.

There appear to be a significant number of people who are being prescribed opiate and opioid medications for chronic pain, often at high doses and for long periods, but may not be receiving support to reduce, stop, or substitute those medications. It appears to me that the ICB is in a position to consider this problem and potential remedies on a regional basis, and feed into national strategies.

### **Derby and Derbyshire ICB Response**

Derby and Derbyshire ICB acknowledges the concerns raised by the coroner in this report and continues to make every effort to address these and other issues already identified with the management of chronic pain within the system. A summary of the work done or on-going within the ICB to this effect, is described below.

#### System-wide collaborative opioid harm reduction project

The National Patient Safety Improvement Programmes (SIPs) are an NHSE led commission delivered by the Patient Safety Collaboratives (PSC). One of the four programmes is the Medicines Safety Improvement Programme (MedSIP) which aims to reduce severe avoidable medication-related harm by focusing on high-risk drugs and avoidable situations, and vulnerable patients. One of the priority areas of the MedSIP is improving the management of chronic non-cancer pain by reducing harm from opioids.

Between January 2022 and March 2025, as part of the national MedSIP, Joined Up Care Derbyshire (JUCD) Integrated Care System took a systems approach to change opioid prescribing in chronic non-cancer pain, supported by Health Innovation East Midlands, who host the East Midlands PSC. The programme involved:

Developing resources for patients and prescribers including

- Quality Improvement (QI) toolkit with suggested best practice interventions for Practices who wish to do some focused work on opioid prescribing,
- Minimum standards for opioids repeat prescribing, supporting implementation of robust procedures specific to their system and patient population while still maintaining expected safety & quality prescribing standards.
- Opioid tapering resource with a clear focus on reducing opioids.

Education –

- pain management webinars delivered by a national Pain Management Specialist for local HCPs
- > 80 people trained to practitioner level in the ten footsteps approach to living with chronic pain.

- Targeted Practice support for Quality Improvement projects
- Optional ICB funded protected Learning (QUEST) sessions for GP practices

#### Innovation

- Collaboration with the national charity Live Well With Pain to develop and evaluate digital tools for primary care to support patients and clinicians to perform a holistic pain management review.
- Roll out of pain support programmes developed in Derby using the evidence based 10 footsteps approach, with 20 pain management support groups facilitated by social prescribing / health coaching teams set up.

#### GP Quality schedule

The GP Quality schedule forms part of the wider GP Local Enhanced Services contract under which practices receive payment from the ICB for meeting the stated quality requirements over the year. The quality schedule includes several prescribing indicators which are updated annually.

During the 2025/26 financial year practices were required under the quality schedule, to identify, produce a register, and complete a review of all non-palliative patients on high dose opioids (oral Morphine equivalent {OME} daily), to include discussion and documentation in the patient record of risks, opportunities for alternative pain management strategies, exploration of dose reduction/weaning, interacting medication, and ensuring visible reminders are in place on the patient record to prevent further dose escalation.

#### Getting it Right First Time (GIRFT) chronic pain review

In January 2026, the ICB participated in an NHS England GIRFT chronic pain virtual system review, working in collaboration with the Faculty of Pain Medicine and the British Pain Society. The review looked to identify variation and challenges across the whole chronic pain pathway to help address challenges in service delivery for pain management, in line with the strategic aims of the Department of Health and Social Care and NHS England. The aim is to develop a structured model to ensure patients receive personalised, holistic and evidence-based care at each stage, with seamless transitions between services– in turn, improving the patient experience. This is part of a programme of multiple ICS reviews, at the end of which a joint report will be published, highlighting priority areas for national improvement

The ICB awaits the final report from the GIRFT review and remains committed to implementing the recommendations in line with national and organisational objectives.

#### Outcomes to date.

NHS England medicines safety team estimates that for every 62 people who stop (or do not start) taking opioids, 1 life is saved. Through the actions of this programme and the reduction in the number of patients receiving long term opioids at least 15 lives have been saved to date.

Latest available data also shows a decrease in prescribing of high dose opioid items from the 2022 baseline, taking the ICB from the 54<sup>th</sup> to 44<sup>th</sup> percentile across ICBs in England.  
<https://openprescribing.net/measure/opioidspercent/sicbl/15M/>

### **Further planned actions to address concerns**

Considering the concerns raised by the coroner in this report, the ICB is undertaking the following further actions:

Action	Timescale
The quality schedule will be updated for 2026/27 to again include high dose opioid reviews, to align with updated recommendations from the Faculty of Pain Medicine which now defines high dose opioid as > 90mg (OME) daily.	Ongoing- expected completion April 2026
ICB funded education sessions for local prescribing leads focussing on opioid prescribing.	May 2026
ICB review and re-procurement of pain management services	Ongoing