Appendix 3(a)

Drug Related Deaths Scrutiny Review

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1.0 Foreword

1.1 The issue of drug related deaths is of huge significance in Blackpool and is something I and my colleagues have a real interest in and desire to help address. When the subject of drug related deaths was first mentioned to the Committee, there was a mutual feeling amongst Members that the impact of the issue on individuals, families, friends and communities was something that needed to be explored with a view to looking at the issue from all angles. The human cost is significant and it was our aim to bring partners together to identify areas for improvement.

1.2 I would like to thank my fellow Members for taking part in this review, the importance of Member engagement and enthusiasm in scrutiny reviews is paramount and without that we would not have been able to come to the conclusions and recommendations that we have done. Recommendations that I hope will make a real difference when implemented.

1.3 I would also like to thank all those who contributed to the review, provided the evidence presented to Members and answered our questions at the Panel meetings, your contribution was vital to Members' understanding of the key issues presented and allowing us to come to the conclusions and recommendations identified. Particular thanks must go to Ms Emily Davis, Drug Harm Reduction Lead for her significant contribution to the review.

Councillor Paula Burdess
Chairman, Drug Related Death Scrutiny Review Panel

2.0 Summary of Recommendations

	Timescale
Recommendation One: **To request that the services, led by Emily Davis and Jon Clegg, work together to map the location of death, place of residence, location of non-fatal overdoses and related organised crime in order to identify where to target joint resources and to share the intelligence as appropriate, reporting back to Committee in six months on progress.**	Progress report 3 February 2021
Recommendation Two **That the Director of Public Health continues to work in order to increase messaging about Naloxone use and the dangers of being alone when using drugs and report back to Committee on the interventions put in place in approximately 6 months.**	Progress report 3 February 2021
Recommendation Three **To request that Karon Brown and Emily Davis commence work on a comparative costing of Heroin Assisted Treatment and Overdose Prevention Centres to share with all partners and identify what aspects could be legally introduced into services already being provided in order to make an immediate impact, reporting back to Committee in approximately 6 months.**	Progress report 3 February 2021
Recommendation Four **That the Council led by the Cabinet Member for Adult Social Care and Health works with other local authorities and our MPs to lobby Government to introduce legislation and policy to address this critical need, including appropriate overdose prevention facilities.**	Progress report 3 February 2021
Recommendation Five **That the CCG's medication optimisation team work with GPs to ensure safe prescribing methods were embedded within practices with an update on progress provided in approximately 6 months.**	Progress report 3 February 2021
Recommendation Six **The CCG and ICP should work collaboratively with all partners to minimise the long term negative health effects of long-term prescribing of controlled short-term medication.**	Progress report 3 February 2021

Recommendation Seven **That the Council and Blackpool Clinical Commissioning Group be requested to continue the outreach homeless provision continue post pandemic and that the Committee receive an update on the provision and impact in approximately 12 months time.**	Progress report 23 June 2021
Recommendation Eight **At the same meeting, that the Committee invite the Lived Experience Team, in order to assess improvement and how things had changed across the whole remit of mental health and substance misuse service provision.**	Progress report 23 June 2021
Recommendation Nine **That the Committee receives regular updates on the ADDER project in order to monitor the performance, impact and success of the project.**	Progress report 3 February 2021

3.0 Background Information

3.1 During the Adult Social Care and Health Scrutiny Committee Workplanning Workshop held in July 2020, Members identified the issue of drug related deaths as a topic they wished to explore further. Blackpool has one of the highest levels of drug related deaths in the country. In 2019 alone there were 31 drug related deaths of patients who were in receipt of services. Many of those who died whilst in treatment for their drug use had underlying health conditions. Conditions such as COPD, Liver disease and heart disease were prevalent in the large majority of deaths. This is particularly concerning as Public Health England identifies being 'in service' as a protective factor. However, the additional conditions could indicate that despite the efforts of treatment services it is the wider health offer that is needed to help prevent deaths. Blackpool also has high levels of non-fatal overdoses.

3.2 The Scrutiny Review Panel comprised of Councillors Burdess, O'Hara, Mrs Scott, Danny Scott, Hutton, Wing, Hunter and Matthews.

3.3 The following key issues were identified as the main objectives for the review:

- To highlight the scale of the problem and seek to identify any potential opportunities to make improvements to services.
- To bring partners together to provide a more targeted and joined up approach to reducing the number of drug related deaths.

3.4 This review related to the following priority of the Council:

Communities: Creating stronger communities and increasing resilience.

4.0 Methodology

4.1 The Panel held two formal evidence gathering meetings and began to form their conclusions and recommendations during these meetings. An informal meeting was subsequently held with the Chair and Vice Chair of the Adult Social Care and Health Scrutiny Committee and the Harm Reduction Lead in order to formalise the recommendations which were then circulated for approval by the Panel Members.

Details of the meetings are as follows:

Date	Attendees	Purpose
26 January 2021	Councillors Burdess, O'Hara, Mrs Scott, Danny Scott, Hutton, Wing, Hunter and Matthews. Councillor Jo Farrell, Cabinet Member for Adult Social Care and Health Emily Davis, Harm Reduction Lead, Public Health Judith Mills, Consultant in Public Health Karon Brown, Head of Governance and Risk, Delphi Medical Nicola Plumb, Lived Experience Team, Empowerment DCI Jonathan Clegg, Lancashire Constabulary Julian Coxon, Delphi Medical Sharon Davis, Scrutiny Manager	To receive a presentation on Drug Related Deaths, gathering information on the number of deaths, types of drugs, co-morbidities and programmes currently in place to support and reduce substance misuse.
20 April 2021	Councillors Burdess, O'Hara, Mrs Scott, Danny Scott, Hutton, Wing and Hunter. Dr Arif Rajpura, Director of Public Health Emily Davis, Harm Reduction Lead, Public Health Karon Brown, Head of Governance and Risk, Delphi Medical Nicola Plumb, Lived Experience Team, Empowerment DCI Jonathan Clegg, Lancashire Constabulary Julian Coxon, Delphi Medical Dr Ben Butler-Reid, Clinical Director, Blackpool, Fylde and Wyre Clinical Commissioning Groups Sharon Davis, Scrutiny Manager	To cover the issues identified during the first meeting including the ADDER business case, a briefing on drug consumption rooms and the survey carried out by Horizon of treatment services during the pandemic.

5.0 Detailed Findings and Recommendations

5.1 Introduction

5.1.1 For the purposes of the review, Members were presented with the following definitions of drug related deaths and drug overdose:

Drug misuse deaths are "a) deaths where the underlying cause is drug abuse or drug dependence and (b) deaths where the underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act 1971 are involved." (Office National Statistics 1993).

Drug Overdose is, "the ingestion, accidentally or intentionally, of sufficient drug or drugs to cause injury or death" (Medical Dictionary for the Health Professions and Nursing Farlex 2012).

5.1.2 As set out in the reasons for carrying out this much needed review of drug related deaths in Blackpool, the Panel was advised that Blackpool had the highest number of drug related deaths per 100k of population in both males and females during the recording period 2017-2019. Office of National Statistics (ONS) data released in 2020 showed that:

- There had been 4,393 deaths related to drug poisoning in England and Wales during 2017-2019.
- An addition 2,883 deaths had been related to drug misuse in England and Wales during this time period.
- In 2017-2019 Blackpool had the highest rate of deaths related to drug misuse with 18.9 per 100K.
- In the same time period, Blackpool had the highest number of male deaths with 24 per 100k and the highest number of female deaths with 14 per 100k.

5.1.3 Figure 1 below demonstrates that Blackpool is an outlier with a significantly worse average number of deaths than the England average in relation to deaths from drug misuse. The graph also shows the extent to which rates are higher in comparison to the other authorities in the North West region in 2017-2019.

5.1.4 Figure 2, also below, demonstrates the trend in deaths related to drug poisoning from 2001-2003 to 2017-2019 in England and Blackpool which has been standardised to rates per 100k population. In relation to this graph, Members were advised that trends were recorded in three year periods. With regards to the data, it was noted that males accounted for two thirds of the deaths recorded, that of 106 drug poisoning deaths in Blackpool in 2017-2019, 73 had been categorised as drug misuse and that there had been a 57% increase in deaths from drug poisoning over the last 10 years.

5.1.5 The Panel noted that in the data relating to Blackpool in Figure 2, there had been dips in the recording periods of 2003-2005 and 2009-2011 and queried the reasons for these dips. Ms Emily Davis advised that, following further investigation carried out between the two meetings of the Panel, in 2003 there had been a significant change to the way in which drugs were supplied and a number of harm reduction initiatives established. DCI

Clegg advised that there were regular peaks and troughs in the drug supply market due to regular new campaigns in order to target supply and demand. In 2003, there had been a shortage of heroin due to poor weather and crop blight in Afghanistan and increased enforcement in Turkey, which was a key route for supply.

5.1.6 Dr Arif Rajpura, Director of Public Health reminded the Panel that the numbers being discussed were small numbers and therefore statistical variation was expected and therefore not much of significance could be derived from the data. The same point applied when considering the month of death. The Panel was presented with the month of death for 2020 and queried whether a there were any trends in the month of death over the years and whether there had been a specific impact in 2020 due to Covid-19. At the second meeting of the Panel, Members were able to compare the month of death in 2019 and in 2020, however, due to small numbers as previously mentioned, it could not be determined whether the month had had any significant impact. It was noted that Covid had had an impact on many drug users, with those in treatment services potentially receiving more support and contact by phone than usual. Drug users often lived in isolation and in poor situations and there had been an increased focus on their wellbeing during the pandemic with more wraparound support provided than usual such as delivery of food parcels. No correlation between the deaths and lockdown could be established.

5.1.7 During the first Panel meeting, Members also requested that the place of death be broken down by ward and a map was circulated demonstrating that the most number of deaths occurred in central wards, however, this did not necessarily indicate the place where the deceased lived and a number of deaths had occurred in public places.

Figure 1: Deaths from Drug Misuse – North West Region 2017-2019

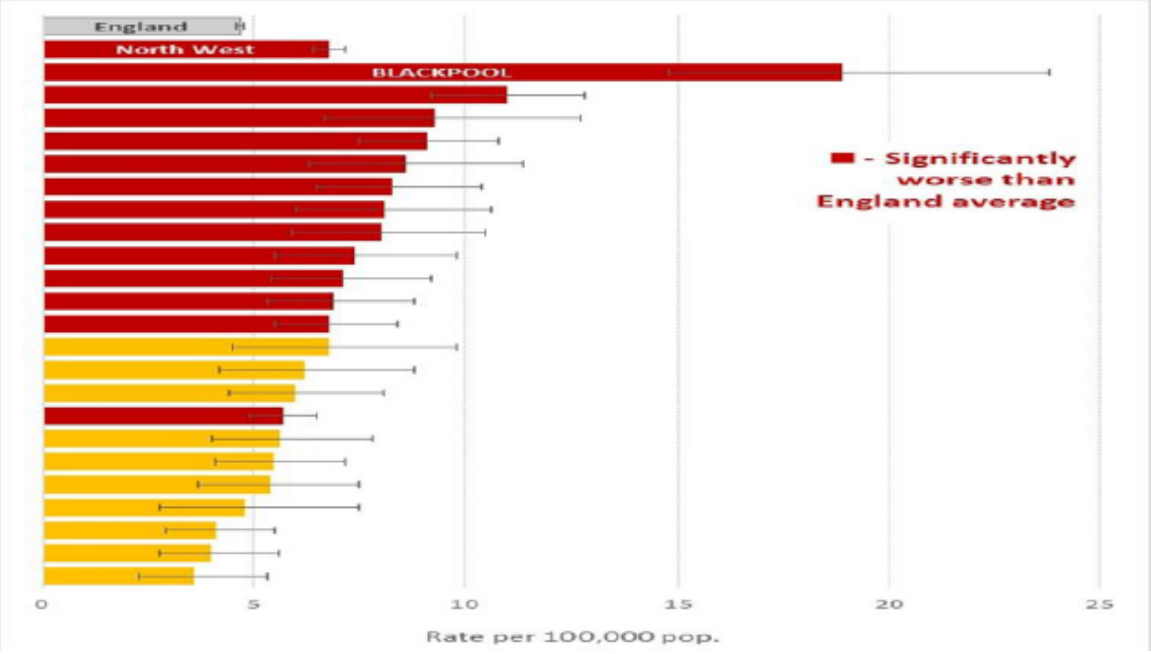
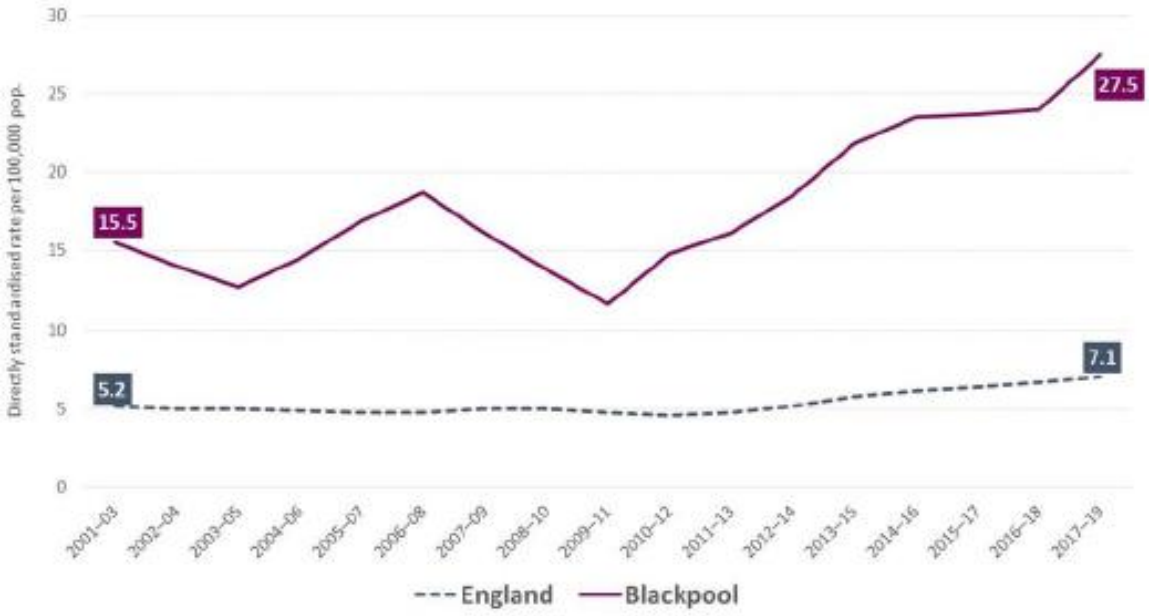


Figure 2: Trend in deaths related to drug poisoning: 2001-2003 to 2017-2019 England and Blackpool. Directly standardised rates per 100,000 population.



5.1.8 The most recent data from 2020 suggested that trends were continuing with the Drug Related Death lead notified in real time of 42 deaths between 1 January 2020 and 31 December 2020. (The number of deaths may increase once the coroner has concluded all inquests for the same reporting period). Of these, 32 were male, 10 female with a total average age of death of 48 years old. It was noted that the following data was incomplete and did not reflect all 42 deaths at the time of being considered by the Panel. Of those that had been analysed to date, 76% of those died had been participating in drug treatment services, 33% died alone, 45% had mental health problems, 19% had experienced suicidal ideation/attempts and self-harm prior to death, 55% had been prescribed methadone with 2% prescribed buprenorphine. Due to the pandemic and delays in inquests no further information was available during the period the review took place.

5.1.9 As a further example of the significance of the problems in Blackpool, Members were presented with the total number of ambulance incidents relating to overdose, ingestion or poisoning by drugs compared to other areas in Lancashire which demonstrated that the number of incidents in Blackpool was almost double the nearest other authority of Blackburn with Darwen. It was considered important to be able to also map the location of non-fatal overdoses and the place of residence (not just the location of the death) in order to gather a fuller picture of the problems in Blackpool and where resource should be targeted.

5.1.10 In addition to mapping the location of death, place of residence and location of non-fatal overdoses, it was suggested that the Police could also add into the mapping an indication of related organised crime. It had been noted that Organised Crime Groups often targeted certain areas and places such as pharmacies in order to deal drugs and target those collecting prescriptions. Such a map would then give a clear indication of where joint resources should be targeted. Dr Ben Butler-Reid added that such a resource would

also be beneficial to the Primary Care Networks in order to direct and deliver care and that such intelligence should be circulated as appropriate.

Recommendation One:

To request that the services, led by Emily Davis and Jon Clegg, work together to map the location of death, place of residence, location of non-fatal overdoses and related organised crime in order to identify where to target joint resources and to share the intelligence as appropriate, reporting back to Committee in six months on progress.

5.2 Naloxone and Drug Consumption Rooms

5.2.1 The Panel was specifically informed of the use of Naloxone to reverse an opiate overdose. One way in which Naloxone was often administered was by the North West Ambulance Service (NWAS) when responding to calls of overdose. Between August 2018 and August 2019, 396 instances of Naloxone use in Blackpool had been recorded by NWAS which equated to more than once per day. It was noted that whilst not all of these were attributed to heroin overdose, the vast majority would be.

5.2.2 Referring back to the statistic that 33% of deaths in 2020 had occurred whilst the person was alone, Ms Davis highlighted the importance of Naloxone in preventing deaths and the importance that drug users were not alone when taking drugs. It was noted that Naloxone could be distributed to friends, family members and peer support workers to administer when necessary. Members were informed by Nicola Plumb that a key issue for many users was that when spending all the money they had on the purchase of drugs they did not wish to alert other users and have to share the drugs that they had acquired which resulted in them using the substances alone.

5.2.3 In a number of other countries including Canada, drug consumption rooms had been introduced to address the issues of taking drugs alone. Such rooms were available for drug users to attend to consume their own drugs, which addressed any concerns that they might have to share their drugs with other users. On site Naloxone was available and professionals were on hand should anything go wrong and the drug user require assistance. Under UK law, drug consumption rooms were currently prohibited. However, Members considered that a safe place for users to consume drugs would be beneficial. A further paper was requested by the Panel on the potential benefits to Blackpool of a drug consumption room to allow Members to determine whether to recommend that the Council lobby the Government for a change to the law.

5.2.4 During the second meeting of the Panel, Ms Davis presented the requested detailed briefing paper on drug consumption rooms. It was noted that a task and finish group had been established amongst partners in order to explore further the possibility of introducing such a facility into Blackpool. It was considered that whilst the opening of such a facility remained illegal, there was little that could be done without a memorandum of understanding (MOU) from the Crime Prosecution Service and the Police that the law would not be enforced if such a facility was to opened. Without an MOU, it would also be impossible to obtain requisite insurance.

5.2.5 The wide range of representatives in attendance, plus Members, had a very fruitful discussion on what could be done and when it could be done in order to start making inroads into the number of deaths as soon as possible and noted the update from Councillor Jo Farrell that the Council was lobbying where possible. It was noted that there was learning from Europe, Vancouver and Sydney that demonstrated that drug consumption rooms/overdose prevention rooms had made a positive impact and the evidence base highlighted that such a route would be the most positive for Blackpool should it be made legal or a MOU made. However, there was a legal option of Heroin Assisted Treatment (HAT) that could also be considered for more immediate implementation. The costs related to a HAT (one of which had been established in Middlesbrough) were considered to be more significant as rather than providing a safe space for people to use their own drugs, clients must meet a criteria and were then prescribed and supplied Diamorphine. This also resulted in a HAT being less accessible and not inclusive for all. However, whilst a HAT might not be considered ideal, one could be part of the solution and perhaps ideally both would be provided in the town.

5.2.6 Members also considered the views of residents of such facilities, and queried the potential impact in drawing more drug users or dealers to the town. The experts in attendance considered that these issues would be unlikely as crime groups would recognise that the unit would be monitored and staffed and that they already had sites and outlets in the town. A drug consumption room also did not supply drugs and clients would bring their own and therefore would be unlikely to attract people to the area for this reason. It was, however, considered extremely important that the idea of such a unit was 'socialised' with residents educated to ensure they understood the benefits of such a service and supported it. The service would provide advice and support with other benefits such as a safe needle exchange and naloxone on hand as an antidote to overdose.

5.2.7 All partners in attendance were happy to support the principle of a drug consumption room in the town should it become legal, but considered it necessary to explore other options and viable alternatives in the interim should such a facility never become legal, noting that there were not likely to be any changes to legislation in the near future. A drug consumption room in the town had been an idea for 14 years and that it was important to look at things from a different angle and take action. It was suggested that an outline business case be developed in support of the introduction of a HAT and a drug consumption room should it become viable. The business case would consider costs, savings and impact and would hopefully pave the way to design something locally at low cost. Karon Brown, Delphi agreed to commence work on a comparative costing and determine what aspects of a drug consumption room/HAT could be legally introduced into services that were already being provided. That being said, it was felt that we should work with other local authorities, notably Glasgow City Council who have done a lot of work in this area, to lobby for appropriate overdose prevention facilities, and our MPs to ensure government policy and legislation recognises addresses and critical need.

Recommendation Two

That the Director of Public Health continues to work in order to increase messaging about Naloxone use and the dangers of being alone when using drugs and report back to Committee on the interventions put in place in approximately 6 months.

Recommendation Three

To request that Karon Brown and Emily Davis commence work on a comparative costing of Heroin Assisted Treatment and Overdose Prevention Centres to share with all partners and identify what aspects could be legally introduced into services already being provided in order to make an immediate impact, reporting back to Committee in approximately 6 months.

Recommendation Four

That the Council led by the Cabinet Member for Adult Social Care and Health works with other local authorities and our MPs to lobby Government to introduce legislation and policy to address this critical need, including appropriate overdose prevention facilities.

5.3 Treatment Services

5.3.1 It was noted that of the deaths investigated in 2020, 76% had been identified as being in treatment services. Members were particularly concerned by the statistic and queried whether the service provision was adequate for needs. In response, it was noted that the average age of death was 48 years and that at the time of their death some people would have been using drugs for as many as 30 or 40 years. Once someone had been a drug user for such a length of time, many other physical health issues would have developed such as COPD, Hepatitis C and heart disease.

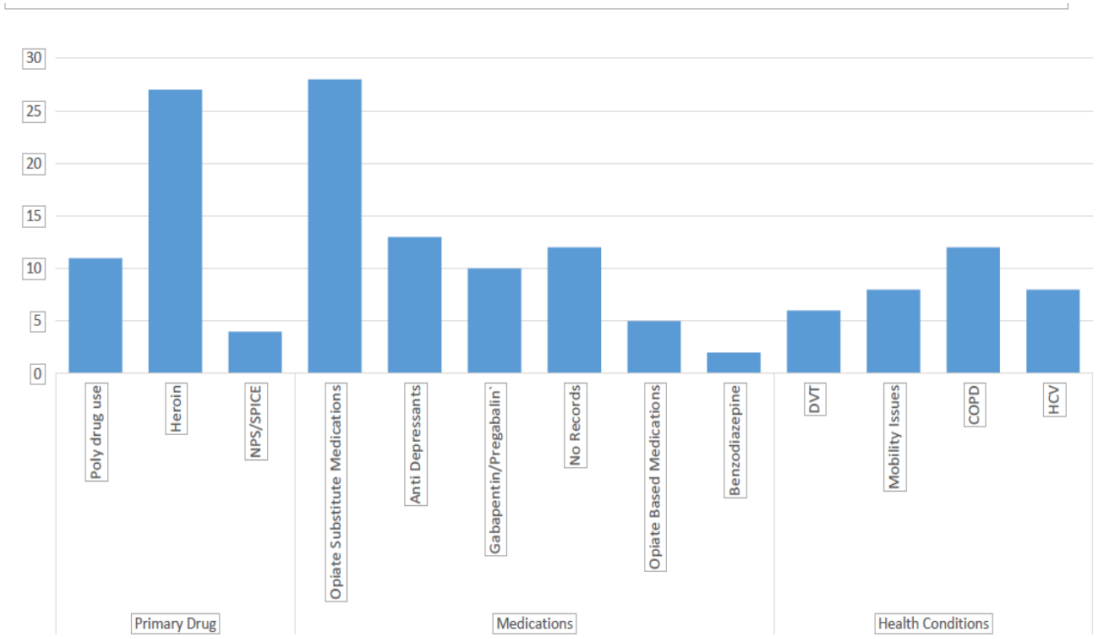
5.3.2 The average age of someone in treatment services was 40 – 49 years old, which was often the age group which had the highest number of other physical medical conditions and was also often the cohort that did not access services in the way that would be expected.

5.3.3 Karon Brown, Delphi Medical highlighted the feedback received of treatment services during the pandemic and it was noted that there had been a number of positives. In particular, service users had preferred receiving a two week prescription rather than having to attend the pharmacy every week or even every day in some circumstances previously. Clients had highlighted that attending the pharmacy so often had reinforced their feeling like an addict and that increasing the length of time between prescriptions had been positive and meant less time waiting in queues at pharmacies where they were open to being approached by dealers.

5.3.4 It was also noted that pre-pandemic the Horizon building had often felt chaotic, and that it was being reopened in a much calmer way. Members praised the response of services during the pandemic and the way in which positives were being explored in a way in which empowered clients. The response of services to clients who were homeless or rough sleepers was also commended, some of whom were also drug users. It was noted that an additional opportunity had presented itself and been taken during the pandemic which would not have ordinarily been available, which was to support some clients through a local detox unit. There had been some success with a number of clients remaining sober. Additional wraparound care had been put in place following their release from the unit

5.3.5 Figure 3 below was provided to demonstrate the health and history of those that had died during 2020. The graph demonstrates the primary drug in the cause of death, other medications that were being taken at the time of death and other health conditions suffered by the person at the time of their death.

Figure 3: Medications, Health and Drug History for Deaths that occurred in 2020



5.3.6 The Panel discussed in detail the additional medication taken by those that had died during 2020 and recorded on the death certificate and spoke in particular of the prescription and use of Gabapentin and Pregablin. Ms Mills advised that the increased use of these two drugs had been identified and raised with the Clinical Commissioning Group prior to the Covid-19 pandemic and remained on the agenda for discussion once the pandemic allowed. Members noted anecdotal evidence regarding the increased use of such drugs and supported the aim to address the issue. It was noted that previously Benzodiazapine had been identified as over-prescribed and steps had been taken successfully to reduce the usage.

5.3.7 Ms Nicola Plumb highlighted additional concerns that should prescriptions of Gabapentin be restricted it would be likely that its availability for sale illegally on the 'dark web' would increase and that the substances sold would be uncontrolled and therefore possibly of increased potency or mixed with other and potentially dangerous substances.

5.3.8 Through discussions, it was considered that it could be of benefit if a designated GP could be identified to focus entirely on drug related deaths, to work with the Coroner, with drug treatment services and related provision in order to support the cohort of drug users in Blackpool in order to provide the best possible service, however, the idea was dismissed as the incorrect approach to take with the Clinical Commissioning Group and Integrated Care Partnership (ICP) as a whole needing to work collaboratively in order to

reduce the long term negative health effects and put interventions in place in order to reduce the impact of prescribed controlled medication and drug related deaths.

Recommendation Five

That the CCG's medication optimisation team work with GPs to ensure safe prescribing methods were embedded within practices with an update on progress provided in approximately 6 months.

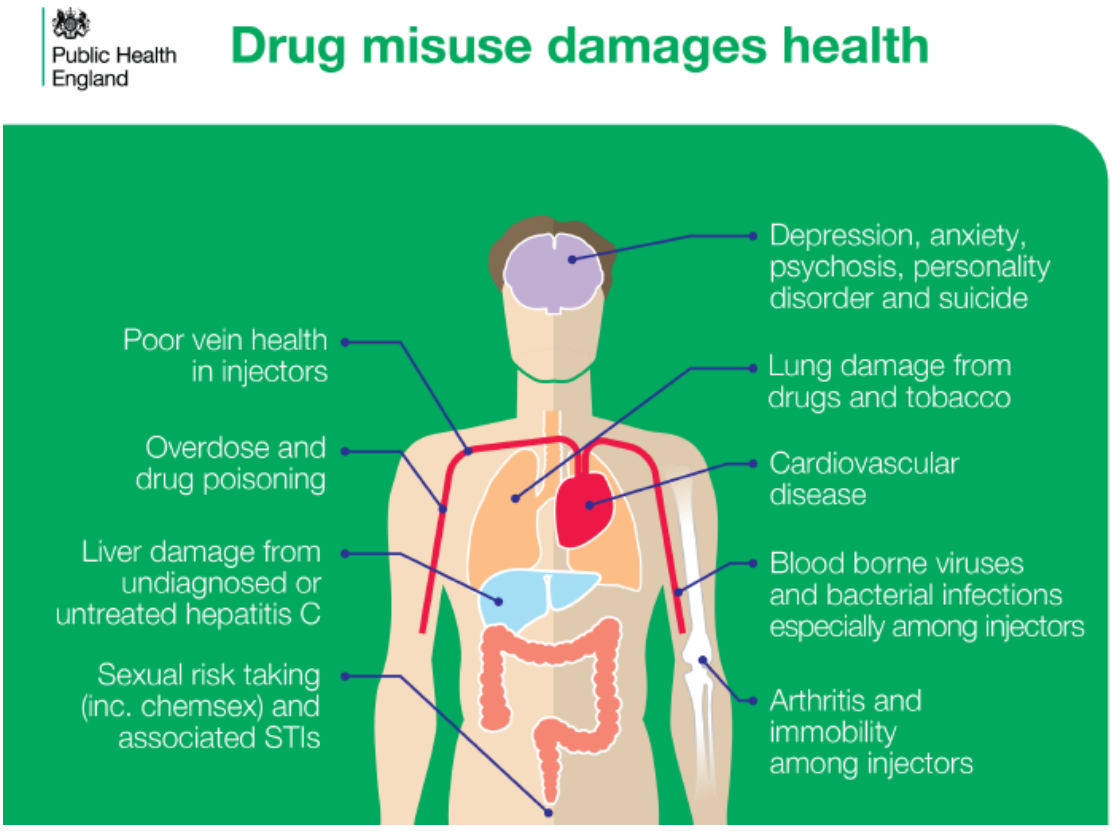
Recommendation Six

The CCG and ICP should work collaboratively with all partners to minimise the long term negative health effects of long-term prescribing of controlled short-term medication.

5.4 Impact of drugs on health

5.4.1 When exploring the impact of drugs on long term health, the Panel noted, as demonstrated within Figure 3 above that those that had died in 2020 suffered from other conditions including Hepatitis C which caused liver disease/cirrhosis, COPD and deep vein thrombosis. These were the most common conditions recorded in Blackpool deaths in 2020, however, as set out in Figure 4 below drug misuse can damage health in a wide variety of ways.

Figure 4: Visual from Public Health England



5.4.2 Members discussed the impact of cannabis on the health of young people in particular and the concerns that use of the drug was increasingly socially acceptable and that it could potentially be a gateway to other drug use. Zohra Dempsey, Public Health Practitioner advised that there was no robust evidence to suggest that use of cannabis led to use of harder drugs. However, it was noted that the ADDER project (detailed at section 5.8 below) included a bespoke cannabis treatment programme within the 'Young ADDER Team.

5.4.3 It was noted that Blackpool had previously experienced an outbreak of a notifiable bacterial infection 'Invasive Group Strep A' which had resulted in a number of the homeless and drug taking community requiring hospitalisation and had unfortunately resulted in some deaths. The outbreak had demonstrated that the way in which people from this community engaged with primary care services was vastly different and had directed how engagement should be provided moving forward, particularly during the Covid-19 pandemic.

5.4.4 A key aspect in successful service provision was that the services were comprehensive and taken to the community. During the pandemic outreach primary care services had been provided via the 'Homeless Health Bus' which had been able to address healthcare needs and provide any other support required in one place such as wound care and harm reduction advice and support. It was noted that individuals had a lifetime of issues such as neglect, abuse, post-traumatic stress disorder, poor mental health as well as addiction that needing addressing in a trauma informed way. This meant that service providers understood that their clients might not always be or appear grateful for assistance and that their trust could be rebuilt in a system that they could and would access.

5.5 Emerging risks and challenges

5.5.1 DCI Jon Clegg reported that increased use and circulation of crack cocaine was of serious concern. He advised that crack cocaine was a dried version of cocaine, often sold in 'rocks' which was 60-70% more potent than cocaine. There was concern that as the substance was cheaper to produce and distribute, it was used in different ways to cocaine which was more expensive.

5.5.2 New variations to existing drugs were becoming more frequently available with substances often mixed with something more harmful, the purity levels could vary as could the strength. A small number of deaths in 2020 had been linked to a batch of harmful 'Spice' (Novel Psychoactive Substance). It was therefore important to be able to identify particularly harmful batches of drugs in order to alert the drug taking community and put in place preventative measures where possible. In response to concerns such as this Lancashire Constabulary had introduced forensic lab capacity to test drugs immediately upon them being seized as a result of attendance at an overdose or death. This provided real time identification of particularly harmful batches following which the community could be alerted.

5.6 Drug Related Death Panel

5.6.1 It was reported that the Drug Related Death Panel had been established approximately one year ago. The purpose of the Panel is to identify what lessons can be learned to influence future practice, address potential gaps in service provision and prevent future deaths through a multi-agency whole-system approach. The Panel comprises of a number of organisations including Horizon, North West Ambulance Service (NWAS), Blackpool Clinical Commissioning Group, Lancashire Constabulary, Blackpool Teaching Hospitals NHS Foundation Trust, the National Probation Service and the Lived Experience Team. The wide representation on the Panel allowed for a larger focus than drug use and treatment and meant that wider issues relating to the individual such as housing, families and bereavement could also be considered.

5.6.2 There is a protocol and process in place which has been refined to allow timelier reporting of deaths related to drugs from the Police and Coroner. However, issues still remained with the transfer of real time data from NWAS. It was noted that the Police only attended an overdose when required whereas NWAS was generally always in attendance. NWAS recorded use of Naloxone in Blackpool as a counter to the effects of opiate overdose and it was noted that it was administered by the service at least once per day. The systems used by NWAS had recently been updated and they now use an Electronic Patient Recording system. It was hoped that real time data would become available from March 2021.

5.7 Impact of the Pandemic

5.7.1 The Covid-19 pandemic had presented ongoing issues with how to engage with homeless and hard to reach people. In general, it was recognised that homeless people did not access treatment in generic health care services. As a result, provision had been most recently provided via a mobile service on a Covid-secure bus whilst the usual facility at The Bridge had been closed. It was reported that there had been concerns raised regarding the location of the bus and at the time of the meeting it had been relocated from the town centre to Central Car Park. Due to its success, even when The Bridge was able to reopen a mobile service would continue.

5.7.2 The success of the mobile provision was noted and it was considered to be reducing the number of admissions to the emergency department. Blackpool Teaching Hospitals Trust were also able to make referrals to the nursing team on the bus to allow for ongoing care for people who injected drugs and required wound management.

5.7.3 Members acknowledged the concerns that had been raised regarding the location of the 'homeless bus' and were of the opinion that access must be provided in a location where it was needed to enable those who needed to access services to easily attend. The Committee wish to extend its support to the provision of services in this way and that it continue post pandemic. There were significant issues regarding mental health in Blackpool and many homeless people and people regularly using drugs also had significant mental health concerns. It was noted that currently to engage with mental health services, clients must be free from alcohol for 12 weeks, however, it was often the case that until support was provided for them to address their mental health concerns they were unable to stop consuming alcohol. The two issues were interlinked.

Recommendation Seven

That the Council and Blackpool Clinical Commissioning Group be requested to continue the outreach homeless provision continue post pandemic and that the Committee receive an update on the provision and impact in approximately 12 months time.

Recommendation Eight

At the same meeting, that the Committee invite the Lived Experience Team, in order to assess improvement and how things had changed across the whole remit of mental health and substance misuse service provision.

5.8 Addiction, Diversion, Disruption, Enforcement and Recovery (ADDER) Pilot to reduce Drug Related Deaths

5.8.1 The Panel was advised that Blackpool was one of four pilot sites for the ADDER project. The pilot was a Home Office initiative in conjunction with Public Health England and the Department of Health and Social Care. The project aimed to deliver reductions in the rate of drug related deaths, drug related offending and the prevalence of drug use. It would work with some of the most difficult to engage drug users, would run until March 2023 and operate in three teams – Adult, Young People and Police Task Force.

5.8.2 It was reported that the budget for drug treatment services had been cut by 31% between 2013 and 2021, which could be considered a significant reduction. Therefore the introduction and funding of the ADDER pilot was very positive and significant to the area. In addition to securing this funding and as a part of the ADDER pilot the Council and providers continued to seek additional funding streams.

5.8.3 The ADDER project would work with the most difficult cohort of people and would try to address and reduce demand for drugs which would in turn impact upon and reduce supply. Aims also included preventing reoffending and providing continuity of care. The Panel received the business case for ADDER at its second meeting and discussed the content in detail and the positive initial outcomes of the project were noted.

5.8.4 Reductions in funding were being counteracted with innovation and collaboration however, the scale of the challenge could not be underestimated. There was currently no specific funding provision at the Council or within health services for dealing with drug related deaths. Addressing drug related deaths was a small area of work within a number of people's workloads, however, services were stretched and therefore it was difficult for focus to be placed on the issue. In addition to the recommendation made earlier that the CCG be requested to identify a specific GP to work on the issue of drug related deaths, it was suggested that the Council also be recommendation to identify a specific officer dedicated to the issue of tackling drug misuse and drug related deaths.

5.8.5 All present commended the work of Emily Davis, Harm Reduction Lead, however it was noted that the issue of drug related deaths was one part of her role and it was considered that the issue was large enough in Blackpool to warrant a full time position in order to work with the Coroner and support the Drug Related Death Panel. As a result of this concern being identified and during the course of the review panel a new Drug

Related Death/Non-Fatal Overdose post was created, which will work closely with public health, police DRD lead, coroner and drug related death panel members. The post holder will support those identified as experiencing non-fatal overdose; provide support and link with all relevant services. They will also identify gaps and develop pathways to support those identified through panel process.

Recommendation Nine

That the Committee receives regular updates on the ADDER project in order to monitor the performance, impact and success of the project.

6.0 Financial and Legal Considerations

6.1 Financial

6.1.1 Any costs for a Heroin Assisted Treatment and Overdose Prevention Centres (Recommendation 3) are expected to be funded by the Police/PCC as they would be leading the project. To continue the Homeless Health Outreach provision Post Pandemic (Recommendation 7) is expected to cost approximately £161k per annum and will be funded by the CCG.

6.2 Legal

6.2.1 As a result of the current legislation, Misuse of Drugs Act 1971, it is illegal for the Council to establish a Drug Consumption Room/Overdose prevention centre.

Such issues could be addressed by legislation, hence the lobbing of Government, they could also be addressed by way of a multi-agency approach, including service design, by which police, prosecutorial, and administrative discretion is sensibly and pragmatically exercised in the interests of personal, public health and welfare. There is no absolute discretion in an authority charged with enforcing the law and there could be circumstances in which the legality of a DCR might be challenged, in particular as a result of s21 of the Misuse of Drugs Act 1971 (UK). Any such agreement would require legal input.

Drug Related Deaths Scrutiny Action Plan

Recommendation	Cabinet Member's Comments	Rec Accepted by Executive?	Target Date for Action	Lead Officer	Committee Update	Notes
Recommendation One: **To request that the services, led by Emily Davis and Jon Clegg, work together to map the location of death, place of residence, location of non-fatal overdoses and related organised crime in order to identify where to target joint resources and to share the intelligence as appropriate, reporting back to Committee in six months on progress.**						
Recommendation Two **That the Director of Public Health continues to work in order to increase messaging about Naloxone use and the dangers of being alone when using drugs and report back to Committee on the interventions put in place in approximately 6 months.**						

Recommendation Three **To request that Karon Brown and Emily Davis commence work on a comparative costing of Heroin Assisted Treatment and Overdose Prevention Centres to share with all partners and identify what aspects could be legally introduced into services already being provided in order to make an immediate impact, reporting back to Committee in approximately 6 months.**						
Recommendation Four **That the Council led by the Cabinet Member for Adult Social Care and Health works with other local authorities and our MPs to lobby Government to introduce legislation and policy to address this critical need, including appropriate overdose prevention facilities.**						

Recommendation Five **That the CCG's medication optimisation team work with GPs to ensure safe prescribing methods were embedded within practices with an update on progress provided in approximately 6 months.**						
Recommendation Six **The CCG and ICP should work collaboratively with all partners to minimise the long term negative health effects of long-term prescribing of controlled short-term medication.**						
Recommendation Seven **That the Council and Blackpool Clinical Commissioning Group be requested to continue the outreach homeless provision continue post pandemic and that the Committee receive an update on the provision and impact in approximately 12 months time.**						

Recommendation Eight **At the same meeting (as Recommendation Seven), that the Committee invite the Lived Experience Team, in order to assess improvement and how things had changed across the whole remit of mental health and substance misuse service provision.**						
Recommendation Nine **That the Committee receives regular updates on the ADDER project in order to monitor the performance, impact and success of the project.**						