Middlesbrough moving forward

Finance, Governance and Support

HEALTH SCRUTINY PANEL

Date: **Tuesday 19th January, 2021**
Time: **4.00 pm**
Venue: **Virtual meeting**

AGENDA

Please note: this is a virtual meeting.

The meeting will be live-streamed via the Council's Youtube channel at 4.00 pm on Tuesday 19th January, 2021

1. Apologies for Absence
2. Declarations of Interest
3. Minutes - Health Scrutiny Panel - 10 November 2020 — 3 - 8

   To receive the minutes of the Health Scrutiny Panel meeting held on 10 November 2020.

4. Covid-19 update

   Mark Adams, Director of Public Heath (South Tees) and Craig Blair, Director of Strategy & Commissioning (Tees Valley CCG) will be in attendance to provide an update on COVID-19 and the local Public Health / NHS response.

5. Health & Wealth - An Introduction — 9 - 22

   Officers will be in attendance to provide an introduction in respect of how the local authority can use economic development to improve health and reduce health inequalities.

6. Draft Final Report - Opioid Dependency: What happens next? — 23 - 60

   Draft Final Report

7. Overview & Scrutiny Board - An update

   The Chair will present a verbal update on the matters that were considered at the meetings of the Overview and Scrutiny Board held on 18 December and 14 January 2020.

8. Any other urgent items which in the opinion of the Chair, may be considered.
9. Date & Time of Next Meeting - Tuesday, 16 February 2021 at 4 pm.

Charlotte Benjamin
Director of Legal and Governance Services

Town Hall
Middlesborough
Monday 11 January 2021

MEMBERSHIP

Councillors J McTigue (Chair), D Coupe (Vice-Chair), B Cooper, A Hellaoui, B Hubbard, T Mawston, D Rooney, M Storey and P Storey

Assistance in accessing information

Should you have any queries on accessing the Agenda and associated information please contact Caroline Breheny, 01642 729752, caroline_breheny@middlesbrough.gov.uk

HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 10 November 2020.

PRESENT: Councillors J McTigue (Chair), B Cooper, D P Coupe, B A Hubbard, T Mawston, J McTigue, D Rooney, M Storey and P Storey and T Higgins(As Substitute)

ALSO IN ATTENDANCE: Lisa Bosomworth (Project Lead - Healthwatch South Tees), Craig Blair (Director of Commissioning, Strategy and Delivery - Tees Valley CCG) and Dr Janet Walker (Medical Director - Tees Valley CCG)

OFFICERS: Mark Adams, Scott Bonner, Caroline Breheny and Joanne Dixon

APOLOGIES FOR ABSENCE Councillor A Hellaoui.

1 **MINUTES - HEALTH SCRUTINY PANEL - 22 SEPTEMBER 2020**

The minutes of the Health Scrutiny Panel meeting held on 22 September 2020 were approved as a correct record.

2 **MINUTES - HEALTH SCRUTINY PANEL - 13 OCTOBER 2020**

The minutes of the Health Scrutiny Panel meeting held on 13 October 2020 were yet to be finalised and would be submitted for consideration by Members at the next panel meeting.

3 **COVID-19 UPDATE**

The Director of Public Health (South Tees) was in attendance to provide the Panel with an update in respect of COVID-19 and the local Public Health and NHS response. The Director advised that at the last Health Scrutiny Panel meeting, as held on 13 October 2020, the 7 day rolling average figure for the COVID-19 infection rate in Middlesbrough was 268.8 per 100,000 (11 October 2020). Today that rate had climbed to 430 per 100,000 (8 November 2020).

Reference was made to the fact that Middlesbrough and Hartlepool had been placed in Tier 2 'high' restrictions from 3 October 2020. It was noted that although around 29 October the rates had started to decrease infection rates had since started to increase. There remained a high prevalence of infection in the community and the current rate of infection was similar to the highest rates seen in the previous peak.

In terms of the regional picture Middlesbrough's testing rate of 2,825 (1 - 7 November) was the highest in the North East, which indicated that access to testing was not an issue. The rate of positive tests at 13.6 per cent was high and a figure of 5 per cent would be an expected ratio. However, the rate was consistent with other Local Authorities in the North East region.

In terms of analysis by age the figures showed that the prevalence of COVID-19 was highest in Middlesbrough amongst people of working age (age ranges 35-49, age 15-34 and age 50-64) with rates of between 350 and 450 per 100,000. Currently the rates amongst those aged 65+ was around the 200 per 100,000 figure.

In relation to the approach that was being adopted to disrupt the spread and protect local communities it was advised that there were four main areas of activity:-

- Community Capacity Building
- Test and Trace
- Protecting Vulnerable People
- Covid-Safe Settings

Within each area specific work was being undertaken, for example, some of the work would be co-ordinated at a regional level including:-

- Mass Testing - Lateral Flow Tests(LFTs)

- NE Test, Trace & Isolate (TTI) Programme
- Building behavioural insights

In terms of the LFT's it was explained that Middlesbrough was anticipating receiving a large supply of LFT's (a weekly amount of 10 per cent of the population) and it was explained that these would be used to protect the most vulnerable people in our community. Across the North East the plan was that the LFT's would be used primarily for the following purposes:

- Opening up testing to care home visitors
- Introducing testing amongst Domiciliary Care staff
- Potentially testing Care Home staff more frequently than weekly

In addition the Local Authority was looking to develop a more locally enhanced contact tracing programme. The Panel was advised that currently the national system reached about 75 per cent of positive cases and less than that figure for contacts of cases. With the introduction of a locally enhanced programme after 8 hours the national contact tracing team would hand over the details to our local teams. Contacts made would then be from a local number and staff would be available to advise on the local offer / support packages available to people to help them self-isolate.

It was advised that in terms of the COVID vaccine programme it would be developed on a North East basis and as of yet the Director had no further information in respect of timescales. However, Members were advised that a wide scale vaccination programme would need to be carefully planned and he anticipated that it would be Easter time before large numbers of people in the local community would receive the vaccine.

The Director of Commissioning and Medical Director at Tees Valley Clinical Commissioning Group (CCG) were in attendance to provide an update on COVID-19 from the NHS' perspective.

In terms of the NHS priorities for this third phase of the pandemic it was explained that these were as follows:-

Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter for:

- Cancer, Elective activity, Primary care and community services, MH & LD/autism

Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally:

- Covid-related practice, Prepare for winter

Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention:

- Workforce, Health inequalities and prevention

Further details in respect of the Tees Valley CCG and ICP's progress towards recovery were detailed in the presentation. In terms of elective surgery it was advised that all cases of patients waiting longer than 52 weeks would undergo a harm review and efforts were being made to maximise the use of Redcar PCH and the Friarage, as well as local independent sector providers.

In terms of primary care and community services 100 per cent of GP practices across the CCG had initiated and video consultation triage services in response to Covid and 100 per cent of GP practices were offering face to face appointments where appropriate.

In relation to the uptake of the flu vaccine it was queried whether issues relating to shortages in supply had been resolved. The Medical Director at TVCCG advised that the uptake this

year had been unprecedented and currently demand did exceed supply. However, GP Practices were receiving additional stocks and it was also the case that this year far more people had been eligible to receive the vaccine than previously. At a national level flu statistics showed that the UK had not entered the peak of the flu season and it was hoped that the low levels of flu prevalence would remain.

With regard to the NHS workforce the CCG had implemented a range of initiatives to support staff wellbeing. This included committing to the implementation of an agile working model in the medium and long term to offer greater flexibility during and after the pandemic. With regard to other developments new ways of working that had been implemented to support the Covid response had now been embedded and were having an impact on reducing overall demand (e.g. A&G, Virtual appointments, Covid Virtual Ward).

COVID OXIMETRY @ HOME - (Virtual Ward and Pulse Oximetry)

Reference was to the Covid Virtual Ward and the Medical Director advised that the Tees Valley COVID Virtual Ward formed part of a national pilot to evaluate both patient and system benefits. The ward used digital technology to support home monitoring. Patients were monitored remotely by a clinical team who could then intervene at the earliest opportunity should a patient show clinical indications of decline requiring a hospital admission.

The Panel was advised that the way in which the COVID Virtual Ward worked was that through the use of a pulse oximeter whereby patients could monitor and report their oxygen levels at home. Evidence from the first wave had suggested that patients conveyed to hospital by ambulance with O2 saturations of 95-100% had a 30 day mortality of 6%. If the patient's O2 saturation was 93-94% the 30 day mortality increased to 13% and if this fell below 93% the 30 day mortality increased to 28%.The aim of the Virtual Ward was to focus on those patient most at risk to detect 'silent hypoxia' at an early stage when intervention would reduce mortality, hospital length ot stay and could reduce the risk of 'long COVID'.

Those patients identified as suitable by clinicians would be admitted to the Virtual Ward in line with the following criteria. The criteria was based on groups at highest risk from the virus:-

- Over 65 years old, COVID diagnosis, symptomatic
- Under 65 years old, symptomatic, clinically vulnerable.

It was explained that examples of populations who were classed ‘clinically vulnerable' included:

- Comorbidities (active cancer treatment, significant immunosuppression, diabetes/chronic lung disease, liver disease, cardiovascular disease), including those as identified as extremely clinically vulnerable (shielded population)
- People with a learning disability
- BMI over 35
- BAME population

In terms of the number of patients currently referred to the COVID Virtual Ward it was advised that to date the total number stood at 283. Of those referrals 248 had been accepted and 222 had been discharged. As of 10 November 2020 there were 34 active patients on the ward with 10 due to be admitted. Feedback from patients and clinical staff had been extremely positive and approval had been given for the project to be rolled out nationally.

AGREED that regular communications be provided to Members in respect of the localised COVID-19 data and a further update be given at the panel's next meeting.

4 **SOUTH TEES HEALTHWATCH - 2019/20 UPDATE**

The Development and Delivery Manager at South Tees Healthwatch was in attendance to provide the panel with an update in respect of the work undertaken by South Tees Healthwatch in 2019/20,

The panel was informed that a Healthwatch was established in every local authority area of England and it acted as the independent champion for people using local health and social care services. In summary the role of Healthwatch was to:

•Listen to what people thought of services
•Use people's views to help shape better services
•Provide information about health and social care services locally.

Healthwatch Middlesbrough and Healthwatch Redcar & Cleveland had been working together across South Tees (HWST), since 1 April 2017.

The panel was advised that since the start of lockdown Healthwatch South Tees had wanted to gather local people's experiences, particularly when accessing and using health, social care and community support services. The aim of the 'Experiences of lockdown across South Tees' research was to shine a light on the positive actions that services had undertaken during lockdown, and to find out what could have been better, to help influence improvements based on public and patient experiences. Due to government guidance and lockdown restrictions, all surveys had to be shared online through Healthwatch's distribution lists and partnerships, social media channels, websites and monthly e-bulletins.

The surveys posted also explored the ‘new normal' in health and social care, asking questions about phone and video consultations, and whether going forward, people would be happy to have appointments in this digital way. It was advised that the findings of the report were supported by the qualitative study ‘The Dr Will Zoom You Now', where Traverse, National Voices and Healthwatch England spoke to 49 people about their experience of remote consultations.

A copy of the report, as produced by South Tees Healthwatch was provided to the panel and it was explained that a great response had been provided by the community. In addition 300 letters / emails of thanks had been received highlighting the difference health, social care and community services had made to people's lives throughout lockdown.

A summary of the key themes was provided as follows:-

- People appreciated how efficient services had been in comparison to what they experienced before COVID-19.
- Staff were described as friendly, helpful and supportive, which had a positive impact on experiences of services.
- Safety measures in health and care settings, e.g. PPE and social distancing were critical for people to feel safe and at ease when attending face-to-face appointments, however the extent to which these were imposed varied between people's experiences of services.
- Video calls were seen as an efficient, safe and reassuring way of accessing care in the current climate, however they weren't always thorough enough or appropriate for the patients' digital literacy, accessibility and actual care needs.
- Some people's access to care had been affected by services' immediate reaction to COVID-19, e.g. postponement of operations.
- Experiences of maternity services had been negatively affected by social distancing guidelines meaning mothers were often alone, however messages of thanks to individuals and staff teams in this department had been received.
- Mental health had been affected by experiences of loneliness and concern for family members, meaning this will be a future area of concern.

It was acknowledged that in respect of the data gathered the demographic profile of the responders did not capture everyone's voice. Heathwatch South Tees were therefore making a concerted effort to capture those seldom heard voices and one way in which this was to be achieved was through the recruitment of community champions. To date 14 community champions had been recruitment and the offer was made to the panel that if any elected Members wished to become community champions or find out more details they simply needed to contact Healthwatch South Tees.

In addition to the work undertaken above in 2019/20 Healthwatch South Tees was currently leading on a consultation about the new South Tees Autism Pathway. It was explained to the panel that from April 2021 there would be a new South Tees pathway for children and young people with autism and other neurological conditions. The new pathway would be called the Neurodevelopmental Pathway and aimed to provide needs led support for both the child and family before, during and after diagnosis.

AGREED that the information provided be noted and any expressions of interest in becoming a Healthwatch Community Champion be forwarded directly to Healthwatch South Tees.

5 **OVERVIEW & SCRUTINY BOARD UPDATE**

A verbal update was provided in relation to the business conducted at the Overview and Scrutiny Board meeting held on 5 November 2020, namely:-

- Executive forward work programme.
- Middlesbrough Council Covid-19 Response - Chief Executive and Director of Public Health.
- Executive Member update - Deputy Mayor and Lead Member for Children's Social Care (Councillor High)
- OSB Membership
- Final Report - Adult Social Care & Services Scrutiny Panel - Physical Activity for older people (65+)
- Final Report - Children & Young People's Learning Scrutiny Panel - Addressing Poverty Issues and the impact on learning.
- Final Report - Economic Development, Environment & Infrastructure Scrutiny Panel - Teesside Crematorium
- Scrutiny Panel Chairs Updates.

AGREED that the information provided be noted.

6 **DATE & TIME OF NEXT MEETING - 8 DECEMBER 2020 AT 4.00PM**

The next meeting of the Health Scrutiny Panel was scheduled for Tuesday, 8 December 2020 at 4.00pm.

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Using economic development to improve health and reduce inequalities in Middlesbrough

1.0 Purpose

1.1 This briefing paper has been pulled together to provide rationale for improved alignment between economic and public health strategy in Middlesbrough, in order to deliver inclusive economies and thriving population health.

2.0 Background

2.1 According to a recent Health Foundation's paper[1], "*people's health and the economy cannot be viewed independently. Both are necessary foundations of a flourishing and prosperous society*". Whilst this assertion has long been accepted academically, the interdependent link between COVID-19 and the short and long-term economic impact, has further heightened awareness of the intrinsic correlation between health and wealth.

2.2 In Middlesbrough, a key indicator of the interdependent relationship between health outcomes and economic status is the correlation between levels of deprivation and life expectancy. For instance, between the most deprived and least deprived wards in Middlesbrough (North Ormesby and Nunthorpe, respectively) there is respective 9.8 and 8.9 year gap in male and female life expectancy.

2.3 This relationship is reflected in multiple health indicators. The table below demonstrates the comparison of high-level health and socioeconomic outcomes, between Middlesbrough and the more affluent area of Richmond upon Thame. These indicators sit worryingly alongside a national trend for increasing income-related health inequalities, which are perhaps indicative of a widening trend.

Indicator	Middlesbrough	Richmond Upon Thames	England average
Deprivation Score (from least deprived at score of 5.8 to most deprived at 45)	**40.5**	**9.4**	21.7
Children living in absolute low income families	**30%**	**5.2%**	15.3%
Children living in relative low income families	**36.8%**	**6.4%**	18.4%
% of people aged 16-64 in employment	**65.2%**	**82.4%**	76.2%
% of children achieving a good level of school readiness at the end of reception (%)	**63.1%**	**80.6%**	71.8%
Healthy Life expectancy males (years)	**57.8**	**71.9**	63.4
Healthy life expectancy females (years)	**58.5**	**69.7**	63.9
Life expectancy males (years)	**75.4**	**82.6**	79.8
Life expectancy females (years)	**80.3**	**86.3**	83.4
Mortality rate for causes that are preventable (DSR per 100,000 pop)	**245**	**106.6**	100

Table 2.3 high-level comparison of health and socio-economic data between Middlesbrough and Richmond upon Thames

[1] Naik et al, 2020, 'Using economic development to improve health and reduce health inequalities'

2.4 Since 2015, Middlesbrough has been identified as the most deprived area nationally (based on proportion of lower super-output areas within the 10% most deprived). The recent Marmot Review highlighted that previous increases in life expectancy in the area, had worrying declined or stagnated in the last decade. Indeed the previous year-on-year improvements in life expectancy observed in Middlesbrough between 2001-2003 and 2011-2013 were mainly driven by gains in the affluent wards across the town, with the deprived wards showing very small changes in life expectancy in the last 15 years.

2.5 Whilst, some of this has been attributed to reduced social protections brought about by increased government austerity, the association between life expectancy and living standards additionally points to the impacts of the 2008 economic recession and persistent levels of income inequality experience since the 1980s - alongside other complex and interacting factors.

2.6 In the run-up to COVID-19, a national paradox between growth in employment and GDP, in the face of entrenched poverty, low quality jobs and poor income and living conditions, cast a light on the unequal distribution of economic progress. Good health is not however just a product of a thriving economy, it is a necessary contributor to it. A recent LGA report[2], highlighted the cost of poor health on the economy, presenting some of the annual costs experienced nationally as a result, this included:

- Over £100 billion a year in productivity lost due to poor health;
- £42 billion a year in workforce costs attached to mental health issues;
- c£4.8 billion a year costs of socio-economic inequality on the NHS; and
- £15 billion worth of sick days

2.7 COVID-19 will undoubtedly amplify the economic costs outlined above, with early findings from the crisis additionally pointing to the unequal distribution of the direct and indirect impacts of the virus across socioeconomic lines. Higher number of death from COVID-19 in people living in socioeconomically deprived areas[3] were observed from as early as May 2020, with some studies suggesting that people residing in poor areas are over twice as likely to be killed by the virus than those in the richest[4].

2.8 In addition to the above, the control measures enforced to stem the virus have broader implications on income and job security. The IFS suggests that (excluding key workers) the majority of the people in the bottom tenth of earning distributions, correlate to sectors that have been shut down as a result of COVID. When those who are unlikely to work from home are included within this, it is estimated that job security of c80% of low income earners, have been indirectly affected by the pandemic. As key determinants of health, these impacts are likely to have a significant influence in person's ability to live a healthy live and will invariably translate to increased risk of premature mortality and morbidity that extends beyond the immediate risk of the virus.

[2] LGA, 2019, 'Nobody left behind: maximising the health benefits on an inclusive economy'.
[3] https://www.health.org.uk/news-and-comment/blogs/inequalities-and-deaths-involving-covid-19
[4] https://www.kingsfund.org.uk/press/press-releases/covid-19-stark-differences-life-expectancy

2.9 A framework for understanding the relationship between health and the economy has been outlined below, which demonstrates the complex interplay between variable factors that work with and through each other to shape health outcomes (which in turn shape the socioeconomic context).

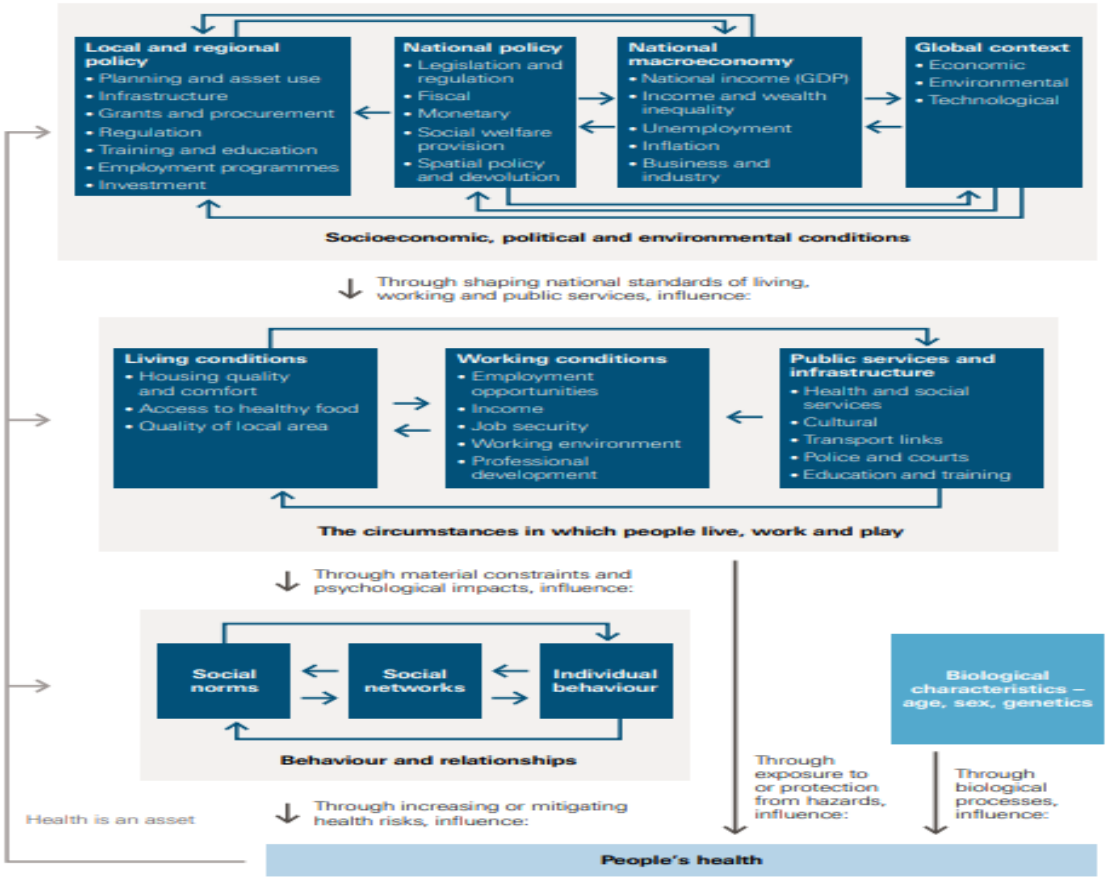


Diagram 2.10, drawn from WHO commission on Social Determinants of Health, 2010

2.10 Whilst the relationship between health and socioeconomic status is highly complex, the above provides a high-level demonstration of the intrinsic link between the two. It also necessitates the prioritisation of inclusive economic strategies in-light of the COVID-19 pandemic, which will undoubtedly by characterised as both a health and economic crisis. As indicated by the LGA - *'there is a danger that inequalities ingrained in the 'old world' will widen, and that those left behind by traditional models of growth will suffer the most from the economic fallout of this global crisis'*.

3.0 Key Local Government Levers

3.1 Councils and Combined Authorities have a significant role to play in developing inclusive economies. By embracing place-based approaches - that acknowledge the collective role of policy, services and communities in maximising the potential for shared prosperity and

growth – shared economic development and public health approaches, can play a critical role in securing a fair and thriving borough.

3.2 6 high-level areas of prioritisation in promoting inclusive economies, have emerged from the evolving evidence base, these have been outlined below and sit alongside a wider call for improved engagement between economic development functions and public health[5]:

- Building a thorough understanding of local issues, to affectively diagnose the challenges and levers to inclusive economic growth and to better understand the impact of growth policies across population groups (e.g. BAME communities);
- Having a long term vision and strong leadership, underpinned by a desire to design local economies that are good for people's health- including rebuilding economies in a way that takes stock of the lessons learnt from COVID-19;
- Building strong citizen engagement to inform priorities and strategies, in a way that builds community momentum and meets local aspirations;
- Capitalising on local assets and using local powers more actively – including harnessing local government powers to shape economic conditions and capitalising on key assets such as, industrial sector, cultural heritage, natural environment and anchor institutions;
- Providing services that meet people's economic and health needs together.

3.3 The imperatives outlined above for improved alignment between health and wealth, provide a critical starting point for prioritising action at the local government level.

4.0 Recommendations

4.1 It is recommended that the Health Scrutiny Board consider the high-level actions outlined in section 3.2 and make recommendations on how these can be explored locally, as a first step in:

- ensuring the Council's ability to shape the conditions for inclusive economies are fully harnessed, and
- identifying ways in which improved alignment can be achieved between strategies to address health and economic development

[5] Naik et al, 2020, 'Using economic development to improve health and reduce health inequalities'

PUBLIC HEALTH
SOUTH TEES

Using economic development to improve health and reduce inequalities in Middlesbrough

Lisa Jones

Public Health South Tees

Middlesbrough
moving forward

this is
Redcar & Cleveland

Context

"People's health and the economy cannot be viewed independently. Both are necessary foundations of a flourishing and prosperous society."

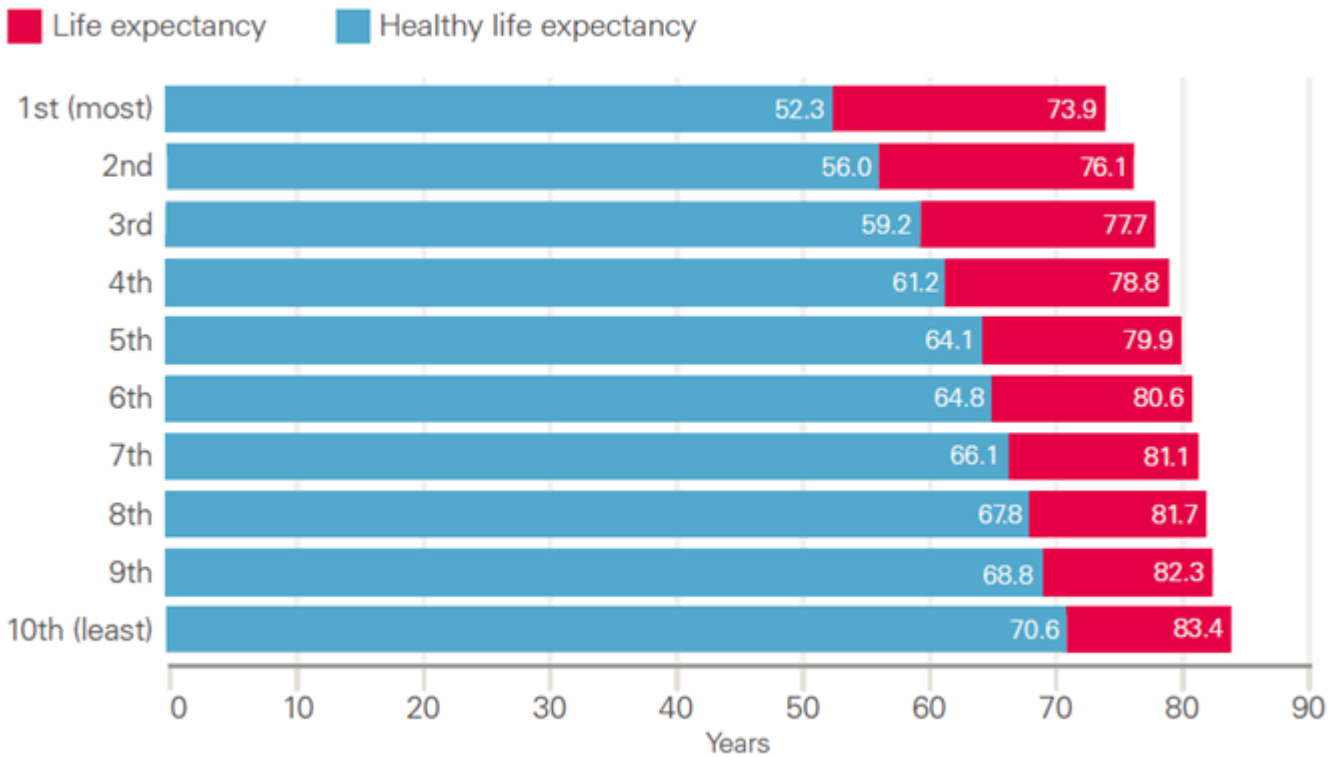
Health Foundations, 2002

Context

- Economic growth affects places differently - with England showing higher place variation in productivity, income, health and employment than almost every other developed country.
- In order to develop sustainable economic growth, the benefits need to be shared in a fair and equitable manner.
- Health is not just a product of a thriving economy, it is a necessary contributor to it.

PUBLIC HEALTH
SOUTH TEES

Male life expectancy and healthy life expectancy at birth by decile of deprivation, England: 2016–18



Source: ONS, Health state life expectancies by decile of deprivation, England: 2016-18

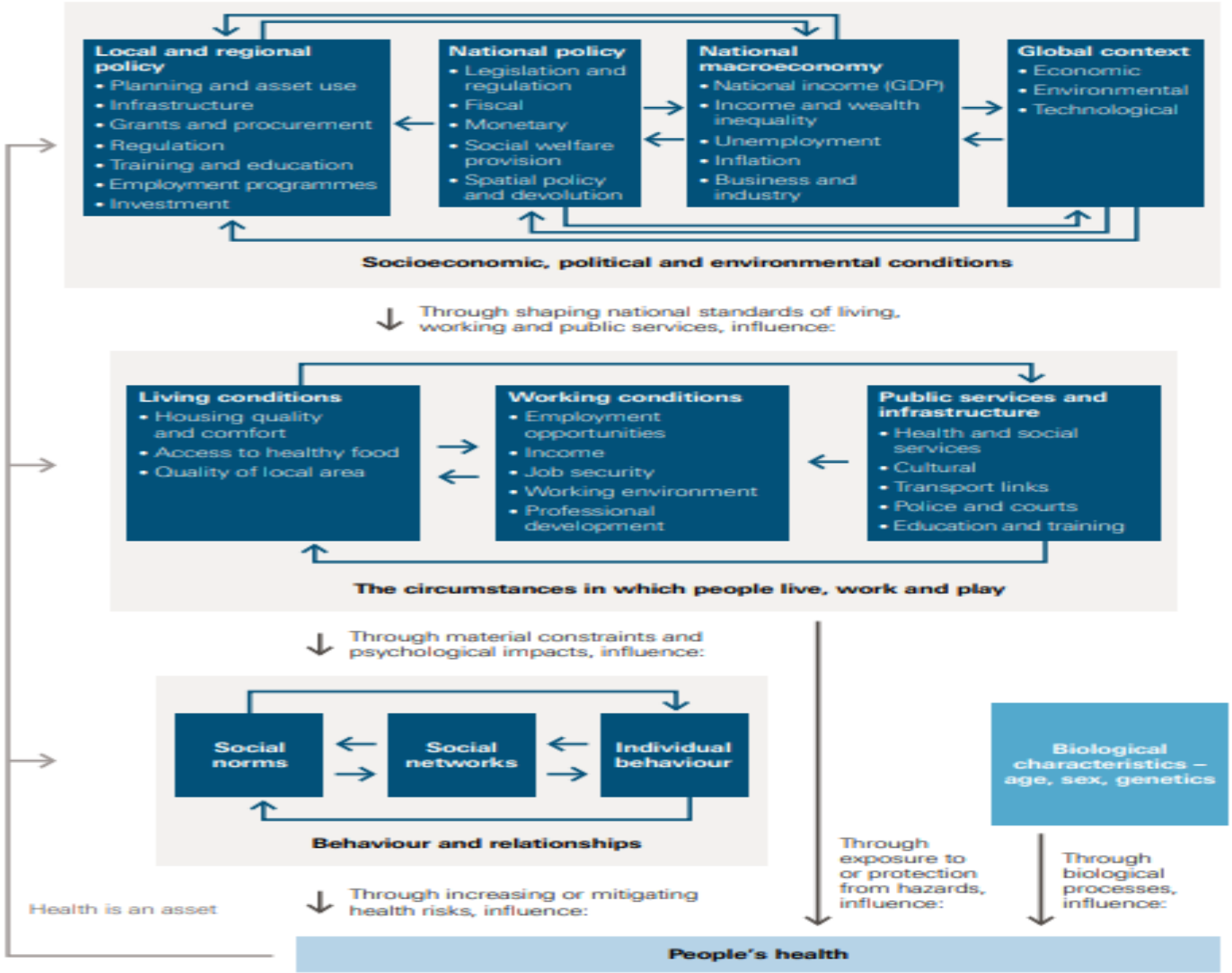
Annual Pre-COVID cost of poor health on the economy

- >£100bn in lost productivity
- c£42bn in workforce costs attached to mental health
- c£15bn in sick days

In addition, c£4.8bn cost of socio-economic inequality on the NHS

COVID-19 & Socio-economic Inequality

- People in most socio-economically deprived areas, twice as likely to die as those in the richest;
- Men in low skilled jobs, almost 4 times more likely to die from C19 than professionals;
- 25% of critical care COVID patients were from most socioeconomically deprived, compared to 15% from least deprived;
- Low income earners represent c80% of those working within sectors that were shut down or unable to work from home (excluding key workers);
- ½ of at-risk jobs with permanent lay-offs, were from jobs that pay less than £10 p/hour.


Local and regional policy
• Planning and asset use
• Infrastructure
• Grants and procurement
• Regulation
• Training and education
• Employment programmes
• Investment
National policy
• Legislation and regulation
• Fiscal
• Monetary
• Social welfare provision
• Spatial policy and devolution
National macroeconomy
• National income (GDP)
• Income and wealth inequality
• Unemployment
• Inflation
• Business and industry
Global context
• Economic
• Environmental
• Technological
Socioeconomic, political and environmental conditions
Through shaping national standards of living, working and public services, influence:
Living conditions
• Housing quality and comfort
• Access to healthy food
• Quality of local area
Working conditions
• Employment opportunities
• Income
• Job security
• Working environment
• Professional development
Public services and infrastructure
• Health and social services
• Cultural
• Transport links
• Police and courts
• Education and training
The circumstances in which people live, work and play
Through material constraints and psychological impacts, influence:
Social norms
Social networks
Individual behaviour
Behaviour and relationships
Biological characteristics – age, sex, genetics
Through exposure to or protection from hazards, influence:
Through biological processes, influence:
Through increasing or mitigating health risks, influence:
Health is an asset
People's health

Inclusive growth

Need for place-based approaches that acknowledge the collective role of policy, services and communities in shaping the distribution of economic growth.

Role of local Councils – aligning economic development & health

Civic-level

- Having a long-term vision and strong leadership that is underpinned by a desire to design economies that are good for people's health;
- Building a thorough understanding of local issues to effectively diagnose the challenges/levers to inclusive growth (public health approach) and to better understand the impact of growth policies across population groups (health inequalities impact assessment);
- Capitalising on local assets and using local powers more actively.

Community-level

- Building strong citizen engagement to inform priorities and strategies.

Service-level

- Providing services the meet people's economic and health need together.

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MIDDLESBROUGH COUNCIL

Final DRAFT Report
Health Scrutiny Panel

Opioid Dependency: What happens next?

CONTENTS

AIM OF THE SCRUTINY REVIEW

1. To examine where we want to be in 5 years' time in terms of reducing opioid dependency and supporting people in Middlesbrough with opioid tapering / pain management.

MAYOR'S VISION

2. The scrutiny of this topic fits within the following priorities of the Mayor's Vision:

    - Making Middlesbrough look and feel amazing.
    - Tackling crime and anti-social behaviour head on – the ravages of drug addiction and its effects are destroying lives and communities and are killing parts of the town.
    - Creating positive perceptions of our town on a national basis.

COUNCIL'S THREE CORE OBJECTIVES

3. The scrutiny of this topic aligns with the Council's three core objectives as detailed in the Strategic Plan 2020-2023:

    • People - We will continue to promote the welfare of our children, young people and vulnerable adults and protect them from harm, abuse and neglect.

    • Place - We will transform our town centre, tackling crime and antisocial behaviour, improving accessibility, developing Centre Square as an iconic Tees Valley office, leisure and residential location, and creating other iconic spaces for digital, media and leisure businesses.

    • Business - We will create positive perceptions of our town on a national basis, improving our reputation, and attracting new investment, visitors and residents.

TERMS OF REFERENCE

2. The terms of reference, for the scrutiny panel's review, were as follows:

    a) To examine local opioid dependency rates
    b) To consider the commissioned services in place and level of resource currently invested by the local authority and partner agencies in reducing dependency in Middlesbrough
    c) To investigate the work undertaken by the local authority and partners to tackle opioid dependency amongst:-
        - Women (case study)
        - Older opioid users (case study)
        - Residents living in deprived wards (case study)
    d) To identify good practice and evidence based approaches that aim to support opioid tapering / pain management (including campaigns to increase people's knowledge of the risks associated with prescribed opioids and over the counter medications).

BACKGROUND INFORMATION

What are opioids?

3. Opioids are drugs which come from opium poppies or which have been synthetically produced to mimic the poppy's effects. That includes legal medicines like morphine and codeine, as well as the illegal drug heroin. Opium poppies have been used to ease pain and aid sleep for centuries. Today, they are still used by doctors to treat severe pain. They work by blocking the body's pain signals. They also produce the hormone dopamine, which creates the euphoric feeling of being "high".

   Britain's most prescribed opioid drugs are:-

   - co-codamol
   - tramadol
   - codeine
   - co-dydramol
   - dihydrocodeine
   - oxycodone
   - fentanyl

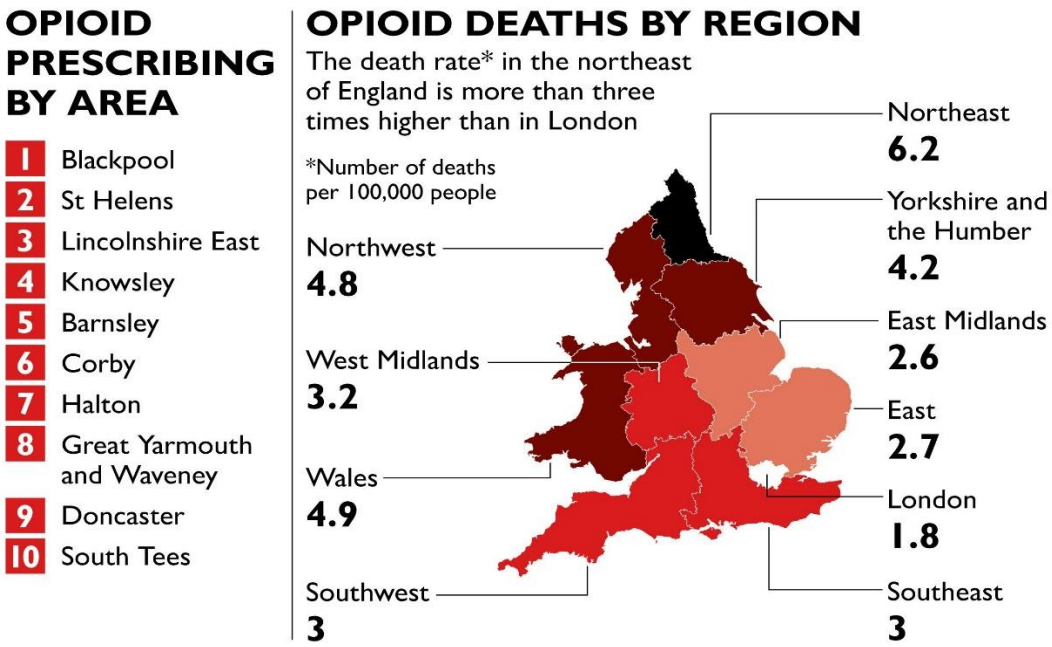
Why are they so dangerous?

4. Opioids are good at stopping pain in the short-term. But they are extremely addictive, and as the body builds up tolerance they become less effective at stopping pain. If they are not used properly, this can lead to a dangerous spiral, in which someone takes higher and higher doses as the drugs get less effective. However, coming off them is extremely unpleasant. It is easy to become trapped. If an opioid dosage is too high, breathing begins to slow – sometimes so much that it stops altogether.

An epidemic of opioid use

5. In February 2019, *The Sunday Times* published an investigation into Britain's rising number of opioid prescriptions, deaths and overdoses over the last 10 years. It found that around five people were dying from drugs every day. That includes deaths from heroin, as well as legal painkillers. Britain's poorest areas, such as Wales and the North, were the worst affected. Dr Andrew Green, of the British Medical Association, told the paper there was "no doubt" that the UK is experiencing an "epidemic of opioid use".

6. The director of the charity DrugWise told *The Sunday Times* that there is a "perfect storm" of GPs "under huge pressure" and an ageing population, meaning more patients complaining of chronic pain. "It is not surprising that more and more prescriptions are being written as demand increases." Tackling the crisis will involve finding alternative pain medicines, changing the amount of drugs prescribed and supervising patients more closely.



7. In addition to the challenges presented by high rates of prescribed opioids the use of illegal drugs including heroin continues to damage our local communities. In February 2020 Dame Carol Black published her independent review of drugs and a summary of the key findings are detailed below:-

- The illegal drugs market has long existed but has never caused greater harm to society than now. An estimated 3 million people took drugs in England and Wales last year, with around 300,000 using the most harmful drugs (opiates and/or crack cocaine). Drug deaths in 2018 were the highest on record (2,917). The increases have been primarily driven by deaths involving heroin, which have more than doubled since 2012.

- The UK has the highest number of rough sleepers dying on our streets from drug poisoning since records began. Huge geographical and socioeconomic inequalities lie beneath these trends, with entrenched drug use and premature deaths occurring disproportionately in deprived areas and in the north of the country.[1]

- Much of the 'core' heroin population are entrenched users with increasingly severe and costly health problems, many of them cycling in and out of treatment services. The ageing of the heroin population and their length of drug use is a big factor in the record number of drug-related deaths.

- On a given day approximately 20,000 people, or nearly 1 in 4 prisoners, are detained because of offending related to their drug use, as opposed to being involved in supply. Long-term drug users are cycling in and out of our prisons, at great expense but very rarely achieving recovery or finding meaningful work.

[1] https://www.gov.uk/government/publications/review-of-drugs-phase-one-report/review-of-drugs-summary

- Dependency on prescription medicines is an emerging and worrying issue which requires greater attention from government.

SUMMARY OF EVIDENCE

TERM OF REFERENCE A – To examine local opioid dependency rates

8. Middlesbrough has high levels of estimated drug misuse, 25.51 opiate and crack users per 1000 population, triple the national rate of 8.4 and is the highest in the country. (PHE, 2019)

9. **The average age of drug related deaths in Middlesbrough is 38.2 years old**. In comparison, average life expectancy is 76.2 years old. The Middlesbrough wards with the highest Drug Related Death rates are: Central, Newport, Park, Longlands & Beechwood and Brambles & Thorntree.

Drug Related Deaths in the Tees Valley

10. For the period 2015-17 the drugs related death figures from the Office for National Statistics (ONS) for the Tees Valley show:-

Drug related Deaths, 2015-2017 in England (Public Health England)

11. Between 2008 and 2019 the most common drugs detected from Coroner Inquests into substance related deaths were heroin, alcohol, methadone, cocaine, mirtazapine, benzodiazepines, zopiclone and pregabalin.

12. In terms of the number of drugs detected post-mortem it is now increasingly common to see all of the above drugs in someone's system.

13. Teesside Coroner Inquest data shows that between 2008 and 2019 there was a notable increase in the number of drugs detected. In 2008-09 there were frequently 1-2 drugs detected. In 2019 a third of cases involved 5 or more drugs. There is a tendency for pregabalin and benzodiazepam to be used by younger people.

14. Middlesbrough currently has:

- 1257 opiate users
- 255 non-opiate users
- 142 non-opiate and alcohol users

15. In terms the demographic of patients in treatment in Middlesbrough 72 per cent are males, with the highest numbers seen in the 30-39 age group. In addition 51 per cent of those in treatment have an identified mental health need.

Evidence from Foundations GP Medical Practice

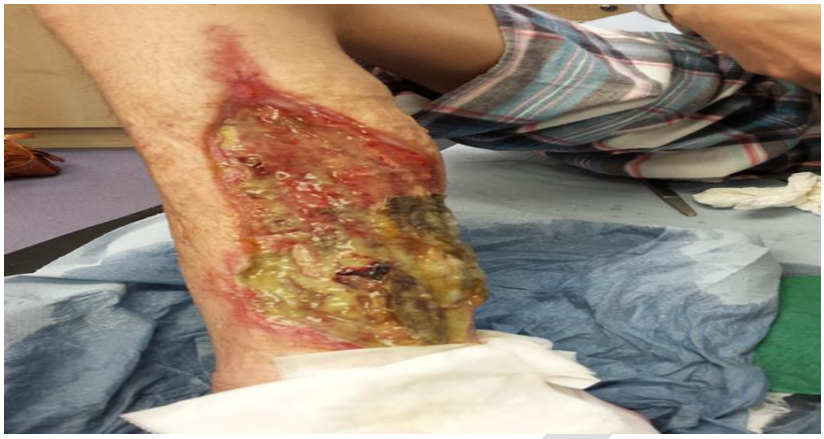
16. Foundations GP medical practice in Middlesbrough is commissioned to provide a specialist prescribing service. The profile of patients at the practice is as follows:-

- Around 70% of referrals come via self- presentation.
- 47% are unemployed, with a further 28% long term sick.
- 17% are identified as having a housing issue or homeless.
- 20% are currently living with children (that we are aware of)
- 17% admit to buying illicit prescriptions
- 33% of opiate clients have been in treatment for six years or more.

17. The average age of patients registered at the practice is 38 years old and all have significant health problems, including a staggering increased prevalence of chronic health conditions:-

- Asthma 200 per cent above the national average
- COPD 225 per cent above the national average
- Mental health issues 193 per cent above the national average
- Palliative care 211 per cent above the national average.

18. All patients have also experienced a high prevalence of emotional trauma and no patient has not experienced some form of trauma. Physical wounds, as shown below, sustained through drug use further highlight the extremity of harm along with medieval levels of life expectancy.



19. Dr John Bye, GP at Foundations Medical Practice, Middlesbrough advised:-

This is a group of patients that do not often seek help and only at the point of crisis will they approach services for support. The prevalence of asthma and COPD are related to the drug use, as some drugs are smoked, which impacts on respiratory health. From a GP's perspective it cannot be stressed enough how often these patients do not seek help. It is also the case they are often very transient and will not, for example, return the next day for any follow up treatment. Efforts are always made to try and complete treatment immediately when people present.

20. The cost and availability of various substances locally is as follows:-

- Pregabalin is readily available, selling for around £10 for a strip of 7x 300mg tablets, or £50 for a box of 50. Tend to be counterfeit tablets.
- Gabapentin is not as readily available currently as Pregabalin, but this changes regularly. Gabapentin tends to be around £10 a strip of 500mg tablets and is usually diverted prescriptions.
- Zopiclone is cheap, it can be as little as £5 a strip and can vary in strength.
- Diazepam (£10) is in high demand but there are reports of an increase in counterfeit with reports of other tablets being dyed blue and sold on.
- Buprenorphine prices have risen again in the prison setting, some reports of up to £30 per tablet (previous high for branded Subutex was £60)
- Tramadol is still used widely, low cost and easy to get hold of.

21. A number of methods are used to source the various substances including family, friends, GP prescribing, internet, local dealers and social media. Complex issues can also arise where restrictions are imposed on prescribed substances, as a black market of those substances can develop, which are not quality controlled.

We Talk, They Die: A Call for Action

22. On 9 October 2019 the 'We Talk, They Die: A Call for Action' conference was held at the Jury's Inn in Middlesbrough. The event was organised by Foundations Medical Practice and a range of international and national harm reduction experts were in attendance to share their knowledge and expertise. The attendees included:-

- Ricardo Baptista Leite, Medical Doctor and Member of the Portuguese Parliament - For better or worse - decriminalisation of drug use: outcomes from Parliament.
- Jason Harwin, Deputy Chief Constable of Lincolnshire Police and National Police Chief Councils (NPCC) lead for Drugs - Harm reduction policing and the need for evidence based practice.
- Dr Magdalena Harris, London School of Hygiene Tropical Medicine - Harm Reduction: Listening to the experts to inform harm reduction.

23. A number of presentations were given to highlight the various approaches adopted to reduce drug related harm: -

- Portugal's decriminalisation of drugs demonstrated the significant impact that could be made if legislative changes were to be introduced in the UK.
- Foundations Medical Practice has launched a Heroin Assisted Treatment (HAT) Project, where people are given diamorphine twice a day under medical supervision. The scheme is part funded by the Police and Crime Commissioner (PCC) for Cleveland and is targeted at those for whom all other current treatment options have failed.
- Naloxone (opioid overdose drug) kits are being distributed by volunteers, who have all battled addiction as part of a Middlesbrough Peer Project. .
- Checkpoint (an offender management programme that offers those eligible an alternative to prosecution) is established in Durham Constabulary's force area. It provides an opportunity for individuals to tackle the underlying issues such as their mental health, alcohol and drug misuse and aims to improve the life chances of the participants. A similar scheme has been launched in Cleveland.

Portugal's health focused and harm reduction approach

24. In respect of the approaches introduced to tackle drug related ham some other countries have introduced decriminalised markets. Portugal, for example, has taken a much more **health focused approach, resulting in a reduction of drug use across the country and a huge reduction in drug related deaths.**

25. In Portugal pre-2001 heroin was the main substance of problematic drug. Increases in reported drug-related deaths between 1991 and 1998 highlighted the public risk of injecting and the need for drug policy reform. **On 1 July 2001 Law 30/2000 was introduced which decriminalised drug possession, acquisition and consumption for personal use.**

26. Ricardo Baptista Leite, Medical Doctor and Member of the Portuguese Parliament advised:-

- Decriminalisation of drug use **did not increase drug use, drug-related crime or 'drug tourism' in Portugal**
- **Decreases in HIV and overdose-related deaths** have been observed since 2001
- Decriminalisation is **only part of the journey** – further work needs to be done on **stigma**, **safety** and **availability of other harm reduction initiatives**

Local Action

27. In terms of work undertaken by Public Health (South Tees) to tackle these issues locally the following measures have been implemented:-

    - The Preventing Drug Related Deaths post has conducted reviews of deaths and looked at patterns of drug use.
    - Middlesbrough Council has taken part in Heroin and Crack Cocaine Action Area (HACAA) work with Cleveland Police
    - An integrated commissioning model has been developed to look at wider issues.
    - Capital funding has been secured for Middlesbrough's Alcohol Centre of Excellence (MACE) – Hall Gate depot building.
    - Live Well Centre approach has been adopted.

28. Value for Money conservative estimates highlight a £3/4 saving on each £1 invested. In 2016/17 Public Health England (PHE) figures showed that £5m invested resulted in a £10m social / economic return.

Future Funding Opportunities – Changing Futures

29. On 10 December 2020 the Ministry of Housing, Communities and Local Government launched the 'Changing Futures' scheme – a £46 million programme, which aims to establish new, innovative and co-ordinated ways to better support vulnerable adults and particularly those facing entrenched disadvantage and trauma. The initial delivery period will be for two years in 2021/22 and 2022/23, with options to extend if more funding is available, including through local match funding. There is an expectation that local areas will be able to demonstrate plans to sustain a legacy of system change and improved working for adults experiencing multiple disadvantage beyond the initial programme period.

30. The prospectus for the 'Changing Futures' scheme invites expressions of interest from organisations such as councils, health bodies, police, probation services, voluntary and community sector organisations to form local partnerships. The planned timescale for the mobilisation of the national 'Changing Futures' programme is as follows:- 21 January 2021 deadline for Expressions of Interest (EOI's), February – shortlist of areas announced, March to April – Delivery Plan development and Spring – Year 2 delivery grants agreed, funding provided and delivery commences.

31. The prospectus highlights that a range of government programmes are currently underway led by different parts of the public sector or targeting specific groups with high levels of multiple disadvantage, such as people sleeping rough, repeat offenders, or women in or at risk of contact with the criminal justice system. One of the projects referenced is Project ADDER (Addiction, Disruption, Diversion, Enforcement and Recovery) – Home Office.

32. The Home Office in conjunction with the Department for Health and Social Care and Public Health England are funding an intensive whole system approach to tackling drug misuse in select locations worst affected by drug misuse, alongside national activity to disrupt the middle market supply of drugs. A programme designed to assist agencies and organisations to work together to reduce the volume of deaths, criminal activities and anti-social behaviour relating to drug-taking. The pilot is referred to as Project ADDER and will involve co-ordinated law enforcement activity, alongside expanded diversionary activity

and treatment/recovery programmes. It aims to reduce drug related deaths and move individuals away from drug addiction.

33. A number of towns have been selected as pilots for the project, for example Hastings is set to receive £5 million funding, which is to be spread over the next two and a half years. Similarly Blackpool has been identified as a pilot town.

TERM OF REFERENCE B - To consider the commissioned services in place and level of resource currently invested by the local authority and partner agencies in reducing dependency in Middlesbrough

Middlesbrough Recovering Together (MRT)

34. Middlesbrough Recovering Together (MRT) is the local substance misuse model that aims to offer people seamless services as if delivered from a single provider. MRT has been delivering local substance misuse support since 1 October 2016, with three providers working in partnership:

    Change, grow, live (CGL) (formerly CRi) provide the psychosocial treatment aspect of the model for both adults and young people, adopting a whole family approach wherever possible.

    Foundations Medical Practice (formerly Fulcrum) is a specialist GP practice that provides primary care to people who are experiencing or at risk of social exclusion. The service operates over two sites: Acklam Road for substance users and violent/aggressive patients, and Harris Street for asylum seekers. Both have been rated 'outstanding' by the CQC. On behalf of Public Health, Middlesbrough Council they provided a clinical recovery service.

    Recovery Connections (formerly Hope NE) are the provider of all recovery interventions and also deliver a twelve step-based, quasi-residential rehab model via their current building. There are a number of recovery activities delivered in the community such as the Collegiate Recovery Campus at Teesside University, Recovery Choir, community garden project, drop-in services, SMART Recovery groups and a range of health and wellbeing groups. There is emphasis placed on facilitating people into Mutual Aid (alcoholics anonymous, narcotics anonymous, etc.). Recovery Connections is rated ‘outstanding’ by the CQC.

35. Representatives from all three organisations provided evidence and it was emphasised that the harms caused by the misuse of opioids and other drugs are far reaching and affect people’s lives at every level:

    - crime committed to fuel drug dependence;
    - organised criminality,
    - violence and exploitation;
    - irreparable damage to families and individuals;
    - negative impact on communities.

36. In public health terms it is the cumulative impact of the misuse of drugs and all of the surrounding issues that make it a wicked problem. The message that **you alone can recover but you cannot recover alone** was emphasised**.**

Evidence from Change, Grow, Live (CGL) - A Care Co-ordination Service

37. Access to the services provided by CGL is open entry and is available at a range of locations including the Live Well Centre and Foundations GP Medical Practice.

    The service focuses on providing:-

    - Care co-ordination of effective treatment pathways through collaboration with key stakeholders
    - Person-led, holistic care planning and risk management
    - Criminal Justice System support
    - Family focussed approach
    - Harm Minimisation service

38. Psychosocial interventions involve intervening in the psychology (thoughts/feelings) or the social (context/environment), which are tailored to the individual depending on needs.

    For example:-

    - Motivational Interviewing to address ambivalence about change
    - CBA (Cognitive Behavioural Approaches) structured support around behavioural change
    - Identifying and change thought process
    - Education around Emotional management
    - Relapse prevention to support sustainability
    - Structured and Unstructured group work
    - Family work
    - Impact of parental substance misuse
    - Social interventions e.g. SBNT (Social Behavioural Network Therapy)
    - Enhancing recovery capital
    - Developing social support for change

39. CGL also provide a young persons' service to offer specialist support for young people who are either using alcohol / drugs or are affected by someone else's alcohol / drug use.

Evidence from Foundations (GP Medical Practice) - Clinical Service

40. Daniel Ahmed, Clinical Partner at Foundations GP Practice made reference to a quote from Gabor Mate (a Canadian Physician known for his expertise on trauma, addiction, stress and childhood development). It sums up the stark reality of providing care to people who have become so dehumanised they no longer care if they live or die.

    'My patients' addictions make every medical treatment encounter a challenge. Where else do you find people in such poor health and yet so averse to taking care of themselves or even to allow others to take care of them.'

41. To address the issue of opioid dependency a **health focussed harm reduction approach** is required. Such an approach is used all the time in everyday life, kids on skateboards, we don't stop them we provide them with helmets and pads, people jumping out of planes, we don't stop them they have training, a parachute. Harm reduction is normal, yet with drug use, we don't use all the tools we have available to reduce harm.

'**We expect drug users to jump out of a plane without a parachute every time they use drugs.'**

Evidence based approach:

42. The following health focussed harm reduction approaches were highlighted as best practice:-

- **Rapid access to treatment** - no wait times. Why, there is clear evidence that being in treatment protects lives.
- **Trauma informed approach** - A trauma informed approach, I am ok you are ok, we don't ask what's wrong with people but what's happened to people. We meet people with respect and love. We need to acknowledge that a path of often horrific life events have led people to need our support. We respect they may find it too difficult to express their thoughts and feelings about their trauma, that they have survived to this point.
- **Opiate substitute prescribing at optimal doses** - The strongest evidence base in all guidance for heroin use is substitute prescribing, the use of methadone/Buprenorphine within particular dose ranges is the number one protective factor in preserving life and providing stability in people who use opiates. Doses should be between 60mg to 120mg for maximum benefit. However, there is often a stigma attached to this, people are encouraged to reduce doses, the lower the dose the better, a moral value is attached to the dose that isn't applied in other areas of medicine. We do not draw breath when we need to take 500mg of paracetamol. A patient who requires insulin is not pressured into reducing the dose.
- **Heroin Assisted Treatment -** Heroin assisted treatment, a further treatment option with a global evidence base of effectiveness. Middlesbrough should be proud it supported the introduction of HAT, allowing treatment options for patients who have failed to benefit from front line treatment options. The rest of the UK treatment sector is in awe of Middlesbrough's HAT programme.

43. Danny Ahmed, Clinical Partner at Foundations GP Medical Practice advised that,

'**Embracing a wider definition of recovery is critical in supporting people who use opiates**.'

Recovery must be understood to have a multitude of outcomes:

44. Recovery is a journey and not an end point:-

- **Abstinence from substances** - Recovery has come to mean abstinence from substances. It has come to mean anybody who isn't abstinent from substances or requires medication has not recovered.
- **Stability on medication** - Recovery needs to be acknowledged as multi-faceted. Its right we have a treatment system that aspires to abstinence but not right that we have one that discounts people who have stabilised on medication as recovered.
- **Reduction in harmful behaviours -** It is not right that a reduction in harmful behaviours is not celebrated.
- **Defined by the individual** - It is not right that recovery is not defined by the individual.

'You can't recover if you're dead, right now people are dying.'

45. In order to reduce the number of drug related deaths a radical approach is needed, with the introduction of measures that directly impact the most vulnerable with evidence based solutions.

Evidence based solutions:

46. What works and what is needed:-

- **Introduce safe spaces for people to consume substances** - Safe spaces to use substances safely are widely used in Europe, Canada and Australia and have been for up to 16 years. **No one had ever died of a drug over dose in any of these facilities**.
- **Introduction of drug sampling** - Introducing drug sampling would allow those who use substances to ensure the substance is safe. Drug users do not want to die
- **Active drug users as part of the treatment system response** - Introducing active drug users to treatment service structures and treatment provision will allow services to reach those we don't currently and to engage them on the path to recovery. An example of this is Middlesbrough's peer to peer Naloxone programme

47. Photographs were shown, taken in areas of the town centre, although it was emphasised that this could be any town or city in the country. The photographs show human waste and discarded needles, works and crack pipes. This is the current state of play, this is how the most vulnerable people in our local communities who use drugs are currently living and using. We have a drug related death crisis and yet this, this is the place where some people are having to use. In 2019 a young lady had been found dead in this area and a young man died here last Christmas.

Heroin Assisted Treatment (HAT)

48. The Heroin Assisted Treatment (HAT) programme is based at Foundations GP Medical Practice, it is an evidence based intervention undertaken in partnership with the Police and Crime Commissioner (PCC) and Probation services. It involves a cohort of high volume users of emergency services, those committing the most crimes and those who have previously failed to engage in treatment. All of the clients involved in the programme attend twice a day to inject, 7 days a week and receive a full package of support from other relevant services. The programme has shown excellent early outcomes and all participants have terminated their use of street heroin.

49. The following feedback has been received from a Cleveland Police Officer in respect of the programme,

'I stopped a well-known offender in Middlesbrough recently. I've known him for 15 years and he's always wanted or a suspect. But this time he was neither. He told me he was taking part in Heroin Assisted Treatment, that the course was excellent and that it was working for him. He looked the best I had seen him in years. I couldn't believe the difference in him.'

50. At the time of presenting evidence it was advised that there were currently nine people involved in the scheme, with spaces for up to fifteen. Members expressed the view that they are very supportive of the initiative and keen to explore the possibility of expanding the scheme, as well as increasing their knowledge about Drug Consumption Rooms (DCRs). The point was made that at present the Home Office is not in favour of DCRs. Glasgow has openly requested a trial, however, to date the request has not been approved. Bristol has also recently set up some mock DCR's to demonstrate to the public what would be involved.

Evidence from Recovery Connections

51. Recovery Connections' in Middlesbrough provides the following services:-

- **Quasi Residential Rehab (QRR)** in Middlesbrough is one of the only free to enter rehabs in the country (8 flats). The CQC rated has rated it as Outstanding and a 12 step rehab programme is available for Middlesbrough residents who wish to complete an intense 6 month programme.
- **Community support** includes structured and recovery focused groups such as SMART and ACT peer recovery, as well as unstructured groups such as cooking and arts and crafts, which are designed to teach people skills and get people mixing with similar people aiming for similar goals.
- **Housing support** is also provided, mainly for people leaving rehab however there is some support available for people accessing community groups.
- **Young person's worker** is based at the Students Union at Teesside University 2 days per week, helping to support people in recovery to get into education and maintain attendance and work.
- **Trauma therapy** is mainly for people in rehab however therapists also work with people accessing community provision across MRT. Recovery connections has secured funding from the National Lottery to employ two full time trauma therapists adding value to the current treatment provision.

52. In terms of the offer provided at the Quasi Residential Rehab each individual signs a contract, which includes 12 weeks residential housing and 12 weeks supported peer

housing, as well as help finding accommodation if required. Trained Coaches guide and support each person through the 12 steps programme and it's a very structured environment. Attendance at mutual aid, for example, narcotics anonymous / alcoholics anonymous is also required. The ambassador programme is also of key importance and many of those involved in the centre have been living and breathing recovery for many years. **It is not the harm that is the focus but the good.**

53. Recovery Connections is also out in the community as much as possible in an effort to send out a positive message to the community about recovery. The coffee bike is an effective way of engaging with people in the street and each time the bike goes out staff from the organisation will engage approximately 40 people in a conversation about recovery.

54. Upon visiting Recovery Connections Quasi Residential Rehab facility on Marton Road it was evident that the offer provided is unique. In order for individuals to secure a rehab placement a significant amount of preparation is undertaken. A rehab admission panel assess the likelihood of an individual successfully completing the intense 6 month programme and there is currently a waiting list of 2-3 months to access the 8 bed facility. In terms of expanding the offer consideration has previously been given to providing a 16-18 bedded detox and drug rehabilitation facility at Letitia House in Middlesbrough. However, a bid by the Public Health Team to the Council's Capital Fund for £200,000 to fund the necessary structural changes was unsuccessful.

55. Currently, those with medical complications have to access in-patient detox facilities in Manchester and Leeds. The current cost to access a 7-10 day detox programme is approximately £25,000 per patient and is funded via the Public Health Grant. If a local detox facility was available that cost would reduce significantly and more patients could be supported using the funding available. Income could also be generated through placements commissioned by other bodies, as currently **there are no publically funded in-patient detox and drug rehabilitation facilities available elsewhere in the region.**

Budget reductions

56. In terms of the funding reductions **over the last seven years the Public Health budget that is used to fund substance misuse services in Middlesbrough has been cut by more than half, from approximately £6m per annum in 2014/5 to around £2.3m for 2020/21**. There is no longer a dedicated prevention budget, the ability to innovate has been reduced and the future of the **Hospital Intervention and Liaison Team (HILT)** remains uncertain. **There has also been a loss of specialist skills, knowledge and experience, as less capacity has resulted in an increase in more generic posts.**

    Gaps

    - The pain management clinic remains vastly oversubscribed.
    - Recovery campus, first one in the world outside America, cohort is easy to dismiss, more palatable to prioritise other agenda, deeper understanding of the sources to restrict supply.
    - Incredibly high stigmatization remains.

    Next Steps

- The integrated model should bring numerous benefits.
- In making every contact count, respect is key, as is a restorative approach.

Longer Term Opportunities

- Collaboration with key partner organisations
- Pooled budgets.

Requests

- Commitment to continued investment

57. Public Health (South Tees) has a really good track record of securing external grant funding but there is a need for the real term cuts to be highlighted. Long term financial stability is needed to deliver and plan future service delivery.

58. The Heroin Assisted Treatment (HAT) programme is currently funded through a partnership arrangement using time limited funding, secured until October 2021. Additional funding is needed, as else there remains a risk that Middlesbrough could lose this innovative work. The Police and Crime Commissioner (PCC) elections are due to be held in May 2021 and there is a need to ensure PCC funding continues to be secured. A number of measures are needed:-

- Help to engage key partner organisations and stakeholders to tackle the issue collaboratively;
- Work collectively to tackle stigma;
- **Make Middlesbrough a Recovery City**

59. The point was also made that **the value for money evidence is clear and investing in prevention is a win win, it saves lives and saves families.**

60. Public Health is currently in the process of maximising value for money by commissioning **an integrated commissioning model**. This innovative approach will join up homeless services, domestic abuse services and substance misuse services to address the multiple, complex issues faced by vulnerable adults in Middlesbrough. **Building social capital and ensuring people have 'somewhere to live, something to do and someone to love'[2]is of the utmost importance.**

[2] Social capital is an important ingredient in the maintenance of physical and mental wellbeing, In 1990 Physiatrist Sheldon Berrol noted that what is important to all of us is to have somewhere to live, something to do and someone to love.

TERM OF REFERENCE C – To investigate the work undertaken by the local authority and partners to tackle opioid dependency amongst:-

- **Women (case study)**
- **Older opioid users (case study)**
- **Residents living in deprived wards (case study)**

Evidence from Middlesbrough Community Safety Partnership

61. Middlesbrough Community Safety Partnership is a statutory body made up of representatives from the Police, Probation Service, Local Authority, Youth Offending Service and the Fire and Rescue Authority and it produces a community safety plan that is reviewed every two years.

62. The Community Safety Partnership plan identifies the following priorities:

Priority 1—Perceptions and Feeling Safe

- We will aim to better understand and improve the public perception of safety and crime in Middlesbrough
- Tackling crime and ASB head on

Priority 2 - Tackling the Root Causes

- Adverse Experiences
- Trauma Informed approach

Priority 3 - Locality Working, Inc. Town Centre

- Reconfigure relationships between statutory organisations and the community. Encouraging and supporting a collaborative approach and building capacity within the community. Create a safe town centre environment to live, work and visit

63. Neighbourhood Safety Wardens in Middlesbrough have a significant role to play in identifying and engaging with vulnerable people and referring to commissioned services. All of the Wardens carry naloxone kits, a drug that reverses the effects of an overdose. **By administering the drug the Wardens, who are also trained in first aid, have saved the lives of 9 people in Middlesbrough since December 2019.**

64. Wardens, who are also accredited by the Chief Constable of Cleveland Police, regularly gather intelligence and share information with the Police relating to drug dealing so that appropriate action can be taken. This has resulted in drug raids taking place in a number of local communities.

65. The Council's Officers also regularly build a portfolio of evidence to support an application to the courts for a house closure where there is evidence of ASB, crime and drug dealing from a property.

66. The following case studies detailing the support offered through a multi-agency approach were provided:-

2018 Example with Community Safety (Assertive Outreach)

S was homeless, sleeping on the street and begging in Middlesbrough town centre, he was a heroin user and wasn't engaging with any services. He had benefits in place however couldn't access them as he didn't have a fixed address for the bank card to be sent out to. S couldn't gain housing in Middlesbrough as he had "burnt his bridges" with all landlords.

10 weeks after S started to engage with the community safety team he was housed in temporary accommodation. He continued his engagement with the team and was offered a more permanent address with 2020 properties. He is now attending all of his Probation appointments and is now in receipt of Housing Benefit. His landlord have no complaints and have said he is *'doing well'*. He has held down his tenancy and pays his rent top up and he now has a bank card and can therefore easily access his benefits.

The team organised an assessment at CGL, which S attended, allowing him to be put on a methadone script. The team later supported him to attend Foundations and he states he hasn't used heroin since and is now feeling much healthier. He wanted to stop begging so the Town Centre Team arranged for him to start selling the Big Issue as long as he attends Recovery Connections once a week.
He keeps out of the town centre and sells the Big Issue in the Linthorpe area.

S now feels ready for a DISC referral to support him into securing a permanent tenancy and he has asked the team if they can also help him look at his mental health once he has settled.

S has messaged the team on several occasions, here are some quotes

"Thanks, I wouldn't have been here if it was left to me, so thanks very much it means a lot"

"I wouldn't have known where to start without your support"

Example from November 2020 Town Centre Wardens

X

X had been homeless for 12 months when the Town Centre Wardens started to engage with him. He was a prolific beggar in the town centre and was sleeping in shop doorways within the main precinct area, which was of concern to town centre businesses. Although X had benefits in place, he was misusing substances which was the reason he was also begging. He had 'burnt bridges' with housing providers but he said he wanted to change and stop living like this.

After a number of calls and discussions with the Homeless Team eventually a landlord agreed to give X a tenancy and he was placed into a private rented property. X was supported to set up his Housing Benefit claim by the homelessness team.

A community award scheme was successfully applied for to provide him with white goods, household furniture and clothing.

X is continuing to work with the team, he has also started to sell the Big Issue and he is now ready to address his substance misuse and will be supported to make links with the relevant agencies for ongoing support. It is recognised that X still has a long way to go but he is making small steps in the right direction. Below is a quote from X

"Thank you, I wanna make changes and I wouldn't have been able to do this much without you"

67. Marion Walker, Head of Stronger Communities advised,

'People don't choose to live a challenging life, they often find themselves in a situation that gradually creeps up on them. Individual circumstances and life experiences can lead to people being in a certain environment that can lead to harmful behaviours. Every drug user is someone's brother, sister, mother, daughter, son and they deserve another chance and support to change their behavior when they are ready for it. If their behavior is causing harm to the community, they need to understand that that it is not acceptable and their actions will have consequences. Therefore enforcement does have a place too.'

68. It was also advised that **additional benefits would be derived from increased assertive outreach work to support people to make small, positive steps to changing behavior.**

Evidence from Cleveland Police

69. Following publication of the recent HM Inspectorate of Constabulary and Fire & Rescue Services report, which had highlighted serious concerns about Cleveland Police leaving vulnerable victims at risk the Chief Inspector advised that there has been a significant culture change within the force, particularly in respect of Police understanding around the vulnerability of drug users and how people become dependent. In 2019/20 Cleveland Police have also led on the Heroin and Crack Cocaine Action Area (HCCAA) project.

70. The Chief Inspector advised that streamlined processes for dealing with possession of drugs are currently being considered. For example, if an individual is stopped with a very small amounts of drugs but there is no risk of threat or harm, procedures to interview them on body worn cameras and submit a streamlined case file outside the court process could be introduced. At the same time the individual concerned would be referred to the relevant support agency or local authority to help them to address the issue rather than the case still being stuck in the court system three months down the line. As valuable visible police presence is being taken out by relatively low level offending.

71. Cleveland Police is also currently working with partners on trying to divert people from heading into the criminal justice system by offering rehabilitation - rather than putting them through short-term custody sentences for drug possession. Healthcare professionals are employed as part of the custody and diversion team and will assist individuals who have some sort of drug dependency whether it be to opioids or prescribed medications.

72. Cleveland Police's Neighbourhood Policing Team also host 'threat, risk and harm meetings' on a daily basis with partners including the local authority, local housing providers and fire & rescue services to discuss crime, anti-social behaviour (ASB) and vulnerability. Many of the issues discussed are linked to drugs and alcohol and the majority of incidents reported to the Police are rooted in these issues. At present there are a significant number of reports around street dealing and Cleveland Police will not tolerate dealers causing problems on the streets. The Police are working alongside the Council to close down troublesome properties

73. Cleveland Police have a number of harm reduction schemes in place including:-

- Divert schemes to divert people from the criminal prosecution system to rehabilitation
- Young engagement meetings
- New programmes to educate school aged children to deliver a holistic approach to the danger of drugs

Trends in Middlesbrough

74. In terms of the enforcement work undertaken by Cleveland Police this is currently yielding very little in terms of recovering Heroin. It would appear to be a generational change - Heroin is a dying drug in terms of the younger generation picking it up. However, **Cleveland Police have seen an increase in the misuse and abuse of prescribed drugs and drugs imported over the internet including tablets, painkillers and sleeping tablets.** People are also moving towards cocaine and crack cocaine.

Evidence from Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust

75. Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust is a provider of Mental Health and Learning Disability Services and is not commissioned to provide Substance Misuse Services or services related to primary Opiate dependence. In the course of providing Mental Health and Learning Disability Services TEWV provides help to persons with dual diagnosis. The definition of dual diagnosis is a co-existing mental health and alcohol and / or drug misuse problems.

76. In respect of the level of resources invested by TEWV in dual diagnosis regular mandatory training is provided to staff, a dedicated dual diagnosis lead has been appointed within the Trust and dual diagnosis link clinicians / link champions also work across a number of teams. In addition these practitioners work in partnership with the locally commissioned substance misuse services. A Mental Health and Substance Misuse network is also in place in Teesside and inpatient services / wards are often needed to provide detox for patients.

77. Dr Sinha, Clinical Director at TEWV advised that in terms of TEWV's experience of working with those addicted to opioids it's felt that:-

    Difficulties are increasing (anecdotal reports) and getting the right help at the right time (in terms of helping an individual addicted to opioids) can be challenging. There is also an association with adverse outcomes including fatalities and the individual often faces a number of difficulties in addition to mental health and substance misuse including issues relating to finance, housing and physical medical conditions.

78. In terms of recent initiatives undertaken by TEWV a series of Rapid Process Improvement Workshops (RPIW) involving partner organisations have been held. Change, Grow, Live (CGL) were involved in Middlesbrough and TEWV has also initiated the Mental Health / Substance Misuse Network with other stakeholders. The crisis assessment suite at Roseberry Park receives support from the Substance Misuse services and joined up care is provided on site. It is hoped the training of inpatient staff in the use and distribution of Naloxone kits will also lead to a reduction in deaths linked to opiates.

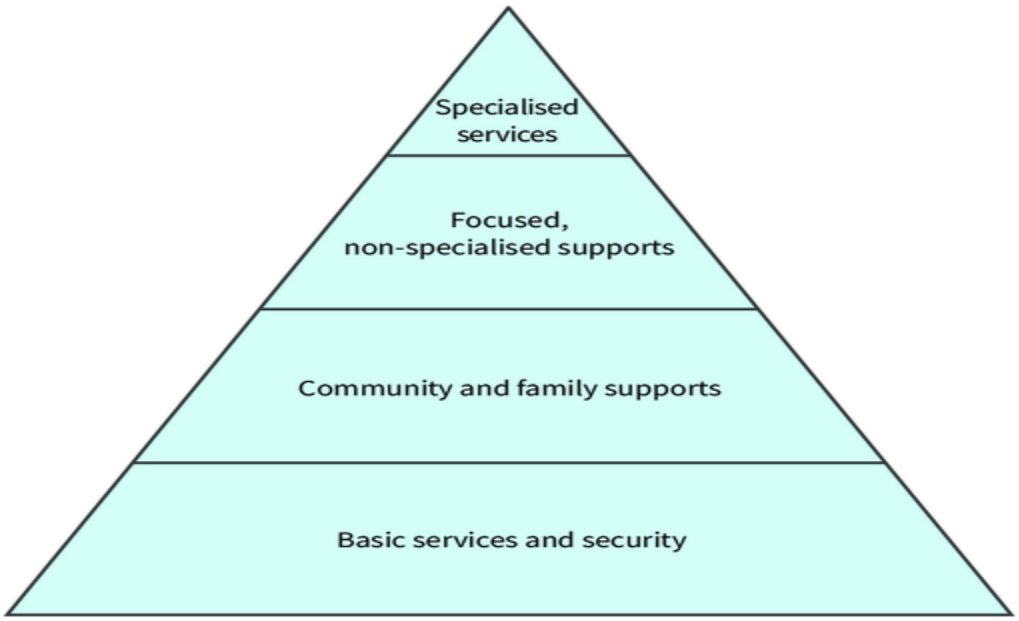
79. With regard to TEWV's views on the impact of opioid dependency on children and young people in Middlesbrough, Dr Sinha, Clinical Director advised that colleagues in the field report that the number of young people physically dependent on opioids in Middlesbrough is small but growing. There are young people who are at risk of developing dependency and for those young people born substance dependent it impacts on their development. Young people in Middlesbrough are also impacted by parents and significant adults own opioid dependence.

80. TEWV put forward the following suggestions for interventions that are needed over the next 5 years to better support people in their recovery from opioid dependency:-

    - Mental Health, Substance Misuse, Primary Care Networks (PCNs), Mental Health services especially Psychological interventions working jointly
    - Quick and reliable access to specialist Substance Misuse help especially in Crisis, Crisis Assessment Suite and Inpatient wards

- Single point of access in Mental Health to include Substance Misuse workers for joint triage/joint initial assessment; also Social workers, other colleagues
- Substance Misuse workers to attend joint meetings like formulation, pre-discharge meetings
- Substance Misuse Services to contribute to TEWV's co-produced Crisis management plans / Wellness Recovery Action Plans (WRAP)
- Mental Health services to deliver joint clinics in Substance Misuse premises
- Role of peer support workers across organisations
- Prescribers in commissioned Substance Misuse services to work with TEWV prescribers (at times meds may be given by prescribers in different organisations like GP, Substance Misuse, Mental Health, Acute hospitals etc. with limited sharing of information)
- Pathways for young people at risk of dependency and a way for those already dependent to access timely treatment
- Prescribing substitute treatment for those under 18 years needs further exploring
- Cross fertilisation in terms of training for Substance Misuse and Mental Health services (to each other)

81. Reference was made to the four levels of interventions, as highlighted in the pictorial triangle below:-.



82. Level 4 is the base of the triangle and represents basic services and security, level 3 is the next tier and is defined as community and family support, tier 2 is focused on non-specialised support and the top tier relates to specialised services. The vast majority of people sit below the top tier but are still in need of support.

83. **One of the main issues is that currently the majority of resources invested are concentrated on the very acute services, which people are accessing at the point of crisis. There really needs to be a shift in that resource but one of the difficulties in achieving this is that support is still needed for those at crisis point whilst trying to stop the future flow.** Only through investment in the more preventative measures can there be any sort of solution in the long term. There is a definite willingness from the

different service providers to work more closely and capitalise on how, through closer integration, the system can perform better with the resources currently available to it.

Evidence from the North East Ambulance Service (NEAS)

84. Over the last three years NEAS has seen an increase in the number of overdose cases attended in the TS1-8 postcode areas; with 2019 being the last full year of data available. In 2017 the number of overdose cases attended was 982 and in 2019 this has risen to 1757. The term overdose has a very wide definition and may include both accidental and unintentional overdose of both prescription and illicit drugs. In terms of identifying patients who have probably taken an overdose of an opioid based drug, the use of Naloxone is a more accurate measure.

85. NEAS has documented 778 cases where Naloxone has been administered to a patient between January 2017 and the present day, with a significant increase (38 per cent) in usage between 2018 and 2019. This accounts for approximately 1 per cent of all face to face ambulance encounters in the same area.

86. During this time period the indications for the administration of Naloxone Hydrochloride have not changed and therefore it is reasonable to assume that NEAS has seen more cases of opioid toxicity. However, the figures in Middlesbrough broadly aligned with similar increases in the use of Naloxone throughout the North East and there is nothing to suggest in the data that Middlesbrough is a significant outlier.

87. There is some seasonal variation in the number of cases, with the summer months seeing greater number of cases than winter. However, with only 3 years' worth if data it is not a large enough sample to draw definitive conclusions.

88. The TS1 and TS3 postcodes have the highest usage of Naloxone in the Middlesbrough area. Whilst NEAS do not hold data on hospital admissions this increased activity has certainly resulted in more patients transported to hospital for overdoses, opioid and none opioid related. Demographic information held by NEAS is limited but the majority of patients who received Naloxone Hydrochloride are men and the largest age bracket is for those aged 31-40.

89. NEAS advised that there are two areas of practice from other parts of the world that are worthy of attention:

    1. Information sharing between ambulance services and other public health bodies.

    - In some communities, Ambulance services regularly share data with public health and law enforcement agencies to help community partners better understand when unexpected peaks are occurring and put plans in place to address them. This requires information sharing agreements and support from NHS commissioning colleagues but can provide a very useful early warning when a potentially fatal batch of drugs were in circulation.

    2. Within the US many law enforcement agencies have issued their officers with Naloxone kits, in order to provide immediate treatment model to patients.

- This is being adopted by some police forces elsewhere in the UK.

TERM OF REFERENCE D – To identify good practice and evidence based approaches that aim to support opioid tapering / pain management (including campaigns to increase people's knowledge of the risks associated with prescribed opioids and over the counter medications).

90. In September 2019 Public Health England published the Prescribed Medicine Review. The review highlighted that in the period 2017 to 2018, 11.5 million adults in England (26% of adult pop) received, and had dispensed, one or more prescriptions for any of the medicines within the scope of the review. The review included:-

    - Antidepressants
    - **Opioids**
    - Gabapentinoids
    - Benzodiazepines
    - Z-drugs

91. The report highlighted that in the period 2017-2018 the rate of prescribing for antidepressants had increased from 15.8% of the adult population to 16.6% and for gabapentinoids from 2.9% to 3.3%. Annual prescriptions for opioid pain medicines had decreased slightly since 2016 but these figures vary throughout the country. It was noted that **opioid pain medicines and gabapentinoids have a strong association with deprivation**. The proportion of length of time of people receiving prescriptions continuously varies. **For all classes who had at least a year of prescriptions the figures increase with higher deprivation.**

    Opioid use in the UK

    - 28 million people in the UK living in chronic pain
    - 5.6 million adults are on prescription opioids or 1 in 8 adults
    - 500,000 people have been on opioids continually for more than 3 years
    - 20 years ago there were 47 drug poisoning deaths in England and Wales involving 2 drugs codeine or tramadol, last year there was nearly 400 – a worrying trend
    - Opioids are now so common people forget how powerful they are especially when they're mixed with alcohol
    - The use of prescription opioids is a major public health issue - it's up there with heart disease and cancer

92. The data contained in the Prescribed Medicine Review suggests that most people who start prescriptions receive them for a short time. However, each month there is a group of patients who continue to receive a prescription for longer. **Benzodiazepines, Z-drugs, opioid pain medicines and gabapentinoids are associated with a risk of dependence and withdrawal.** Patients report harmful effects with stopping these medicines, which affect their well-being, personal, social and occupational functioning. These effects can last several months.

    Addicted to Pain Killers

93. The Prescribed Medicine Review report (2019) details South Tees CCG and Hartlepool and Stockton (HaST) CCG's ranking compared to other CCG's across the country. The

ranking is highlighted, with "1" being the highest indicating higher prescribing rates per head of population and "195" being the lowest.

94. For South Tees CCG prescribing rankings for the following prescribed medicines are as follows:-

- Antidepressants - 2
- Opioid pain - 4
- Gabapentinoids - 2
- Benzodiazepines - 67
- Z-drugs - 143

95. Blackpool CCG is the only CCG with a lower ranking for the prescribing of opioid pain medicines and antidepressants.

	Antidepressants		Opioid pain		Gabapentinoids		Benzodiazepines		Z-drugs	
CCG name	Number with at least one dispensed prescription (2017/18) *	*Rank within CCGs (1=highest ISR, 195=lowest ISR)***	Number with at least one dispensed prescription (2017/18) *	*Rank within CCGs (1=highest ISR, 195=lowest ISR)***	Number with at least one dispensed prescription (2017/18) *	*Rank within CCGs (1=highest ISR, 195=lowest ISR)***	Number with at least one dispensed prescription (2017/18) *	*Rank within CCGs (1=highest ISR, 195=lowest ISR)***	Number with at least one dispensed prescription (2017/18) *	*Rank within CCGs (1=highest ISR, 195=lowest ISR)***
HARTLEPOOL AND STOCKTON-ON-TEES CCG	46,657	*15*	37,819	*21*	11,402	*15*	5,304	*170*	2,078	*195*
SOUTH TEES CCG	49,884	*2*	41,326	*4*	13,228	*2*	7,228	*67*	4,208	*143*

96. In terms of the data for repeat prescriptions of the drugs over 12 months, again with ranking relative to other CCG's across the UK the figures for South Tees CCG are as follows:-

- Antidepressants - 35
- Opioid pain - 21
- Gabapentinoids - 23
- Benzodiazepines - 9
- Z-drugs - 1

How powerful is opioid pain medication?

- **Morphine (15mg) - equivalent to 13 co-codamol (**morphine a close relation to heroin) and is highly addictive
- **Codeine (30mg) is far more powerful than co-codamol** and patients may experience withdrawal symptoms
- **Oxycodone** - **equivalent to 75 codeine tablets** and is one of the most widely abused prescription opioids and has been implicated in thousands of US deaths
- **Diamorphine** (30mg) - more commonly known as heroin
- **Fentanyl** (75micro-grams/hour) – **equivalent to 338 co-codamol tablets (all of it in one little patch)** is usually given via a slow release skin patch

97. Views were invited from Middlesbrough residents in respect of their personal experiences of opioids and the following comments were received:-

> *"Painkillers are far too easily prescribed, but there is always the pressure from the patient as we have been programmed to believe that painkillers are the solution and the suggestion of the brain playing a part puts up people's defences that someone is suggesting that 'it is all in the head' (believe me my pain was real)."*

> *"Opioids are far too commonly prescribed, from codeine to morphine. From personal experience it is frightening how a seemingly harmless drug such as codeine can be so addictive."*

> *"The brain plays a massive part in pain and I think medical professionals are starting to focus more on this pathway, but it's not easy because of the expectation that a painkiller is the answer."*

> *"I suffer with back spasms and was prescribed Tramadol. I hated them. I've never taken anything like that before and couldn't function on them. I took 3 doses and decided they weren't for me. For nearly four years my back went into spasm approximately every six weeks and I mainly relied on ibuprofen & co-codamol."*

> *"I've had great success with a physio (I've tried acupuncture and 3 other physio before) who looked at the root of my pain and didn't believe that painkillers are always the answer. He identified that my brain and nervous system has become over sensitised from an initial injury and described how I needed to retrain the signals from my brain to my back (there are some great books on this too)."*

<u>An opioid and gapentinoid reduction programme</u>

98. In October 2019 Professor Eldabe, Consultant Anaesthetist at South Tees NHS Foundation Trust (ST NHS FT), Associate Professor Sandhu, University of Warwick, G O'Kane, Specialist Pain Management Pharmacist, ST NHS FT) and A Monk, Medicines Optimisation Pharmacist, North of England Commissioning Support (NECS) submitted a proposals to pilot a pharmacist-led opioid and gabapentinoid reduction programme within South Tees CCG, Hartlepool and Stockton-On-Tees CCG and Darlington CCG, based on the **I-WOTCH** (**I**mproving the **W**ellBeing of people with **O**pioid **T**reated **CH**ronic pain) model.

99. In terms of background information the proposal highlighted that nearly eight million people (15 per cent) in England have moderate to severe chronic non-malignant pain. The condition has a major impact on the wellbeing and productivity of those affected with its prevalence reported to be higher among older people and those from socio-economically deprived areas. The common disorders contributing to this epidemic include low back pain,

neck pain, osteoarthritis, neuropathic pain, fibromyalgia, chronic widespread pain and post-surgical pain. **This is also limited data supporting the effectiveness of long-term strong opioids for chronic non-malignant pain. Adverse effects often outweigh the benefits of long-term opioid treatment on pain.**

100. A summary of the pharmacist led opioid and gapentinoid reduction proposal is detailed below:

There is an international epidemic of opioid prescribing for chronic non-malignant (non cancer) pain. Gabapentinoid prescribing is also high, despite questionable efficacy.

South Tees CCG and Hartlepool & Stockton CCG are two of the highest opioid and gabapentinoid prescribing areas in the region. Prescribing volumes are higher than the national average. Recent data shows drugs drug-related deaths in Middlesbrough, Stockton-On-Tees, Redcar & Cleveland and Hartlepool are higher than the North East and England average.

There is a need to address the high opioid and gabapentinoid prescribing volumes in North East England, particularly within South Tees CCG, Hartlepool & Stockton CCG and Darlington CCG. **There is little evidence to suggest that there are any existing pathways specific to people with opioid treated chronic non-malignant pain.** Working with practice pharmacists in primary care we would like to adopt the I-WOTCH model to deliver an opioid and gabapentinoid education and reduction programme within GP practices. We propose that we pilot the programme for 2 years. If the pilot is successful we plan to up-scale the programme and deliver it across the region.

The I-WOTCH model

101. The I-WOTCH model is designed to assist people with long standing pain to engage in reducing their opioids without fear of pain or relapse. It consists of three days of self-management intervention jointly led by a clinical and lay facilitator plus one-to-one support from the nurse (face to face and telephone) to support tapering of opioid medication. The clinical facilitators receive 3 days of training prior to delivering the programme. A key role of the clinical facilitator is to generate motivation.

The outline of the I-WOTCH structure is as follows:-

- **Week 1: I-WOTCH Day 1**: One-to-one consultation with specialist nurse. Jointly agreed withdrawal treatment plan. Education on living and dealing with pain.
- **Week 2: I-WOTCH DAY 2:** Goal setting, discussing barriers to change
- **Week 3: I-WOTCH DAY 3:** Managing communications and relationships
- **Week 4 to 6:** Up to two telephone consultations
- **Week 7 to 10:** One-to-one consultation with specialist nurse.

The aim of the intervention is complete withdrawal from opioids over ten weeks.

102. In 2019 71 GP Practices in the North East took part in the I-WOTCH trial. GP lists were screened using the I-WOTCH inclusion and exclusion criteria and **10,000 people were deemed eligible to take part in trial.** Of those 10,000 people, 228 were successfully randomised into the trial. **This leaves 9772 patients who could benefit from education on opioids and managing chronic pain.**

Evidence from Tees Valley CCG

103. Tees Valley CCG is extremely mindful of the current issues in relation to both high levels of opioid medication prescribing and the high levels of drug related deaths in Middlesbrough, as well as in the Tees Valley in general. The CCG is engaging actively with local authority partners, in particular the Tees Preventing Drug Related Deaths Co-ordinator; the pain clinic at James Cook Hospital, in particular Professor Eldabe and his team; and local GP practices, in order to raise awareness amongst all clinicians of high levels of opioid prescribing in the Tees Valley.

104. The CCG's Medicines Optimisation practice team is working with GP practices to assist in the identification of patients on particularly high doses of opioid medication. There is a wide variation in both volume and cost of opioid prescribing by GP practices throughout Middlesbrough. Although the overall trend is decreasing it is acknowledged that **Middlesbrough practices are still prescribing at more than double the volume of opioid medication when compared with the national average.**

105. During 2019/20 and continuing into 2020/21, the CCG is focusing on how it can assist GP practices to reduce inappropriate prescribing of high dose opioid medication to Middlesbrough's population.

106. The CCG is working closely with South Tees Hospital NHS Foundation Trust (STHFT) to highlight current high levels of opioid prescribing in primary care. The Trust is working to both limit the number of patients commencing opioid therapy, but also assisting patients who needed to reduce their doses of opioid medication.

107. There is a dedicated opioid reduction clinic at James Cook University Hospital (JCUH), operating as part of Prof Eldabe's team, where a specialist Pharmacist is able to consult with patients referred by GP practices. Work has progressed on an opioid specific discharge protocol in order to limit the amount of opioid medication being given to patients on discharge from hospital. Clearer advice is included for patients in order to ensure they do not ask for further medication, unnecessarily, from their GP.

108. CCG led initiatives include:-

- The CCG medicines optimisation team are assisting practices in identifying high dose opioid patients and highlighting these patients to prescribers. GPs are then able to initiate reduction programmes in appropriate patients, ideally using a structured reduction programme of gradually decreasing doses. More complex patients are able to be referred to the Trust clinic.

- South Tees CCG is taking part in the CROP (Campaign to Reduce Opioid Prescribing) initiative. This initiative is being co-ordinated by the Academic Health Science Network (AHSN), on behalf of all CCGs in the North East & North Cumbria. The initiative consists of specific practice information being sent to practices every 2 months, commencing in April 2020.

  The report contains:-

  - details of practice opioid prescribing
  - where the practice featured compared to all practices

- age and gender information related to opioid prescribing
- national resource's to assist prescribers in reducing the prescribing of opioid medication

109. Additional patient focused work will take place in 2020/21, when pharmacist led community opioid/gabapentinoid reduction clinics will be established, operating at Primary Care Network (PCN) level. The CCG is currently funding a pilot, which involves the education of 5 Pharmacists to deliver a series of structured patient level opioid reduction interventions in a primary care setting.

110. Nottingham Clinical Commissioning Group's Area Prescribing Committee has recently produced a number of resources in respect of opioid dependency for both clinicians (Appendix 1) and patients (Appendix 2). These resources highlight a number of best practice initiatives and key messages in relation to the deprescibing of opioids.

CONCLUSIONS

129. Based on the evidence, given throughout the investigation, the scrutiny panel concluded that:

To be determined.

RECOMMENDATIONS

130. To be determined

a)
b)

ACKNOWLEDGEMENTS

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- Daniel Ahmed, Clinical Partner, Foundations
- Dr John Bye, Clinical Partner, Foundations
- Chief Inspector Daryll Tomlinson, Cleveland Police
- Marion Walker, Head of Stronger Communities, Middlesbrough Council
- Debra Cochrane, Community Support Officer (Homelessness), Middlesbrough Council
- Jill Fidan, Community Outreach Officer (Homelessness)
- Edward Kunonga, Director of Public Health, South Tees
- Tom Le Ruez, Tees Preventing Drug Related Deaths Co-ordinator
- Councillor Antony High, Deputy Mayor and Thematic Lead for Drugs, Middlesbrough Council
- Vicky Franks, Project Manager, Change, Grow, Live (CGL)
- Richy Cunningham, Regional Manager, Recovery Connections
- Jonathan Bowden, Advanced Practitioner, Public Health (South Tees)
- Rachel Burns, Advanced Practitioner, Public Health (South Tees)
- Craig Blair, Director of Strategic Planning and Performance, Tees Valley CCG

- Dr Janet Walker, Medical Director, Tees Valley CCG
- Alastair Monk, Medicine Optimisation Pharmacist, North East Commissioning Support (NECS)
- Dan Haworth, Consultant Paramedic, North East Ambulance Service (NEAS)
- Mark Cotton, Assistant Director of Communications, North East Ambulance Service (NEAS)
- Dominic Gardner, Director of Operations (Teesside), Tees, Esk & Wear Valley NHS FT
- Dr Baxi Sinha, Clinical Director Adult Mental Health (Teesside), Tees, Esk & Wear Valley NHS FT
- Professor S Eldabe, Consultant Anaesthetist, South Tees Hospitals NHS Foundation Trust
- Associate Professor H Sandhu, University of Warwick

ACRONYMS

132. A-Z listing of common acronyms used in the report:

- **CGL** – Change, Grow, Live
- **NEAS** – North East Ambulance Service
- **TEWV** – Tees, Esk & Wear Valley NHS Foundation Trust
- **TVCCG** – Tees Valley Clinical Commissioning Group
- **MRT** - Middlesbrough Recovering Together
- **PCC** - Police and Crime Commissioner
- **HAT** – Heroin Assisted Treatment
- **DCRs** - Drug Consumption Rooms
- **QRR** – Quasi Residential Rehab
- **HILT** – Hospital Intervention and Liaison Team
- **NEAS** - North East Ambulance Service
- **PCN's** - Primary Care Networks
- **RPIW** - Rapid Process Improvement Workshops
- **WRAP** – Wellness, Recovery, Action, Plans
- **TV CCG** – Tees Valley Clinical Commissioning Group
- **ST CCG** – South Tees Clinical Commissioning Group
- **JCUH** – James Cook University Hospital
- **ST NHS FT** – South Tees NHS Foundation Trust
- **CROP** - Campaign to Reduce Opioid Prescribing
- **AHSN** - Academic Health Science Network (AHSN)

BACKGROUND PAPERS

133. The following sources were consulted or referred to in preparing this report:

 Reports to, and minutes of, the Health Scrutiny Panel meetings held on 8 October 2019, 11 February 2020, 10 March 2020, 13 October 2020 and 8 December 2020.

COUNCILLOR JOAN MCTIGUE

CHAIR OF THE HEALTH SCRUTINY PANEL

Membership 2019/2020 - Councillors J McTigue (Chair), D P Coupe (Vice-Chair), A Hellaoui, S Hill, J Rathmell, D Rooney, R M Sands, M Storey and P Storey

Membership 2020/2021 - Councillors J McTigue (Chair), D P Coupe (Vice-Chair), B Cooper, A Hellaoui, B A Hubbard, T Mawston, D Rooney, M Storey and P Storey

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OPIOID DEPRESCRIBING FOR PERSISTENT NON-CANCER PAIN

Key Messages

- Opioids are very good analgesics for acute pain and for pain at the end of life but there is little evidence that they are helpful for long term pain such as lower back pain, fibromyalgia, headache, migraine, abdominal and pelvic pain.
- **Safety concerns** - long term opioid use can lead to fractures, falls, endocrine abnormalities, immunomodulation, opioid induced hyperalgesia and dependence.
- The risk of harm increases substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit. Ref: Faculty of Pain Medicine Key Messages.
- If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, **even if no other treatment is available**.
- By tapering the opioid dose and stopping, patients will be more able to function in the world, and feel less ill. They may still have pain, but are likely to feel better in themselves.
- Opioid analgesia used long term can destroy lives - read Faye's Story.
- Opioids started in hospital should not routinely be continued in primary care. Review patient and assess pain before prescribing more opioids post discharge.
- Before starting an opioid trial, manage patient expectations and explain risks. See Checklist for Prescribers on Opioids Aware website.

Opioids should be tapered or stopped for non-cancer pain, particularly if...

- The opioid(s) is/are not providing useful pain relief or ability to do more.
- The patient develops intolerable side effects.
- The patient is on a dose of more than 120mg/day oral morphine equivalent.
- There is strong evidence that the patient is misusing, abusing or diverting their medicines to others.
- The patient is taking, or is started on, medicines that potentiate the effect of opioids e.g. pregabalin, benzodiazepines, antidepressants., antipsychotics. See BNF for full list.
- The patient has been on opioids for more than 3 months.
- The underlying painful condition resolves.
- The patient receives a definitive pain relieving intervention (e.g. joint replacement).

See over for step-by-step guide to opioid deprescribing

Responsibility for prescribing opioids

- Whilst tapering opioids, the patient should ideally receive prescriptions from a single prescriber and the medicine dispensed from a specified pharmacist. Consider using the home screen of the medical record to highlight which prescriber is managing the opioid deprescribing.
- If the patient needs a prescription from someone other than the usual prescriber, documentation should be clear and accurate to support consistency of safe care.
- Do not issue prescriptions before they are due, this will help to prevent patients increasing their doses on their own or diverting their medicine to others.
- Do not issue more than 28 days supply at one time. Consider prescribing for shorter periods - weekly or two weekly.

Useful resources:

- Faculty of pain medicine Opioids Aware resources - www.fpm.ac.uk/opioids-aware
- Live Well with pain - www.livewellwithpain.co.uk
- DVLA drugs and driving: the law - www.gov.uk/drug-driving-law
- Contact local pain service for advice and support if needed.

OPIOID DEPRESCRIBING FOR PERSISTENT NON-CANCER PAIN

Discussion with the patient

- Explanation of the limited role that opioids have in long term pain and the potential benefits of opioid reduction (avoidance of long term harms and improvement in ability to engage in self management strategies).
- Agree if outcome is stopping or tapering to a specified dose.
- Explanation that withdrawal symptoms (see box 2) or a change in pain may occur following each reduction but these symptoms tend to settle within a few days.
- Stress that opioids should not be stopped suddenly and that the reduction will take time (months not weeks).
- Discuss other ways to manage pain and develop self-management strategies. See NHS Live Well - 10 Ways to Reduce Pain or Live Well with Pain - Ten Footsteps.
- Calculate total oral morphine equivalence of all current opioids by any route (link to calculator). Check with the patient what they are actually taking, don't assume the prescribed dose is being taken.

Is the patient engaged and willing to taper?

No → Box 1

Yes ↓

Agree reduction schedule with patient. Aim to taper the dose by 10% of the original dose two weekly or monthly.

- If taking more than one opioid, reduce one at a time starting with the most potent.
- If taking modified release (MR) / patches as well as immediate release (IR), taper MR / patch first and switch IR liquid to tablets to more easily monitor the amount used.
- Limit number of doses of IR per day and counsel patient not to increase dose of IR to compensate.
- Ensure that scripts are not issued early.
- Agree the reduction schedule with the patient, particularly if they are anxious. You may agree to start with a small dose decrease (e.g. 5% or even less) or monthly rather than two weekly if it helps to gain confidence.
- When considering frequency of reductions, consider your capacity for follow up and review.
- Patients may experience withdrawal symptoms for several days after reduction so weekly reductions may be too quick.
- The reduction becomes a larger proportion of the dose as the dose reduces. This is why patients may run into difficulty as they reach lower doses. Consider smaller dose reductions as the dose becomes lower.

Review

- Check for withdrawal symptoms (box 2) between dose reductions (this can be done over the phone if necessary).
- Offer encouragement and remind of reasons for tapering.
- Offer advice on managing withdrawal symptoms (box 3).
- Anxiety and low mood can exacerbate withdrawal symptoms. See NHS Live Well - 10 Ways to Reduce Pain for tips on managing pain, sleep and low mood.
- If patient wants to give up follow advice in box 1.
- Contact local pain service for advice and support if needed.

Box 1 - What if the patient is not keen?

Ref: Opioids Aware - Tapering and Stopping

- Be empathic and focus discussion on medicines.
- Allow patient time to reflect on information and arrange a further appointment to initiate taper if necessary. If, after reflection, patient is still not keen then review again in 3 to 6 months.
- Take a full medicines history and ask how well the medicines are working, and reflect that the patient is describing severe pain despite medicines.
- Share that the experience of many patients is that taking medicines results in no real benefit for pain.
- Explain that we now have better ways of working out how helpful medicines really are and we know that a lot of things that we thought were helpful in the past have proved to be disappointing and...
- ...take responsibility for contributing to where we are now!
- Pain medicines can cause significant harm.
- Explain the DVLA rules for driving under the influence of prescription medicines.
- It matters a lot that the patient has confidence that all their medicines are working well
- Usually stopping medicines makes no difference to pain but can make people feel better (fewer side effects / better quality of life). Consider filling in a Prescribed Opioids Difficulties Scale to allow the patient to see the problems opioids are causing.
- If a tapering trial doesn't work we can think again
- Brainman videos may be helpful and are used by the local pain service.
- Suggest that the patient watches Louise's story on the Live Well with Pain website.

Box 2 - Withdrawal symptoms

- Sweating, yawning, tremor, abdominal cramps, restlessness, irritability, anxiety & runny nose/eyes.
- Bone or joint aches, which may be confused with perceived worsening of the original pain.
- The clinical opiate withdrawal scale (COWS) can be used to quantify the severity of withdrawal symptoms and monitor changes over time.

Box 3 - Managing Withdrawal symptoms

- Patients experience withdrawals differently and may experience none, some or all of the above symptoms.
- Withdrawal symptoms can be very unpleasant but are generally not life threatening, reassure the patient that these symptoms will resolve with time.
- Tapering may be paused to allow time to overcome symptoms before the next dose reduction, tapering should not be reversed except in exceptional circumstances
- Do not be tempted to treat withdrawal symptoms with more opioids or benzodiazepines.

NHS

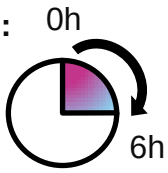
Integrated Care System
Nottingham & Nottinghamshire

Strong Oral Opioids for Acute Pain: Information for Adult Patients (Over 16 years)

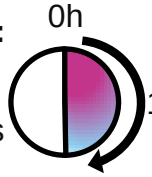
This leaflet is relevant to NEW or CHANGED prescriptions for:

- ❑ *Immediate release* morphine sulphate oral solution (Oramorph®) or tablets (Sevredol®)
- ❑ *Modified release* morphine sulphate capsules (Zomorph®) or tablets (MST®)
- ❑ *Immediate release* Oxycodone capsules (Shortec®) or liquid (Shortec® liquid)
- ❑ *Modified release* Oxycodone tablets (Longtec®)

Immediate release opioids:
For quick pain relief
Work for 4-6 hours



Modified release opioids:
Release gradually
Work for 12 hours



What are strong opioids?

Opioids are a *short term* option for *acute* pain
Opioids can significantly *reduce* pain, but rarely *stop* pain altogether.

- ❑ **Opioids** are strong morphine, or morphine-like, pain relievers.
- ❑ **Acute pain** comes on quickly and usually has a cause such as an injury
- ❑ Opioids are not effective for all types of pain.
- ❑ They are less effective for long-term pain due to tolerance and side effects.
- ❑ The best opioid dose is the lowest dose possible that makes pain manageable.
- ❑ Reducing your pain will allow you to breathe deeply, cough and move around. This lowers the risk of serious complications such as chest infections, blood clots and pressure sores.

How long should I take opioids for?

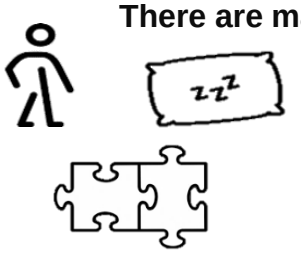
It is important that you do not take opioids for longer than you need.

- ❑ The aim is to gradually lower the amount you are taking and stop them (or return to your normal dose) before your supply runs out.
- ❑ Hopefully you will not require a repeat prescription of opioid medication.

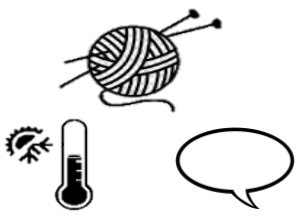
If you are still in significant pain or need support, please contact your GP.

How can I manage my pain?

There are many proven options to help you other than medication:



Gentle exercise
Get a good nights sleep
Distract yourself! Knit, complete a puzzle…
Hot and cold packs
Talk about it with someone you trust



Author: Tiffany Feather, NUH Senior Clinical Pharmacist.
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Strong Oral Opioids for Acute Pain: Information for Adult Patients (Over 16 years)

How should I take these medicines?

Do not drink alcohol or take other medicines that make you drowsy whilst taking these medicines **UNLESS** prescribed by your doctor.

If these medicines make you feel drowsy you may not be fit to drive or operate machinery. For information: www.gov.uk/drug-driving-law

If you have other medicines prescribed for pain make sure you use them as prescribed to lower the amount of opioid you need.

Please do not take more pain relief than you are prescribed. If you do please seek medical advice.

What side effects could I experience?

Nausea or vomiting- can be managed with anti-sickness medication.

Constipation - can be managed with laxatives

Drowsiness or confusion - can be managed by adjusting the dose or opioid choice.

Tolerance - your body can get used to opioids and they can become less effective.

Dependence - if you decrease the dose too quickly you can experience symptoms of withdrawal such as sweating, stomach cramps and muscle aches.

Your local pharmacist is a great source of support and advice for managing your medications. Contact your pharmacist if you have questions or concerns.

If serious side effects occur seek medical advice.

Where can I get more information?

Telephone Helplines:

Nottingham University Hospitals Trust Tel: 0115 924 9924 ext. 64641

Sherwood Forest Hospitals Trust Tel: 01623 672213

Primary Integrated Community Services Pain Services: 03000 830 000

Internet Resources (can be found via google or any other search engine)

- ❑ **Faculty of Pain Medicine:** *Taking opioids for pain*
- ❑ **British Pain Society:** *Understanding and managing pain: information for patients*
- ❑ **My Live Well with Pain**

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