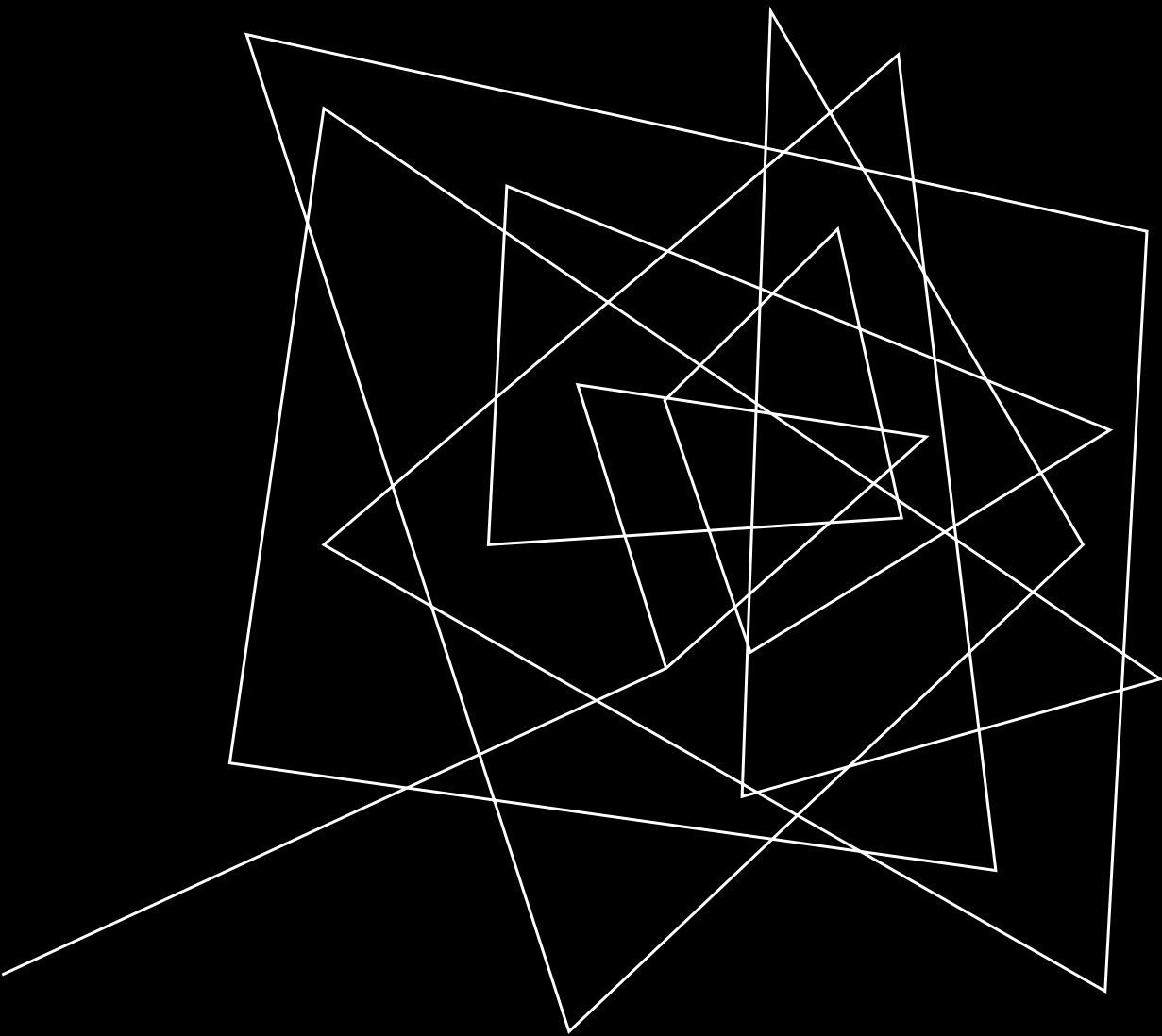


GREATER MANCHESTER: 2021 DRUG RELATED DEATHS AND IN- TREATMENT MORTALITY





ONS DATA

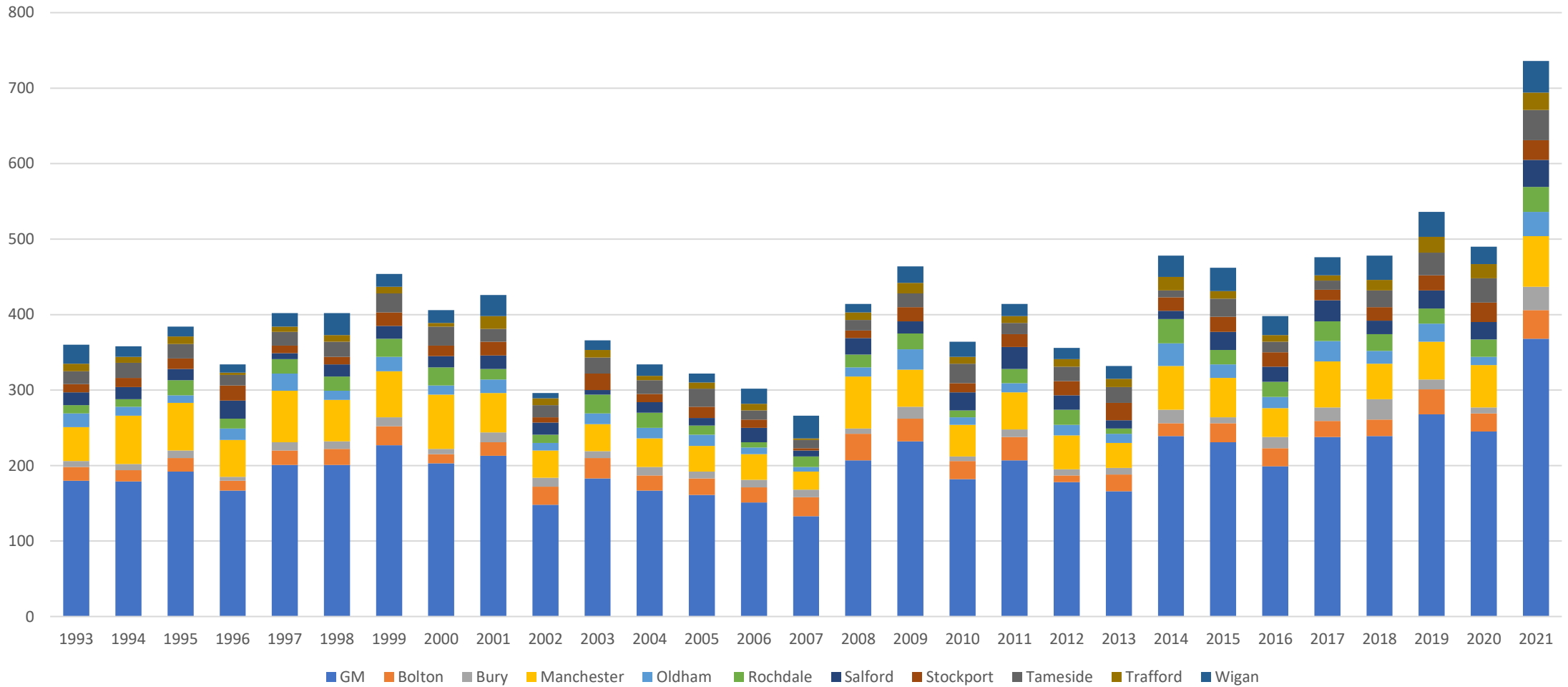
DRUG POISONING REGISTRATIONS FOR GM,
2021

ONS DRUG POISONINGS IN ENGLAND AND WALES 2021

- 4,859 deaths related to drug poisoning were registered in 2021 in England and Wales - this is 6.2% higher than the rate recorded in 2020
- Rates of drug misuse death continue to be elevated among those born in the 1970s, often referred to as “Generation X”, with the highest rate in those aged 45 to 49 years.
- Approximately half of all drug poisoning deaths registered in 2021 involved an opiate (45.7%; 2,219 deaths).
- North-West of England has second highest rate of DRD behind North-East.
- 840 deaths involved cocaine, which is 8.1% more than 2020 and more than seven times the amount recorded a decade ago (112 deaths in 2011).
- Significant increase in methadone deaths - 663 deaths registered in 2021, which is 28.5% higher than the previous year.
- 258 deaths involving new psychoactive substances registered in 2021, 88.3% higher than the previous year, driven by an increase in deaths involving benzodiazepine analogues (primarily flubromazolam and etizolam) from 62 in 2020 to 171 deaths in 2021.
- Increasing numbers of deaths involving benzodiazepines (a rise of 13.0% compared with 2020, from 476 to 538 deaths), pregabalin (a rise of 18.9%, from 344 to 409 deaths) and gabapentin (a rise of 12.7%, from 118 to 133 deaths).

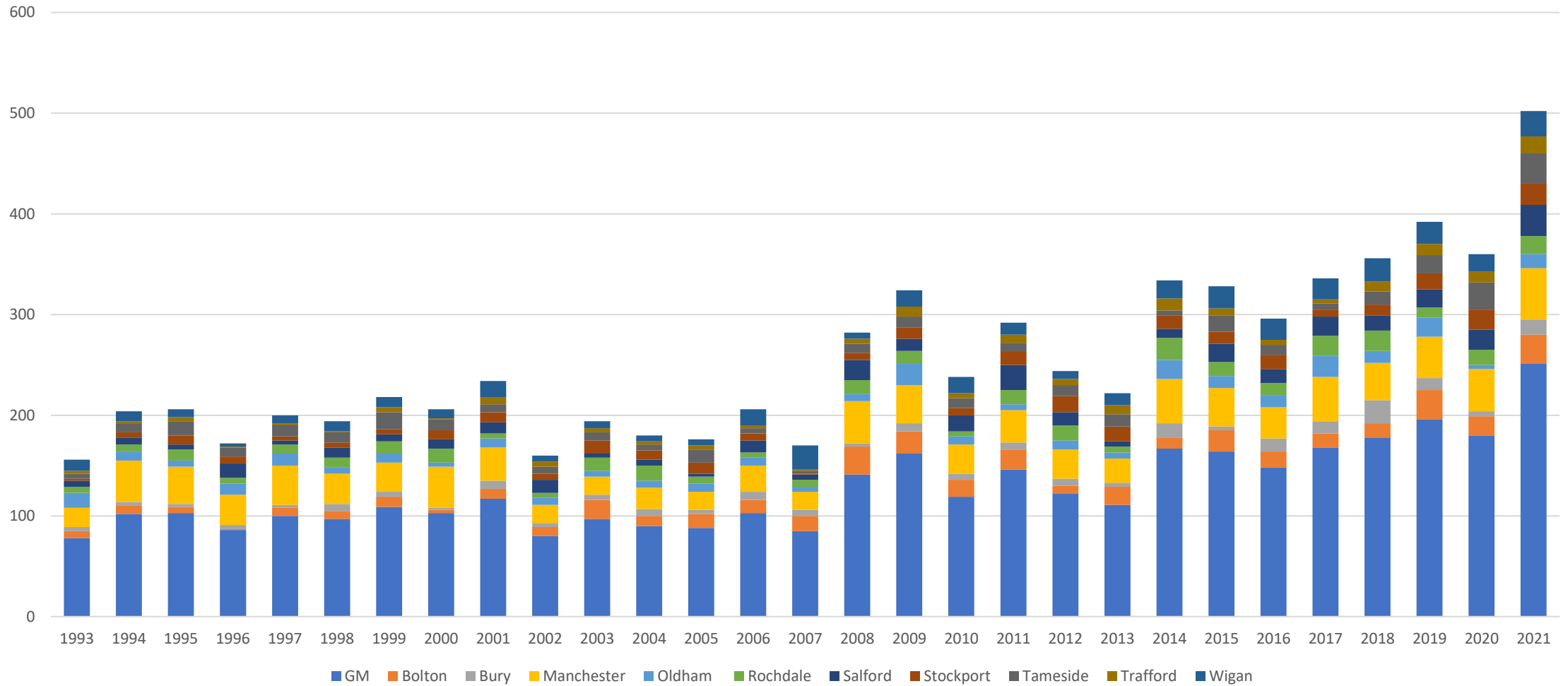
GREATER MANCHESTER DRUG RELATED DEATHS 2021

Drug poisoning deaths, Greater Manchester - registrations 1993-2021

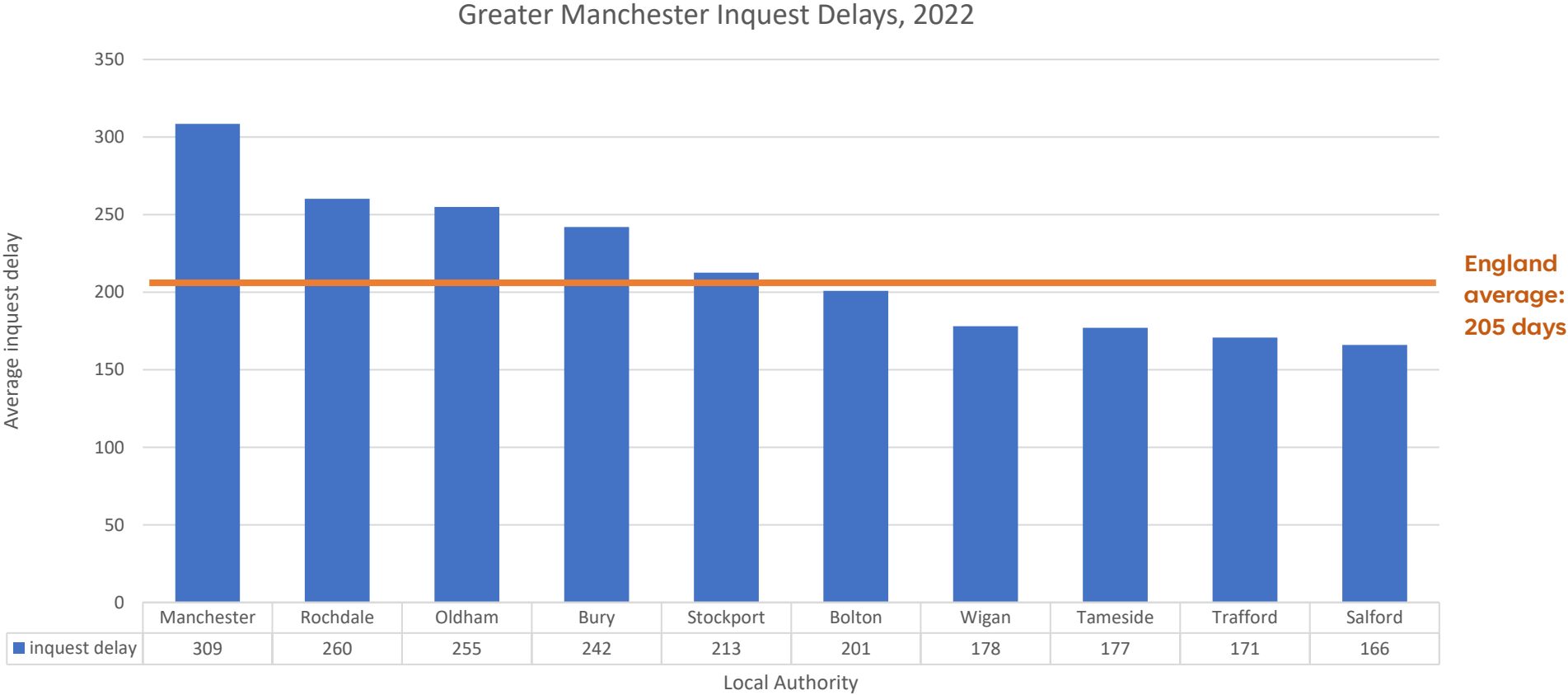


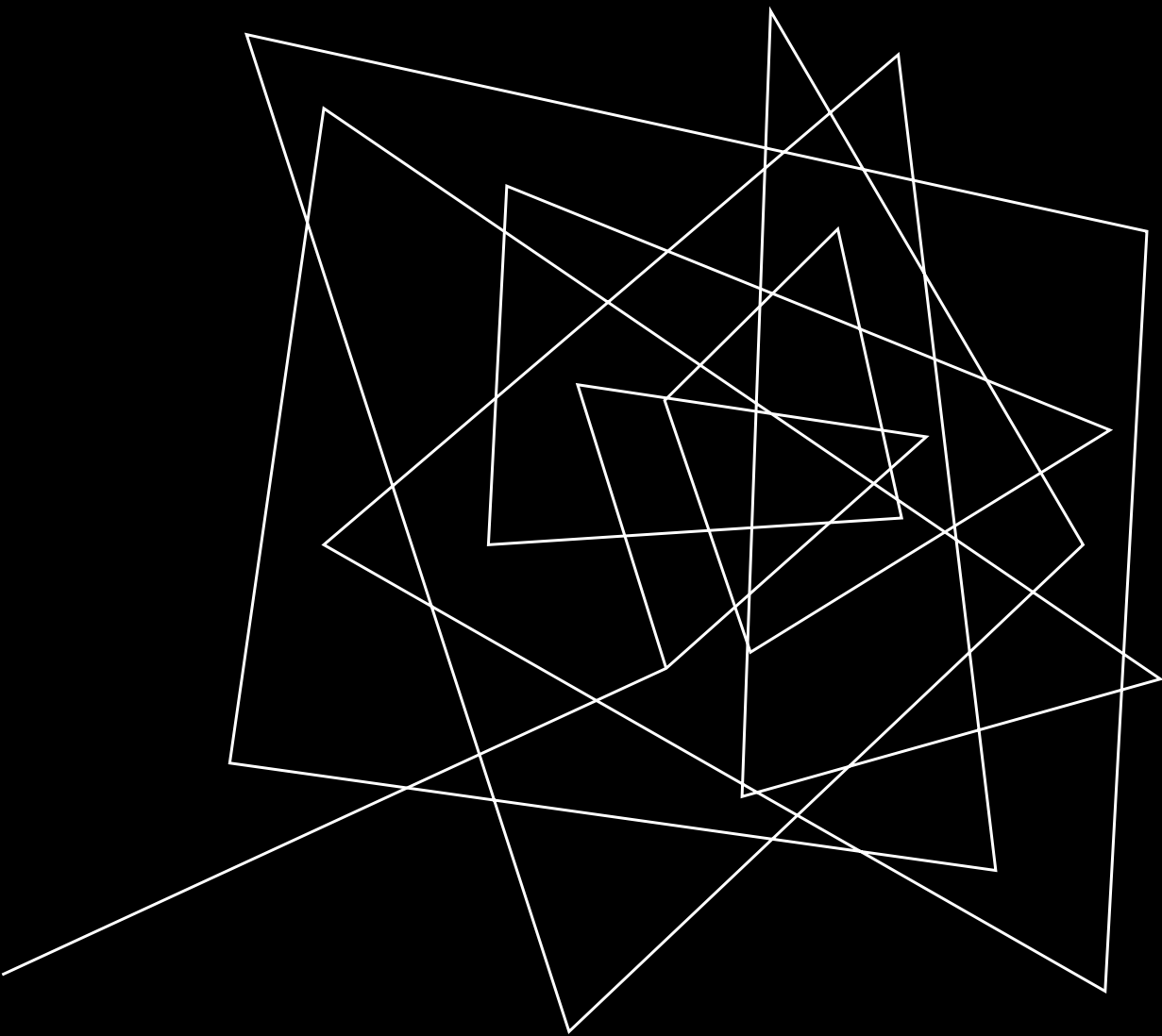
GREATER MANCHESTER DRUG RELATED DEATHS 2021

Drug misuse deaths, Greater Manchester - registrations 1993-2021



GM IMS DRUG RELATED DEATH MONITORING 2021





**IMS DRD
MONITORING FOR
GREATER
MANCHESTER**

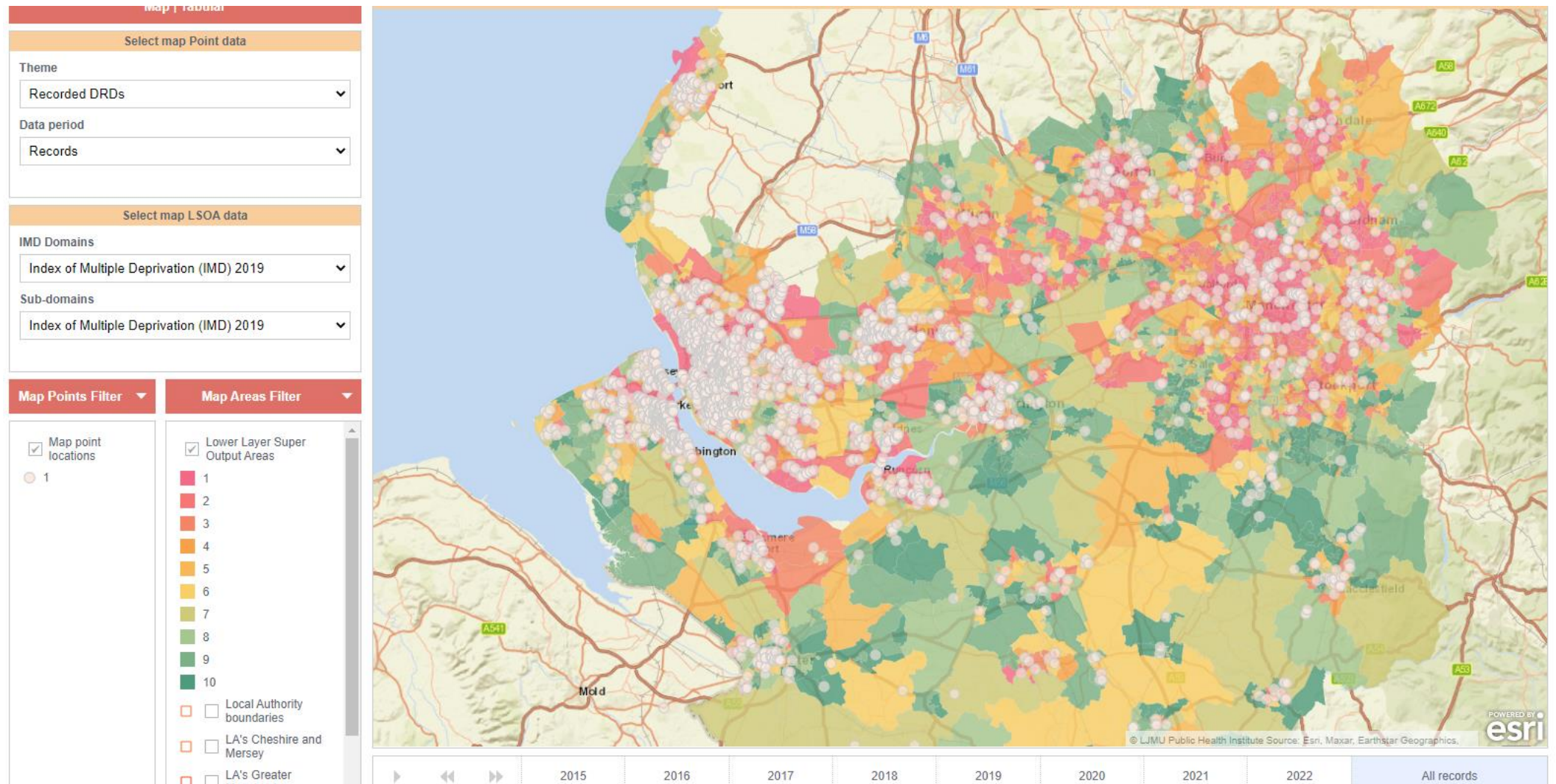
GM IMS DRUG RELATED DEATH MONITORING

- IMS DRD surveillance contract commences 1st September 2021
- Based on Cheshire and Mersey model:
 - quantitative and qualitative
 - focus on deaths both inside and outside of treatment system
 - multi-agency so focus not just on provider
- Panels now operational in nine out of ten areas
- Good buy-in in some areas from sectors including probation, pharmacies, adult social care, mental health, housing
- Information flow established with 3 out of 4 coroners
- Relationship with NPSAD
- Discussions with GMP on data feeding into system
- Intelligence Briefings produced quarterly
- Interim first annual report due January 2023

GREATER MANCHESTER DRUG RELATED DEATHS 2021

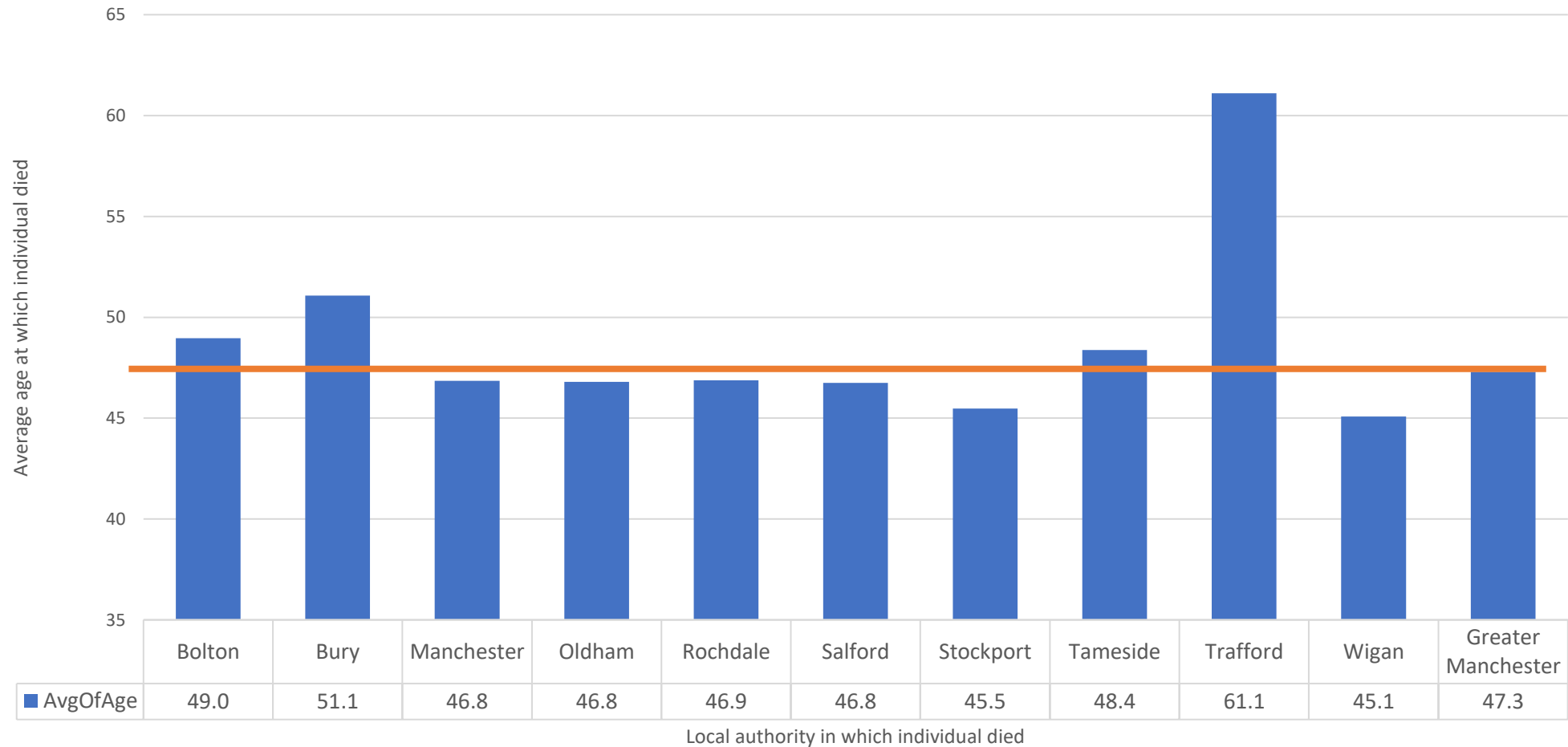
Year	2021		2022	
LAName	provider	coroner	provider	coroner
Bolton	50	3	34	2
Bury	15	11	21	4
Manchester	81	46	63	3
Oldham	28	10	23	3
Rochdale	29	8	28	6
Salford	32	0	31	2
Stockport	15	3	13	0
Tameside	41	0	47	0
Trafford	16	0	10	1
Wigan	20	2	61	2

GREATER MANCHESTER DRUG RELATED DEATHS 2021



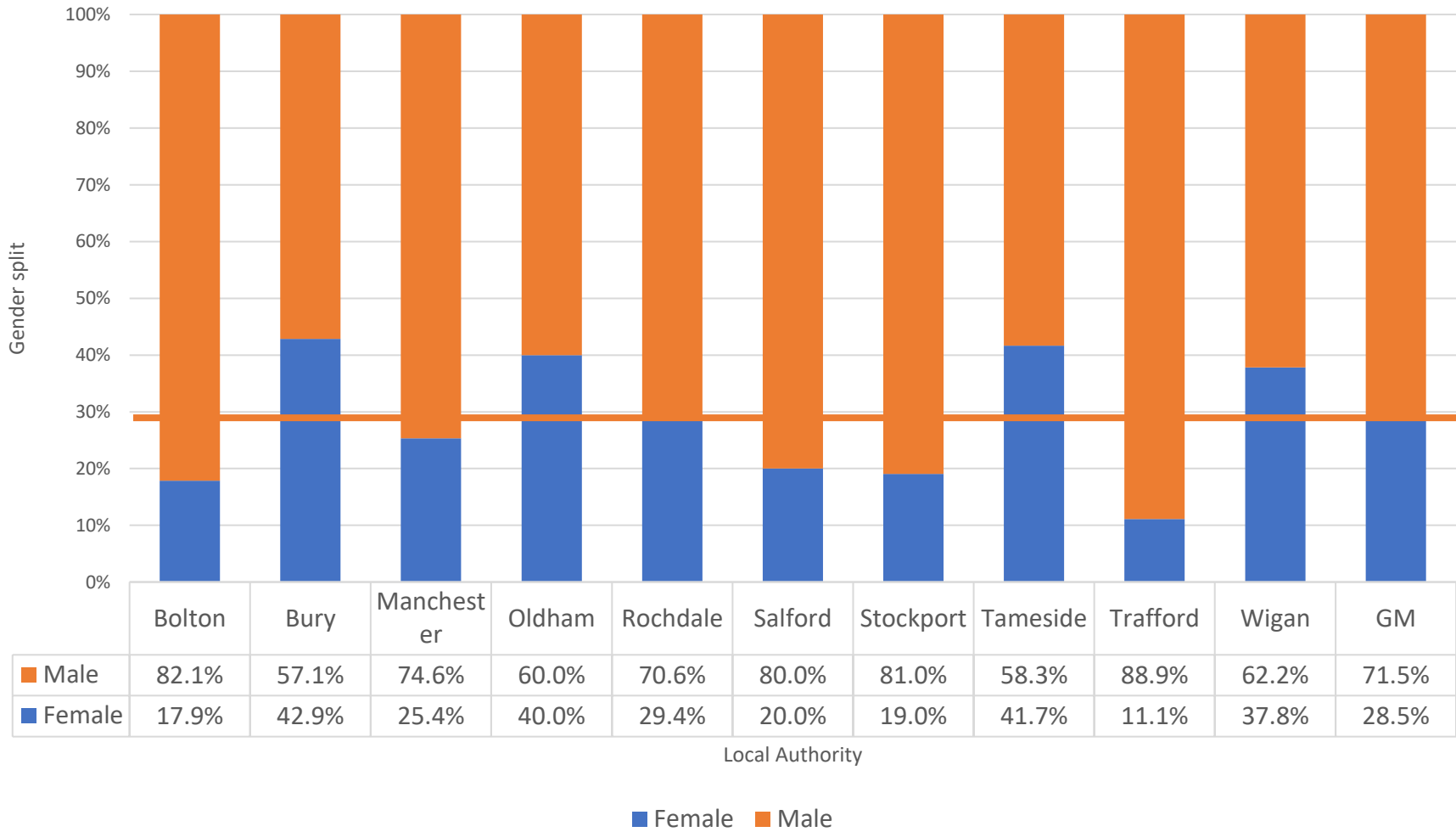
GM IMS DRUG RELATED DEATH MONITORING

Average Age of Toxicity Deaths, GM, 2021



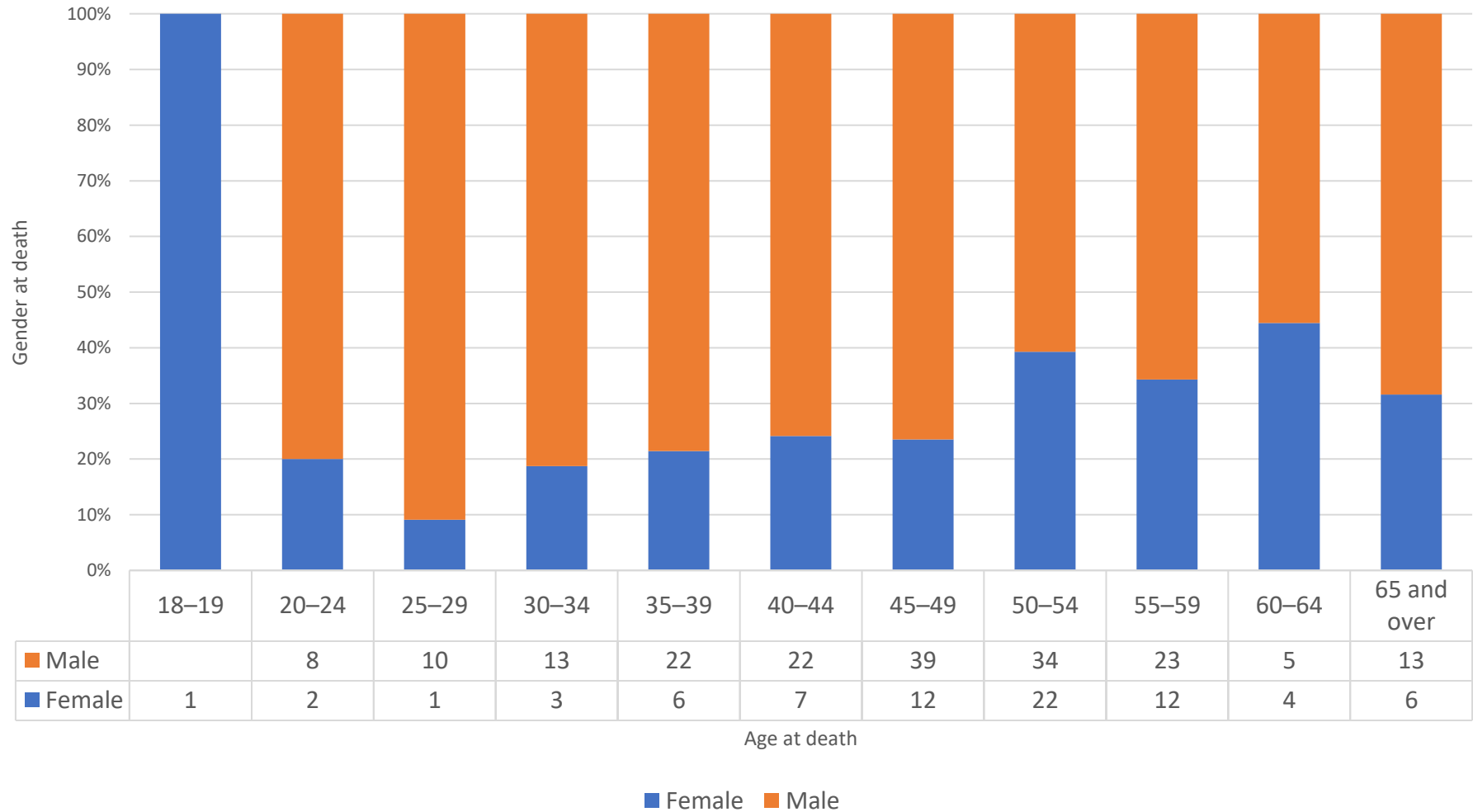
GM IMS DRUG RELATED DEATH MONITORING

Gender of toxicity deaths, GM, 2021



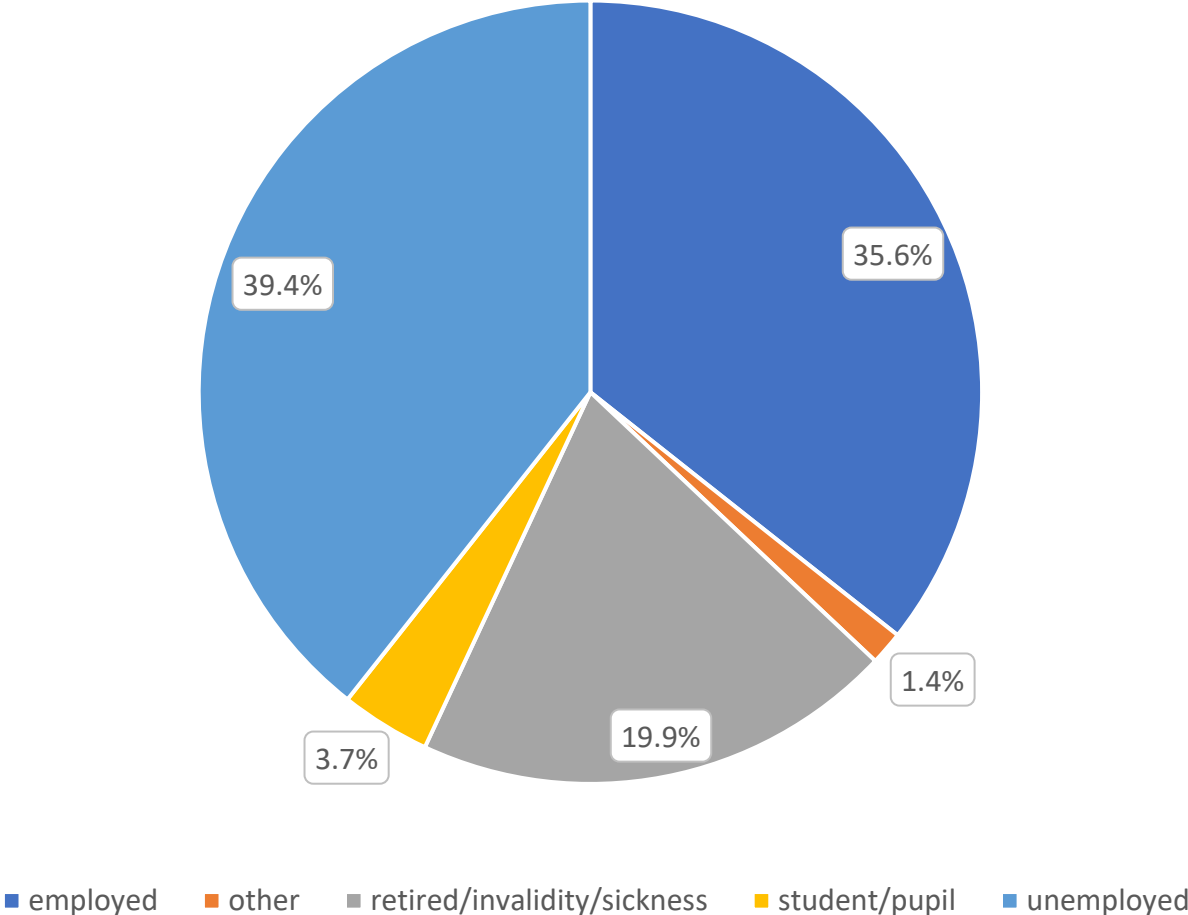
GM IMS DRUG RELATED DEATH MONITORING

Gender and age of toxicity deaths, GM, 2021



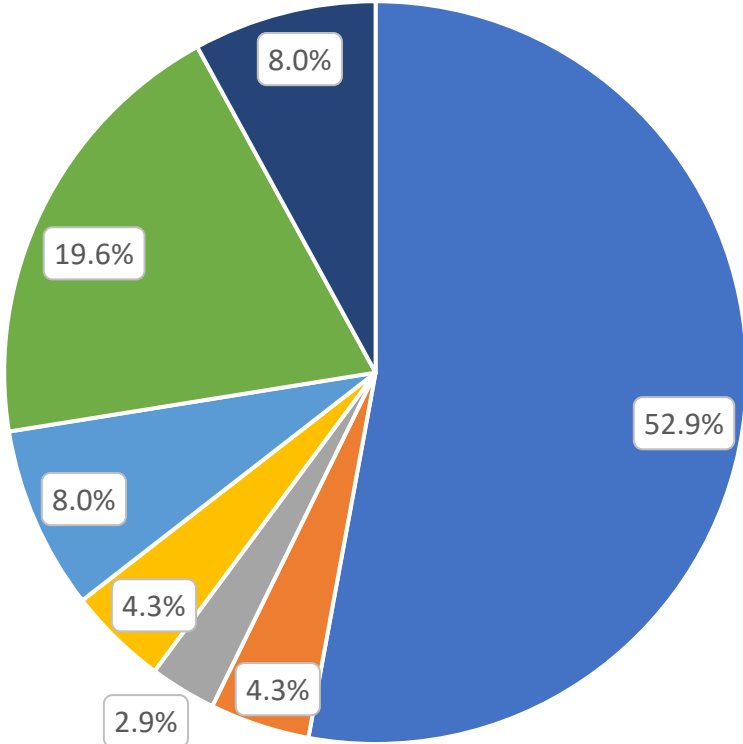
GM IMS DRUG RELATED DEATH MONITORING 2021

Employment status, toxicity deaths, 2021



GM IMS DRUG RELATED DEATH MONITORING 2021

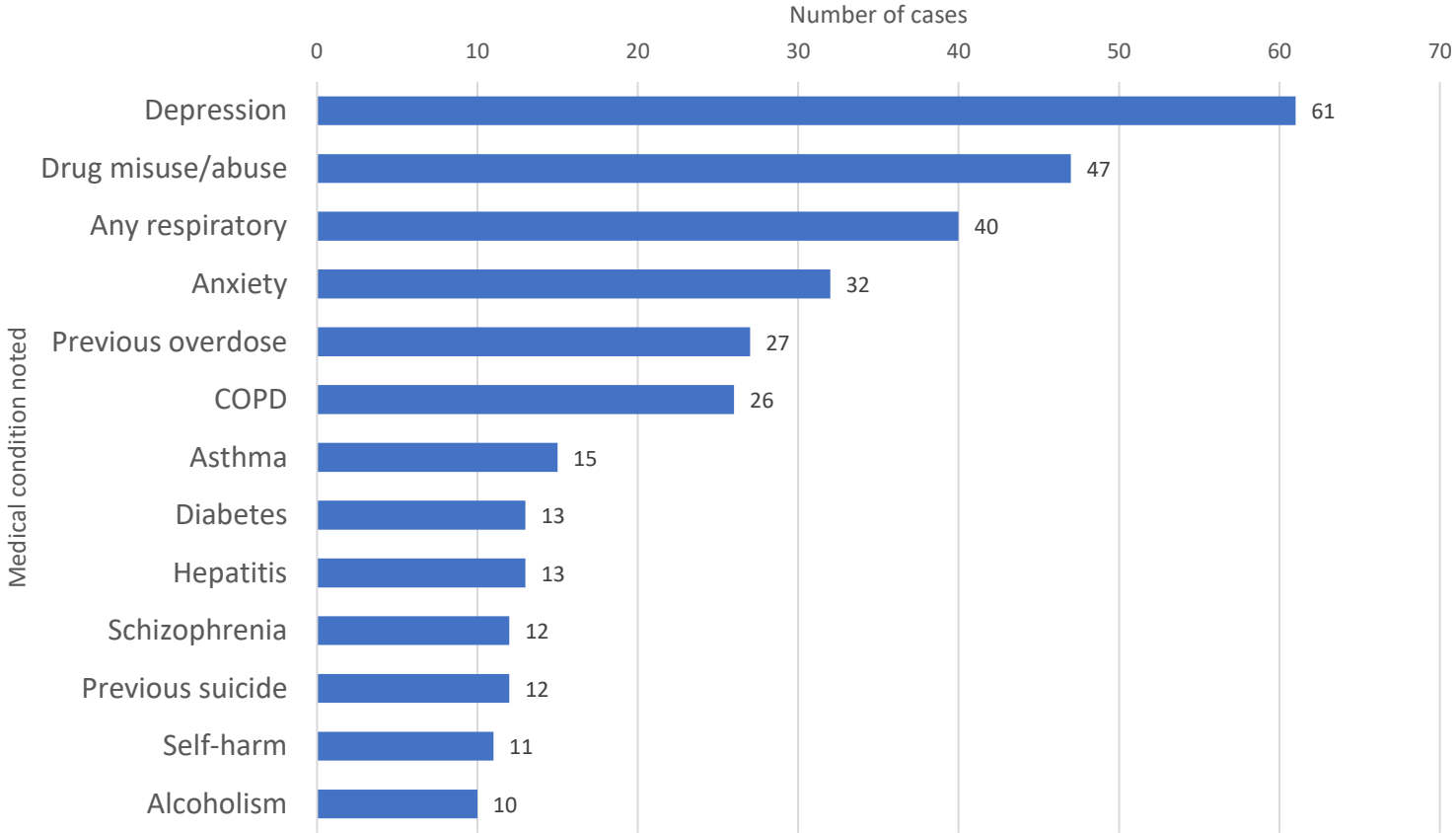
Living status, toxicity deaths, 2021



■ Alone ■ no fixed abode ■ other ■ with friends ■ with parents ■ with partner ■ with partner & children

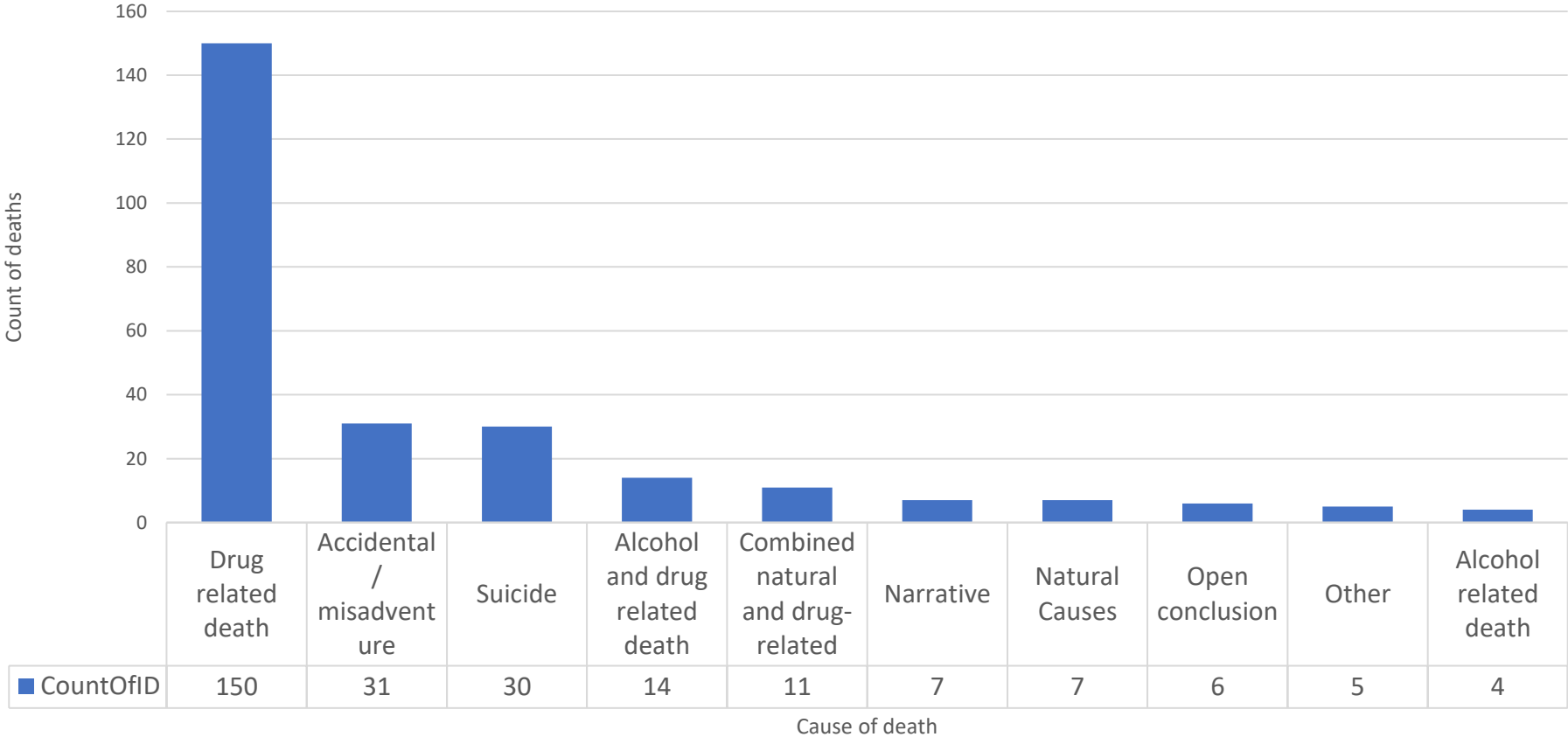
GM IMS DRUG RELATED DEATH MONITORING 2021

Other health conditions noted, GM toxicity deaths, 2021



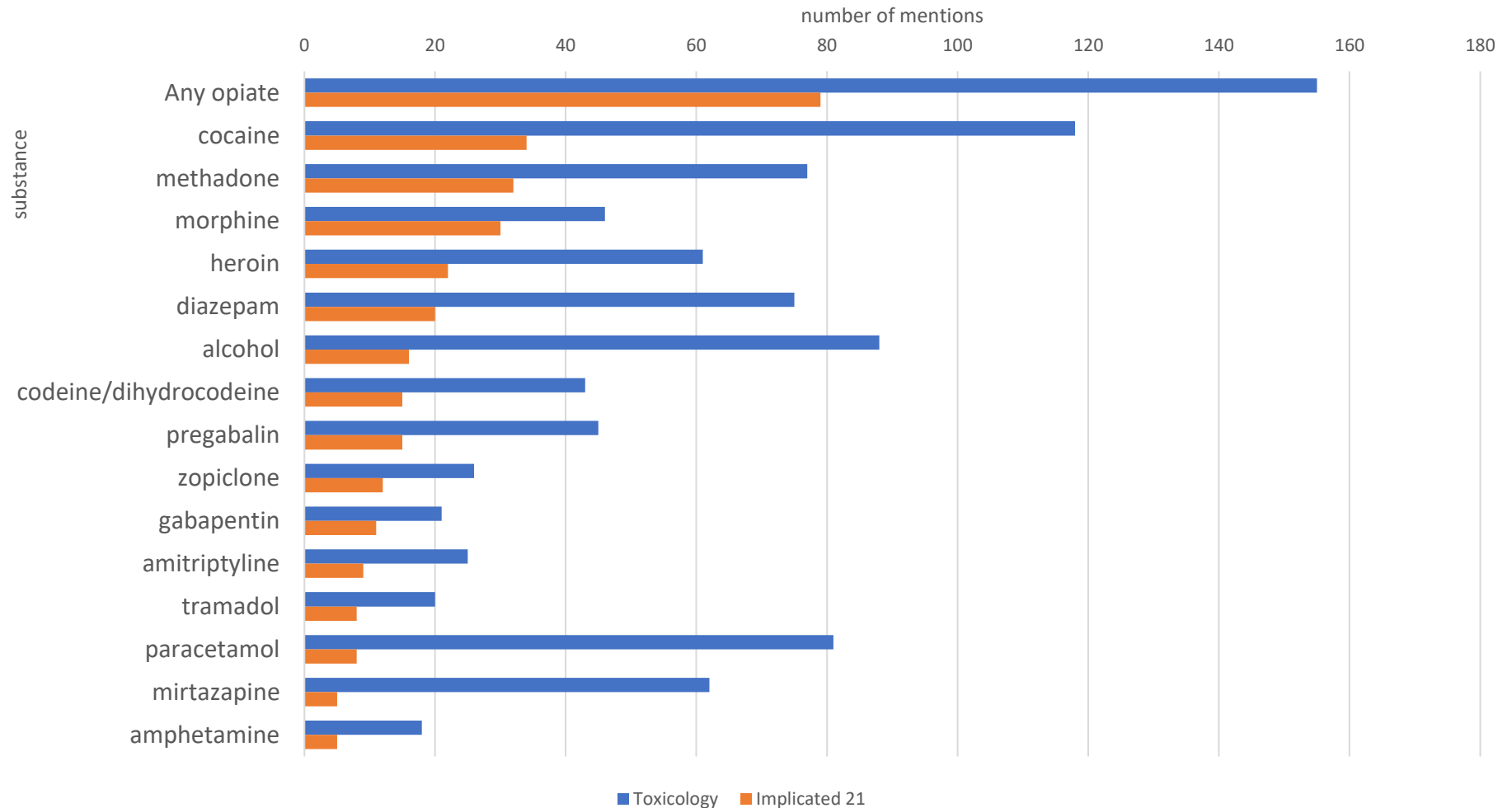
GM IMS DRUG RELATED DEATH MONITORING 2021

Cause of death, GM coroner verdicts, 2021

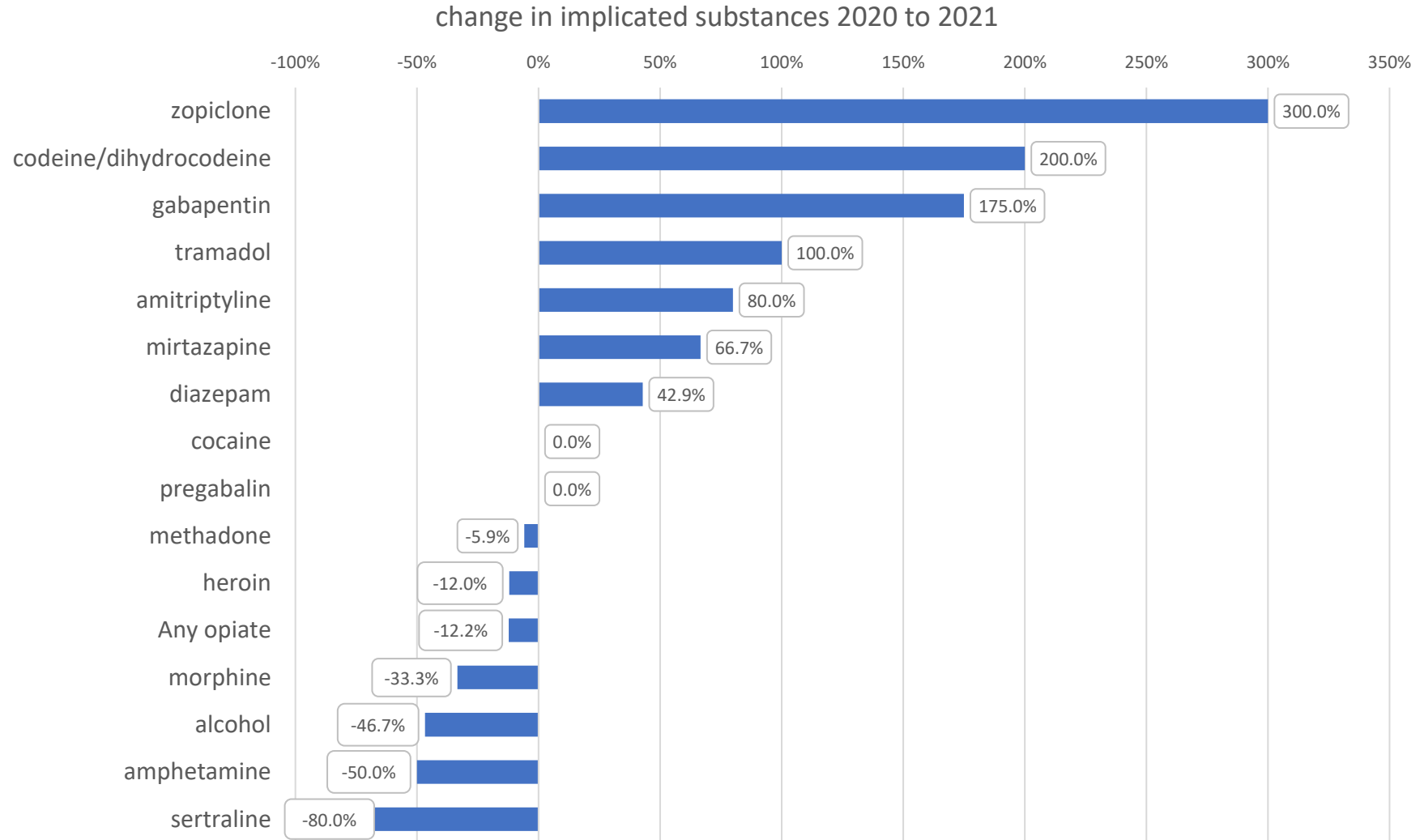


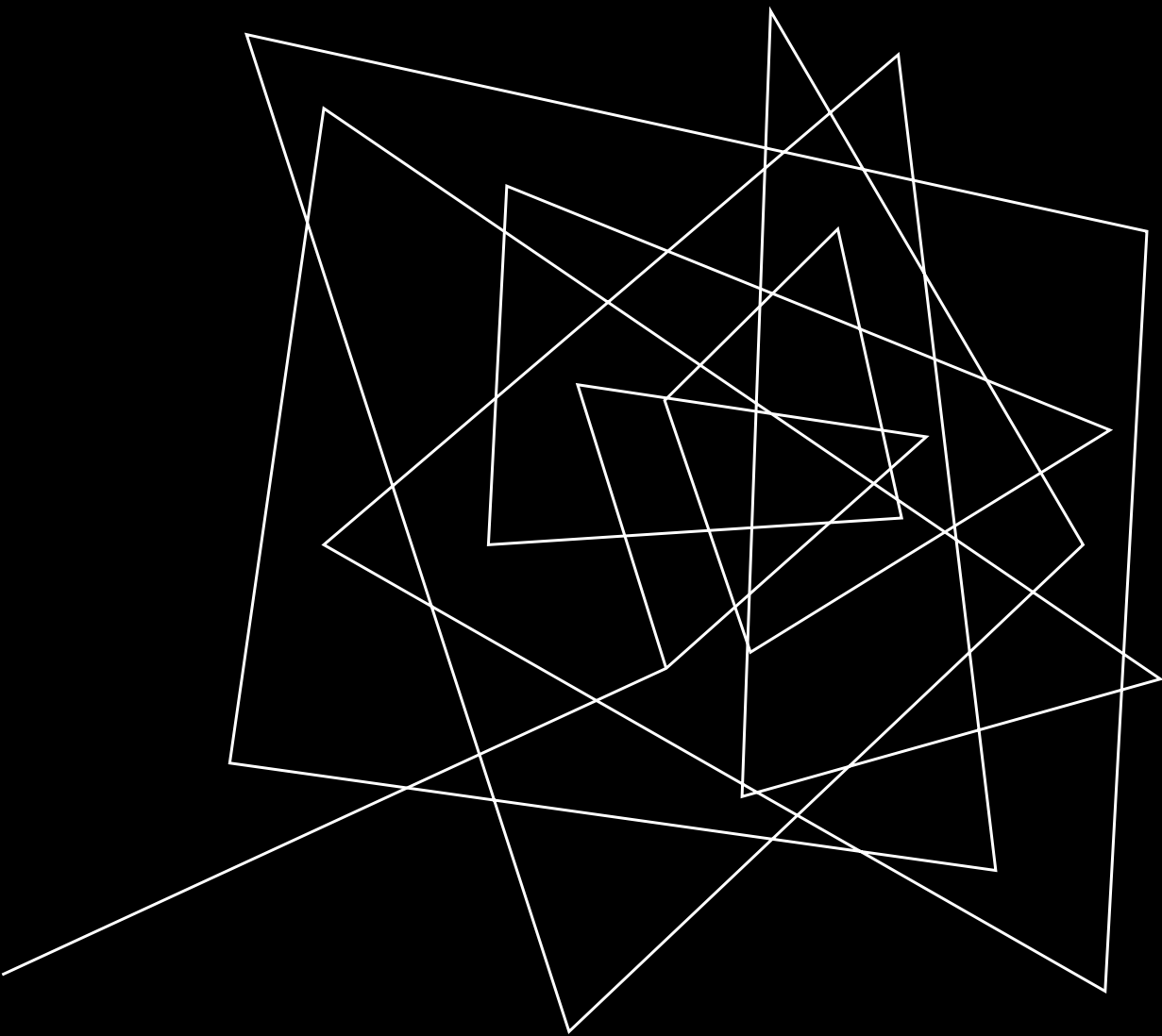
GM IMS DRUG RELATED DEATH MONITORING 2021

Mentions in toxicologies and implicated, GM, 2021



GM IMS DRUG RELATED DEATH MONITORING 2021





DRD PANELS

GREATER MANCHESTER UPDATE

CHESHIRE AND MERSEYSIDE DRUG RELATED DEATHS 2021

DRD Panel composition from 2022:



CHESHIRE AND MERSEYSIDE DRUG RELATED DEATHS 2021

Tier 1:

Anything identified as “drug related death” or “alcohol related” death on “Details of Death” tab; Any deaths reported only by the coroner. Any suicides.

Tier 2:

Anything identified as “tbc, pending inquest” or “unknown” on “Details of Death” tab

Tier 3:

Anything identified as “natural causes” or “other causes” on “Details of Death” tab

But any panel member can nominate any case for discussion

Key common themes from panels in 2022:

- Communication with pharmacies
- Engagement with GPs – prescribing of meds
- Cocaine use amongst an ageing cohort
- Chronic long-term conditions such as COPD
- Sourcing medications online
- People living/using alone
- Bereavement
- Prison leavers
- Naloxone provision
- Deaths outside of the treatment system
- Panel membership

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