HM Government

Local Preparedness for Synthetic Opioids in England

Findings and recommendations for Combating Drugs Partnerships

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1. Introduction

1.1. Purpose

1. This report summarises analysis and recommendations developed from a review of Combating Drugs Partnership[1] (CDPs) synthetic opioid preparedness plans, and a tabletop exercise conducted with a range of relevant local partners.

2. The report offers evidence and insights for CDPs, especially public health and law enforcement leads, intending to help strengthen their preparedness for an evolving threat. The report also informs national initiatives on this topic. Many of the principles and recommendations discussed are relevant to multiple drug types.

1.2. Background

3. Potent synthetic opioids, such as nitazenes and illicit fentanyls, are sometimes added to or substituted for heroin. They have also been added to or substituted for other drugs, or openly sold as synthetic opioids. Drugs of this type are typically many times stronger than heroin and carry a higher risk of overdose[2], and there is concern among government, law enforcement, public health and the treatment sector, about these substances becoming more prevalent in the future.

4. In June 2023 a multi-agency response was established in the West Midlands following a cluster of drug-related deaths where nitazenes were found to be present. A National Patient Safety Alert was issued by the Office for Health Improvement and Disparities (OHID), drawing attention to heroin adulterated with nitazenes, but also referencing detections of synthetic opioids adulterating other drug types.[3]

5. In response to this increased threat, the National Crime Agency (NCA) commenced Project HOUSEBUILDER in July 2023 to lead and coordinate the operational law enforcement response, working closely with OHID, and soon after the government convened the HMG Synthetic Opioids Taskforce to bring together further government departments to respond. These organisations have delivered a range of initiatives[4], including ensuring all lines of investigative inquiry are being pursued, controlling a range of novel synthetic opioids as Class A substances under the Misuse of Drugs Act 1971, strengthening detection at the border and expanding access to naloxone.

6. Potent synthetic opioids have caused deaths in England in previous years, and, in 2018, recognising the critical role local partners play in responding to this risk, the predecessor agency to OHID published guidance called “Fentanyl: preparing for a future threat”[5].

[1] Combating Drugs Partnerships (CDPs) are multi-agency forums that are accountable for delivering National Combating Drugs Outcomes under the 10 Year Drug Strategy within local areas in England: https://www.gov.uk/government/publications/drugs-strategy-guidance-for-local-delivery-partners/guidance-for-local-delivery-partners-accessible-version

[2] https://www.gov.uk/government/publications/deaths-linked-to-potent-synthetic-opioids

[3] https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103236

[4] https://www.gov.uk/government/news/britain-working-at-pace-to-curb-rising-synthetic-drugs-threat

[5] https://www.gov.uk/government/publications/fentanyl-preparing-for-a-future-threat

7. By mid-August 2023, when the West Midlands response was stood down, the number of deaths investigated across the region had tragically reached 18, with an additional 25 non-fatal overdoses recorded. After this "*rising tide event against illicit drugs that contained synthetic opioids*", the West Midlands Local Resilience Forum commissioned the College of Policing to undertake a structured debrief[6], to review their response using emergency preparedness, resilience and response principles.

8. A sustained number of nitazene related deaths continued to be recorded across the UK in the months following[2], and so, in April 2024, the government requested all CDP's Senior Responsible Officers (SROs) to establish plans to manage the risk of synthetic opioids in their areas, utilising the published OHID guidance and their own expertise. In September 2024, the Joint Combating Drugs Unit (JCDU) requested these plans to be submitted to government to help assure local system readiness, using a framework set out in Annex A.

9. Finally, to further support local preparedness, a tabletop exercise was delivered in November 2024 by the JCDU with OHID, the National Police Chiefs' Council (NPCC), and the nonprofit research organisation RAND Europe. The exercise was designed to test local responses to a hypothetical local incident which escalated in severity.

10. This report has been produced by the HMG Synthetic Opioids Taskforce Secretariat with OHID and NPCC, and has been reviewed by a panel of external stakeholders. It is one part of the government's response to synthetic opioids.

1.3. Key findings and recommendations

11. At the time of publishing this report, 108 out of 112 synthetic opioid preparedness plans[7] had been submitted to the JCDU, showing a clear commitment to facing this challenge from CDPs.

12. In general, the quality of the preparedness plans reviewed was strong and largely followed the suggested format of Prepare, Monitor, Treat and Enforce. Whilst varying in levels of detail and specificity, most plans effectively describe how local partners from across public health, drug treatment services and policing will come together to respond to incidents as they arise, building a common understanding of the threat and delivering harm reduction and enforcement interventions. The plans cover activities that are acute, needing a rapid coordinated response, as well as those that are longer-term, such as improving access to drug treatment.

13. The tabletop exercise highlighted that CDPs face a common set of challenges when faced with escalating scenarios. These included gaps in data collection and sharing; aspects of incident response, resilience, and coordination; missing stakeholder engagement; and the need for vigilance in what can be a rapidly evolving threat. Local partners suggested government should improve its reporting of the national threat picture, disseminate best practice harm reduction messaging and materials, and continue its development of centrally delivered data flows (for example, on ambulance use of naloxone), amongst other topics that are covered in this report.

[6] Structured Debrief Matrix, Operation MABBLE, June-August 2023, College of Policing

[7] Some larger CDP areas submitted multiple plans for their constituent parts, whilst some smaller CDPs collaborated to produce plans. As such the number of synthetic opioid preparedness plans does not align with the 103 CDPs that are currently constituted.

14. Based on the findings detailed below, recommendations are made to improve local preparedness and response. The full set of recommendations are:

Recommendation 1: Combating Drugs Partnerships (CDPs) should review their preparedness plans annually, or when the threat assessment changes, and should take xylazine and other synthetic drugs into consideration. CDPs may choose to have public-facing plans as part of their local communications.

Recommendation 2: All CDPs should assure they have an effective system to ensure 'Out of Hours' (OOH) resource is available to respond to incidents, which may include reviewing OOH arrangements for local authority public health teams.

Recommendation 3: Having tested or exercised their preparedness plans with Local Resilience Forum (LRF) partners, all CDPs should ensure plans set out at which point LRFs should be involved in the local response. LRFs should include this and other drug related death incidents as a specific risk in their formal risk registers.

Recommendation 4: Office for Health Improvement and Disparities (OHID) and the Joint Combating Drugs Unit (JCDU) should publish clear drug related death incident protocol and escalation plans from a national and regional perspective, aligned to established law enforcement protocols.

Recommendation 5: All CDPs should include naloxone supply as part of their comprehensive needs assessments and ensure sufficient local capacity for partners to deploy naloxone in a range of scenarios.

Recommendation 6: All Local Drug Information Systems (LDIS) should review their data requirements and establish data sharing agreements with relevant system partners. It is best practice for local coroners and LDIS to collaborate when potent synthetic opioids are confirmed to be present in post-mortem toxicology. OHID, Home Office and National Crime Agency (NCA) should continue to support this work, including through updated LDIS guidance.

Recommendation 7: All LDIS should ensure they have a list of stakeholder organisations to help with communicating alerts and sharing information and knowledge. In many areas this network is known as the Professional Information Network (PIN). This network should be regularly engaged and alerted in the event of an incident. This network should include, but not be limited to, contacts in the prisons and probation sector, the education sector, and the night-time economy.

Recommendation 8: All LDIS should identify and monitor at-risk groups in their communities beyond people who use opioids, given the risk posed by synthetic opioids to people who take drugs other than heroin. This should be part of a wider package of work for CDPs on understanding local levels of drug use, dependence, and consumption as part of their annual needs assessment process.

Recommendation 9: OHID and the JCDU should regularly share threat assessments and accompanying narrative on synthetic opioids to support CDPs to prepare their local communications plans. LDIS should follow the drug alert guidance and ensure LDIS panels meet before local alerts are issued. Updated LDIS guidance should consider the topic of social media misinformation.

Recommendation 10: All CDPs should ensure their treatment offer includes support for any cohort where there is risk of synthetic opioid adulteration.

Recommendation 11: OHID should continue to develop and share with local areas suggested communication materials for use with key stakeholders, the media and for people who use drugs. Updated LDIS guidance should consider developing harm reduction materials for use in settings with less awareness of the risk.

Recommendation 12: All CDPs should align their enforcement plans with the NCA's national operational response to synthetic opioids (Project HOUSEBUILDER), and policing should fast-track drug seizures for forensic testing if synthetic opioids are suspected to be present as per the HOUSEBUILDER forensic strategy.

1.4. Acknowledgements

15. In producing this report, we would like to acknowledge and thank the following organisations for their contributions, either directly through participation in the exercise, or indirectly by inviting the JCDU, OHID or NPCC to attend their events:

Association of Directors of Public Health	Association of Police and Crime Commissioners
Blackpool CDP	Bradford CDP
City of London and Hackney CDP	Collective Voice
Coroner's Office for Birmingham and Solihull	Croydon CDP
Dorset, Bournemouth, Christchurch and Poole CDP	County Durham and Darlington CDP
East Riding of Yorkshire CDP	Emergency Planning College
Greater Manchester CDP	His Majesty's Prison and Probation Service
Hull CDP	Leicester, Leicestershire and Rutland CDP
Metropolitan Police Service	Ministry of Housing, Communities and Local Government
National Crime Agency	New Vision Bradford
NHS Addictions Provider Alliance	Northumbria CDP
North Yorkshire and York CDP	North Yorkshire Horizons
Nottingham and Nottinghamshire CDPs	Plymouth CDP
RAND Europe	Staffordshire CDP
Turning Point	UK Health Security Agency
VIA	Welsh Government
West Midlands CDP	

2. Methodology

2.1. Review of synthetic opioid preparedness plans

16. Tackling acute drug harms effectively requires a coordinated response with active surveillance, communications, harm reduction and enforcement action. Opioids are receptive to naloxone and have highly efficacious treatment pathways, thus providing clear public health intervention options. For these reasons, a common framework to shape synthetic opioid preparedness plans was suggested to CDPs, with activities grouped under the themes of Prepare, Monitor, Treat and Enforce.

17. Of the synthetic opioid preparedness plans that had been submitted to central government, a sample of 25 were selected for analysis, reflecting a geographic spread of regions and a combination of urban and rural areas. These plans were reviewed against the criteria in the checklist (Annex A), with common themes, gaps, and best practice examples identified.

Figure 1 - Summary diagram of the Prevent, Monitor, Treat and Enforce framework

2.2. Synthetic opioid tabletop preparedness exercise

Background and objectives

18. Immersive tabletop exercises are a technique frequently used by organisations to enable open-ended discussion on potential courses of action in response to plausible future scenarios[8]. These are usually conducted in small groups which are placed in a context and asked to respond to unfolding and escalating situations.

19. To support the work of the JCDU, OHID, NPCC and CDPs to prepare and respond to the threat from synthetic opioids, RAND Europe worked with the JCDU to design and deliver a tabletop preparedness exercise. The objectives of the exercise were:

[8] https://www.gov.uk/government/publications/exercising-best-practice-guidance

a) With ‘skeleton’ CDP teams, work through an escalating local scenario to discuss and workshop at a strategic level:
    a. how areas might respond, identifying and recording each course of action
    b. what the challenges might be to their response
    c. where areas need further clarity or support from central government
b) Test key themes identified through analysis of CDP preparedness plans;
c) Discuss and reflect on challenges and obstacles, best practice and next steps;
d) Develop and inform further guidance on best practice and exercise planning materials for use by all CDPs[9].

Exercise structure

20. The exercise was delivered through a full-day workshop, with eight different CDPs represented by a range of public health, commissioner, treatment provider, policing and emergency planning leads. Though focused on local preparedness, the exercise was attended by national stakeholders from non-government organisations as well as central government departments, to observe decisions made by local partners.

21. The schedule for the workshop involved several breakout groups organised by geographic region. These breakout groups then met in multiple plenary sessions to brief the group on their response and discuss their approaches and any concerns.

22. The hypothetical scenario was set across a single month in the summer of 2025. It included eight separate escalation points to which participants in each group needed to respond. These escalation points are summarised in Table 1. These escalation points were designed to test local partners in their responses to particular aspects of an incident involving synthetic opioids, managing heightened political and media interest, and a range of incident severities.

Table 1 – Tabletop exercise hypothetical scenario escalation points

Escalation Point 1 Non-fatal overdoses among rough sleeping population in temporary accommodation, as well as a separate planned police disruption of a local drug supply chain.
Escalation Point 2 Confirmation of the presence of nitazenes and an increase in naloxone administration in neighbouring areas.
Escalation Point 3 Fatal and non-fatal overdoses among different rough sleeping cohort. Used test strips found showing negative results. Health and safety concerns relating to exposure by law enforcement.
Escalation Point 4 Contamination of cocaine supply indicated in police seizure. A national Medicine Supply Notification is issued nationally regarding a shortage of nasal naloxone.
Escalation Point 5 Misinformation circulating online about vapes containing nitazenes is shared locally.
Escalation Point 6 Fatal and non-fatal overdoses of young people at a music festival believed to linked to street benzodiazepines. Ambulance not carrying enough naloxone in immediate time after.
Escalation Point 7 Fatal and non-fatal overdoses at a football match, linked to contamination or adulteration of cocaine.
Escalation Point 8 Teenagers in a rural village hospitalised with overdoses believed to have been linked to disposable vapes. The substances included in the vapes is not clear.

[9] At Annex B, the report provides some generic scenarios to assist CDPs in holding similar exercises.

3. Findings

3.1. Prepare

23. Whilst the primary scope of the plans are synthetic opioids, the core concepts and response strategies contain strong similarities to those for strong or contaminated heroin, and new and emerging drugs. More than half of the plans sampled referenced other emerging synthetic drugs such as xylazine[10], which is increasingly being seen in the heroin market. Discussing response measures for this drug in the context of plans to tackle synthetic opioids can help ensure a unified and resilient approach.

24. Furthermore, the benefits of preparedness planning for synthetic opioids were made apparent in December 2024 in Humberside, which saw 44 hospitalisations, and 2 suspected fatalities[11], for which initial intelligence suggested could be a nitazene-related incident, but ultimately turned out to be caused by synthetic cannabinoids. Leads there commented that having recently developed their preparedness plan, they were better prepared to respond to a range of different drug related threats. So that they can respond to the broad range of current and future threats, it is recommended that local areas consider which aspects of their preparedness plans are threat-agnostic towards other drug types that have the potential to cause immediate harm or mass overdose events.

25. A small number of CDPs have published their plans or other preparedness materials online[12], however, from our sample of plans, few other areas stated their intent to publish, which may reflect the need to operationally sensitive information and staff contact details. The plans are largely designed to be practical documents, tailored for use including in emergency situations, and therefore depending on the detail included may be unsuitable for full publication. However, it can be beneficial for stakeholders and the public to see the core strategic approach.

26. The preparedness plans, alongside other documentation, should be 'live' and iterative documents that CDPs can develop and strengthen over time. Plans should be updated as proportionate to the evolving risk, and as appropriate to local needs, or to reflect updates in national guidance.

Recommendation 1: Combating Drugs Partnerships (CDPs) should review their preparedness plans annually, or when the threat assessment changes, and should take xylazine and other synthetic drugs into consideration. CDPs may choose to have public-facing plans as part of their local communications.

[10] Xylazine is a non-opioid tranquilizer approved for use as a sedative, muscle relaxant and analgesic in veterinary medicine. As of 2025, it is controlled as a Class C substance under the Misuse of Drugs Act 1971

[11] The coronial inquest for this incident is still ongoing at the time of writing.

[12] For example, Greater Manchester CDP: https://democracy.greatermanchester-ca.gov.uk/mgConvert2PDF.aspx?ID=33545; and Leeds CDP:https://observatory.leeds.gov.uk/wp-content/uploads/2024/12/Leeds-Synthetic-Opioids-Incident-Response-Plan.pdf

Incident response arrangements

27. Most plans set out details of their local area's incident response functions and responsibilities, with some also presenting their detailed reporting structures and decision-making frameworks in the form of a dedicated incident response plan. It is important that areas have thought ahead of time about what would constitute an 'incident' requiring a rapid and coordinated response, with a named lead incident director, an established case definition, triggers to support escalation and de-escalation, geographies of interest, the formation of dedicated 'cells' to lead workstreams, and other aspects of emergency response protocol. Examples of situations that may warrant a formal incident response include an increased number of drug related clusters of deaths linked in space or time, suspected 'high strength' batches of heroin, drug contamination incidents, or drugs adulterated with synthetic opioids.

28. Plymouth CDP included in their preparedness plan two distinct pathways to respond to a synthetic opioid incident based on the intelligence received:

Case Study 1: Response Pathways (Plymouth CDP)

"There are two main pathways for assessing drug harm information, depending on how clear it is that synthetic opioids have caused harms and the level of harm caused:

Pathway 1: The evidence is unclear that synthetic opioids are involved in causing the harm, or evidence of harm is limited in terms of number of people affected (such as isolated incidents, not causing death or requiring transport to A&E).

This intelligence is more likely to come through the Plymouth LDIS, from providers or drug testing results. The response to this is outlined in the Plymouth Local Drug Information System (LDIS) SOP and not covered in this document.

Reports to the Plymouth LDIS can be made via Plymouth LDIS Notification form.

The Plymouth LDIS is operated by the Public Health Team at Plymouth City Council. Information submitted to the LDIS will be reviewed by public health and if required by the LDIS panel involving public health, substance use services, the police, and clinicians. The LDIS operates on a 9-5, Monday to Friday basis. Where there is evidence of immediate and significant harm to multiple people, pathway 2 should be used to contact the Police.

Pathway 2: There is clear evidence of significant harm in multiple people who have died or are requiring multiple doses of naloxone to reverse the drug effect.

This intelligence is more likely to come from emergency services and urgent action will be required regardless of whether it is within normal office hours or not. In this situation, the protocol is for the identifying agency to call the police on 999 and report on the situation. The risk will be assessed by the Police together with any other intelligence received. This could lead to the Police contacting partners to undertake a multi-agency response.

A significant incident requiring a multi-agency response will be led by the police. The structure of the response that is stood up will depend on the scale of the incident, and public health and providers working with affected cohorts will join this response.

Regardless of the type of response that is stood up, the immediate public health response (as part of a wider multi-agency response) is outlined below.

To note: Public health teams in local authorities and most providers do not normally operate on weekends, evenings and nights. However, for the purposes of an incident response, key contacts have agreed to share their personal phone numbers that can be contacted in such an incident to activate and deliver this response."

29. In the tabletop exercise, one of the escalation points explored an incident occurring on the boundary of different CDP areas. Attendees explained that collaboration between different CDPs within the same geographic region tends to be effective, but can be weaker when the CDPs sit within different regions. Attendees suggested areas should be mindful of incidents occurring across regions, including into devolved administrations, and to utilise existing networks and frameworks to ensure effective cross-boundary collaboration.

Resilience and Out of Hours

30. A common challenge from both the exercise and the preparedness plans was delivering an effective Out of Hours (OOH) response. Most CDPs only have full OOH capacity provided by the police, meaning the public health aspect of the response could be limited or insufficient outside of core working hours. At the exercise, some areas discussed utilising their on-call emergency planning officers to handle immediate tasks and contact their Director of Public Health out of hours if required. Most areas talked about the use of informal networks when incidents had occurred over a weekend.

31. Whilst in most drug related incidents an immediate response would confer only limited benefit compared to waiting until the next working day, where there are clusters of drug related deaths a comprehensive multi-agency response can lead to substantive public health impact[13]. Should a major incident occur out of hours, existing incident response structures (such as through policing command structures or Local Resilience Forum (LRF)[14] Strategic Coordination Groups or Tactical Support Groups) can be activated, which could approach LDIS members via contact details if those have been shared in advance.

Recommendation 2: All CDPs should assure they have an effective system to ensure 'Out of Hours' (OOH) resource is available to respond to incidents, which may include reviewing OOH arrangements for local authority public health teams.

32. The exercise revealed differing perspectives between CDPs on the need to involve their LRFs in responding to escalations, based on their individual risk assessments and capability needs. Some local areas activated their LRFs early in the exercise, with a limited number of drug related deaths and non-fatal overdoses, whereas

[13] https://www.gov.uk/government/publications/issuing-public-health-alerts-about-drugs

[14] LRFs are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

others waited until more severe or concurrent events occurred. Early engagement with the LRF was highlighted in the West Midlands response.

33. Some areas referenced in their preparedness plans that Local Health Resilience Partnerships (LHRPs) and Integrated Care Boards (ICBs) would play a role in incident response. These organisations can serve similar functions to an LRF in coordinating emergency preparedness and response, and are established as Category One responders under the Civil Contingencies Act 2004.

34. As set out in the guidance for local areas[5]and the checklist in Annex A, local areas should regularly test their plans with existing mechanisms for emergency preparation, response and recovery, such as the LRF or LHRP. Of the 25 plans sampled, only 10 areas set out their intention to do so.

35. LRF involvement in an incident can also include utilising shared IT systems across organisational boundaries, such as shared drives to collaborate on documents, and shared email inboxes. Humberside LRF's IT systems were effectively used in this way during the December 2024 synthetic cannabinoid incident.

36. The exercise also highlighted that extended periods of drug related death incidents can impact on staff resilience and surge capacity, especially where teams are small and with other extensive business-as-usual tasks to cover. CDPs should consider the importance of overtime payments, flexi-time and rest days during incidents that occur to ensure the team are well rested, balanced against the need for continuity of resource during an incident. LRFs may be able to help mitigate some of this risk through strategic support, delegation of tasks among partners and facilitation of mutual aid arrangements where necessary.

Recommendation 3: Having tested or exercised their preparedness plans with Local Resilience Forum (LRF) partners, all CDPs should ensure plans set out at which point LRFs should be involved in the local response. LRFs should include this and other drug related death incidents as a specific risk in their formal risk registers.

37. Finally, the exercise highlighted the importance of links between local and central government in responding to these incidents. Areas should routinely share intelligence with OHID's drug alerts mailbox or the online LDIS report form to support national surveillance. Local partners were keen to see clearer protocol on the role of OHID's regional teams, OHID nationally, the Ministry for Housing, Communities and Local Government (MHCLG)'s Resilience and Emergencies Directorate (RED), the NCA, and the JCDU in incident response, especially if incidents continue over an extended time-period.

Recommendation 4: Office for Health Improvement and Disparities (OHID) and the Joint Combating Drugs Unit (JCDU) should publish clear drug related death incident protocol and escalation plans from a national and regional perspective, aligned to established law enforcement protocols.

Naloxone stock planning

38. Naloxone is a lifesaving medicine that reverses the effects of an opioid overdose and remains effective with novel synthetic opioids. As part of planning for increased prevalence of synthetic opioids, local areas should assure and review their naloxone supplies, including thinking about the shelf-life of stock and of supplies already issued, and how to re-supply to people whose naloxone is approaching its expiry date. The exercise explored a scenario where a national Medicine Supply Notification is issued for nasal naloxone warning of a national shortage, prompting local areas to review their stocks.

39. Many of the plans sampled did not set out their naloxone purchasing and supply arrangements, their local needs assessments, or their arrangements to check inventories. Having this information could support a local area to respond to an incident more effectively should there be a sudden increase in demand or a medicine shortage, for example, in which case areas may have to prioritise their supply. Camden CDP included within their plan a financial modelling estimate of their naloxone purchasing needs in the event of a 'worst case' scenario incident.

40. Naloxone as a harm reduction intervention is covered further below in this report.

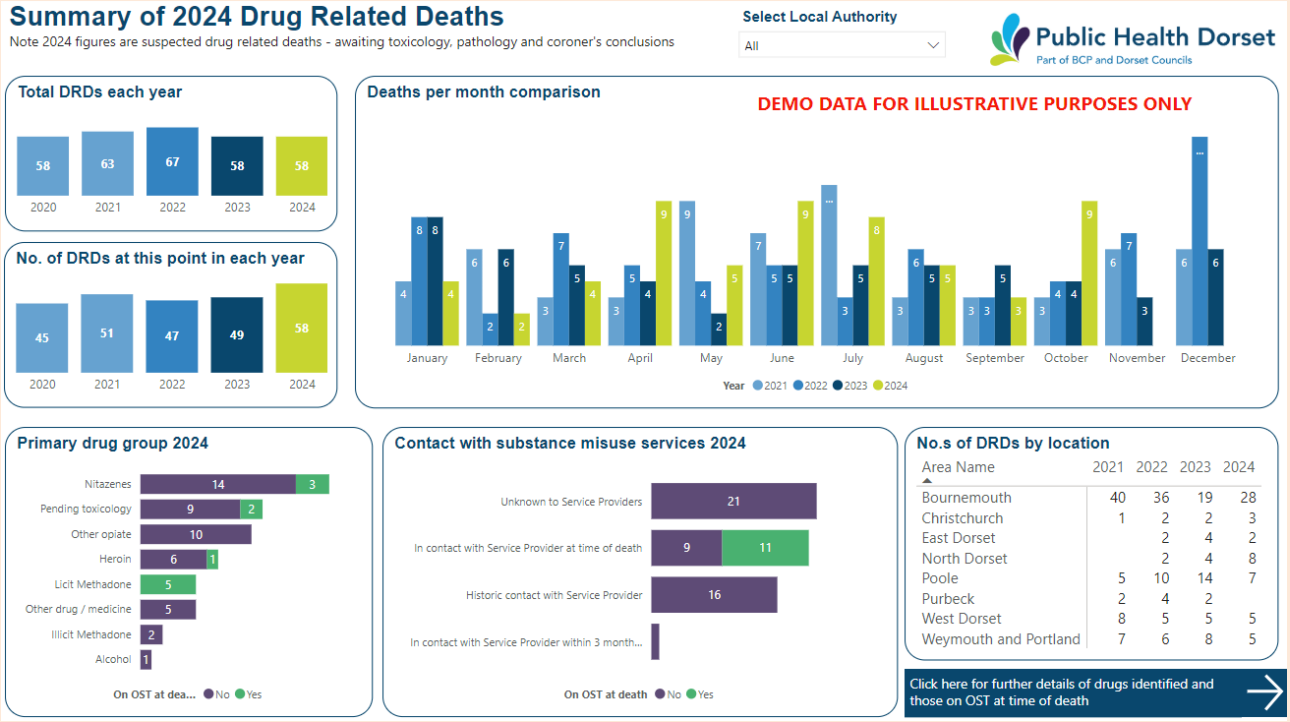
Recommendation 5: All CDPs should include naloxone supply as part of their comprehensive needs assessments and ensure sufficient local capacity for partners to deploy naloxone in a range of scenarios.

3.2. Monitor

41. Access to high-quality and timely information is vital for local areas to understand and respond to drug related incidents. All areas in England now have Local Drug Information Systems (LDIS) established or in active development, which are designed to act as the focal point of data needs and assessment for local partners, and to take responsibility for managing the alert process.

42. Most plans clearly set out the local data and intelligence they are able to monitor through their LDIS, though the range of data sources listed varied between CDP areas. Dorset CDP included a data dashboard showcasing the latest data within their area, which allows for easy visualisation of trends to inform local action, and could form the basis of any reporting required in an incident (see Case Study 2 below). Further, such an approach can help CDPs better understand their baseline of harms and therefore also identify exceedances or unusual events above that baseline that may warrant an alert.

Case Study 2: Data dashboard with demo data (Dorset CDP)



Data sharing and data innovation

43. The West Midlands incident debrief notes that "*Data sharing between NHS partners and other relevant organisations was inconsistent and fractured. Understanding of existing data sharing protocols already in place through the [Civil Contingencies Act 2004] legislation was not understood by all and allowed barriers to exist to the detriment of the operational needs*"[6].

44. Difficulties with data sharing was a major theme at the exercise also, where local partners provided a range of examples, as well as citing the value of early identification of harms as a key factor in improving response outcomes. For example, in areas where the LDIS is public health led, police seizure data is sometimes not

routinely shared across the LDIS, limiting its ability to act on information that could inform public health risk assessments, such as confirmation of substances in circulation, types of adulteration occurring and purity[15]. Some police forces had established enhanced processes to share and collaborate more readily.

45. The exercise also highlighted challenges with data sharing between CDPs, ambulance services and NHS Trusts, so that the LDIS can access timely data on non-fatal overdose call-outs, hospital admissions and toxicology results and establish where harms are exceeding expected levels. Partners raised that they often received no or limited clinical reporting on individuals who suffered non-fatal overdoses or admission to hospital, and identified this as a clear data gap[16]. For example, understanding whether naloxone has been successfully administered gives crucial early intelligence on whether an opioid is present. Further, data sharing proves even more difficult where individuals are admitted to hospital outside their immediate area. It was felt that national guidance for a few critical stakeholders – e.g. ambulance services, emergency departments, and housing providers – to share information to support drug related incidents would support response and preparedness. Areas may wish to consult information governance experts in their organisations to inform their information-sharing arrangements, including an NHS Caldicott guardian[17].

46. In 2023, the Chief Coroner issued advice to all coroners about the likelihood of some drug deaths linked to synthetic opioids, and the need to commission testing for synthetic opioids from labs that have capacity to detect them. Around half of the plans in the sample set out their engagement with local coroners, and many local authority public health teams have reported issues with receiving timely information from their local coroner on drug related deaths.

47. It is recommended that CDPs build and strengthen their relationships with their local coroner's office and prepare for working together during an incident. There are ongoing efforts within government to encourage coroner service engagement with local systems. CDPs can also utilise their OHID regional director to assist with coronial engagement. Coronial and toxicology reporting is vital in the intelligence building phase of identifying a synthetic opioids incident, providing key epidemiological data, as well as reviewing cases where potent synthetic opioids are suspected to have been present.

48. At the tabletop exercise, local areas emphasised the importance of utilising fast-track post-mortem toxicology services to receive results in days rather than weeks or months, where possible. During the West Midlands response there was active involvement from local coroners to provide information as fast as possible to the LDIS.

49. Humberside Police have a policy of 'dual-sending' coronial notifications to their local authority public health teams in parallel to the coroner's office. Other local police forces should consider the feasibility of this approach, which can improve the data sharing between CDPs and the local coroner.

[15] At the exercise partners also queried the absence of a data sharing agreement between regional OHID and local policing, leading to limitations when monitoring at a regional level.

[16] As a partial solution for LDIS not receiving data on ambulance call-outs, OHID have developed a regular report on call-outs in which naloxone was administered which is currently being rolled out to local authorities.

[17] Caldicott guardians are responsible for protecting the confidentiality of people's health and care information.

50. CDPs should consider data sharing agreements with other relevant system partners, given the variety of settings in which an incident could take place. Many of these are listed in the LDIS guidance, such as: adult social care, social services, mental health services, hostels, homeless services, forensic services, prisons, probation, and police and crime commissioner's offices.[13]

51. Leicestershire, Leicester and Rutland CDP provided an example data sharing agreement as part of the preparedness plan, which they have used to establish agreements with their local coroner, police force, probation service, a treatment provider, and local hospitals to facilitate a strong data flow. This enables the work of their Drug and Alcohol Related Death (DARD) panel to respond to acute drug related death incidents. Their data sharing agreement outlines that it is the statutory duty of partners to share data to protect the vital interests of people, particularly vulnerable people, in an incident. This duty is outlined in the Civil Contingencies Act 2004 and applies to all Category One and Category Two responders.

52. Across the plans and the exercise there were good examples of data collection and innovation to build the LDIS' intelligence picture. These include:

- Expedited forensic testing of seized substances, including utilising university testing for intelligence purposes. (See Case Study 3 below)
- Operational intelligence from policing
- Data from drug checking[18] services. Avon and Somerset's preparedness plan references their use of data from The LOOP, a Home Office licenced drug checking service, which *"provides opportunity to test substances and gain evidence of what is circulating in the city."* LDIS may also benefit from analyses of samples sent anonymously from their areas into WEDINOS, a Welsh Government funded drug checking service
- Perspectives from individuals with living, or lived, experience
- Data from use of test strips[19]
- Insights from the drug and alcohol-related death review process[20]
- Testing samples collected from people engaging with drug treatment services, for example at the start of opioid substitution treatment, as is done for services participating in OHID and UKHSA's sentinel testing programme

53. In addition, OHID has developed a regular report on ambulance call-outs in which naloxone was administered. This is currently being rolled out to local authorities and will assist with identifying, tracking and responding to local drug incidents across

[18] Drug checking services provide users with an analysis of the content of a substance and in some situations its strength/potency, as a means of reducing the risk of accidental poisoning. Substances can either be seized ('back-of-house') or voluntarily submitted ('front-of-house'). Drug checking facilities are legal in the UK provided that the possession and supply of controlled drugs are licensed by the Home Office Drugs and Firearms Licensing Unit or, exceptionally, subject to relevant exemptions under the Misuse of Drugs Regulations 2001.

[19] Test strips are discussed in more detail below.

[20] https://www.gov.uk/government/publications/preventing-drug-and-alcohol-deaths-partnership-review-process/preventing-drug-and-alcohol-deaths-partnership-review-process#information-sharing

England. This work is part of broader efforts to improve data sharing on drug threats between government departments, agencies and LDIS in England.

54. Finally, some attendees at the exercise raised whether improvements could be made to hospital data collection by more widespread use of test strips or other methods in point-of-care settings. Local areas should review how they will receive toxicology reporting from their local NHS Trust in an incident scenario.[21]

Case Study 3: Expedited testing of illicit substances for intelligence purposes (York and North Yorkshire CDP)

"Both North Yorkshire & York Public health teams are working collaboratively with North Yorkshire Police & York University via the North Yorkshire Drug Analysis Project. This project aims to test illicit substances within police property or at the scene of a potential drug related death for non-evidential harm reduction purposes. The agreed time frame for receipt of toxicology to the LDIS co-ordinator and police is 48 hrs where the sample has been identified as causing harm. This resource is critical in evaluating the threat and risk of further harm across North Yorkshire and is seen as best practice nationally.

The key action and outputs of North Yorkshire Drug Analysis Project are:

1. Co-ordination of illicit drugs that are in police property

2. Leading weekly meetings to see what samples are available to be sent to York University for analysis.

3. Consideration of all drug related deaths where police are in attendance.

4. York University considers all drug samples and paraphernalia for fast-track analysis.

5. Sample results are disseminated to LDIS coordinator and if required used to substantiate any known risks in the community."

Recommendation 6: All Local Drug Information Systems (LDIS) should review their data requirements and establish data sharing agreements with relevant system partners. It is best practice for local coroners and LDIS to collaborate when potent synthetic opioids are confirmed to be present in post-mortem toxicology. OHID, Home Office and National Crime Agency (NCA) should continue to support this work, including through updated LDIS guidance.

Stakeholder engagement and the Professional Information Network

55. Cross-system engagement was highlighted throughout the plans, with the majority including specific processes to work with front-line services, police forces, ambulance services, NHS Trusts, and treatment providers, should synthetic opioids be detected.

[21] This and further examples are given in the following paper produced by the Association of Police and Crime Commissioners: https://www.fph.org.uk/media/1hlfrrh0/contingency-planning-components-of-a-synthetic-opioid-preparedness-plan-jody-clark.pdf

56. The guidance on issuing drug alerts[13] describes the concept of the Professional Information Network (PIN) as a *"network of local professionals who are likely to encounter new and/or novel, potent, adulterated or contaminated drugs and/or the people who use them. The purpose of this network is to share information, experience and knowledge that may inform any subsequent alerts or action by the LDIS."* It was clear from the exercise that many local areas would benefit from reviewing and refreshing their PINs.

57. The exercise initially focussed on two drug related death incidents in rough sleeping accommodation settings, for which partners had good connections and intelligence-sharing arrangements and were generally assured they would receive rapid updates from these providers.

58. The exercise also highlighted that stakeholders in the night-time economy, music festivals, major events (including their Safety Advisory Groups[22]) and educational settings need to be easily accessible and that those relationships require maintenance. Drug related death incidents and non-fatal overdoses can unfold and escalate quickly, and ensuring that all stakeholders are aware of their roles and responsibilities will improve any responses required if, for example, contaminated drugs are detected in their settings.

59. Whilst 16 of the 25 plans sampled referenced engagement with prison and probation services, more could be done to set out any regular information sharing of drug intelligence with the prisons and probation sector, alongside measures to support at-risk groups in prison and providing continuity of care for those leaving prison. During the exercise, His Majesty's Prison and Probation Service (HMPPS) partners discussed the importance of receiving early reporting of incidents in the community, enabling preparations in their settings.

Recommendation 7: All LDIS should ensure they have a list of stakeholder organisations to help with communicating alerts and sharing information and knowledge. In many areas this network is known as the Professional Information Network (PIN). This network should be regularly engaged and alerted in the event of an incident. This network should include, but not be limited to, contacts in the prisons and probation sector, the education sector, and the night-time economy.

Identifying at-risk cohorts

60. Of the plans evaluated, more than half demonstrated an understanding of the levels of dependency and consumption in their local area, highlighting cohorts at greatest risk should an incident occur. Some areas detailed how they were reaching populations with multiple or complex needs that services have historically struggled to cater for, including ensuring treatment providers and needle and syringe pharmacy programmes, have official communication products to distribute.

61. York and North Yorkshire CDP included a geographical analysis of opiate 'hotspots' within their area, and referenced the following demographic groups that are vulnerable to synthetic opioids:

[22] https://www.hse.gov.uk/event-safety/safety-advisory-groups.htm

- *"Young people: young people experimenting with drugs may unknowingly encounter synthetic opioids (illicit tablets, unknown powders etc.).*

- *Prison leavers: Those who have recently been released from prison may be at increased risk due to factors such as reduced tolerance to opioids.*

- *Online buyers: Those buying pills and powders online (especially diazepam, Xanax, oxycodone)"*

62. People who do not intend to consume opiates should be considered carefully, including people who use 'street' benzodiazepines, illicit oxycodone, powder cocaine, illicit vapes, and ketamine, as if drug contamination or adulteration has taken place they will have a higher risk of overdosing, compared to those with an opiate dependency. If contaminated vapes are of concern then educational settings may need to be alerted, as was explored in the exercise. All these cohorts will also be less known to treatment services, making direct communication more difficult, and so tailored harm reduction interventions may be required. CDPs can use existing local work such as their police force's drug market profile, and the CDP local needs assessment to understand the needs of these cohorts and tailor the support package for them.

Recommendation 8: All LDIS should identify and monitor at-risk groups in their communities beyond people who use opioids, given the risk posed by synthetic opioids to people who take drugs other than heroin. This should be part of a wider package of work for CDPs on understanding local levels of drug use, dependence, and consumption as part of their annual needs assessment process.

Issuing alerts and public communications

63. In all plans, and throughout the exercise, partners made clear the critical role for issuing drug alerts to reduce harm during drug related incidents. The guidance for issuing alerts[13] provides a wealth of information that should be used to support this capability and is scheduled to be updated this year.

64. During the exercise, partners agreed the first priority in issuing alerts was to the most at-risk people using drugs, working through local outreach and treatment providers to ensure messages are issued to people in treatment or are known to providers through their networks. For alerts to wider cohorts, there was varying opinion on when the right time to issue an alert would be, without creating undue concern in the community, contributing to 'alert fatigue' if issued too soon or too frequently. The messages within an alert should be factual and focussed on harm reduction messaging, as discussed in further detail below.

65. Attendees agreed that communications should not be issued until they have been reviewed by both public health and policing leads via the LDIS panel. There have been examples of partners, including the police, issuing alerts out of hours that would have benefited from wider review. CDPs should ensure protocols for issuing alerts, including decision-makers, sign-off procedures and thresholds, are agreed ahead of time, socialised with partners and detailed in their plans. CDPs should also ensure that communications are coordinated with neighbouring authorities if an incident is suspected to cross boundaries. Similarly, communications should be coordinated

with the devolved administrations in Scotland and Wales if an incident is suspected to cross national boundaries.

66. Beyond the concept of alerting, a robust media and communications strategy, including 'pre-planned messages,' is essential for CDPs to issue or respond to requests for information during an incident, with consistent messaging across partners. The vast majority of plans reviewed included a communications strategy, with some consideration of how to communicate with the media, use social media, and who their nominated spokespeople would be (including Directors of Public Health or Chief Constables). Partners at the exercise requested more regular national threat assessments and narratives from central government that could be used within their communications, ensuring messages are aligned.

67. Finally, the exercise explored the risk of false rumours and social media disinformation about drug harms where the cause of hospitalisations/deaths are uncertain. There are examples of inaccurate media reporting relating to synthetic opioids adulterating drugs, especially where toxicology or forensic analysis is partial or not yet available, and these stories can rapidly spread. Partners discussed how to counter this by commissioning fast-tracked analyses, and by working with news outlets to correct false reporting and issuing communications on social media.

Recommendation 9: OHID and the JCDU should regularly share threat assessments and accompanying narrative on synthetic opioids to support CDPs to prepare their local communications plans. LDIS should follow the drug alert guidance and ensure LDIS panels meet before local alerts are issued. Updated LDIS guidance should consider the topic of social media misinformation.

3.3. Treat

68. Attractive, effective, accessible drug treatment that gets people in and retains them is a crucial part of any local system working to prevent and respond to drug incidents. Treatment provides some protection from overdose, ensures people know where to turn for reliable advice and support and provides a route for rapid information dissemination. This is important in reducing unmet need, but it becomes even more pressing when an area is faced with an incident.

69. Many preparedness plans discussed how they would deliver proactive outreach and communications to high-risk opiate dependent populations, offering quick-access pathways to Opioid Substitution Treatment (OST), including same-day prescribing as recommended in the latest clinical guidance[23]. Partners at the exercise talked about engaging directly with people at risk who had dropped out of treatment, for example through home visits, and expanding their outreach services to include evenings and weekends where needed.

70. However very few of the plans evaluated put forward proposals for people who may not need treatment for opiate dependence, but who may be at risk from drugs other than heroin adulterated with synthetic opioids, for example people who use 'street' benzodiazepines or illicit oxycodone. Examples of this could include optimising psychosocial interventions, delivering non-OST pharmacological interventions, and ensuring these cohorts are aware of the risk, including via harm reduction interventions as discussed below.

Recommendation 10: All CDPs should ensure their treatment offer includes support for any cohort where there is risk of synthetic opioid adulteration.

Harm reduction interventions

71. Harm reduction interventions to prevent or delay an incident, or mitigate its worst outcomes, were described in almost all of the plans sampled, and came out clearly throughout the tabletop exercise. Notable interventions include surging naloxone deployment, tailored communications to at-risk cohorts to increase awareness of the synthetic opioid threat, and the distribution of point-of-care test strips.

72. As discussed above in relation to naloxone stocks, the vital use of naloxone as a harm reduction tool was made clear in all plans. Partners at the exercise explained how they would surge supply to people who use drugs through harm reduction organisations and treatment providers, and would make use of the new 'take-home' legislation now in force[24] which enables a wider number of professionals to supply naloxone[25].

73. There is evidence to suggest that the effect of some synthetic opioids may last longer than heroin and it may take more naloxone to reverse an overdose. There is also

[23] https://www.gov.uk/government/publications/medicine-choices-in-opioid-substitution-treatment

[24] https://www.gov.uk/guidance/supplying-take-home-naloxone-without-a-prescription

[25] However, partners at the exercise highlighted the limitations of naloxone only being issued to people and not places, so administration relies on the 'right person' being present, rather than, for example, having naloxone on-site.

concern about the risks of giving too much naloxone too quickly, which can cause someone to:

- Get agitated and confused;
- Leave the scene (and potentially then either go back into overdose or take more opioid and overdose, perhaps now away from help);
- Think badly of naloxone, avoid it in future, or even warn others off it.

74. OHID has issued advice that non-medic or paramedic staff responding to opioid overdose incidents should continue to administer only the established incremental single doses until there is sufficient reversal of the overdose. OHID continues to work with experts to establish if this advice needs to be changed.

75. During the exercise, attendees discussed the importance of rough sleeping accommodation and supported accommodation providers having naloxone supplies, being trained to administer and being aware they can provide take-home supplies when service-users leave. The CDP has a role in assuring this as part of their preparedness work.

76. The exercise also discussed the need for other stakeholders, for example, St John Ambulance, event organisers and night-time economy venues, to carry (or have rapid access to) sufficient naloxone to respond to overdoses. Safety Advisory Groups should be briefed about the importance of naloxone ahead of major events where drug related deaths are possible. In recent years good progress has made with training and increasing carriage of naloxone by prison staff.

77. Some of the preparedness plans discussed their progress in training and increasing carriage of naloxone by police officers, including some setting deadlines for officers within their area to be trained. The government is supportive of this, and police officers in forces across the country are now trained to carry and administer naloxone[26].

Case Study 4: Engaging with at-risk cohorts and deploying treatment services during an incident (Bradford CDP)

"A collective multi-agency harm-reduction approach will be undertaken to engage those furthest from support, who are often those at risk of the greatest harm, as well as ensuring that those already in treatment are supported to remain engaged.

Bradford's plan will follow the priorities outlined in OHID's synthetic opioid guidance, including the four principals:

1. Reducing the incidence of people using alone

2. Reducing the incidence of people using without naloxone being available

3. Reducing the incidence of injecting drug use

[26] Ultimately, the provision of naloxone for police officers is an operational decision for Chief Constables and the government expects individual police chiefs to allocate resources appropriately with regard to the local area and need.

4. Reduce the incidence of people using illicit drugs

Once activated New Vision Bradford (NVB)'s Crisis Response Team will mobilize outreach and harm reduction services across Bradford, Keighley, and surrounding areas. The team, comprising trained outreach staff from NVB, Project 6, and The Bridge Project, will provide on-the-ground support, including Naloxone distribution, overdose response, and harm reduction education. They will also work closely with emergency services for coordinated action, though trained in First Aid they do not replace statutory services."

78. Some plans provided useful detail on the types of harm reduction messaging[27] being issued to people who use drugs in alerts or routine communications, for example Nottingham and Nottinghamshire's pamphlet at Case Study 5. LDIS should word any public communications carefully, to avoid any risk of arousing interest or encouraging use. As advised in guidance[5,13], best practice harm reduction messaging could include statements such as those listed below:

    - "Look out for your mates - if possible, use with your mates"
    - "Don't use alone"
    - "Start low, go slow"
    - "Naloxone: get it, carry it, use it"

79. As part of their alerts, some areas publish pictures of pills where adulteration or contamination has been analytically confirmed and there is a real-time and ongoing risk to other people who use drugs. For example, Manchester's LDIS uses 'MANDRAKE', a Home Office licensed testing service to rapidly test samples involved in incidents when they occur.

80. The exercise highlighted limited coordination of harm reduction communication assets between local areas, despite the ultimate commonality of the messages and intent. CDPs in attendance requested regional and national coordination from OHID and JCDU to share best practice communications, especially during any large incidents. Alerting is discussed in the Monitor section of this report.

81. Also, the exercise suggested there are various settings which may benefit from specific and easily understandable harm reduction advice should a drug related incident occur, providing individuals, organisations or businesses with immediate guidance and useful contact details. For example, not all night-time economy venues will have considered steps they could take to respond to a drug related incident.

Recommendation 11: OHID should continue to develop and share with local areas suggested communication materials for use with key stakeholders, the media and for people who use drugs. Updated LDIS guidance should consider developing harm reduction materials for use in settings with less awareness of the risk.

82. Nitazene point-of-care test strips were referenced in some of the preparedness plans, including ensuring instructions for the use of test strips is clear, and that test

[27] It was noted during the exercise that the term 'nitazenes' is less well understood than 'fentanyl' and that effective harm reduction language could include both, given the similarities between the compounds and the public health responses.

strip results data should be collected to inform the LDIS if possible. Other plans noted the need to review the evidence for test strips as an effective harm reduction measure, before further adoption.

83. In the exercise, one of the escalation points explored the idea of test strips producing a negative result, despite potent synthetic opioids being present. Current test strips on the market are clear with which nitazenes they have been validated for, however new nitazenes continue to be detected in the UK and Europe. The scenario was designed to test how partners would react and respond to the evidence that test strips hadn't been working and had produced 'false negatives'.

84. It remains the view of central government that test strips can trigger useful conversations with people who take drugs, and encourage them to think about the risks of synthetic opioids and how to mitigate them. However, the test strip manufacturers' and suppliers' own information make clear the limitations of the strips. These limitations can include: that strips will not detect drug concentrations below specified limits or may fail to detect a drug that is present (also known as a 'false negative'), that strips may not detect all variations of a drug type, that strips may not be used correctly, that strips may fail because the drug does not dissolve properly or that other substances interfere with the test, that strips do not indicate the presence of potentially harmful drugs other than those being tested for, and that strips do not indicate the quantity of a detected drug[5].

85. Finally, on wider harm reduction initiatives, partners at the exercise discussed whether, in an emergency, local areas could temporarily stand up supervised and 'safer' spaces within current facilities, for example, in supported housing, drug treatment centres and community hospitals. The UK government has no plans to change the law, therefore this topic is not covered in further detail in this report.

Case Study 5: Harm reduction advice leaflet (Nottingham and Nottinghamshire CDP)

WHAT IS NALOXONE?

Naloxone is a drug that can reverse the effects of an opioid overdose. This includes overdoses caused by synthetic opioids.
It saves lives when given quickly.
The effects of naloxone don't last very long, so it is still important to call 999 for an ambulance.
Naloxone will only work on opioid overdoses but does not harm people who have not used opioids. **Some people may need more than one dose of naloxone.** The leaflet inside the kit will tell you how to use it.

NALOXONE SAVES LIVES.

Naloxone is free

Anyone can get a kit from local drug support services.

You will also be trained on how to use it in an emergency.

FIND LOCAL TREATMENT AND SUPPORT

Get naloxone or other information and support around drug use from local drug treatment and support services:

CHANGE GROW LIVE NOTTINGHAMSHIRE
- 0115 896 0798
- www.changegrowlive.org/nottinghamshire
- Nottinghamshire County (Ashfield, Bassetlaw, Broxtowe, Gedling, Mansfield, Newark and Sherwood, Rushcliffe)

CHANGE GROW LIVE – THE PLACE (UNDER 25S)
- 0115 948 4314
- www.changegrowlive.org/the-place-nottingham/info
- Nottingham City

NOTTINGHAM RECOVERY NETWORK (OVER 18S)
- 0800 066 5362
- www.nottinghamrecoverynetwork.com
- Nottingham City

THE HEALTH SHOP
- 0115 9055001
- www.healthshopnottingham.co.uk
- Nottingham City

KNOW THE TREND

SAVE A FRIEND

HARM REDUCTION ADVICE

WHAT ARE SYNTHETIC OPIOIDS?

Synthetic opioids are made in a laboratory. Nitazenes and fentanyl are examples of synthetic opioids.

Nitazenes have been found in lots of different drugs. They are much stronger than heroin. They have been linked with **overdoses and deaths** in Nottingham.

Nitazenes have been linked with overdoses and deaths.

It's important to know how to reduce your risk of overdose

Even small amounts can cause overdose and death.

Most people who overdosed did not know they were taking a drug with nitazenes in it.

SIGNS OF AN OVERDOSE:

- **Small "pinpoint" pupils**
- **Not responding. doesn't move, can't wake them**
- **Blue/grey lips or nails**
- **Breathing has slowed or stopped**
- **Deep snoring or gurgling noises**
- **Moist skin which may appear pale or grey**
- **Vomiting**

If someone goes over, don't leave them. **Dial 999 for an ambulance** and stay with them until paramedics arrive. If naloxone is available, give it as soon as possible.

999

REDUCE RISK OF AN OVERDOSE:

- **Get and carry naloxone*.** It could help save a life.
- **Avoid using substances which seem different to normal.**
- **Avoid mixing substances,** including mixing drugs and alcohol.
- **Go low and slow.** Use a smaller amount first to test the effects.
- **Don't use drugs alone,** so someone is there to get help if things go wrong.
- **Access drug treatment services.** They can give you information and advice about risks.
- **Being on a script** could help reduce your risk of dying of an overdose.
- **Get your drugs tested.** Speak to your local drug service for more information.

*If you already have a naloxone kit, check it is in date and nothing is missing. Tell your friends and family where to find it and how to use it.

3.4. Enforce

86. Enforcement action by the NCA, Border Force and Police Forces is crucial to disrupt drug supply chains and remove dangerous substances from circulation, with the ultimate goal being the preservation of life for some of the most vulnerable in society. However, the least detailed of the themes within the preparedness plans was 'Enforce'.

87. Most of the plans in the sample set out proposals for regular engagement across the CDP with policing before and throughout an incident, either through local governance boards, or issuing alerts within their LDIS. Several plans highlighted direct links from their CDP to Project ADDER[28], which is aimed at reducing drug related deaths, drug related offending, the prevalence of drug use and sustained and major disruption of high-harm criminals and networks involved in middle market drug/firearms supply and importation.

88. Only some of the plans included explicit alignment with the NCA-led Project HOUSEBUILDER, which coordinates the operational law enforcement response to the threat of synthetic opioids. The Project HOUSEBUILDER response includes the use of local intelligence where available to help prevent these harmful drugs from reaching communities. It is important that preparedness plans draw out strong links with policing and the NCA-led national enforcement response. Within the representative sample, only one CDP made their connection with Project HOUSEBUILDER explicit, discussing information sharing with the NCA, detailed at Case Study 6 below.

89. During the tabletop exercise, one of the escalation points involved the potential involvement of county lines gangs operating across the borders of rural CDP areas. Police attendees talked about how county lines operations would be used to analyse information collected at the scene, creating an intelligence base which allows for the disruption of the supply from other parts of the country and identification of those most at risk from high harm drugs. Furthermore, using Op PESTER tactics[29], police forces can issue messages to people who use drugs connected to county lines, providing life-saving advice directing them to locally available treatment services or to issue public health alerts as part of their LDIS processes.

90. The tabletop exercise also explored the health risk to police officers who come across hazardous drug mixing facilities wearing insufficient Personal Protective Equipment (PPE). Any individuals handling potent synthetic opioids or coming into contact with clandestine laboratories or facilities should ensure they have consulted the relevant protocols and are wearing appropriate PPE. Police forces across the UK have received updated guidance from the NCA[30] on the sufficient steps to take in a range of different scenarios, which includes advice to consider carrying naloxone in case of personal need.

91. Less than half of the plans evaluated for this report mentioned fast-tracking of forensic submissions for testing if synthetic opioids are suspected to be present.

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[28] https://www.gov.uk/government/publications/project-adder/about-project-adder

[29] https://www.npcc.police.uk/SysSiteAssets/media/downloads/publications/publications-log/national-crime-coordination-committee/2024/disrupting-county-lines-policing-strategy-2024-to-2027.pdf

[30] The Potency Risk Guidance Matrix is a guide for forces and agencies, and not a risk assessment. The risk assessment should be designed and locally implemented based on the PRGM advice.

Whilst police forces have different agreements and contracts in place with their forensic service providers, it is possible for samples to be analysed within 24-48 hours, as per the Project HOUSBUILDER Forensics Strategy. This occurs when the sample is submitted via a fast-tracked route, because it is understood that there is an evidential or incident need to do so. This ensures that local intelligence is up to date and partners can respond swiftly to the threat by progressing investigations rapidly and issuing public health alerts if required. As discussed above, some areas are using university testing services to support rapid analysis for intelligence purposes.

Recommendation 12: All CDPs should align their enforcement plans with the NCA's national operational response to synthetic opioids (Project HOUSEBUILDER), and policing should fast-track drug seizures for forensic testing if synthetic opioids are suspected to be present as per the HOUSEBUILDER forensic strategy.

Case Study 6: Local enforcement activity to disrupt the supply of synthetic opioids (Blackpool CDP)

"Lancashire Constabulary has developed Operation Guru, an internal response plan, to support our reporting back to the NCA's Project HOUSEBUILDER. A 4P plan has been developed alongside this, which will directly link to the pan-Lancashire risk plan.

Within each of our Basic Command Units we have appointed SPOCs at Detective Inspector rank who will act as coordinators for activity associated with, or likely to be associated with, the supply of drugs contaminated with synthetic opioids. A dedicated resource page is available for all staff for advice and guidance regarding synthetic opioids.

On receipt of information or intelligence regarding a drug related death, near fatal overdose, or series of NFOs that suggests the presence of synthetic opioids, a trigger plan is in place for all relevant evidence and intelligence to be collected. This avoids a situation where the police will only be alerted some months later, following post-mortem toxicology results, the nitazenes were present in the blood of the deceased person. By securing and preserving evidence early, and developing intelligence in a timely fashion, police can take swift enforcement or disruption activity to limit the further supply of contaminated drugs and prevent further deaths and NFOs.

Lancashire Constabulary recognise there will be significant overlap with the mapping and disruption of county lines drug supply networks. As such, our county lines analyst and county lines coordinator, have tactical ownership of Op Guru activity. If a county line is known to be supplying drugs contaminated with nitazenes, this will elevate the risk and early intervention against that line will be undertaken. Multi-agency intelligence sharing will enhance this assessment. For example, where partners report strong heroin, or NFO's in a particular area, which coincides with a new county line mapped in that same area, it may infer that the new county line is the source of the contaminated drugs and early action should be considered to mitigate risk.

Lancashire Constabulary will record all 4P disruption activity against Op Guru and share this with the NCA to develop the national intelligence picture."

Annex A: Preparedness plans checklist

The checklist below was issued to all Combating Drug Partnership SROs in a formal communication email in September 2024, to support them in developing their preparedness plans.

Synthetic Opioid Preparedness Plans Checklist

CDP Synthetic Opioid Preparedness Plans should include:

- Named leads or roles identified to oversee each element of the Synthetic Opioid Preparedness Plan.
- A media and communications strategy to respond to requests for information, or proactively send information, following an incident, with aligned and consistent messaging across all local bodies.
- Cross-system engagement highlighted throughout the plan, including plans to engage and alert front-line services, health, health protection, and prison and probation partners should synthetic opioids be detected in their area.
- Co-development with leads across the Combating Drugs Partnership.
- A structure that covers the four elements to 1. Prepare, 2. Monitor, 3. Treat and 4. Enforce, and accounts for other drugs threats (such as xylazine) that may develop within this structure.

Prepare*: All local areas should have a preparedness plan in place to manage this risk, including an incident response plan that:*

- Follows the regularly updated *"Guidance for local areas on planning to deal with potent synthetic opioids"* published by the Office for Health Improvement and Disparities (OHID)[1].
- Includes incident response functions, responsibilities and reporting structures.
- Includes harm reduction interventions to prevent or delay an incident or its worst outcomes, including local messaging to those at risk, enhanced naloxone provision, needle and syringe programmes, etc.
- Include a clear demonstration of naloxone availability, purchasing and supply arrangements, including needs assessment, and which individuals naloxone is supplied to in what volumes by drug services.
- Is tested regularly with Local Resilience Forum partners.
- Should be considered for publication on your relevant website.

Monitor: *Preparedness plans should include up-to-date information about local patterns of use and need, which should*:

- Draw on a range of local data and intelligence which CDPs should be monitoring through their local drug information system (LDIS), including police force drugs market profiles and, where available, ambulance callout data, and drug checking/testing findings. These data sources should be kept under review, and plans updated to reflect any changes.
- Plans should follow "*Issuing public health alerts about drugs*", guidance for local authorities about alerting health professionals and the public to the risks of new and

modified drugs, published by the Office for Health Improvement and Disparities (OHID)[2].

- Clearly set out any intention to intensify resource from health, police and partners in response to a change in the risk if demonstrated in your local data.
- Align with the work being undertaken by OHID to enhance the national surveillance and early warning system.
- Support advice issued in 2023 from the Chief Coroner to all coroners about the likelihood that some drug deaths will involve synthetic opioids, and the need to commission testing for synthetic opioids from labs that have the capability to detect them.

***Treat**: Delivering scaled up high-quality treatment and recovery, as set in the 2021 Drug Strategy, is our central response to this challenge. Preparedness plans should:*

- Demonstrate a clear understanding of the levels of dependency and consumption in your local area. Highlight cohorts at greatest risk of overdose and dependence, set out plans to inform them of synthetic opioid detection in the supply chain and make efforts to ensure quick, attractive and easy access to treatment, including a range of OST options, and continuity of care between the community and other environments.
- Include an offer for people who may not need treatment for dependence but may be at risk from drugs other than opioids adulterated with synthetic opioids.
- Set out engagement with police forces, ambulance services, prison services, probation services, and other professionals who engage with people who use drugs on their overdose response plans, including with respect to naloxone.

***Enforce**: If synthetic opioids are detected in your local area, preparedness plans should indicate how local police should*:

- Be proactively alerted in the event they are not already aware. This will allow the police to continue to prioritise investigations into the supply of these drugs, and work with the national coordinated response through the National Crime Agency.
- Be fast tracking submissions for forensic testing if they suspect synthetic opioids are present.

Annex B: Tabletop exercise template scenarios

This section includes brief practical guidance for local areas to develop and deliver their own incident response exercises related to synthetic opioids. Tabletop exercises tend to use hypothetical scenarios to help test and ensure processes are robust and that those responsible for responding to an incident are prepared to implement them.

Guidance for running a local preparedness tabletop exercise

CDP areas should plan to run their own exercises at regular intervals proportionate to the risk and their capacity, to test their local response to a synthetic opioid incident.

To run an effective exercise, local areas should ensure attendance from the key individuals who currently manage incident response, with roles and responsibilities decided in advance.

To make the exercise immersive it can be beneficial to produce supporting materials for attendees to view throughout the event.

Scenario 1: Nitazenes in heroin supply

Summary of issue: Particularly strong or potent heroin due to nitazenes

Primary population affected: Adults who use substances, including those engaged with treatment services

Areas to test:

- Local communications to at risk communities, drawing from harm reduction messaging
- Naloxone supply
- Drugs analysis and testing
- Engagement with Coroner
- Access to treatment for at-risk group
- Join-up with NHS Trust and Ambulance Trust
- Policing response
- Communications and engagement with the media

Scenario 2: Synthetic opioid poisoning in a large public event setting

Summary of issue: Ambulance service reports to Director of Public Health that several young people have been hospitalised during the weekend at a public event (for example a music festival or in the night-time economy). There are reported fatalities while others remain critically ill in hospital. Friends of victims report they did not believe to be taking an opioid, and purchased their drugs online.

Primary population affected: Non-opiate using cohort; young people.

Areas to test:

- Non-opiate using cohort response

- Potential contamination of other drug supply
- Online drug supply
- Drug analysis and testing
- Join-up with NHS Trust and Ambulance Trust
- Engagement with Coroner
- Setting in broader community (for example at a music festival, which would require engagement with their Safety Advisory Group)
- Naloxone supply and stock to ensure widespread availability
- Resourcing and surge capacity within the LDIS, including over the weekend
- Link to central government
- Communications and engagement with the media

Scenario 3: Nitazenes in a prison setting

Summary of issue: White powder and drug paraphernalia is discovered in a local prison. Several prisoners have been rendered unconscious and non-responsive, so naloxone is administered by prison staff. All prisoners recover except one, who remains unconscious and later unfortunately dies. Several members of prison staff report feeling unwell after handling the substance. One prisoner reports that a 'load of spice' has come into the prison via social mail.

Primary population affected: Prison population, some of whom will have a history of opiate use. Prison staff after handling the substance.

Areas to test:

- NCA potency risk guidance matrix (PPE when handling substances)
- Forensic analysis to confirm presence of nitazenes
- Resourcing within the prison if staff need time off work due to feeling unwell
- Collaboration/data sharing between partners (the prison, the CDP, the local NHS Trust and Ambulance Trust)
- Resource implications on the Ambulance Trust
- Working with prisoners who may be resistant to treatment offer
- Tackling supply. The intelligence regarding spice supply into the prison should be escalated to police and National Crime Agency for further investigation
- Potential for a wider ripple effect impacting wider drug using cohort beyond the opiate cohort
- Communications and engagement with the media

Annex C: List of acronyms

Acronym	
ADPH	Association of Directors of Public Health
APCC	Association of Police and Crime Commissioners
CDP	Combating Drugs Partnership
ICB	Integrated Care Board
JCDU	Joint Combating Drugs Unit
LDIS	Local Drug Information System
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
NCA	National Crime Agency
NHS APA	National Health Service Addiction Provider Alliance
NPCC	National Police Chiefs' Council
NSO	Novel Synthetic Opioid
OHID	Office for Health Improvement and Disparities
OOH	Out Of Hours
OST	Opioid Substitution Treatment
PPE	Personal Protective Equipment
ROCU	Regional Organised Crime Unit
SIO	Senior Investigating Officer
SRO	Senior Responsible Officer
SOC	Serious and Organised Crime
UKHSA	UK Health Security Agency