Additional guidance to support the development of synthetic opioid preparedness plans

May 2024

In line with the recent letter from the Combating Drugs Minister, all areas have been requested to have a plan in place on managing the risk of synthetic opioids entering local drug supplies, including an incident response plan. Over the coming months, government, likely through the JCDU, will be looking to review and assure local plans.

This document is intended as a companion to OHID's synthetic opioid guidance and should be read alongside it. Information within draws on a number of sources, including; the recommendations coming out of Operation Mabble (the West Midlands' response to nitazenes in the summer of 2023); 'PREPARE - impact of a reduced Afghan opium harvest', circulated via CDPs in June 2023; and the information shared in the Synthetic Opioid Preparedness Plan Workshop on 16th May 2024. It covers the following areas:

1. Coordination

Based on the learning from Operation Mabble in the West Midlands, it is recommended you include the following components within your plan to ensure it can be enacted as swiftly as possible. Whilst much of this is likely already known by you, capturing these elements within a written plan will mitigate against your absence should an incident occur at a time you are unavailable (e.g. through sickness, leave, started a new role, etc.).

Who will coordinate the local plan?

Who is the person that will ensure this plan is developed, monitored and enacted as required? This will include agreeing the involvement of partners and ensuring key strategic boards are sighted.

Who will chair?

Should nitazenes be suspected or confirmed, ensure the plan contains the details of who is going to chair the local incident response meetings.

Who will be invited?

State which partners will be invited to join the incident response group and any associated sub-groups. Review whether your Professional Information Network has sufficient coverage of key partners or if it needs updating.

As well as local community drug services, consideration should be given to those who have significant contact with at risk groups – e.g. hostel providers, homelessness outreach teams, neighbourhood police teams, police custody drug workers, A&E representatives, etc – as well as peer harm reduction workers, as these will be able to provide the most up-to-date intelligence in regards local drug using trends and developments

What is the trigger for enacting an incident response?

Ensure there is local clarity on what harms will be covered within the emergency response and ensure this is included within the plan. See Appendix 1 for details of the case definition used within Op Mabble

Agree a threshold for enacting the plan, e.g. is there a given number of events that would trigger a meeting being convened, e.g.:

- suspected drug-related deaths/overdoses within a given time period
- non-fatal overdoses
- drug-related A&E admissions
- drug-related ambulance call outs
- anecdotal reports of drug-related health harms from partner organisations

Consider adopting a stepped approach within your planning. Internal guidance developed by CGL outlines a stepped approach that is recommended for adoption within wider incident response planning. These steps are:

- Step 1: Be prepared for NSOs arriving locally
- Step 2: You have received reliable intelligence that NSOs may be in circulation in your local area (this could include from nitazene test strips)
- Step 3: Confirmed NSOs and/or rising number of overdoses/deaths in local area

These steps are particularly useful for supporting the development of partner contributions to the whole-system approach that will be needed to effectively respond to the risks posed by nitazenes – see Operational response

What are the local triggers for escalation?

Include the contact details for your Local Resilience Forum within your plan and link to relevant local guidance so all partners are aware. Invite a representative to all meetings and review whether they are included within the LDIS/PIN for your area?

Share the plan

Once developed, ensure the plan is circulated to all relevant partners. At a minimum this should include your Professional Information Network, although membership of this may need to be reviewed to ensure appropriate partners are included.

2. Monitoring local harms

Is your LDIS working?

Success of an LDIS is reliant on key strategic partners being sufficiently engaged and routinely sharing information? Consider reviewing the membership of your LDIS panel to ensure it meets the recommendations within the current LDIS guidance, e.g. a multidisciplinary panel of up to six people having a suitable level of expertise in relevant disciplines (medical, policing, pharmacology, drugs specialists, etc).

Arrange a local trial runs with partners to stress test system processes. This should include your LRF.

Map the gaps in your current information sharing

Review reports submitted to your LDIS and understand where information is flowing from and where more work is needed. Do you have the ability to track drug harms with any level of confidence? As a minimum, do you have established baselines and ongoing monitoring for:

- suspected drug-related deaths
- non-fatal overdoses
- drug-related A&E admissions
- drug-related ambulance call outs/naloxone use
- Community naloxone use (incl. by drug using peers, family & friends, and professionals)

To improve information sharing into your LDIS and to increase the number of reports being submitted, consider circulating a regular report to your PIN, highlighting the number and variety of submissions received in the latest period. See Information Sharing for further on improving data flows.

Centralise analysis of partnership data

Identify who/where partnership data will be sent for analysis as well as who will receive the reports subsequently generated from this analysis. This may include sensitive data so review whether there will be the capability to create redacted copies for wider partners or whether this will need to be restricted.

3. Information sharing

Local authorities, treatment providers and CDPs are all attempting to increase the routine sharing of information from key strategic partners to increase early warning capabilities. Appendix 2 contains some draft data items that would be useful to agree across all areas to a) ensure a consistent approach to monitoring harms across the region and b) increase the likelihood of getting agreement from partners to share the data.

Please review the items contained in Appendix 2 and send thoughts, comments and amendments to jody.clark@westmidlands.police.uk. If you have had success in any of the areas included in Appendix 2, or similar, please include the detail in your response so that other areas can learn from your experiences.

Case-by-case data collection

Once an incident response has been enacted, it will be important to collate information on each case that meets the agreed case definition. A dataset will need to be shared with partners outlining the information that is sought and agreement reached for them to share (easier if achieve if a Strategic Coordination Group is stood up). The dataset can always be refined once an incident response in enacted. See Appendix 1 for details of the dataset utilised by Op Mabble.

Strategic Coordination Group

To prepare for the event a Strategic Coordination Group is stood up, ensure that partners clearly understand their obligations under the Civil Contingencies Act. Consider whether to include familiarisation training for partners within your plan.

4. Comms plan

Current OHID guidance states that local areas will need to communicate the threat of synthetic opioids to specialist drug treatment services, harm reduction & outreach services, ambulance trusts,

emergency departments and people who use drugs. However, it is likely that there would be benefits from including additional groups. Consideration should also be given to include:

- Friends and families of people who use drugs
- Homelessness and supported accommodation providers
- Services likely to come into contact with people who use drug or their friends and families. This may include Children and Adult social care, Probation, GPs/Primary Care Networks, and mental health services.
- The wider public

Special consideration will need to be given to any information received from a coroner, especially if received before the completion of the respective inquest. It is recommended that permission to share information is secured before including any of their information in external, public-facing comms.

5. Operational response

Stepped approach

Based on the guidance developed by CGL, it is recommended a stepped approach is taken when developing the operational roles and responsibilities of partners within the response plan. These steps are:

- Step 1: Being prepared for NSOs arriving locally
- Step 2: Having received reliable intelligence that NSOs may be in circulation in the local area
- Step 3: Confirmation that NSOs and/or rising number of overdoses/deaths are in the local area

Individual agency response to the threat

In both preparing for, and responding to the presence of synthetic opioids, there are a range of activities that individual agencies can undertake to contribute to a whole-system approach to the threat. Examples of how the three-steps may be adopted by partners are included in Appendix 3 - please note these are only intended by way of illustrating the approach and all activities should be developed and agreed with local partners.

As well as individual activities each partner can undertake, a collective multi-agency harm-reduction approach will be required 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. It is recommended this is based around following priorities:

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
4. Reduce the incidence of people using illicit drugs

[*more information can be found in the slides from the Synthetic Opioid Preparedness Plan workshop, circulated by email on 17th May 2023*]

Some of these priorities are included in 'Annexe B: messages for people who use drugs' within OHID's synthetic opioid guidance but others will need to be developed with support from community drug services to ensure all partners are confident and competent in supporting these objectives.

Appendix 1 – Case definition and additional information dataset

Case Definition

The following case definition was utilised by the Op Mabble Multi-Agency information Cell:

- Individuals who have died as a result of suspected illicit drug overdose or presented with symptoms of overdose and/or responded to Naloxone from the 1st June 2023
- Where the use of synthetic opioids is suspected or confirmed
- Within the geographical area of the West Midlands conurbation.

Additional information request

The following information was requested from partners for each case meeting the above case definition:

Additional information requested from partners in each case is:

- Death – yes/no
- Date of Death
- Age
- Sex
- Non-fatal overdose – yes/no
- Postcode
- HMO – yes / no
- Street Sleeping – yes/no
- Suspected class A drug user – yes/no
- Individual currently in drug treatment
- Suspected route of administration – IDU, oral – tablet , oral – smoking
- Evidential forensics indicate nitazene is present - yes/no
- Toxicology- sample tested for nitazene - yes/no
- Toxicology – sample indicates presence of nitazene – yes /no
- Toxicology – sample indicates presence of nitazene - N-Desethyl Isotonitazene – yes / no

Coronial aspects (could be added later):

- Whether nitazene caused or contributed to the death
- Whether nitazene has a more adverse effect on the outcome when taken in combination with other illicit substances and if so which ones.

Appendix 2 – partner information requests

Agency	Proposed data	Rationale	Considerations
Police	Unexpected deaths where there is a suspicion of being drug related (Demographics, place of death, relevant notes of investigation (e.g. paraphernalia found at scene, individual known to use drugs, etc.))	To ensure drug-related death review boards are aware of suspected drug-related deaths to allow relevant partners to be informed and for reviews to be carried out	Requires forces to have capacity to analyse unexpected death reports
Police	Information on forensic testing of drug seizures	To understand the purity of drugs in circulation and the presence of any adulterants/ contaminants to support informed harm reduction messaging to be developed	Street level seizures would offer the best information
Coroner	Results of coroners' toxicology tests that include substances controlled under the Misuse of Drugs Act and/or substances prescribed to treat drug dependency to be shared with drug-related death review boards/LDIS as soon as available	To allow drug-related death review boards to understand the trends within drug use amongst those who die and develop harm reduction messaging to prevent further deaths where necessary	Need to be mindful that this will be prior to confirmation of causation of death Coroners independently decide on what to share and with whom – currently no standard information sharing agreement/process in place
Coroner	Following inquest, information relating to deaths meeting the ONS definition of drug poisoning and drug misuse deaths to be shared with drug related death review boards/LDIS	To ensure drug-related death review boards/LDIS are fully aware of the harms occurring with their areas to enable the development of effective preventative responses	Coroners independently decide on what to share and with whom - no standard information sharing agreement/process in place
ICB/Ambulance Trust	Number and location of ambulance call-outs to drug overdoses and the outcome of the call-outs (e.g. taken to hospital, treated at scene, no treatment needed, died, etc.) Broken down by drug type if possible	To ensure drug-related death review boards/LDIS are fully aware of the harms occurring with their areas to enable the development of effective preventative responses	Dependent on the level of detail able to be extracted from the electronic database

ICB/Ambulance Trust	Number and location of ambulance callouts where naloxone was administrated and the outcome of the call-outs (e.g. taken to hospital, treated at scene, no treatment needed, died, etc.)		
ICB/Hospital Trusts	Number of drug overdoses treated in A&E and the outcome of treatment (e.g. no treatment needed, treated and left, naloxone administered, admitted to ward, died, etc.) Broken down by drug type and including toxicology test results if available		
Local authority/drug services	Number and location of naloxone administration in the community (e.g. hostels, outreach, police, etc.)	To allow greater understanding of overdoses within localities to support improved targeting of resources	Requires a partner to have developed a centralised system of recording uses of naloxone
Local authority/drug services	Doses of naloxone supplied by drug services in the latest time period to replace doses used to save a life Broken down by groups supplied if possible (e.g. PWUDs, family members, professionals, etc)	Improved understanding of the response to preventing DRDs	
Local authority/drug services	Proportion of OST caseload on a stable dose (i.e. not titrating/detoxing) who are optimally prescribed	Improved understanding of the response to preventing DRDs	
Prisons	Drug finds within each prison	Improved understanding by community partners of the culture within prison drug use	
Prisons	Under the influence test results (e.g. the drugs people are using inside each prison)	Improved understanding by community partners of the culture within prison drug use	

Prisons	Number of drug related heath events (e.g. ambulance, hospitalisation etc).	Improved understanding by community partners of drug-related harms within prison	

Appendix 3 - suggestions of operational activity to include within plans

Operational service	**Step 1 – prepare for SOs**	**Step 2 – reliable intelligence that SOs are present. As per Step 1, plus:**	**Step 3 – Confirmed presence of SOs and/or local rise in deaths/ODs. As per Steps 1&2, plus:**
Harm Reduction and Treatment services	See CGL's NSO guidance as an example of planning. Ideally, this should include: - Naloxone - supply, stock management, identification of partners who should hold doses) - OST provision - Targeted outreach to treatment resistant populations and gain feedback on reasons why treatment is not being utilised - Identification of all at-risk individuals (including those currently on caseload as well as those known to Tier 2 services - Drafting of harm reduction messages and sharing with all staff	See CGL's NSO guidance as an example of planning. Ideally, this should include: - Increased outreach - Naloxone - Prioritising supply to people not in treatment and to places with high levels of contact with at-risk groups (e.g. hostels, street outreach etc) - OST (access, choice of meds) - Cascade harm reduction messaging to all at-risk individuals and relevant services	See CGL's NSO guidance as an example of planning. Ideally, this should include: - Rapid scaling up of supply to all partners identified in Step 1. - Low threshold/same day OST prescribing
LDIS	Review membership of the PIN to ensure key partners are included	Arrange response meeting and enact response plan ensuring all key partners are engaged	Liaise with LRF and escalate to SCG if meeting local thresholds
	Review LDIS process and arrange trial run with partners (incl. LRF)	Regular requests for information sent to PIN	Daily request for information sent to PIN

	Consider circulating a monthly report to PIN on number and variety of submissions received in latest month	Analyse available data and circulate reports to PIN when information is available	Bi-weekly/Weekly analysis circulated
	Frequent monitoring of results from the testing of local drug samples, including from: - Police forensic testing - WEDNIOS - Drug checking services (e.g. The Loop)		
Local authorities	As per OHID's guidance, identify sources of additional and emergency funding to provide new or extended services in Steps 2&3, including: - Enhanced drug testing - Drug checking services - naloxone - treatment access (esp. OST) Agree critical components of frontline services to support prioritisation of services within Steps 2&3	Close liaison with frontline services to understand demands on services and to prioritise service delivery	Supporting frontline services to reallocate resources and staffing away from BAU towards emergency response Pausing of current performance management framework to support harm reduction and treatment services focussing on emergency response without fear of future recrimination
	Review hostel/supported housing drug policies to ensure 'eyes wide open' approach is supported – including giving due consideration to varying contracts to make this a condition of service	Ensure all relevant adverse incidents occurring in hostels/supported accommodation are being reported into LDIS	Work with partners to ensure hostel/supported accommodation environments are identifying people who use drugs and are working to effectively mitigate the risk of death
	Review current OST offer. Ensure appropriate focus on retention in treatment.	Track access into treatment and monitor unplanned discharges (dropped out, etc.) and ensure resources appropriately allocated to maximise engagement of opiate clients.	

	Understand baseline in terms of access, optimisation of treatment, drop-out rates, operational capacity (as opposed to the less useful 'numbers in treatment'/'unmet need') Undertake consultation, including with people reluctant to engage with OST, to understand the barriers to increasing treatment engagement – with view to creating an improvement plan Consideration for the provision of injectable opioid treatment for those who do not respond to oral medications	Oversight/management of referral pathways to ensure strategic partners are appropriately referring at-risk cohorts (e.g. hospitals, police custody, prisons, etc).	
Police	Review current forensic testing capabilities and ability to share test results with partners	Ensure substances of concern are submitted for testing and results shared with the incident response analyst	
	Review current process for sharing information on suspected drug deaths with LDIS and treatment services Review referral pathways into treatment, ensuring all positive DTOAs for opiates are prioritised for referral	Ensure all deaths meeting the agreed case definition are shared with the incident response analyst	
Probation			
Prisons	Review info sharing with CDPs (for onward sharing to respective LDIS) on: - prison drug finds	Ensure all information related to drug harms is shared with CDPs (for onward sharing to respective LDIS)	

	- under the influence test results (by substance) - Number of drug-related heath events (e.g. ambulance, hospitalisation etc).		
Homelessness services (including outreach, hostels and supported housing)	Review policies to ensure 'eyes wide open' approach is supported to mitigate the risk of death Identify people who use drugs and ensure support/care plans are updated to include an overdose, "staying alive" plan		

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