LIVERPOOL JOHN MOORES UNIVERSITY

Analysis of survey data on the implementation of NICE PH18 guidance relating to needle and syringe provision in England

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Acknowledgements

The authors would like to thank colleagues from Public Health England and the National Needle Exchange Forum for their contributions to this report.

Abbreviations

HIV	Human immunodeficiency virus
HPA	Health Protection Agency
NICE	National Institute for Health and Care Excellence
NNEF	National Needle Exchange Forum
NSP	Needle and syringe programme
NTA	National Treatment Agency
PHE	Public Health England
PIED	Performance and image enhancing drug users

Executive Summary

This data analysis was undertaken to evaluate findings from a joint survey carried out by the National Institute for Health and Care Excellence (NICE) and Public Health England (PHE, including the former National Treatment Agency [NTA] and Health Protection Agency [HPA]) of those commissioning and providing Needle and Syringe Programme (NSP) services.

The primary aims of the survey were to:

- Assess how widely NICE PH18 guidance has been implemented in England, including if there have been any barriers to applying the guidance recommendations.
- Gain a better understanding on the current extent and nature of NSP provision in England.

This report examines findings in relation to the implementation of NICE PH18 guidance only.

Survey design and dissemination

Two online questionnaires were developed in March 2013 by PHE and NICE, with input from National Needle Exchange Forum (NNEF), to survey both NSP commissioners and providers. The questionnaires sought to understand the level of implementation regarding NICE PH18 guidance. The questionnaires were available to commissioners and providers from 27/03/2013 to 15/05/2013. The survey was promoted by PHE through their centre teams. Local NSP commissioners were asked to complete the commissioners' questionnaire and forward details of the providers' questionnaire to providers in their area. Additionally, NNEF promoted the survey through their networks.

Findings

In total, data from 182 respondents was used in this analysis. This included 91 commissioners out of a possible 151 respondents (60.2%) and 91 providers. It is not possible to estimate a response rate for providers, as the total number of NSP programmes in England is unknown and services are configured differently in each area.

Findings: implementation of NICE guidance

Implementation of recommendations from PH18 guidance

Full implementation of recommendations was lowest in both commissioners and providers regarding R1 (Planning, needs assessment and community engagement) followed by R2 (Meeting need). Less than 10% of commissioners reported not implementing any recommendation, but non-implementation was more substantial amongst providers. Full implementation of R2 (Meeting need) and R3 (Types of service) was more likely amongst commissioners from local authorities and lower among those from local drug partnerships. In addition commissioners from specialist drug treatment services were more likely than other

commissioners to report full implementation of R2 (Meeting need), R4 (Equipment and advice) and R5 (Community pharmacy-based NSPs). Providers in pharmacy-based NSPs were less likely to have implemented any of the six recommendations than other providers, with the exception of recommendation 5 (Specialist NSPs: level three services).

Implementation of PH18 guidance to young people

The application of any of the recommendations to young people was reported by similar rates of providers (23.2%) and commissioners (21.7%). Comparable proportions (22.0% providers and 26.5% commissioners) were not sure if this had taken place.

Barriers to the implementation of recommendations

Implementation of R1 (Planning, needs assessment and community engagement), R2 (Meeting need) and R5 (Community pharmacy-based NSPs) were the recommendations most likely to be associated with barriers by commissioners and, among a higher proportion, by providers. A lack of capacity and requiring workforce education or training were the most frequently encountered barriers for commissioners implementing recommendations. Generally, lower proportions of providers identified that they had encountered barriers compared to commissioners in relation to each recommendation. For each recommendation, with the exception of R4 (Equipment and advice), the most frequently reported reason among providers for not applying guidance was that the recommendation was not relevant to their area of practice (10.8 - 15.7%). Common barriers encountered included that education or training was required for the workforce, there were difficulties changing commissioning arrangements and a lack of capacity to apply guidance. The most common additional barriers suggested by participants related to the lack of availability data on hard to reach groups and a lack of engagement with needle exchange, harm minimisation and relevant training amongst pharmacy staff.

Usefulness of NICE tools published alongside guidance

The majority of commissioners (89.2%) and providers (76.3%) reported that they found at least one of the NICE tools introduced alongside PH18 guidance to be useful. The most useful tools for commissioners were the commissioning guide (73.5%), local authority planning checklist (30.1%) and audit support (28.9%). Findings were similar for providers with nearly half reporting the audit support and commissioning guide to be useful. One quarter of providers did not find any of the tools to be useful, including over half of pharmacy NSP providers. Not being aware of tools and the tools not being relevant to the provider's work were the two most common reasons given for not using the NICE tools.

Conclusions

This survey finds that the extent to which the recommendations in PH18 guidance have been implemented by providers and commissioners of NSP services has varied, but that in the majority of cases, recommendations have been at least partially or fully applied. The implementation of NICE public health guidance on the optimal provision of NSP provides the opportunity to bring greater uniformity in the commissioning and provision of NSP services in England, however, despite the indication that PH18 guidance has generally been widely implemented in one form or another, there remains clear variability in commissioning policy and practice across England. Tackling common barriers such as through improving data collection and monitoring of NSP clients and increasing staff training opportunities is likely to help further implementation of the recommendations.

1 Introduction

The National Institute for Health and Care Excellence (NICE) and Public Health England (PHE, including the former National Treatment Agency [NTA] and Health Protection Agency [HPA]) agreed to undertake a joint survey of those commissioning and providing Needle and Syringe Programme (NSP) services. The survey was developed and disseminated jointly by NICE and PHE with support from the National Needle Exchange Forum (NNEF).

The primary aims of the survey were to:

- Assess how widely NICE PH18 guidance (see Section 2: Guidance recommendations) has been implemented in England, including if there have been any barriers to applying the guidance recommendations.
- Gain a better understanding on the current extent and nature of NSP provision in England.

This report examines findings in relation to the implementation of NICE PH18 guidance only.

2 Guidance recommendations

NICE PH18 guidance 'Needle and syringe programmes: providing people who inject drugs with injecting equipment' was first issued in February 2009[1]. In summary, PH18 guidance recommended that action was taken to increase access to and availability of sterile injecting equipment based on local needs. The guidance also recommended that action was taken to increase the proportion of people with 100% coverage of sterile injecting equipment and the proportion of people from different groups of injecting drug users in contact with NSPs. Areas were encouraged to provide a balanced mix of different levels of service and to coordinate services to ensure injecting equipment was available at all hours.

This report refers to the recommendations made in NICE PH18 guidance. The six recommendations were:

R1 Planning, needs assessment and community engagement

R2 Meeting need

R3 Types of service

R4 Equipment and advice

R5 Community pharmacy-based NSPs

R6 Specialist NSPs: level three services

[1] National Institute for Health and Clinical Excellence. (2009). Needle and syringe programmes: providing people who inject drugs with injecting equipment. London: National Institute for Health and Clinical Excellence.

Full details of the six recommendations are provided in appendix 1.

3 Methodology

3.1 Survey design

Two online questionnaires were developed in March 2013 by PHE and NICE, with input from NNEF, to survey both NSP commissioners and providers. The questionnaires sought to understand the level of implementation regarding NICE PH18 guidance.

3.2 Dissemination

The questionnaires were available to commissioners and providers from 27/03/2013 to 15/05/2013. The survey was promoted by PHE through their centre teams. Local NSP commissioners were asked to complete the commissioners' questionnaire and forward details of the providers' questionnaire to providers in their area. Additionally, NNEF promoted the survey through their networks. Two follow up reminders were sent out by PHE and NNEF in April, and commissioners in non-responding areas were targeted in further follow ups.

3.3 Analysis notes

Several participants in both surveys did not answer all questions. Wherever possible, participants have been included up to the point in the survey where they dropped out. Details of participant numbers for each part of the analysis are detailed throughout the report. Percentages in the analysis have been calculated using the number of participants who answered that question, rather than the total number of participants who took part in the survey unless otherwise stated.

It was hoped to examine whether the types of NSP service that participants provided influenced any of the findings presented. However, some participants stated that they were involved with service provision at more than one type of service. It was not recorded whether these participants were primarily involved with any one service that they detailed. Therefore, the findings presented that relate to the types of services provided should be treated with caution, as throughout the survey these responses are a generalisation across all of the types of services a respondent provides.

Further analyses focusing on data relating to the current extent and nature of NSP in England will be published separately by PHE.

4 Participants

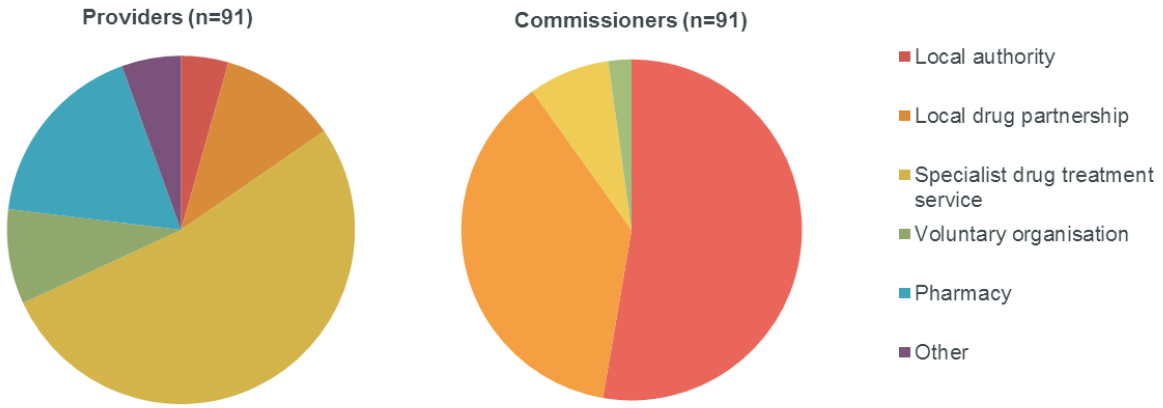
In total, 182 respondents provided data that could be used in this analysis. This included 91 commissioners out of a possible 151 respondents (60.2%) and 91 providers. It is not

possible to estimate a response rate for providers, as the total number of NSP programmes in England is unknown and services are configured differently in each area.

4.1 Role and place of work

A breakdown of where participants worked is provided in figure 1. The vast majority of commissioners worked in a local authority (52.7%) or local drug partnership (37.4%) with a small proportion located in a specialist drug treatment agency (7.7%). Over half of providers (52.7%) were located in specialist drug treatment services. One quarter (26.1%) of providers were specialist NSP service managers, with the remainder including pharmacy NSP coordinators (21.6%), healthcare professionals in not for profit organisations (13.6%) or the NHS (12.5%) and specialist NSP service staff (10.2%).

Figure 1: Participants' place of work (%)



4.2 Services provided

Providers detailed the NSP service(s) that they deliver. It should be noted that many participants stated that they provided multiple types of service [n=45] and it was not recorded if there was a primary service provided (3.3 Analysis notes). The majority of providers reported providing specialist treatment service-based NSP at fixed sites (70.5%) and pharmacy based NSPs (63.6%). Smaller proportions provided NSP through mobile or outreach services (19.3%), as part of structured treatment (14.8) and in the custody suite (10.2%). The provision of other NSP services (included in hostels, hospitals and through peer distribution networks) were each reported by less than 10% respondents.

4.3 Location

Commissioners provided details of the local authority within which they were based. The regional breakdown of respondents is displayed in figure 2.

4.4 Deprivation

The local authorities which commissioners and providers were based within represented a range of average scores on the 2010 measures of deprivation[2]. Average deprivation scores in 2010 for local authorities represented in this study ranged from 5.45 (low deprivation) to 43.45 (high deprivation). Average scores of deprivation were evenly distributed among both commissioners and providers (table 1). For outcomes relating to the NICE guidance, we examined whether local authority deprivation scores may have impacted upon implementation; findings in relation to this are noted where relevant.

Figure 2: Survey respondents by region (%).

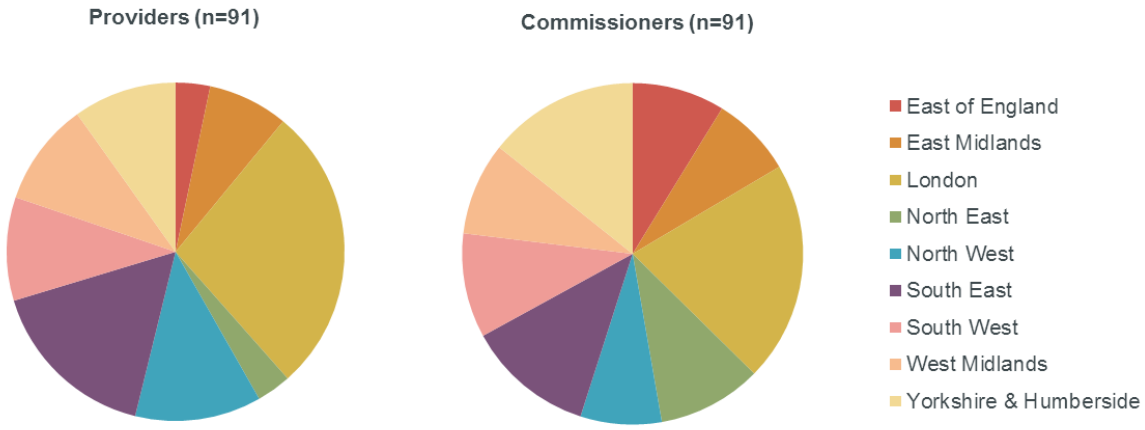


Table 1: Deprivation scores for local authorities that participants were based in

	Highest	Lowest	Mean score	Median score	Quartile 1 n	Quartile 2 n	Quartile 3 n	Quartile 4 n
Commissioners	42.89	5.45	22.76	23.12	23	23	24	21
Providers	43.45	8.80	24.16	24.16	23	23	25	20

5 Findings: implementation of NICE PH18 guidance

5.1 Implementation of recommendations from PH18 guidance

Overall, a higher proportion of commissioners than providers reported implementation of any of the six recommendations (figures 3 and 4). Between 62.0% and 78.0% commissioners reported full implementation of each of recommendations 2 to 6, while over 60% providers reported full implementation of R4 (Equipment and advice, 82.4%) and R6 (Specialist NSPs: level three services, 65.9%).

[2] Figures were obtained for an Index of Multiple Deprivation score across each local authority represented in the survey. The figures should be treated with caution as they represented the aggregate deprivation score from neighbourhoods across the local authority, which may include complex geographical areas.

Full implementation was lowest in both groups regarding R1 (Planning, needs assessment and community engagement) followed by R2 (Meeting need). Less than 10% of commissioners reported not implementing any recommendation, but non-implementation was more substantial amongst providers. Across all recommendations, but with the exception of R4 (Equipment and advice) more than 10% of providers reported non-implementation[3].

Figure 3: Rate of implementation of recommendations reported by commissioners (n=91)

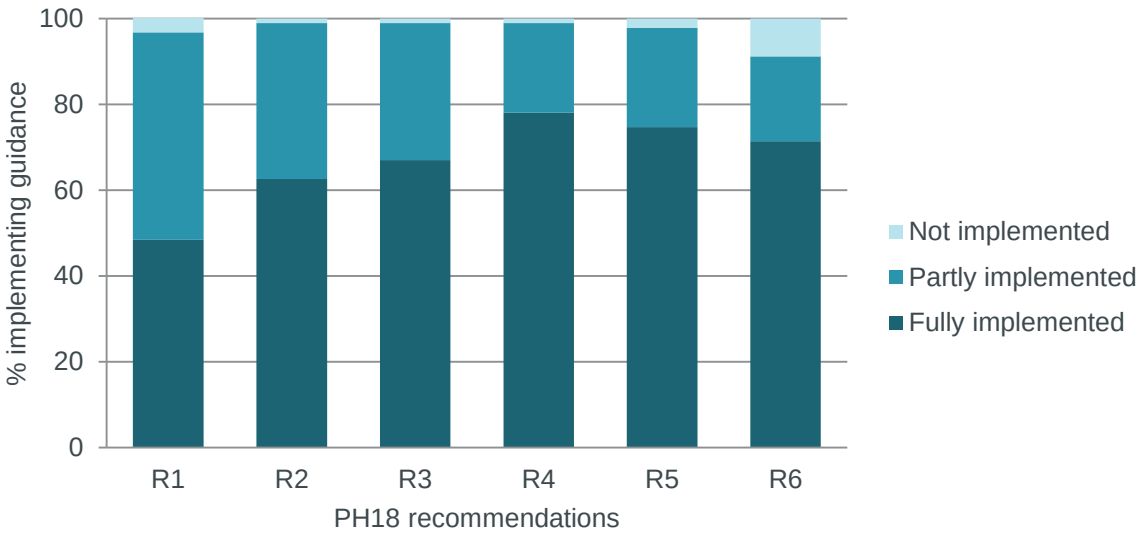
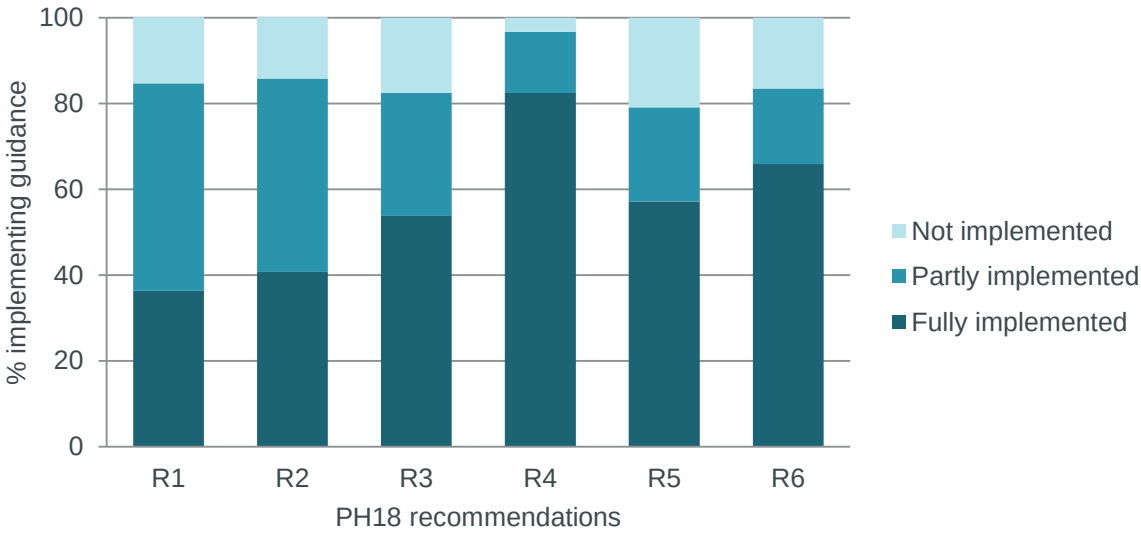


Figure 4: Rate of Implementation of recommendations reported by providers (n=91)



[3] It should be noted that the six recommendations may be aimed at different types of NSP services and at either commissioners or providers. Detail about the recommendations, including who it is intended should take action regarding implementation, is contained in Appendix 1.

5.1.1 Implementation in different places of work

There were differences in implementation reported by commissioners and providers according to their place of work. Full implementation of R2 (Meeting need) and R3 (Types of service) was more likely amongst commissioners from local authorities (n=48) and lower among those from local drug partnerships (n=34). In addition commissioners from specialist drug treatment services were more likely than other commissioners to report full implementation of R2 (Meeting need), R4 (Equipment and advice) and R5 (Community pharmacy-based NSPs).

Analysis of recommendation implementation by providers' place of work revealed that providers in pharmacy-based NSPs (n=16) were less likely to have implemented any of the six recommendations than other providers, with the exception of recommendation 5 (Specialist NSPs: level three services). Providers from local drug partnerships (n=10) were more likely than other providers to report full implementation of R3 (Types of service) and R4 (Equipment and advice).

5.1.2 Implementation of PH18 guidance to young people

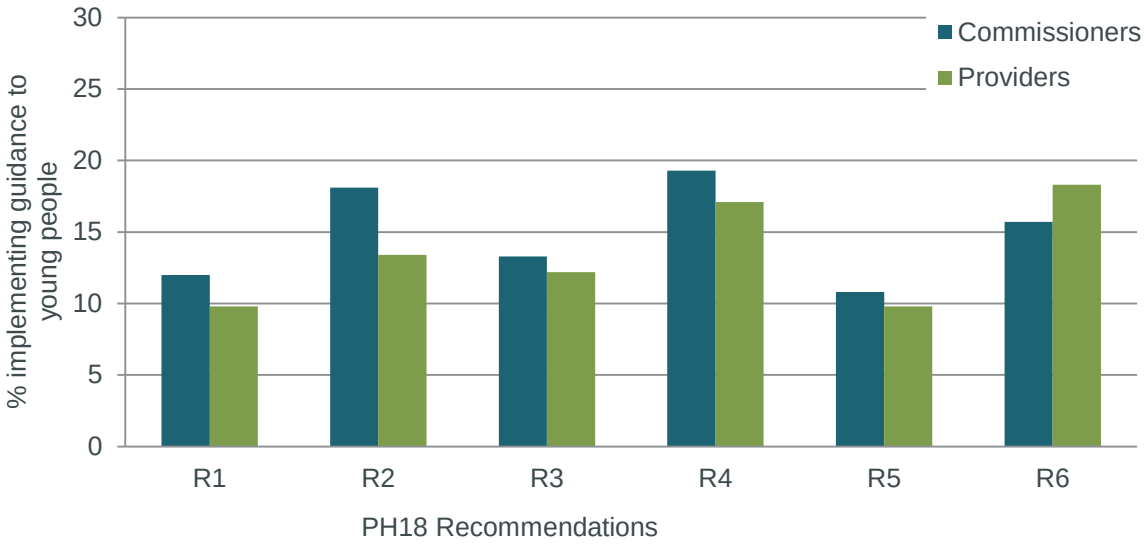
The application of any of the recommendations contained in PH18 guidance to young people[4] was reported by similar rates of providers (23.2%) and commissioners (21.7%). Comparable proportions (22.0% providers and 26.5% commissioners) were not sure if this had taken place, and over half (54.9% and 51.2% respectively) reported that the recommendations had not been applied to young people.

Application individually of any of the six recommendations to young people was also reported to be low by both commissioners and providers (figure 5). R6 (NSPs: Level three services) and R4 (Equipment and advice) were reported to have been applied to young people by over 15% of providers. These same two recommendations along with R2 (Meeting need) were reported to have been applied by over 15% of commissioners.

Analysis of application to young people by provider's and commissioner's place of work revealed that implementation to this age group was reported to be particularly low amongst commissioners from specialist drug treatment services (7.0%). A lower proportion of providers from specialist drug treatment services (n=45) reported application of the guidance to young people than the average proportion for all providers across all recommendations. Across all six recommendations, providers from pharmacies (n=13) reported no application of the guidance to young people. Although the number of providers from local drug partnerships was low (n=9), figures showed that a high proportion in this group reported application of the guidance to young people across all six recommendations.

[4] It should be noted that the recommendations in PH18 were intended to relate to people over the age of 18.

Figure 5: Proportion of commissioners (n=83) and providers (n=82) reporting the application of the recommendations to young people



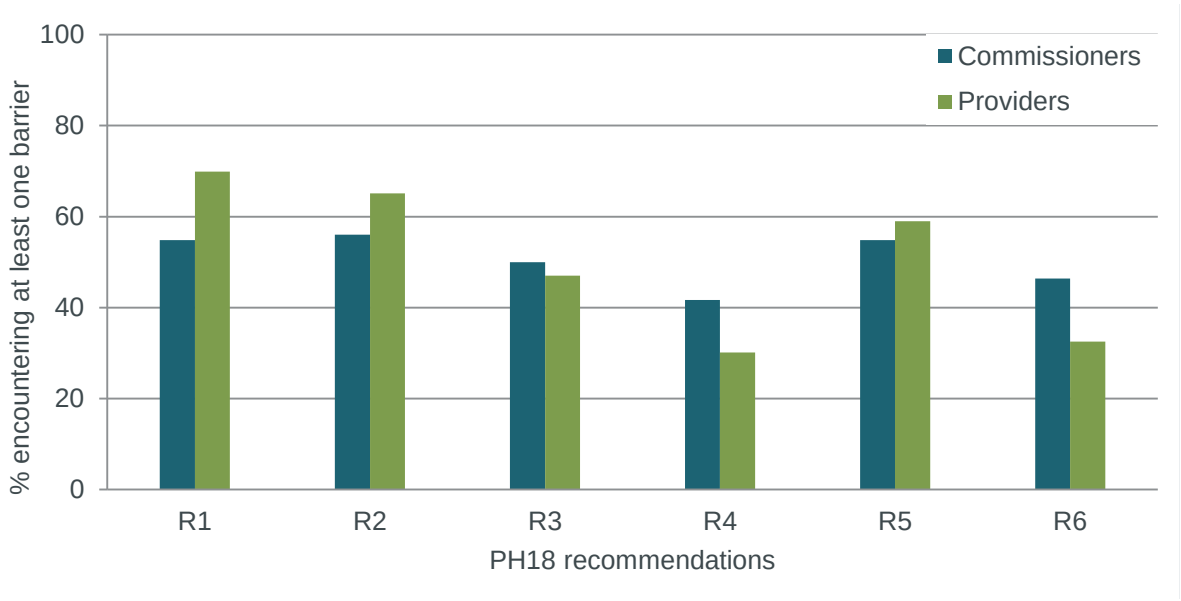
5.2 Barriers to applying PH18 guidance

5.2.1 Overall barriers to the implementation of recommendations

Participants were provided with a list of 12 potential barriers to applying the guidance, and asked to select as many as they had encountered (appendix 2). They were also given the opportunity to detail any other barriers they had encountered that were not on the list. Implementation of R1 (Planning, needs assessment and community engagement), R2 (Meeting need) and R5 (Community pharmacy-based NSPs) were the recommendations most likely to be associated with barriers by commissioners and, among a higher proportion, by providers (figure 6). For each of the six recommendations, approximately half of commissioners reported encountering at least one barrier to implementing that recommendation. Smaller proportions of providers reported barriers to the implementation of R6 (Specialist NSPs: level three services, 32.5%) and R4 (Equipment and advice, 30.1%).

The vast majority of commissioners (n=84) were located in local drug partnerships (n=32) or local authorities (n=43). Analysis suggested that commissioners in local drug partnerships were more likely to report barriers to implementing the recommendations than those from local authorities. Encountering barriers to R1 (Planning, needs assessment and community engagement) and R5 (Community pharmacy-based NSPs) was most frequent among commissioners from specialist drug treatment settings (n=7), although numbers in this group were low.

Figure 6: Proportion of commissioners (n=84) and providers (n=83) encountering at least one barrier to the implementation of the recommendations



The majority of providers (n=83) were from specialist drug treatment services (n=46) and the proportion encountering barriers were highest in this group regarding the implementation of R1 (Planning, needs assessment and community engagement, 63.0%), R2 (Meeting need, 58.7%), and R5 (Community-based pharmacy NSPs, 63.0%). In general however, providers from specialist drug treatment services reported fewer barriers to meeting recommendations than providers from other services. Over three quarters of providers working in pharmacies (n=13) and local drug partnerships (n=9) encountered barriers to applying R1 (Community pharmacy-based NSPs; 76.9% and 88.9% respectively) and R2 (Meeting need; 76.9% and 88.9% respectively) and, for pharmacy based providers only, R6 (Specialist NSPs: level three services; 76.9%).

Providers from local authorities in the highest deprivation quartile were more likely to encounter barriers to all six recommendations than the average proportion across all providers. However, this was not reflected in the experiences of commissioners in local authorities in the highest deprivation quartile.

5.2.2 Common barriers encountered

Analysis revealed the most frequently encountered barriers to the implementation of each recommendation as reported by commissioners (table 2). A lack of capacity and requiring workforce education or training were the most frequently encountered barriers for commissioners implementing recommendations. Difficulties changing commissioning arrangements and implementation requiring a change to existing practice were also consistently recognised by a smaller proportion of commissioners as barriers to applying guidance. Regarding R1 (Planning, needs assessment and community engagement) and R2 (Meeting need) only, a lack of service user information was identified as a barrier for implementation by commissioners.

Table 2: Most frequently encountered barriers to implementing the recommendations by commissioners (n=84)

	Most frequent barriers (%)	2nd most frequent barriers (%)	3rd most frequent barriers (%)
R1	Lack of capacity (25.0)	Lack of service user information (22.6)	Difficulties changing commissioning arrangements (10.7)
R2	Lack of capacity (17.9)	Lack of service user information (14.3)	Difficulties changing commissioning arrangements (11.9)
R3	Workforce education or training required (16.7)	Lack of capacity (14.3)	Difficulties changing commissioning arrangements (10.7)
R4	Workforce education or training required (14.3)	Lack of capacity (11.9)	Required significant change to existing practice (9.5)
R5	Workforce education or training required (26.2)	Lack of capacity (13.1)	Initial costs of adopting into practice (11.9)
R6	Workforce education or training required (17.9)	Required significant change to existing practice (11.9)	Lack of capacity & Difficulties changing commissioning requirements (10.7)

Generally, lower proportions of providers identified that they had encountered the given barriers compared to commissioners in relation to each recommendation. Based on all six recommendations, with the exception of R4 (Equipment and advice), the most frequently reported reason among providers for not applying guidance was that the recommendation was not relevant to their area of practice (10.8 - 15.7%). Similarly to commissioners, common barriers encountered included that education or training was required for the workforce, there were difficulties changing commissioning arrangements and a lack of capacity to apply guidance. The need for workforce training or education was a particular barrier to implementing R5 (Community pharmacy-based NSPs; 21.7%). Although proportions were still low, a higher proportion of providers than commissioners reported that it was unclear who should lead the implementation of guidance in all recommendations, particularly regarding R1 (Planning, needs assessment and community engagement, 14.5%).

Frequently, participants identified that they had encountered other barriers to the application of recommendations to the ones presented in the survey. Generally, there was a lack of homogeneity amongst comments to draw out commonly experienced barriers but participants tended to build upon the barriers presented to them and identified a variety of difficulties they had encountered. Comments by participants (n=12) suggested difficulty

regarding implementing R1 (Planning, needs assessment and community engagement); this may be due to a lack of available data that commissioners and providers have access to. This was particularly regarding hard to reach groups who may not access NSPs, including sex workers, people who inject PIEDs and people who are homeless, who it was felt were hard to collect data on. In some cases, this related to the nature of data collection by NSP services.

"Information only collected from existing service users - no assessment of need undertaken with 'high risk' groups regarding their injecting habits"

"Given the anonymous nature of NSP we are not able to know accurately the number, demographics or injecting behaviour of service users accessing the NSP. With greater knowledge, services could arguably be better targeted"

"Although we assess all needle exchange clients there are some questions that we do not ask on our paperwork e.g. whether a client is a sex worker or homeless, although we often know the answers"

"We are not collecting data to the level that is recommended i.e. numbers of homeless, number of percentage of injections, number of individuals who had more sterile needles than needed etc. This is due to lack of time and capacity"

Lack of engagement amongst pharmacy staff to meet training requirements and to offer high quality services was identified by some participants (n=11) as a barrier to successfully applying R5 (Community pharmacy-based NSPs). Explanations given generally included the limited availability of pharmacy staff for training and time constraints they are under, or the belief that pharmacy workers are not willing to attend training. A lack of engagement by pharmacists regarding the provision of needle exchange and harm minimisation was identified by participants, but the constraints of pharmacy services that limit engagement were also recognised.

"Staff may not have the training, time or knowledge to offer more than a shop service"

"Staff at community pharmacies being reluctant to engage in training opportunities. Those most interested attend, but those that need to be educated about stigma etc. are harder to engage. They see it as an 'add on', not their priority, not why they came into the job etc."

"We still conduct pharmacy education events, but we are aware that some staff may not be able to attend these events. In future we will look to increase in-house pharmacy events to provide specialised training"

Pharmacies not being able to offer pick and mix needle packs, possibly due to issues relating to pharmacy capacity, were identified by some participants (n=4) as barriers to implementation of R3 (Types of service). Through comments made it was apparent that some areas were lacking 24 hour needle exchange coverage.

"Lack of capacity to provide pick 'n' mix in pharmacies, however the service is provided within the specialist service"

"Lack of experience from those running pharmacy programs means that clients report that the pharmacy packs do not always have the equipment that they use"

Additionally, difficulties relating to location were recognised by a small number of participants (n=3) regarding the implementation of R3 (Types of service). Comments included the difficulty of providing a comprehensive service in rural areas or large geographical locations.

"The implementation of injecting equipment availability throughout the geographical area, particularly across a large rural county, can be problematic in terms of ensuring total availability"

Participants described a variety of further difficulties that they had experienced regarding the implementation of all six recommendations. However, as these issues were reported by one or two commissioners or providers it was unknown whether these experiences were common across different localities.

5.3 NICE tools published alongside PH18 guidance

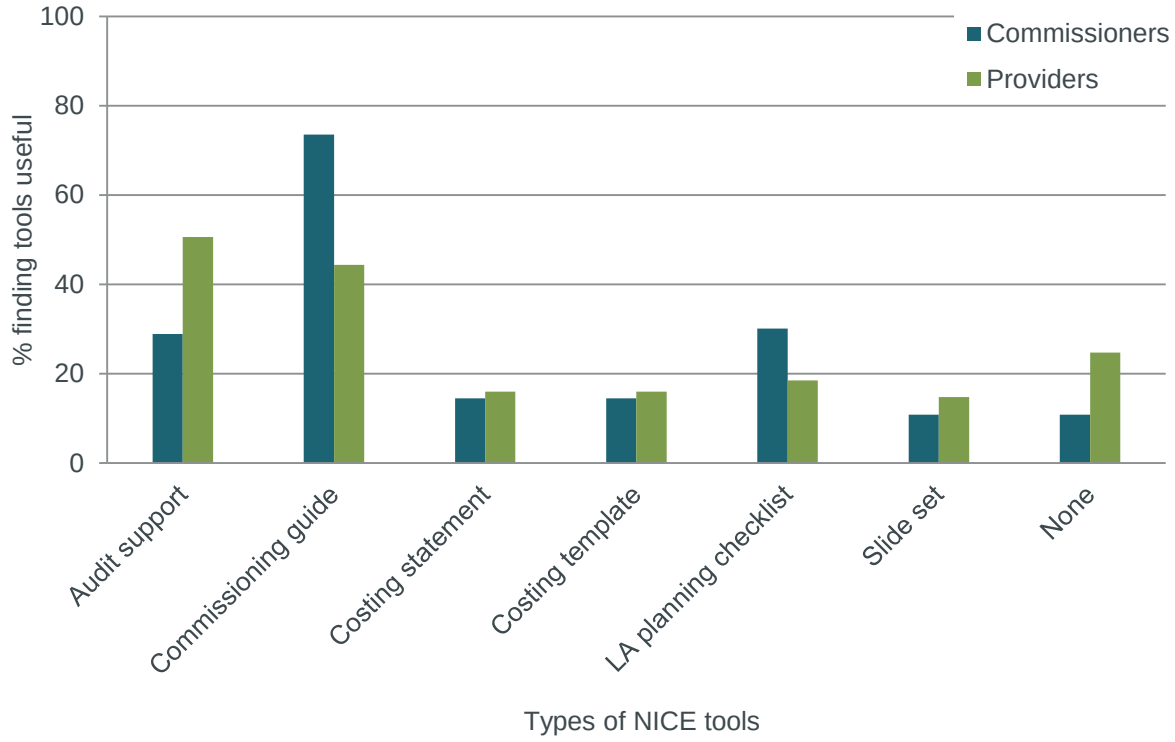
5.3.1 Usefulness of tools

The majority of commissioners (89.2%) and providers (76.3%) reported that they found at least one of the NICE tools introduced alongside PH18 guidance to be useful (figure 7). The most useful tools for commissioners (n=83) were the commissioning guide (73.5%), local authority planning checklist (30.1%) and audit support (28.9%). The commissioning guide was reported to be useful among a higher proportion of commissioners from local authorities (83.7%), and the local authority planning checklist was reported as being useful by a higher proportion of commissioners from local drug partnerships (41.9%) and specialist drug treatment services (42.9%).

Findings were similar for providers (n=81), with nearly half (49.4%) reporting the audit support to be useful, followed by the commissioning guide (44.4%). A smaller proportion found the local authority planning checklist useful (18.5%). The proportion reporting approval for these tools was lower than average among pharmacy-based providers. Less than 20% of both providers and commissioners reported that the costing statement, costing template and

slide set were useful to them, although for pharmacists the costing statement was reported to be useful by one quarter of respondents (25.0%).

Figure 7: Proportion of commissioners (n=83) and providers (n=81) who reported finding NICE tools introduced alongside PH18 guidance to be useful



5.3.2 Barriers to using tools

One quarter of providers (24.7%) did not find any of the tools to be useful, including a high proportion of pharmacy NSP providers (58.3%). For providers, not being aware of tools (55.0%) and the tools not being relevant to the provider's work (40.0%) were the two most common reasons given for not using the NICE tools.

6 Discussion and conclusions

This survey was conducted to gain an understanding of how widely NICE PH18 guidance has been implemented among commissioners and providers of NSP services in England. The last survey of NSP provision in England, undertaken by the NTA in 2005, found that wide variability existed throughout England in the commissioning and the provision of NSP services.

6.1 Implementation and barriers to implementation

This survey provides some insight into the responses of providers and commissioners of NSP services to PH18 guidance. It shows that the extent to which the recommendations have been implemented varies, but that in the majority of cases, recommendations have been at least partially or fully applied. Among both commissioners and providers responding

to this survey, Recommendation 4 (Equipment and advice) has been the most widely implemented and Recommendation 1 (Planning, needs assessment and community engagement) the least widely implemented. Among the survey sample, providers who included pharmacy based-services within their mix of service provision appeared to have been less likely to have implemented the recommendations. This survey found that PH18 guidance has been applied to young people by a low proportion of survey respondents. That the recommendations in PH18 guidance were intended to relate to people over the age of 18 may partially explain this, as may the finding that half of providers believed that young people did not access their services.

Recommendations 1 (Planning, needs assessment and community engagement), 2 (Meeting need) and 5 (Community pharmacy-based NSPs) were the recommendations most commonly associated with barriers to implementation by both commissioners and providers. Lacking capacity and requiring workforce education or training were the most common obstacles identified to implementing recommendations. For the least widely implemented recommendation, Recommendation 1, participants indicated that limited availability of, or access to, data in their area was an additional barrier. Additionally, amongst the providers responding to this survey it appeared that a small but consistent proportion of respondents did not believe that the recommendations were relevant to their work. These findings highlight some of the challenges encountered in the implementation of PH18 guidance. Further difficulties encountered by respondents were varied suggesting that a more detailed understanding of the needs of those who are in a position to implement public health guidance is required.

A range of implementation tools were produced by NICE to support the implementation of PH18 guidance. The commissioning guide, local authority planning checklist and audit support were the most popular tools amongst survey respondents. Among the survey sample, providers based in pharmacies were less likely to report that tools were useful. One quarter of providers did not report tools to be useful either because they were not aware of the tools, or believed they were not relevant to their work.

6.2 Conclusions

This survey finds that the extent to which the recommendations in PH18 guidance have been implemented by providers and commissioners of NSP services has varied, but that in the majority of cases, recommendations have been at least partially or fully applied. The implementation of NICE public health guidance on the optimal provision of NSP provides the opportunity to bring greater uniformity in the commissioning and provision of NSP services in England, however, despite the indication that PH18 guidance has generally been widely implemented in one form or another, there remains clear variability in commissioning policy and practice across England. Tackling common barriers such as through improving data collection and monitoring of NSP clients and increasing staff training opportunities is likely to help further implementation of the recommendations.

Appendix 1. NICE PH18 Guidelines: Recommendations

Recommendation 1 Planning, needs assessment and community engagement

Who should take action?

- Local strategic partnerships (LSPs), local drug partnerships (including drug [and alcohol] action teams [D(A)ATs]), drug joint commissioning managers and primary care trust (PCT) commissioners.
- Public health practitioners with a remit for substance misuse.

What action should they take?

- With the help of the Health Protection Agency and public health observatories, collect and analyse local data to estimate the:
    - prevalence and incidence of infections related to injecting drug use (for example, hepatitis C) and other problems caused by injecting drug use (for example, number of people overdosing)
    - numbers, demographics, types of drugs used and other characteristics of injecting drug users (for example, the number of sex workers or homeless people who are crack and speedball injectors)
    - number and percentage of injections 'covered' by sterile needles and syringes (that is, the number and percentage of occasions when sterile equipment was available to use)
    - the number and percentage of individuals who had more sterile needles and syringes than they needed (over 100% coverage)
    - number and percentage of people who inject drugs and who are in regular contact with an NSP (that is, at least once a month).
- Use these data to ensure NSP services meet local need (for example, in terms of opening times and locations), taking the geography of the location into account (for example, whether it is in an urban or rural area).
- Consult people who inject drugs to help assess the need for – and to plan – NSPs.
- Consult local communities about how best to implement new or reconfigured NSPs. Promote the benefits of the service. For example, explain how it will help reduce drug-related litter by providing safe disposal facilities and sharps bins. Actively involve them in implementation.

Recommendation 2 Meeting need

Who should take action?

LSPs, local drug partnerships (including D[A]ATs), drug joint commissioning managers and PCT commissioners.

What action should they take?

- Commission a mix of generic and targeted NSP services to meet local need within the area covered by the LSP (see recommendation 1). Targeted services should focus on specific groups (for example, homeless people and women who inject drugs). Services should aim to:
    - increase the proportion of people who have over 100% 'coverage' (that is, the number who have more than one sterile needle and syringe available for every injection)
    - increase the proportion of people from each group of injecting drug users who are in contact with NSPs
    - ensure syringes and needles are available in a range of sizes and at a range of locations throughout the area
    - offer advice and information on, and referrals to, services which aim to: reduce the harm associated with injecting drug use; encourage people to stop using drugs or to switch to non-injecting methods (for example, opioid substitution therapy); and address their other health needs.
- Develop plans for needle and syringe disposal, in line with 'Tackling drug-related litter' (Department for Environment, Food and Rural Affairs 2005).
- Encourage identification schemes (involving, for example, the use of coloured syringes).
- Commission 'integrated care pathways' for people who inject drugs.
- Audit and monitor services to ensure they meet the health needs of people who inject drugs and address the concerns of the local community.

Recommendation 3 Types of service

Who should take action?

LSPs, local drug partnerships (including D[A]ATs), drug joint commissioning managers and PCT commissioners.

What action should they take?

- Use pharmacies, specialist NSPs and other healthcare settings to provide a balanced mix of the following levels of service:
    - level one: distribution of injecting equipment either loose or in packs, with written information on harm reduction (for example, on safer injecting or overdose prevention)
    - level two: distribution of 'pick and mix' (bespoke) injecting equipment plus health promotion advice (including advice and information on how to reduce the harms caused by injecting drugs)
    - level three: level two plus provision of, or referral to, specialist services (for example, vaccinations, drug treatment and secondary care).
- Coordinate services to ensure injecting equipment is available throughout the LSP area for a significant time during any 24-hour period. As an example, PCTs could ensure that NSPs form part of the 'necessary enhanced services' offered by '100 hour' pharmacies. Commissioners could also consider providing NSPs through community pharmacies that operate extended opening hours.
- Ensure services offering opioid substitution therapy also make needles and syringes available to their clients, in line with the National Treatment Agency 'Models of care' (2006).

Recommendation 4 Equipment and advice

Who should take action?

NSP providers (community pharmacies and specialist NSPs).

What action should they take?

- Provide people who inject drugs with needles, syringes and other injecting equipment. The quantity dispensed should not be subject to an arbitrary limit but, rather, should meet their needs. Where possible, needles and syringes should be made available in a range of sizes.
- Ensure people who use NSPs are provided with sharps bins and advice on how to dispose of needles and syringes safely.

- Ensure safer injecting advice and information are available when providing long needles and other equipment that could be used for more dangerous practices (long needles, for example, could be used for injecting into the groin).
- Provide other injecting equipment associated with illicit drug use and encourage people who inject drugs to switch to other methods of drug use (at the time of publication, legally permitted equipment included filters, mixing containers and sterile water).
- Encourage people who inject drugs to mark their syringes and other injecting equipment or to use easily identifiable equipment to prevent mix-ups.
- Encourage people who inject drugs to use services which aim to: reduce the harm associated with injecting drug use; encourage them to stop using drugs or to switch to non-injecting methods (for example, opioid substitution therapy); and address their other health needs. Advise them where they can access these services.

Recommendation 5 Community pharmacy-based NSPs

Who should take action?

- Community pharmacies that run an NSP (regardless of the level of service they offer – see recommendation 3).
- Coordinators of community pharmacy-based NSP services.

What action should they take?

- Provide sharps bins and advice on how to dispose of needles and syringes safely. In addition, provide a service for safe disposal of used equipment.
- Ensure staff who dispense needles and syringes receive appropriate training for the level of service they offer. As a minimum, this should include awareness training on the need for discretion and the need to respect the privacy of people who inject drugs. It should also include training on how to treat them in a non-stigmatising way.
- Ensure staff providing level two or three services (see recommendation 3) are trained to provide health promotion advice, in particular, advice on how to reduce the harm caused by injecting.
- Ensure staff have health and safety training.
- Ensure hepatitis B vaccination is available for staff.

- Ensure staff can provide people who inject drugs with information about local agencies offering further support (this includes details about local opioid substitution therapy services).

Recommendation 6 Specialist NSPs: level three services

Who should take action?

Specialist NSPs.

What action should they take?

- Provide sharps bins and advice on how to dispose of needles and syringes safely. In addition, provide a service for safe disposal of used equipment.
- Ensure staff receive appropriate training for the level of service on offer.
- Ensure a selection of individual needles, syringes and other injecting equipment is available.
- Offer comprehensive harm-reduction services including advice on safer injecting practices, assessment of injection-site infections, advice on preventing overdoses and help to stop injecting drugs. Where appropriate, offer a referral to opioid substitution therapy services.
- Offer (or help people to access):
    - opioid substitution therapy
    - treatment of injection-site infections
    - vaccinations and boosters (including those offering protection from hepatitis A, hepatitis B and tetanus)
    - testing (and counselling, where appropriate) for hepatitis B, hepatitis C and HIV
    - psychosocial interventions
    - primary care services (including condom provision and general sexual health services, dental care and general health promotion advice)
    - secondary care services (for example, treatment for hepatitis C and HIV)
    - welfare and advocacy services (for example, advice on housing and legal issues).

Appendix 2. Barriers encountered to the implementation of PH18 guidance recommendations: options presented to survey participants

For each of the six recommendations, participants were asked to identify any barriers to implementation they had encountered from a list of 12 options:

- Unclear who should lead implementation
- Difficulties changing commissioning arrangements
- Initial costs of adopting into practice
- Contradicts existing guidance or practice
- Lack of capacity
- Lack of service user information
- Unaware of the recommendation
- Not seen as a local priority
- Required significant change to existing practice
- Lack of equipment
- Workforce education or training required
- Not relevant to my area of practice

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