Needle and syringe programmes

Commissioning guide
Implementing NICE guidance

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Needle and syringe programmes

This commissioning guide provides support for the local implementation of NICE public health guidance through commissioning, and is a resource to help 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 in England to commission effective needle and syringe programmes (NSPs) using a harm-reduction approach.

This commissioning guide should be read together with the following NICE guidance:

- NICE public health guidance PH18. Needle and syringe programmes: providing people who inject drugs with injecting equipment

The public health guidance promotes the optimal provision of NSPs among injecting drug users. The recommendations aim to help people over the age of 18 who inject illicit substances. Some of the recommendations are also relevant to adults who inject non-prescribed anabolic steroids and other performance and image-enhancing drugs (PIEDs).

The commissioning guide complements broader drug treatment commissioning guidance from the National Treatment Agency for Substance Misuse.

Implementation of the guidance noted above is the responsibility of LSPs, local drug partnerships (including D[A]ATs), drug joint commissioning managers and PCT commissioners. Commissioners and providers are reminded that it is their responsibility to implement this guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in the guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

The guide:

- makes the case for commissioning needle and syringe programmes
- specifies service requirements
- helps you determine local service levels
- helps you ensure corporate and quality assurance.

The full text of this commissioning guide is accessed from the navigation menu on the right hand side of the screen. The associated commissioning tool is available until 25 June 2010 to primary care organisations in England who are already registered to use the tool. New registrations for the existing commissioning tool will not be possible after 31 March 2010.

From 1 April 2010 the new freely available commissioning and benchmarking tool can be downloaded here. There is no need to register.
We are keen to improve the commissioning guides in order to better meet the needs of commissioners. Please send us your ideas for future topic-specific guides or other comments.

Read the NICE disclaimer for information on the use and accuracy of content on the NICE website.

- **Topic-specific Advisory Group: needle and syringe programmes**
Commissioning needle and syringe programmes

Needle and syringe programmes (NSPs) supply needles and syringes, and often other equipment, used to prepare and take illicit drugs. NSPs reduce the transmission of blood-borne viruses (BBVs) and other infections caused by sharing injecting equipment. Many NSPs also aim to reduce the harm caused by injecting drugs through providing information and advice and acting as a gateway to other services, including drug treatment such as opioid substitution therapy (OST). NSPs may be the only contact that some people (for example, those who inject performance and image-enhancing drugs [PIEDs]) have with health services. NSPs in England are based across a range of services including specialist services, pharmacies, outreach/mobile services, police custody suites, walk-in centres and accident and emergency departments. However, over 70% of NSPs are provided by pharmacies.

The true extent of injecting drug use is difficult to determine. The latest data suggest the number of injecting drug users aged 15–64 years in England is between 115,000 and 122,000, although it could be over 200,000. These estimates relate to people injecting heroin, other opiate drugs or crack cocaine and do not include people injecting PIEDs such as anabolic steroids. However, recent anecdotal reports from across the country suggest that the use of anabolic steroids is on the increase, particularly among young men[1].

Needle and syringe sharing has declined in recent years. However, in 2007 almost a quarter of respondents to the Unlinked Anonymous Prevalence Monitoring Programme reported sharing needles and syringes during the previous 4 weeks. In addition, almost half reported that they had shared filters, mixing containers and water during the same period[2].

In the UK almost half of injecting drug users are infected with hepatitis C and about 1 in 90 with HIV. The Advisory Council on the Misuse of Drugs 2009 report states that in England and Wales 120,000 to 300,000 people are infected with hepatitis C. Approximately one in five people recover, with the rest becoming chronically infected. There is no vaccine to protect against hepatitis C and chronic infection can lead to severe liver disease, liver cancer and death. Chronic hepatitis C can be cleared successfully in at least half of treated patients.

In 2006 there were 1469 deaths relating to drug use in England. This includes people who died as a result of accidental overdose, intentional self-poisoning, drug use and drug dependence.

The joint Healthcare Commission–National Treatment Agency for Substance Misuse improvement review of harm reduction services revealed that pharmacy and specialist NSPs provide a wide range of information and advice on harm reduction. However, the review highlighted that there was a clear national shortfall in the provision of out-of-hours NSPs, and that vaccination against hepatitis B and testing and treatment for hepatitis C were not provided widely enough by local drug partnerships. Currently, the accessibility and
availability of NSPs (along with interventions to reduce harm) vary widely. There is also wide variation in the number of people who use NSPs and how often they use them.

**Benefits**

The potential benefits of commissioning NSPs as part of a local treatment system that also provides OST are:

- **increasing availability of injecting equipment**, reducing risk behaviours such as sharing needles and syringes and lowering injection frequency
- reducing injection-site infections and the transmission of BBVs
- **reducing** accidental deaths and drug-related overdoses
- **providing a route into** a range of other treatment services
- reducing the number of attendances at accident and emergency departments (and subsequent hospital bed-days) for injection-site infections
- **reducing harms caused by drug-related litter** by providing safe disposal facilities and sharps bins
- **reducing inequalities** and improving access for people from specific groups such as homeless people and women who inject drugs, and speedball users (people who inject an opioid such as heroin in combination with a stimulant such as cocaine)
- **increasing service user choice** through offering flexible opening times and locations
- **better value for money** – NSPs are a cost-effective way of reducing the transmission of BBVs and the development of injection-site infections. If the gateway effects of NSPs are included, a fall in the number of people who inject drugs is likely. This would, in turn, lead to a reduction in crime. If that is the case, modelling shows that NSPs are likely to save society money in the longer term\(^1\).

**Key issues**

Key issues in providing effective needle and syringe programmes are:

- **identifying, engaging and assessing** all people who inject illicit drugs and encouraging them to access drug treatment
- encouraging people to find alternatives to injecting and/or helping people to stop injecting drugs

\(^1\) Figures in relation to the size of gateway effects are subject to uncertainty, as are figures relating to any effect that an increase in NSPs will have on the number of people injecting drugs.
- commissioning a mix of generic and targeted NSP services to meet local need
- **increasing the proportion of people who have over 100% coverage** (that is, the proportion who have more than one sterile needle and syringe available for every injection)
- **providing advice and information** to reduce the harms associated with injecting drug use
- **ensuring access** to BBV testing, vaccination and treatment services
- **promoting healthy and safe communities**, reducing the fear of crime and reducing drug related litter
- providing the best possible outcomes for individuals, their families and communities
- **providing a quality assured service**.

**National drivers**

National priorities and initiatives relevant to commissioning needle and syringe programmes include:

- **World class commissioning**.
- **The NHS in England: The operating framework for 2009/10**.
- **Public service agreement (PSA) delivery targets**: stronger communities and reducing the harm caused by alcohol and drugs, targets 21–25.
- The Government’s drug strategy: **Drugs: protecting families and communities – 2008**.
- **Commissioning framework for health and well-being**.
- The **Expert patients programme** for people in recovery from alcohol and substance misuse.
- **A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services**.
- Implementation of NICE clinical and public health guidelines. These are currently core standards, and performance against these standards will be assessed by the **Care Quality Commission** in line with **Standards for better health**.

Although many or all of these priorities may be relevant to the services nationally, your local service redesign may address only one or two of them.
References


Specifying needle and syringe programmes

Service components

The key components of needle and syringe programmes (NSPs) are:

- providing needles and syringes and other injecting equipment together with information and advice on harm reduction
- providing a gateway to other services and ensuring access to blood-borne virus testing, vaccinations and drug treatment
- developing high-quality NSPs.

Providing needles and syringes and other injecting equipment together with information and advice on harm reduction

NICE public health guidance PH18 on needle and syringe programmes recommends that 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 use pharmacies, specialist NSPs and other healthcare settings to provide a balanced mix of services across three levels:

- level 1: distribution of injecting equipment either loose or in packs, with written information on harm reduction (for example, on safer injecting or overdose prevention)
- level 2: distribution of ‘pick and mix’ (bespoke) injecting equipment plus health promotion advice (including advice and information on how to reduce harms caused by injecting drugs)
- level 3: level 2 plus provision of, or referral to, specialist services (for example, vaccinations, drug treatment and secondary care).

Commissioners should ensure that NSP providers (community pharmacies and specialist NSPs) supply people who inject drugs with needles, syringes and other injecting equipment such as filters, mixing containers, sterile water and sharps bins. The quantity of injecting equipment dispensed should be adequate to meet the needs of the injecting drug user (including increased numbers of syringes for stimulant users) and not subject to an arbitrary limit.

Staff who dispense needles and syringes in community pharmacies and specialist NSPs should receive the appropriate level of training for the level of service they offer. For community pharmacists, 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 people in a non-stigmatising way. Staff providing level 2 or level 3 services should be trained to provide health promotion advice, in particular advice on how to reduce the harm caused by injecting.
Providing a gateway to other services and ensuring access to blood-borne virus testing, vaccinations and drug treatment

NSPs can provide an important gateway function for people who inject drugs and bring them into contact with a range of drug treatment services. Therefore commissioners should ensure that local agencies offering further support (level 3 services) are available and accessible and that NSP staff are able to advise people who inject drugs on where and how they can access these services.

Level 3 services should provide:

- injecting equipment, sharps bins and advice on how to dispose of needles and syringes and a service for the safe disposal of used equipment
- 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
- access, where appropriate, to opioid substitution therapy (OST), treatment for injection-site infections, vaccinations and boosters (including those offering protection from hepatitis A, hepatitis B and tetanus), and testing and counselling for hepatitis B, hepatitis C and HIV.

Commissioners should also ensure that people who inject drugs have access to: secondary care services, for example, treatment for hepatitis C and HIV; primary care services including condom provision, general sexual health services, dental care and general health promotion advice; and welfare and advocacy services, for example advice on housing and legal issues.

Developing high-quality needle and syringe programmes

LSPs, local drug partnerships (including D[A]ATs), drug joint commissioning managers and PCT commissioners should, with the help of the Health Protection Agency and public health observatories, collect and analyse local data to estimate the level of service needed. NICE public health guidance PH18 on needle and syringe programmes recommends analysing data and undertaking consultation with local communities and service users about how best to implement new or reconfigured NSPs and recommends:

- Commissioning a mix of generic and targeted NSP services to meet local need within the area covered by the LSP. Targeted services should focus on specific groups (for example, homeless people and women).
- Commissioners should ensure that services aim to:
  - increase the proportion of people who have over 100% ‘coverage’ (that is, the proportion 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 that needles and syringes 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 that aim to: reduce harm associated with injecting drug use; encourage people to stop using drugs or switch to non-injecting methods (for example, opioid substitution therapy); and address their other health needs.

LSPs, local drug partnerships (including D[A]ATs), drug joint commissioning managers, PCT commissioners, NSP providers, public health practitioners with a remit for substance misuse and service users should be involved in determining what is needed from an NSP when considering the design or redesign of service models.

Commissioners need to be aware that legal and operational considerations regarding the provision of needles and syringes to people under the age of 18 differ from those for adults. Needle and syringe programmes are commissioned for people under the age of 18 in a number of areas as part of a care plan activity and an intervention should only be provided following a comprehensive young person’s assessment.

**Service models**

NSPs in England are based across a range of services including specialist services, pharmacies, outreach/mobile services, police custody suites, walk-in centres and accident and emergency departments. Over 70% of NSPs are provided by pharmacies. Commissioners should ensure that NSPs are coordinated to provide injecting equipment throughout the area for a significant proportion of any 24-hour period. Therefore commissioners may wish to consider commissioning NSPs in a number of different ways. Mixed models of provision may be appropriate across the LSP area. Commissioners should consult with relevant stakeholders such as the local pharmaceutical committee and local communities about how best to implement new or reconfigured NSPs.

Community pharmacy-based NSPs may be commissioned as 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. Services offering OST should also make needles and syringes available to their clients, in line with the National Treatment Agency for Substance Misuse’s Models of care for treatment of adult drug misusers.

There is a lack of evidence on how particular groups such as women, users of performance and image-enhancing drugs (PIEDs), young people, crack cocaine and speedball injectors (people who inject an opioid such as heroin in combination with a stimulant such as cocaine), homeless people and prison populations can be encouraged to use NSPs. Therefore commissioners may wish to commission and evaluate novel methods of service delivery such as vending machines, mobile vans and non-pharmacy outlets, including sports venues for PIED users.
A NSP in Walsall provides a ‘one-stop shop’ for a range of services as part of the Hepatitis Action Project. All clients entering the NSP are assessed, given advice on harm reduction and offered screening for hepatitis, HIV and chlamydia. Vaccinations for hepatitis A and B and regular health checks by the project nurse are also offered, and when necessary referrals are made to the local hospital hepatology clinic. The Hepatitis Action Project also provides an outreach service for anabolic steroid users.

This example is offered to share practice and NICE makes no judgment on the compliance of this service with its guidance.

**Service specification**

The service should be client-centred and integrated with other elements of care for people with drug and alcohol problems.

The service specification needs to address:

- the required competencies of, and training for, staff responsible for providing the service at all three service levels and across different settings
- the prevalence and incidence of infections related to injecting drug use (for example, hepatitis C) and other problems caused by injecting drug use, such as number of people overdosing, with help from the Health Protection Agency and the public health observatories
- the expected number of clients, demographics, types of drugs used and other characteristics of injecting drug users (for example, the number of sex workers, number of homeless people, number of crack cocaine and speedball injectors)
- accessibility and service location – see NICE needle and syringe programmes: local authority planning committee checklist; commissioners should place services in response to community consultation and engage service users, other relevant individuals and organisations locally when taking the location of the service into account
- plans for needle and syringe disposal
- integrated care and referral pathways
- information, monitoring and audit requirements, including IT support and infrastructure, and details of data to be submitted to the needle exchange monitoring system
- planned service improvement, including redesign, quality, equitable access and referral-to-treatment times according to the 18 week patient pathway or equitable waiting times locally for those services currently outside 18 weeks
- service monitoring criteria.
Useful sources of information may include:

- **Drug misuse and dependence: UK guidelines on clinical management.**
- **Good practice in harm reduction.**
- **Reducing drug-related harm: an action plan.**
- **Tackling drug related litter**
- **Best practice guidance for commissioners and providers of pharmaceutical services for drug users.**
- **Commissioning young people’s specialist substance misuse treatment services.**
- **NICE public health guidance PH9. Community engagement.**
- The **NICE shared learning database** offers examples of how organisations have implemented NICE guidance locally.
- **NICE public health guidance PH18. Needle and syringe programmes: Implementation advice slide set, costing template and commissioner’s factsheet.**
- **NICE public health guidance PH4. Interventions to reduce substance misuse among vulnerable young people.**
- **NICE clinical guideline CG52. Drug misuse: opioid detoxification.**
- **NICE clinical guideline CG51. Drug misuse: psychosocial interventions.**
- **NICE technology appraisal TA114. Methadone and buprenorphine for the management of opioid dependence.**
- **NICE technology appraisal TA115. Naltrexone for the management of opioid dependence.**
- **NICE technology appraisal TA96. Adefovir dipivoxil and peginterferon alfa-2a for the treatment of chronic hepatitis B.**
- **NICE technology appraisal TA106. Peginterferon alfa and ribavirin for the treatment of mild chronic hepatitis C.**
- **NICE technology appraisal TA75. Interferon alfa (pegylated and non-pegylated) and ribavirin for the treatment of chronic hepatitis C.**
Determining local service levels for needle and syringe programmes

**Benchmark for a standard population**

Commissioners should ensure that services aim to increase the proportion of people who have over 100% ‘coverage’ (that is, the proportion who have more than one sterile needle and syringe available for every injection) and increase the proportion of people from each group of injecting drug users who are in contact with NSPs.

The indicative benchmark rate for needle and syringe programmes (NSPs) is therefore, individual ‘coverage’ of over 100% (that is, each individual having more than one sterile needle and syringe available for every injection).

For a population of 100,000 the average number of needles and syringes distributed would be at least **85,000 per year** (to provide each individual with over 100% coverage). This is based on the assumption that each person who injects drugs accesses an NSP either directly or indirectly. Currently 90% of people who inject drugs may access NSPs in a given year. The proportion who routinely access an NSP is likely to be much lower. We have used the assumption of 100% since it reflects optimal service provision (complete coverage for a given population). Examine the remaining assumptions used in estimating these figures.

This service is likely to be funded by the **pooled treatment budget** and/or fall under the **programme budgeting** category 205A mental health disorders – substance misuse.

Use the NSP **commissioning and benchmarking tool** to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

**Further information**

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- **Coverage calculator** assesses the coverage of needles and syringes locally and determines the number of needles and syringes required to achieve individual coverage of over 100%.
- Annex A of the **Commissioning framework for health and well-being** outlines the process and data needed to undertake a joint strategic needs assessment.
- Department of Health **Delivering quality and value – focus on benchmarking**.
- **NICE Health equity audit – learning from practice briefing**.
• National Treatment Agency for Substance Misuse [Needs assessment and treatment planning templates and guidance.](#)
• [Association of Public Health Observatories](#) provides a summary of key health indicators for each local council in England.
Assumptions used in estimating a population benchmark

The assumptions used in estimating the number of needles and syringes required for a benchmark of over 100% coverage (that is, each individual having more than one sterile needle and syringe available for every injection) are based on the following sources of information:

- **epidemiological data** on the prevalence of injecting drug use
- **expert opinion** of the topic-specific advisory group, based on practice and literature review.

For the purpose of this commissioning guide the adult population has been defined as people aged between 15 and 64 years. This is because of the availability of prevalence data on injecting drug use. Approximately 66% of the population in England is aged between 15 and 64 years. The recommendations in NICE public health guidance PH18 on needle and syringe programmes relate to people aged 18 years and older.

**Epidemiological data**

The true extent of injecting drug use is difficult to determine. Latest data suggest the number of injecting drug users aged 15–64 years in England is between 115,000 and 122,000\(^1\), although it could be over 200,000. Prevalence varies across regions, ranging from around 3 per 1000 in London, the East and the South East to 6 per 1000 in Yorkshire and the Humber. These estimates relate to people injecting heroin, other opiate drugs or crack cocaine, and do not include people injecting performance and image-enhancing drugs (PIEDs) such as anabolic steroids.

The proportion of people who frequently access a needle and syringe programme (NSP) is not known. The 2007 Unlinked Anonymous Prevalence Monitoring Programme’s survey\(^2\) found that, in England, around 90% (2757 of 3025) of people who inject drugs (or have previously injected drugs) reported that they had accessed a NSP. In the UK, 86% (415 of 480) of recent initiates (people who reported first injecting during the previous 3 years) had contact with NSPs. However, both these figures are likely to include people who may have accessed an NSP infrequently in a year.

According to the National Treatment Agency for Substance Misuse report Findings of a survey of needle exchanges in England there is large variability between services in the number of contacts (visits) per client and the total number of syringes given out in a drugs (and alcohol) action team area, as well as wide differences in the numbers of syringes given to clients per contact per year.

The number of needles and syringes and other equipment needed in a locality to achieve individual coverage of over 100% depends on many factors. These include the prevalence of injecting drug use, the proportion of people who...
inject drugs who are receiving opioid substitution therapy (OST) and the proportion of people who inject drugs who access other treatment services.

**PH18 Needle and syringe programmes: economic modelling – revised full report (2008)** used data collected from Bristol and Teesside that suggests the proportion of people who inject drugs and receive OST is 50–75%. This estimate is likely to vary around the country.

The National Treatment Agency for Substance Misuse and the Department of Health provide an online coverage calculator as part of their harm reduction works campaign. The coverage calculator allows the modelling of key factors that impact on the adequacy of local provision of needles and syringes. It does not provide definitive estimates of need because of uncertainty in the accuracy of estimates at a local level, but when taken together with relevant local knowledge, it can enhance commissioner discussions of the suitability of their needle and syringe programme provision.

The tool requires the average number of injections per day per person out of treatment and the average number of injections per day per person in treatment.

The default settings for these are:

- three needles and syringes are needed each day for each person injecting drugs not in treatment
- one needle and syringe is needed approximately every 3 days for people receiving OST.

**Expert opinion**

The proportion of injecting drug users who are receiving OST is likely to vary across the country and commissioners will need to take this into account when assessing service need. The consensus opinion of the topic-specific advisory group is that 75% is the optimal proportion of people who inject drugs who could also be receiving OST, and this proportion is therefore considered appropriate to use in the benchmark.

The 2008 British crime survey reports that 0.1% of people aged 16–59 have injected PIEDs. Commissioners will need to consider the needs of people who inject PIEDs when planning services, since recent anecdotal reports from across the country suggest that the use of anabolic steroids is on the increase, particularly among young men, and that this group is increasingly accessing NSPs for their own use and for secondary distribution.

The number of needles and syringes provided to people who inject PIEDs and other drugs such as stimulants is not included in the coverage provided by the coverage calculator or the commissioning and benchmarking tool; therefore commissioners will need to include these numbers when considering the overall requirements and cost of an NSP.
Conclusions

Based on the epidemiological data and other information outlined above, it is concluded that to achieve individual coverage of over 100% for a population of 100,000, the number of needles and syringes required would be at least 85,000 per year. This is based on the following assumptions:

- 66% of the base population are aged 15–64 years (the same age profile as the English population in 2007)
- the prevalence of injecting drug use is 0.35% of the population aged 15–64 years (the national mean prevalence of injecting drug use)
- 100% of people who inject drugs access NSPs (suggested by the topic-specific advisory group)
- 75% of people who inject drugs receive OST (based on information presented in the economic modelling above)
- one needle and syringe is needed approximately every 3 days for people receiving OST
- three needles and syringes are needed each day for each person injecting drugs and not receiving OST.

Commissioners and providers will need to use local data to determine the number of needles and syringes currently supplied and may wish to use the coverage calculator link to determine current coverage and the number of needles and syringes needed to reach the benchmark rate of over 100% individual coverage.

Commissioners can use the NSPs commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

References


The commissioning and benchmarking tool

**Download the needle and syringe programmes commissioning and benchmarking tool**

Use the needle and syringe programmes (NSPs) commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service, as described below.

**Identify indicative local service requirements**

The indicative benchmark is over 100% coverage (that is, each individual having more than one sterile needle and syringe available for every injection), which for a notional population of 100,000 equates to around 85,000 needles and syringes per year.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographic, you can amend the benchmark to better reflect your local circumstances. For example, if your population has a significantly lower or higher number of injecting drug users, you may need to provide a lower or higher number of needles and syringes per year to achieve individual coverage of over 100%.

The number of needles and syringes provided for people who inject performance and image-enhancing drugs (PIEDs) such as anabolic steroids are not included in this calculation, but may be included in the tool when calculating the current and planned costs of NSPs.

**Review current commissioned activity**

You may already commission NSPs for your population. The tool provides tables that you can populate to help you calculate your current coverage (excluding needles and syringes distributed to people who inject PIEDs) and the costs associated with your NSPs.

**Identify future change in capacity required**

Using the indicative benchmark provided, or your own local benchmark, you can use the commissioning and benchmarking tool to compare the activity that you might need to commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.

**Model future commissioning intentions and associated costs**

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark level, and to model the required changes over a period of 3 years.
Use the commissioning and benchmarking tool to calculate the level and cost of activity you intend to commission and to consider the settings in which NSPs might be provided, comparing the costs of commissioning the service across the various settings. The commissioning and benchmarking tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and take into account the views of local people. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.
Ensuring corporate and quality assurance

Commissioners should ensure that the services they commission represent value for money and offer the best possible outcomes for clients, their families and communities. Commissioners need to set clear specifications for monitoring and assuring quality in the service contract.

Commissioners should ensure that they consider both the clinical and economic viability of the service, and any related services, and take into account service users’ views and those of other stakeholders when making commissioning decisions.

Needle and syringe programmes (NSPs) need to:

- be effective and efficient
- be responsive to the needs of clients, their families and communities
- provide services based on best practice, as defined in NICE public health guidance PH18 on needle and syringe programmes
- deliver the required capacity
- be integrated with other elements of care for people who use drugs
- define agreed criteria for referral, local protocols and the care pathway for people who inject drugs
- be client-centred and provide equitable access, ensuring that clients are treated with dignity and respect, are fully informed about their care and are able to make decisions about their care in partnership with relevant professionals
- consider and respond to recommendations arising from any audit or from serious untoward or client safety incidents
- demonstrate how they meet requirements under equalities legislation
- demonstrate value for money.

Local quality assurance

Any mechanisms for quality assurance at a local level are likely to refer to the following.

- Service and performance targets, including estimated activity levels and case mix, complaints procedures.
- Clinical governance arrangements, including incident reporting.
- Clinical quality criteria: appropriateness of referral, consenting procedures, clinical protocols.
- Audit arrangements: frequency of reporting, reporting route and format, and dissemination mechanisms; arrangements should include auditing, equipment return rates, training, number of referrals to
specialist services, number of staff vaccinated against hepatitis B, and monitoring of patient outcomes and complications (see audit support for NICE public health guidance PH18 on needle and syringe programmes for further information).

- **Health, safety and security**: infection prevention, health and safety training for staff, safe disposal of used equipment, waste management, confidentiality procedures, legislative requirements, needle stick injury protocols and hepatitis B vaccination for staff.

- **Equipment**: plans on how equipment will be stored and distributed throughout the area.

- **Client and service user experience**: using the national patient survey; taking into account perspectives and perception of service provision to help shape services; engagement to inform commissioning decisions; complaints.

- **Outcomes**: numbers receiving hepatitis C testing, numbers vaccinated against hepatitis A and B, numbers referred for opioid substitution therapy (OST), numbers who take up offer of OST, numbers who stop injecting, reduced numbers of drug-related deaths.

- **Staff competencies**: individual and team baseline requirements, monitoring and performance.

- **Information requirements**, non-identifiable data, aggregate data on the distribution and return of injecting equipment plus limited information on the client profile in line with data collected for National Drug Treatment Monitoring System and the Needle Exchange Monitoring System.

- **The process for reviewing the service with stakeholders**, including decisions on changes necessary to improve or to decommission the service.

- Achieving targets associated with equalities legislation.

**Further information**

**General information** on quality and corporate assurance can be obtained from the following sources:

- The National Patient Safety Agency (NPSA) oversees the implementation of a system to report and learn from adverse events and near misses occurring in the NHS. The publication ‘Seven steps to patient safety’ provides an overview of patient safety and gives updates on the tools that the NPSA is developing to support patient safety across the health service.

- NHS Alliance online resources. NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.
• The **DH commissioning framework** provides guidance on the commissioning process in the context of the NHS reform agenda.

• NHS Institute for Innovation and Improvement support for commissioners, includes **Commissioning for Health Improvement** products to accelerate the achievement of world class commissioning; **The Productive Leader** programme to enable leadership teams to reduce waste and variation in personal work processes, and **Better care, better value indicators** to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care, and to generate ideas on how to achieve these savings.

• **10 Steps to your SES: a guide to developing a single equality scheme.** This guidance has been developed to assist NHS organisations that have a duty, as public authorities, to comply with the race, disability and gender public sector duties, and in anticipation of new duties in relation to age, religion and belief, and sexual orientation.

**Specific information** on quality and corporate assurance for NSPs can be obtained from the following sources:

• The **National Treatment Agency for Substance Misuse** is a special health authority established by the Government to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

• Royal College of General Practitioners **Certificate in the Management of Drug Misuse** includes an online harm reduction module. The certificate is endorsed by the National Treatment Agency for Substance Misuse and is available for pharmacists, nurses, drug workers and other healthcare professionals.

• **NHS North West Community Pharmacy Enhanced Services Harmonisation of Accreditation** defines the core competencies for pharmacists wishing to provide a specified enhanced service.

• **Implementing care closer to home – providing convenient quality care for patients: a national framework for Pharmacists with Special Interests** published by the Department of Health and NHS Primary Care Commissioning; provides guidance and a competency framework.
Topic-specific Advisory Group

A topic-specific advisory group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

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