NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

PUBLIC HEALTH DRAFT GUIDANCE

Needle and syringe programmes (update)

Introduction: scope and purpose of this draft guidance

This guidance is an update of Needle and syringe programmes: providing people who inject drugs with injecting equipment, NICE public health guidance 18 (2009).

See 'About this guidance' for details of how the guidance was developed.

What is this guidance about?

This guidance is an update of, and will replace, 'Needle and syringe programmes: providing people who inject drugs with injecting equipment', NICE public health guidance 18 (2009). It aims to support the commissioning and provision of needle and syringe programmes, including those provided by pharmacies and drugs services.

In addition, the guidance has been extended to focus on providing needle and syringe programmes (NSPs) for young people aged under 16 who inject drugs and users of performance and image-enhancing drugs.

The term 'drugs' is used in this guidance to mean: opioids (for example, heroin); stimulants (for example, cocaine) either separately or in combination (speedballing); novel psychoactive substances ('legal highs', for example, mephedrone); performance- and image-enhancing drugs (for example, anabolic steroids); and other drugs (for example, ketamine).

The draft recommendations cover:

- community consultation and involvement

- collating and analysing data
- meeting local need
- monitoring services
- developing a policy for young people aged under 16
- providing a mix of services
- providing equipment and advice
- community pharmacy-based needle and syringe programmes
- specialist needle and syringe programmes: level 3 services
- providing needle and syringe programmes for users of performance- and image-enhancing drugs.

Who is this guidance for?

The guidance is for commissioners and providers of needle and syringe programmes and those with a remit for infectious disease prevention. This includes those working in: drug services, pharmacies, local authorities and the wider public, voluntary and community sectors.

It may also be of interest to people who inject drugs, their families and other members of the public.

Contents

1 Draft recommendations

The Public Health Advisory Committee (PHAC) considers that the recommended approaches are cost effective.

The evidence underpinning the recommendations is listed in The evidence.

See also Needle and syringe programmes (update) for the full reports of the supporting evidence.

For the research recommendations and gaps in research, see Recommendations for research and Gaps in the evidence respectively.

Needle and syringe programmes

Needle and syringe programmes (NSPs) supply needles and syringes for people who inject drugs. In addition, they often supply other equipment used to prepare and take drugs (for example, filters, mixing containers and sterile water). The majority of needle and syringe programmes are run by pharmacies and drug services. They may operate from fixed, mobile or outreach sites.

The main aim of needle and syringe programmes is to reduce the transmission of blood-borne viruses and other infections caused by sharing injecting equipment. Many also aim to reduce the other harms caused by injecting and provide:

- advice on safer injecting practices
- advice on minimising the harm done by drugs, including performance and image-enhancing drugs
- advice on how to avoid and manage an overdose
- information on the safe handling and disposal of injecting equipment
- access to blood-borne virus testing, vaccination and treatment services
- help to stop injecting drugs, including access to drug treatment (for example, opioid substitution therapy) and encouragement to switch to safer drug taking practices, if these are available
- other health and welfare services (including condom provision).

Whose health will benefit?

The recommendations aim to reduce the harm caused to people who inject drugs. This, in turn, will reduce the prevalence of blood-borne viruses and bacterial infections, so benefiting wider society.

Recommendation 1 Community consultation and involvement

Who should take action?

- Health and wellbeing boards.
- Commissioners of:
  - drug services
  - infectious disease services
  - pharmacy services
  - primary care services.
- Public health practitioners whose remit includes needle and syringe programmes (NSPs) and infectious disease prevention.

What action should they take?

- To help assess the need for, and to plan, a needle and syringe programme, consult:
  - different groups of people who inject drugs (including both those who use a needle and syringe programme and those who don't)
  - families and carers of people who inject
  - frontline workers in needle and syringe programmes and related services.
- Consult local communities about how best to implement new or reconfigured needle and syringe programmes. Promote the benefits of the service. For example, explain how it will help reduce drug-related litter by providing safe disposal facilities such as drop boxes and sharps bins.

For further recommendations on community engagement, see Community engagement to improve health (NICE public health guidance 9).

Recommendation 2 Collating and analysing data

Who should take action?

- Health and wellbeing boards.
- Commissioners of:
    - drug services
    - infectious disease services
    - pharmacy services
    - primary care services.
- Public health practitioners whose remit includes needle and syringe programmes (NSPs) and infectious disease prevention.

What action should they take?

- Collate and analyse local data from Public Health England and other sources to estimate the:
    - Prevalence and incidence of infections related to injecting drug use (for example, hepatitis C and acute septicaemia) and other problems caused by injecting drug use (for example, number of people overdosing).
    - Numbers, demographics, types of drugs used and other characteristics of people who inject, for example:
        - ◊ rates of poly-drug use
        - ◊ number of young people (aged under 16) who are injecting
        - ◊ number of performance and image-enhancing drugs users
        - ◊ people who inject occasionally, for example, when they go to night clubs
        - ◊ other at-risk groups, such as sex workers or homeless people.
    - Number and percentage of injections covered by sterile needles and syringes in each of the groups identified above. (That is, the number and percentage of occasions when sterile equipment was available to use.)

  - Number and percentage of people who had more sterile needles and syringes than they needed (more than 100% coverage).
  - Number and percentage of people who inject drugs and who are in regular contact with a needle and syringe programme. (The definition of regular will vary depending on the needle and syringe programme user and the types of drugs they use.)

- Map other services that are commonly used by people who inject drugs, for example, opioid substitution therapy services, homeless services and custody centres.

Recommendation 3 Meeting local need

Who should take action?

- Health and wellbeing boards.

- Commissioners of:
  - drug services
  - infectious disease services
  - pharmacy services
  - primary care services.

What action should they take?

- Ensure the results of consultation and data analysis (see recommendations 1 and 2) form part of the local joint strategic needs assessment.

- Commission a range of generic and targeted needle and syringe programmes to meet local need, based on these results. For example, ensure services are offered at a range of times and in a number of different locations. Take the geography of the area covered into account (for example, whether it is an urban or rural area). Targeted services should focus on the specific groups identified.

- Ensure services aim to:
  - Be accessible.

  - Increase the proportion of people who have more than 100% coverage (that is, the number who have more than 1 sterile needle and syringe available for every injection).
  - Increase the proportion of each group of people who inject drugs who are in contact with a needle and syringe programme.
  - Ensure syringes and needles are available in a range of sizes and at a range of locations throughout the area.
  - Encourage identification schemes (involving, for example, the use of coloured syringes).
  - Consider supplying low dead-space injecting equipment (if this can be obtained at equivalent prices).
  - Offer advice and information on services that aim to: reduce the harm associated with injecting drug use; encourage people to stop using drugs or to switch to a safer approach if one is available (for example, opioid substitution therapy); and address their other health needs. Where possible, offer referrals to those services.

- If applicable, commission outreach or detached services for areas where there are high levels of drug use or populations that do not use existing needle and syringe programmes.

- Develop plans for needle and syringe disposal, in line with Tackling drug-related litter (Department for Environment, Food and Rural Affairs 2005). Include the provision and disposal of sharps boxes for the safe disposal of needles. Consider providing public sharps bins (drop boxes) in areas where drug-related litter is common. Work with members of the local community, people who inject drugs and the local police service to agree the location for drop boxes.

- Commission integrated care pathways for people who inject drugs so that they can move seamlessly between the full range of services, including treatment services.

Recommendation 4 Monitoring services

Who should take action?

- Commissioners and providers of needle and syringe programmes (NSPs).
- Public health practitioners whose remit includes needle and syringe programmes and infectious diseases.

What action should they take?

- Providers of needle and syringe programmes should collect data on service usage:
    - All services should monitor the number and types of packs or equipment they distribute.
    - Specialist services should collect more detailed data on: the amount and type of equipment distributed, the demographic details of the person who is injecting, along with details of their injecting practices and the drugs they are injecting (see recommendation 2).
- Commissioners of needle and syringe programmes and public health practitioners should ensure a local mechanism is in place to aggregate and analyse the data collected on an annual basis. The aim is to build up a picture of injecting in the local area. This data should be used as part of the collecting and analysing data process (see recommendation 2).
- Ensure local service use data are available, in anonymised form for relevant national bodies and research units.

Recommendation 5 Developing a policy for young people aged under 16

Who should take action?

- Children's safeguarding boards.
- Commissioners and providers of needle and syringe programmes.
- Commissioners and providers of young people's services.

What action should they take?

- Work together to agree a local, area-wide policy on providing needle and syringe programmes and related services to meet the needs of different groups of young people aged under 16 who inject drugs.

- Make the governance responsibilities of drug services and safeguarding boards clear. The safeguarding board should approve the local policy.

- Ensure the policy covers the following:
  - How to achieve the right balance between protecting (safeguarding) the young person and providing them with advice on harm reduction and other services. This should take due account of: the young person's capacity to consent; the risks they face; the benefits of them using services; and the likelihood that they would inject anyway even if sterile needles and syringes were not provided.
  - How to encourage young people to ask for advice and help from staff providing the services (as well as, or instead of, providing them with needles, syringes and injecting equipment).
  - How to assess service users: their age and how mature they are; the degree or seriousness of their drug misuse; whether the harm or risk they face is continuing or increasing; and the general context in which they are using drugs.
  - The skills, knowledge and awareness that staff need to provide services.
  - Parental or carer involvement: generally this should be encouraged, although it is not always possible or appropriate.
  - Pharmacy provision: pharmacies with staff trained in assessing young people's competence to consent may be suitable venues for providing young people with needles, syringes and injecting equipment, if the young person is also encouraged to make contact with specialist services.
  - The role of needle and syringe programmes as part of a range of services for young people and including seamless transition from youth to adult services.

- Regularly review the policy.

Recommendation 6 Providing a mix of services

Who should take action?

- Health and wellbeing boards.

- Commissioners of:
    - drug services
    - infectious disease prevention services
    - pharmacy services
    - primary care services.

What action should they take?

- Use pharmacies, specialist needle and syringe programmes and other settings, and approaches, including outreach and detached services, to provide geographical coverage and a balanced mix of the following levels of service:
    - Level 1: distribution of injecting equipment either loose or in packs, suitable for different types of injecting practice, 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 the harms caused by injecting drugs).
    - Level 3: level 2 plus provision of, or referral to, specialist services (for example, specialist clinics, vaccinations, drug treatment and secondary care).

- Coordinate services to ensure injecting equipment is available throughout the local area for a significant time during any 24-hour period. For example, encourage needle and syringe provision in pharmacies with longer opening hours. Or increase capacity through the use of out-of-hours vending machines for groups that wouldn't otherwise have access to services – or not at the time that they need them.

- 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 for treatment of adult drug misusers: update (2006).

Recommendation 7 Providing equipment and advice

Who should take action?

Needle and syringe programme (NSP) providers.

What action should they take?

- Provide people who inject drugs with needles, syringes and other injecting equipment. The quantity provided should not be subject to a limit but, rather, should meet their needs. Where possible, make needles available in a range of sizes and colours and provide syringes in a range of sizes.

- Do not discourage people from taking equipment for other people (secondary distribution), but ask them to encourage those people to use the service themselves.

- Ensure people who use needle and syringe programmes are provided with sharps bins and advice on how to dispose of needles and syringes safely.

- Provide advice relevant to the type of drug and injecting practices, especially risky practices such as injecting in the groin or neck.

- Provide other equipment associated with injecting drugs and encourage people who inject drugs to switch to a safer method, if one is available.

- Encourage people who inject drugs to mark their syringes and other injecting equipment or to use easily identifiable equipment to prevent sharing.

- Encourage people who inject drugs to use other services that aim to: reduce the harm associated with injecting drug use; encourage them to stop using drugs or to switch to safer methods if these are available (for example, opioid substitution therapy); and address their other health needs. Advise them where they can access these services.

Recommendation 8 Community pharmacy-based needle and syringe programmes

Who should take action?

- Community pharmacies that run a needle and syringe programme (NSP), regardless of the level of service they offer (see recommendation 6).
- Coordinators and commissioners of community pharmacy-based needle and syringe programme services.

What action should they take?

- Ensure staff who distribute needles and syringes have received 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 people in a non-stigmatising way.
- Ensure staff providing level 2 or 3 services (see recommendation 6) are trained to provide advice about the full range of drugs that people may use. In particular, they should be able to advise on how to reduce the harm caused by injecting and how to prevent and manage an overdose.
- Ensure staff have received health and safety training, for example, in relation to blood-borne viruses, needlestick injuries and the safe disposal of needles and syringes and other sharp equipment.
- Ensure hepatitis B vaccination is available for staff directly involved in the needle and syringe programme.
- Encourage people who inject drugs to access other healthcare services, including drug treatment.
- Provide sharps bins and advice on how to dispose of needles and syringes safely. In addition, provide a service for safe disposal of used bins.

Recommendation 9 Specialist needle and syringe programmes: level 3 services

Who should take action?

Specialist needle and syringe programmes (including pharmacies offering a level 3 service).

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 have received 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. If 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 for hepatitis B, hepatitis C and HIV
    - specialist (non-needle and syringe programme [NSP]) services for performance and image-enhancing drug users
    - specialist youth services (for young people aged under 16 who inject)
    - other specialist clinics and services
    - 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).

Recommendation 10 Providing needle and syringe programmes for people who inject performance and image-enhancing drugs

Who should take action?

- Providers of needle and syringe programmes.
- Public health practitioners with a remit for needle and syringe programmes and for the prevention of infectious diseases.

What action should they take?

- Ensure needle and syringe programmes:
  - Are provided at times and in places that meet the needs of people who inject performance and image-enhancing drugs. (For example, by offering outreach or detached services in gyms or services outside normal working hours.)
  - Provide the equipment needed to support these users.
  - Are provided by appropriately trained staff (in line with recommendation 8 and recommendation 9).

- Needle and syringe programmes (including pharmacies) that are used by a high proportion of people who take performance and image-enhancing drugs should provide more specialist services for this group. This includes:
  - specialist advice about stacking (using multiple products) and cycling (the length of time you take them for)
  - specialist advice about performance and image-enhancing drugs
  - specialist advice about the side effects of these drugs

- alternatives to using these drugs (for example, nutrition and physical training can be used an alternative to anabolic steroids)
- information about, and referral to, sexual health services for anabolic steroid users
- information about, and referral to, specialist performance and image-enhancing drugs clinics, if these exist locally.

2 Public health need and practice

Background

Although it is difficult to estimate, figures suggest that the prevalence of opiate and crack cocaine injecting is in decline. The most recent figures (for 2010/11) suggest that an estimated 93,400 people who inject opiates and/or crack in England (Hay et al. 2011). Prevalence seems to vary across regions.

In 2006, almost one-quarter (23%) of respondents to the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) reported sharing needles and syringes in the previous 4 weeks. Almost half (45%) reported that they had shared filters, mixing containers and water within that time (Health Protection Agency et al. 2007).

Between 2001 and 2011, the number of people who inject drugs and are in contact with specialist services who reported sharing needles and syringes declined from 33% to 17% (Health Protection Agency 2012a).

The number of opiate-related (heroin or methadone) deaths has decreased over the years. However, over the past decade (2002–2010), they have accounted for around two-thirds of all drug-related deaths in the UK (Davies et al. 2012). Although not all opiate-related deaths occur in people who inject, it is thought that the vast majority do.

Sharing needles and syringes is a key route for transmitting blood-borne viruses among users. Sharing injecting equipment such as filters, mixing containers and water is also an important route of infection, particularly in the case of the hepatitis C virus. Data suggests that needle and syringe programmes are being accessed by increasing numbers of people who inject drugs across the UK. However, ‘there

remains a need to increase the amount of equipment distributed, with better targeting of this provision and education on appropriate needle and syringe cleaning techniques', according to Public Health England (Hepatitis C in the UK 2013 report).

Hepatitis C is still the most widespread infectious disease affecting people who inject drugs, with 43% testing positive for antibodies in 2011 (Health Protection Agency 2012a). In contrast, HIV prevalence has remained relatively low among injecting drug populations over the last decade (Health Protection Agency 2012b). In addition, the prevalence of hepatitis B infection has declined (Health Protection Agency 2010).

Performance and image-enhancing drugs

Information is limited regarding the number of people using performance and image-enhancing drugs. Anabolic steroid use is relatively widespread, with an estimated 70,000 people aged 16–59 years in England and Wales having used them in the past year (Home Office 2012).

UK data suggest that the majority of people who use anabolic steroids inject them (Advisory Council on the Misuse of Drugs 2010), putting them at risk of bacterial and fungal infections and the transmission of blood-borne viruses. The risk of blood-borne virus transmission among people who inject performance and image-enhancing drugs may be lower than among groups who inject other drugs. However, a recent analysis estimated that the prevalence of HIV among men who inject these drugs is similar to that among people who inject psychoactive drugs. The authors urge targeted interventions for this group (Hope et al. 2013).

Users of performance and image-enhancing drugs may represent a significant proportion of the people who use needle and syringe programmes (Lenehan et al. 1996). There is evidence that people who inject steroids visit these services fewer times a year – collecting larger numbers of syringes in a single visit – than other users (McVeigh et al. 2003). Interviews with steroid injectors indicate that they often distribute injecting equipment among themselves (secondary distribution) (McVeigh et al. 2007).

In addition to anabolic steroids, increasing numbers of new products are being injected. These include growth hormone and novel drugs (such as those that claim to

stimulate secretion of growth hormone), IGF-1 and analogues, and human chorionic gonadotrophin, which may enhance physical performance (Evans-Brown et al. 2012). They also include melanotans – products that claim to contain melanotan II (and to a lesser extent melanotan I). These are injected to look tanned and, in the case of melanotan II and bremelanotide, for their effect on sexual behaviour and function.

Although it is not known how many people use these new products, researchers have been alerted to their use in the general population through needle and syringe programmes seeking information after clients reported injecting these types of drugs (Evans-Brown et al 2009). It is not known how many people in the United Kingdom use drugs such as botulinum toxin or dermal fillers to reduce the appearance of wrinkles and lines but a number of factors suggest that there may considerable interest in these types of products among the general population (Evans-Brown et al. 2012).

Young people who inject drugs

Prevalence of drug injecting is higher among the 25–34 age group (17.9 per 1000) than the 15–24 age group (6.9 per 1000) (Davies et al. 2010). It is not known how many under-16s in England and Wales are involved.

Data from the National Treatment Agency suggest that in 2011/12, 156 young people aged 17 or under who were in drug treatment were currently injecting drugs, and 257 of this group had experience of injecting. This is a decrease from 2010/11.

Data from the Health Protection Agency's unlinked anonymous survey of people who inject drugs suggest that in 2011, out of 2838 participants, 0.6% were under 18 (n=16) and 23% reported first injecting before age 18 (n=509). These numbers will represent a minority of young people who inject drugs, because UK evidence suggests that only 25% of this group are in treatment at any one time (Hickman 2004). It also suggests the proportion in treatment may be smaller for under-18s.

Evidence also suggests that among young people, vulnerable groups are more likely to inject drugs. This includes:

- young offenders and those who are homeless or involved in sex work (Cusick et al. 2003)
- those excluded from school (Melrose 2004)
- young people with parents with drug or alcohol problems (Advisory Council on Misuse of Drugs 2003)
- those who are, or have been, in care (Ward et al. 2003).

Government action

The government's drug strategy, published in 2010, aims to reduce illicit and other harmful drug use. It also encourages an integrated approach to supporting people who want to recover from drug use.

In line with this emphasis on recovery, there is little mention of needle and syringe programmes. However, the strategy does mention how needle and syringe programmes, alongside treatment programmes, can help 'reduce the harms caused by dependence such as the spread of blood-borne viruses like HIV'.

3 Considerations

The Public Health Interventions Advisory Committee (PHIAC) for the original NICE guidance on needle and syringe programmes (NICE public health guidance 18, 2009) took account of a number of factors and issues when developing the recommendations. Many of these are still relevant (see 3.1 to 3.7 below) and informed the discussions of the Public Health Advisory Committee (PHAC) responsible for updating the guidance. In addition, PHAC took account of a number of additional factors and issues (see 3.8 to 3.19 below).

Please note: this section does not contain recommendations. (See Recommendations.)

3.1 Needle and syringe programmes (NSPs) need to be considered as part of a comprehensive substance-misuse strategy that covers prevention, treatment and harm reduction.

3.2 The remit of this guidance was to consider the optimal provision of NSPs, not whether or not these programmes should be provided. Evidence from

systematic reviews shows that NSPs are an effective way to reduce some of the risks associated with injecting drugs.

3.3 The ethical issues and social values related to NSPs were discussed in some depth. The Public Health Interventions Advisory Committee (PHIAC) noted that it is difficult to meet the health needs of people who inject drugs without appearing to condone or 'normalise' drug use, especially in young people. It also noted that NSPs can reduce only some of the potential harms associated with injecting drug use. Furthermore, NSPs might have disadvantages; for example, they may deter people who inject drugs from using safer forms of drug taking or from quitting their habit altogether. On the other hand, NSPs can provide a means of contact with people who inject drugs and, hence, opportunities for harm reduction as well as support to help them stop injecting. NSPs can also help reduce blood-borne infections among people who inject drugs, to the benefit of society at large. After considering these issues at some length PHIAC felt that, on balance, recommendations on the optimal provision of NSPs were justified.

3.4 Most published research was conducted in the USA. However, PHIAC judged that some of the evidence was applicable to England and could be used to inform the recommendations.

3.5 The coverage provided by NSPs has been defined in a number of ways. The World Health Organization (2007) uses 3 definitions of 'coverage':

- percentage of injections 'covered' by sterile needles and syringes
- number of needles and syringes supplied to each injecting drug user per year
- percentage of injecting drug users in regular contact with NSPs.

PHIAC used the first definition above to describe 'coverage': that is, 'coverage' in this guidance means the percentage of injections for which sterile equipment was available to use.

3.6 Local communities need information about the aims of an NSP and evidence of its effectiveness when proposals are put forward for siting one in their neighbourhood.

3.7 PHIAC emphasised the important 'gateway' function that NSPs may perform in bringing people who inject drugs into contact with a range of services. In particular, NSPs may bring them into contact with services that may help by:

- emphasising the dangers of overdosing (about 1% of people who inject drugs die of an overdose each year)
- encouraging people to switch to less harmful forms of drug taking
- encouraging people to opt for opioid substitution therapy
- encouraging people to stop using drugs
- encouraging people to be tested and treated for hepatitis C and HIV
- encouraging people to address their other health needs.

The Public Health Advisory Committee (PHAC) took account of a number of additional factors and issues when developing the updated recommendations, as follows.

3.8 PHAC noted that only a small amount of evidence had been published since the previous guidance, especially in relation to young people's drug use and the use of performance and image-enhancing drugs. Furthermore, most of this evidence came from outside the UK. In response, PHAC used Committee members' own knowledge and experience to extrapolate from the evidence and add further detail to the recommendations,

3.9 PHAC noted the need to balance the number of people who have a sterile needle and syringe for each injection (coverage), with the number of people in direct contact with the NSP. Overall, members felt it was more important to achieve high rates of coverage, because this is the biggest predictor of sterile needle and syringe use. On this basis, the Committee felt that it was acceptable to knowingly provide equipment for secondary

distribution (whereby drug users pass on sterile needles and syringes to others).

3.10 Some evidence suggests that 100% coverage among 60% of the population is enough to slow the spread of bloodborne viruses and bacterial infections among people who inject drugs. However, higher coverage rates will have more of an impact. On this basis, PHAC retained the target of more than 100% coverage, as set out in the recommendations made in NICE public health guidance 18. The Committee also noted the need to monitor coverage rates for different sub-populations – not just for the overall population.

3.11 PHAC noted that needle and syringe vending machines seem to attract a different type of injector to needle and syringe programmes, notably young people and others at very high risk from injecting drugs. The Committee considered that they were a good way of providing additional, out-of-hours services – but not as a cheaper alternative to staffed NSP services.

3.12 PHAC discussed the distinction between people who regularly inject drugs and those who inject occasionally. The evidence was not clear enough to make a specific recommendation for the latter. However, the Committee agreed that it was important to provide them with a service.

3.13 PHAC discussed at length the potential conflict between safeguarding young people and vulnerable adults who inject drugs and the need to provide them with harm reduction services, including sterile needles and syringes. The Committee was clear that a balance needed to be struck. It noted the need for professionals with skills in delivering needle and syringe programmes and with expertise in assessing young people from a safeguarding perspective. Members felt that, with adequate support, this could fall within the remit of both specialist workers and many community pharmacists.

3.14 PHAC discussed how parents and carers could be consulted and involved when their children are using needle and syringe programmes. However,

the Committee did not have enough evidence to make a recommendation on how to do this.

3.15 PHAC agreed that a societal focus on abstinence (that is to say, to encourage people to stop taking drugs completely) should not compromise the provision of needle and syringe programmes and any associated harm-reduction initiatives.

3.16 PHAC discussed the lack of information available about the needs of specific populations of people who inject. It also discussed innovative ways of reaching them to reduce the harms associated with injecting (see research recommendation 4.2).

3.17 PHAC considered a summary of the findings from the health economic modelling undertaken for the original guidance. This showed that providing people who inject opioid drugs with sterile injecting equipment is estimated to be cost effective from an NHS/personal social services (PSS) perspective (that is, excluding the costs of crime). It is similarly cost effective from a societal perspective. If the indirect 'gateway' effects of needle and syringe programmes – of increasing the proportion of people who inject drugs who take up opioid substitution therapy, or take part in other drug treatment – are included, a fall in the number who inject drugs is likely. This would, in turn, lead to a reduction in crime. If that is the case, modelling shows that these programmes are likely to be cost effective in the longer term. However, the figures in relation to the size of the 'gateway effect' are subject to considerable uncertainty, as are figures relating to any effect that an increase in needle and syringe programmes will have on the number of people injecting drugs.

3.18 PHAC noted that there are insufficient data relating to young people aged under 16 who inject drugs to populate the economic model. However, PHAC thought that the findings are unlikely to differ significantly from people over that age. In fact, the benefits of needle and syringe programmes are probably greater for this group because they are more likely to reuse or share equipment. The marginal costs of extending

provision to young people aged under 16 would be lower than the average cost for existing users.

3.19 PHAC noted that there are insufficient data to allow useful modelling for people who inject performance- and image-enhancing drugs. The incidence of hepatitis C virus is probably lower in this group than among groups using other types of drugs because the substances used do not cause such acute withdrawal effects. As the need to inject may be less urgent, users probably have more time to obtain a sterile needle (and can think more clearly about where to get one). Also, many of these drugs are not controlled under the Misuse of Drugs Act/Regulations, or have lesser penalties for use than opiates and stimulants. As a result, users will not be deterred from associating with a supplier of sterile needles. The cost of recommending that all people from this group use existing programmes would be relatively small. However, there is insufficient evidence to determine whether it is cost effective to develop dedicated services for this group.

This section will be completed in the final document.

4 Recommendations for research

The Public Health Advisory Committee (PHAC) recommends that the following research questions should be addressed. It notes that 'effectiveness' in this context relates not only to the size of the effect, but also to cost effectiveness and duration of effect. It also takes into account any harmful/negative side effects.

4.1 How many people in England inject drugs and is there a demographic pattern, in terms of subgroups of people who inject and in terms of the substance injected?

4.2 How can needle and syringe programmes (NSPs) encourage specific groups of people who inject drugs to use the service effectively? Examples include: those who have recently started injecting; women; sex workers; ex-prisoners; people who are homeless; people who occasionally inject drugs; and people who inject novel psychoactive drugs.

4.3 What are the most effective and cost effective ways of delivering NSP to (i) young people aged under 16 and (ii) users of performance and image-enhancing drugs?

4.4 What type of behaviour-change interventions delivered by NSPs are effective in increasing safer drug practices (apart from providing needles, syringes and other injecting equipment)?

4.5 What types of injecting equipment, paraphernalia and non-injecting equipment (for example, crack pipes or foil) effectively and cost effectively reduce the harm associated with injecting drug use?

4.6 What is the impact of NSPs on the local community? Do they affect drug-related litter, crime rates or the fear of crime?

4.7 Does the provision of needle and syringe disposal facilities (for example, drop-boxes) affect the amount of drug-related litter in an area? Is the amount of such litter influenced by whether the local NSP provides packs or pick-and-mix equipment?

4.8 Do NSPs have any unintended consequences, for example, do they increase the uptake, frequency and length of injecting drug use?

More detail identified during development of this guidance is provided in Gaps in the evidence.

5 Related NICE guidance

- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Interventions to reduce substance misuse among vulnerable young people. NICE public health guidance 4 (2007).
- Naltrexone for the management of opioid dependence. NICE technology appraisal guidance 115 (2007).
- Methadone and buprenorphine for the management of opioid dependence. NICE technology appraisal guidance 114 (2007).
- Peginterferon alfa and ribavirin for the treatment of mild chronic hepatitis C. NICE technology appraisal guidance 106 (2006).
- Adefovir dipivoxil and peginterferon alfa-2a for the treatment of chronic hepatitis B. NICE technology appraisal guidance 96 (2006).
- Interferon alfa (pegylated and non-pegylated) and ribavirin for the treatment of chronic hepatitis C. NICE technology appraisal guidance 75 (2004).

6 Glossary

Detached services

Workers from needle and syringe programmes deliver services away from the main venue.

Injecting equipment

The equipment supplied by needle and syringe programmes is regulated by a 2003 amendment to The Misuse of Drugs Act (2001). A Home Office circular on the supply of drug injecting paraphernalia (Home Office 2003) clarifies that, in addition to needles and syringes, needle and syringe programmes may also supply:

(a) swabs

(b) utensils for the preparation of a controlled drug (that would include articles such as spoons, bowls, cups, dishes)

(c) citric acid

(d) filters

(e) ampoules of water for injection.

In 2013, the Advisory Council on the Misuse of Drugs suggested that the government consider whether or not there is merit in making provision of foil legal through needle and syringe programmes.

Low dead-space injecting equipment

Low dead-space injecting equipment seeks to limit the amount of (potentially contaminated) drug that remains in the equipment after it has been used, by reducing the amount of 'dead space' it contains. It is believed that this may reduce the risk of transmission of infectious diseases among people who share injecting equipment.

Outreach services

Workers from drug and needle and syringe programmes go out and encourage people to use the service.

Performance- and image-enhancing drugs

The term 'performance- and image-enhancing drugs' is used in this guidance to mean:

- anabolic steroids, growth hormone and novel drugs (such as those that stimulate secretion of growth hormone, IGF-1 and analogues, and human chorionic gonadotrophin)
- melanotans, bremelanotide, botulinum toxin and dermal fillers.

Poly-drug use

Using more than 1 drug at the same time (although not necessarily in the same syringe). Often 1 drug is used to enhance or counter the effects of another. This

practice is common among people who use performance- and image-enhancing drugs. They refer to it as ‘stacking’.

Secondary distribution

Where someone collects needles, syringes and other injecting equipment at the needle and syringe programme on behalf of others.

7 References

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8 Summary of the methods used to develop this guidance

Introduction

The reviews include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the Public Health Advisory Committee (PHAC) meetings provide further detail about the Committee's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in About this guidance.

Guidance development

The stages involved in developing updates of public health programme guidance are outlined in the box below.

1. Update proposal prepared
2. Expert meeting to discuss update proposal
3. Stakeholder consultation on update proposal
4. Final update decision made
5. Evidence reviews undertaken and submitted to PHAC
6. PHAC produces draft recommendations
7. Draft guidance (and evidence) released for consultation and for field testing
8. PHAC amends recommendations
9. Final update guidance published on website
10. Responses to comments published on website

Key questions

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and were used by the PHAC to help develop the recommendations. The overarching questions for the original guidance were:

1. What level of coverage should needle and syringe programmes provide to keep HIV prevalence low and to reduce the prevalence of hepatitis C among people who inject drugs?

2. What type of needle and syringe programmes are effective and cost effective in reducing the transmission of blood-borne viruses and preventing injecting- site bacterial infections among people who inject drugs?

3. Which additional harm-reduction services offered by needle and syringe programmes are effective and cost effective in reducing the transmission of blood-borne viruses and preventing the occurrence of injecting-site bacterial infections among people who inject drugs?

4. Are needle and syringe programmes more effective and cost effective if they are offered in parallel with, or alongside, services that provide opiate substitution therapy?

These questions were used to update the original review of the evidence.

Subsidiary questions for the guidance update included:

1. What types of needle and syringe programme are effective and cost-effective for reducing the prevalence of HIV, hepatitis C and other blood-borne viruses, and morbidity and mortality relating to injecting drug use in people who inject performance- and image-enhancing drugs?

2. Which additional harm-reduction services offered by needle and syringe programmes are effective and cost-effective for reducing the prevalence of HIV, hepatitis C and other blood-borne viruses, and morbidity and mortality relating to injecting drug use in people who inject performance- and image-enhancing drugs?

3. What do people who inject performance- and image-enhancing drugs identify as suitable types of needle and syringe programme, and what do they believe to be a suitable level of coverage of needles, syringes and other types of injecting equipment?

4. What are their views and perspectives on, and experiences of, different types of needle and syringe programme?

5. How do the key harms associated with injecting drug use among people under 16 differ from those for older populations who inject drugs?

6. What are the barriers to service use among young people who inject drugs?

7. What are the social factors shaping patterns of use, perceptions of risk, harm, benefit and pleasure, and help-seeking (especially the use of needle and syringe programmes) among young people who use drugs?

Reviewing the evidence

See What evidence is the guidance based on? for details of the evidence used to support the original guidance.

The evidence used to update the guidance was as follows.

Evidence reviews

Three reviews of the evidence were conducted. For more details on the reviews see What evidence is the guidance based on?

Identifying the evidence

Several databases were searched between January and March 2013 for all types of study published from 1990 onwards (reviews 2 and 3) and from 2008 onwards for the update (review 1). See each review for details of the databases searched.

In addition, a call for evidence via the NICE website was used to generate further studies

Selection criteria

Inclusion and exclusion criteria for each review varied and details can be found in the Supporting evidence.

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in Methods for the development of NICE public health guidance. Each study was graded (++, +, −) to reflect the risk of potential bias arising from its design and execution.

Study quality

++ All or most of the checklist criteria have been fulfilled. Where they have not been fulfilled, the conclusions are very unlikely to alter.

+ Some of the checklist criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are unlikely to alter the conclusions.

− Few or no checklist criteria have been fulfilled. The conclusions of the study are likely or very likely to alter.

Summarising the evidence and making evidence statements

The review data was summarised in evidence tables (see full reviews).

The findings from the reviews were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements were prepared by the external contractors (see About this guidance). The statements reflect their judgement of the strength (quality, quantity and consistency) of evidence and its applicability to the populations and settings in the scope.

Policy review and consensus exercise

Several databases were searched in January 2013 for policy documents from 1990 onwards. In addition key websites were searched. See the full report for details.

A consensus development exercise was conducted through a series of interviews, a 1-day meeting and a subsequent Delphi study (see full report).

Cost effectiveness

See What evidence is the guidance based on? for details of the cost effectiveness evidence used to support the original guidance. No additional analyses were undertaken for this update.

Fieldwork

This section will be completed in the final document.

How the PHAC formulated the recommendations

At its meetings in June and July 2013, the Public Health Advisory Committee (PHAC) considered the evidence and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of strength and applicability) to form a judgement

- where relevant, whether (on balance) the evidence demonstrates that the intervention or programme/activity can be effective or is inconclusive
- where relevant, the typical size of effect (where there is one)
- whether the evidence is applicable to the target groups and context covered by the guidance.

PHAC developed draft recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of the evidence.
- The applicability of the evidence to the populations/settings referred to in the scope.
- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

Where possible, recommendations were linked to an evidence statement(s) (see The evidence for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

9 The evidence

This section lists the evidence statements from the 2 reviews conducted for the original guidance and two of the reviews conducted for the updated guidance (reviews 1 and 3). It also links to the evidence provided in review 2 and in the policy review and consensus development exercise (see What evidence is the guidance

based on?) and links them to the relevant recommendations. (See Summary of the methods used to develop this guidance for the key to quality assessments.)

This section also sets out a brief summary of findings from the economic analysis conducted for the original guidance.

The evidence statements are short summaries of evidence, in a review, report or paper (provided by an expert in the topic area). Each statement has a short code indicating which document the evidence has come from.

Evidence statement E6.2b indicates that the linked statement is numbered 6.2b in the review, 'A review of the effectiveness and cost-effectiveness of needle and syringe programmes for injecting drug users' (conducted for the original guidance).

Evidence statement Q3.3a indicates that the linked statement is numbered 3.3a in the review, 'Injecting equipment schemes for injecting drug users: qualitative evidence review' (conducted for the original guidance).

Evidence statement U2b indicates that the linked statement is numbered 2b in the review, ‘Update of NICE guidance PH18 on needle and syringe programmes: qualitative and quantitative review updates’.

Evidence statement Y10 indicates that the linked statement is numbered 10 in the review, ‘Injecting drug use among young people – risk, harm and factors affecting access to services: a systematic review of the evidence’.

The reviews and the policy review and consensus development exercise are available.

Where a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by IDE (inference derived from the evidence).

Recommendation 1: evidence statements Q3.2a, Q3.3b, Q3.3c, Q3.3d, Q3.4a, Q3.6a, Q3.6b; IDE

Recommendation 2: evidence statements E7.1b, E7.1c, U1a, U1b, Y13, IDE

Recommendation 3: evidence statements E5.1a, E5.1b, E5.1c, E6.3b, E6.3c, E7.1a, E7.1b, E7.1c, Q3.3a, Q3.3b, Q3.3d, Q3.4a, Q3.4c, Q3.6a, U2c, U3c, U8; IDE

Recommendation 4: IDE

Recommendation 5: Y5, Y6; Consensus statements from table 1 of the policy review and consensus development

Recommendation 6: evidence statements E5.1a, E5.1b, E5.1c, E6.3b, E6.3c, E6.4b, E7.1a, E7.1b, Q3.3c, Q3.3d, Q3.4b, Q3.5a, U2b; IDE

Recommendation 7: evidence statements E5.1a, E5.1b, E6.3b, E6.3c, E7.1a, E7.1b, Q3.3a, U2e, U3a, U3b, U6; IDE

Recommendation 8: E5.1c, E6.3b, E6.3c, E7.1a, E7.1b, Q3.3b, Q3.4b, Q3.6b, U5, U7, Y14; IDE

Recommendation 9: evidence statements E6.3b, E6.3c, E7.1a, E7.1b, Q3.3b, Q3.3c, Q3.4b, Q3.6b, U7; IDE

Recommendation 10: IDE from review 2

Evidence statements

Please note that the wording of some evidence statements has been altered slightly from those in the evidence review(s) to make them more consistent with each other and NICE's standard house style.

Evidence statement E5.1a

There is evidence from 1 good quality (++)[1] and 5 moderate quality (+)[2–6] systematic reviews and meta-analyses that participation in needle and syringe programmes reduces injection risk behaviours among people who inject drugs, in particular self-reported sharing of needles and syringes, and frequency of injection. The evidence is not clear in relation to the impact of participation in needle and syringe programmes on sharing of other injection equipment such as cookers, filters or water because few studies have examined these outcomes.

[1] Tilson et al. 2006

[2] Gibson et al. 2001

[3] Cross et al. 1998

[4] Ksobiech 2003

[5] Ksobiech 2006

[6] Ritter and Cameron 2006

Evidence statement E5.1b

There is evidence from 2 good quality (++) systematic reviews[1,2] to support the effectiveness of needle and syringe programmes in reducing HIV infection among people who inject drugs. However, findings from 2 other systematic reviews[3,4], including 1 high-quality (++) review, suggest that the evidence may be less convincing. There is insufficient evidence from 2 systematic reviews[5,6] to determine the impact of needle and syringe programmes on hepatitis C virus infection in people who inject drugs.

[1] Wodak and Cooney 2004

[2] Gibson et al. 2001

[3] Tilson et al. 2006

[4] Kall et al. 2007

[5] Tilson et al. 2006

[6] Wright et al. 2005

Evidence statement E5.1c

There is evidence from 2 good quality (++) systematic reviews[1,2] to suggest that access to sterile needles and syringes through pharmacies provides specific benefits in addition to those available through specialist needle and syringe programmes.

[1] Wodak and Cooney 2004

[2] Tilson et al. 2006

Evidence statement E6.3b

There is evidence from 1 moderate quality (+) cohort study[1] to suggest that the provision of needle and syringe programme-based healthcare services may decrease emergency department admissions.

[1] Pollack et al. 2002

Evidence statement E6.3c

There is evidence from 1 moderate quality (+) cohort study[1] and 1 poor quality (−) cross-sectional study[2] to suggest that people who inject drugs who obtain their needles exclusively from needle and syringe programmes are less likely to engage in high risk injection behaviours than those who obtain them from secondary distribution. However, there is evidence from 2 poor quality (−) cross-sectional studies[3,4] to suggest that people who inject drugs who obtain needles from secondary distribution engage in high risk injection behaviours less than people who inject drugs who do not obtain any needles, directly or indirectly, from needle and syringe programmes.

[1] Tyndall et al. 2001

[2] Huo et al. 2005

[3] Sears et al. 2001

[4] Huo et al. 2005

Evidence statement E6.4b

There is evidence from 1 moderate quality (+) cohort study[1] to suggest that the combination of methadone treatment and full participation in needle and syringe programmes reduces the incidence of HIV and hepatitis C virus among drug users.

[1] Van Den Berg et al. 2007

Evidence statement E7.1a

There is evidence from 11 cost-effectiveness analyses (6 [+][1–6] and 5 [−][7–11]) and 1 cost-benefit analysis (+)[12] to suggest that in terms of reducing HIV incidence and

prevalence among people who inject drugs, needle and syringe programmes are cost effective.

[1] Cabases and Sanchez 2003

[2] Cohen et al. 2004

[3] Harris 2006

[4] Kumaranayake et al. 2004

[5] Laufer 2001

[6] Vickerman et al. 2006

[7] Cohen et al. 2006

[8] Gold et al. 1997

[9] Holtgrave et al. 1998

[10] Jacobs et al. 1998

[11] Lurie and Drucker 1997

[12] Health Outcomes International et al. 2002

Evidence statement E7.1b

There is evidence from 2 cost-effectiveness analyses (1 [+][1] and 1 [−][2]) to suggest that intervention coverage may be increased to higher levels at a low cost per HIV infection averted.

[1] Vickerman et al. 2006

[2] Holtgrave et al. 1998

Evidence statement E7.1c

There is evidence from 1 cost-effectiveness analysis (+)[1] to suggest that cost-effective allocation within a multi-site needle and syringe programme requires that

sites are located where the density of people who inject drugs is highest and that the number of syringes exchanged per client is equal across sites.

[1] Harris 2006

Evidence statement Q3.2a

There is evidence from 1 moderate quality (+)[1] US study that the features of a successful needle and syringe programme include: flexibility in process and management models, knowledge, coalition building and community involvement, strong leadership, staging debate with sensitivity to political and cultural norms, access to resources, use of research, and overcoming fear.

[1] Downing 2005

Evidence statement Q3.3a

There is evidence from 1 good quality (++)[1] UK study and 2 moderate quality (+)[2,3] UK studies to suggest that immediate availability of injecting equipment is more important to injecting drug users than perceptions of risk associated with injecting behaviour.

[1] Power 1996

[2] Barnard 1993

[3] Neale 1998

Evidence statement Q3.3b

There is evidence from 2 good quality (++)[1,2] UK studies and 3 moderate quality (+) studies[3–5], 2 of which are from the UK, that pharmacy-based needle and syringe programmes are popular with injecting drug users. Pharmacies were rated more highly than drug agency-based needle and syringe programmes for accessibility in 3 UK studies; although in another 2 UK studies, embarrassment, negative staff attitudes or fear of exposure led to negative feelings about pharmacy-based needle and syringe programmes, particularly in women. Agency-based needle and syringe programmes were rated more highly than pharmacies for advice and information.

[1] Matheson 1999

[2] Power 1996

[3] Clarke 2001

[4] Lewis 1996

[5] Neale 1998

Evidence statement Q3.3c

There is evidence from 1 good quality (++) UK study[1], 1 good quality (++) US study[2], 1 moderate quality (+) UK study[3], 2 moderate quality (++) US studies[4,5] and 1 poor quality (−) UK study[6] to suggest that convenience or otherwise (specifically opening hours, location and queues) of needle and syringe programmes are very important to people who inject drugs and can influence decisions on whether to obtain equipment from them or from street sellers or via secondary distribution.

[1] Power 1996

[2] Finlinson 2000

[3] Neale 1998

[4] Voytek 2003

[5] Miller 2001

[6] Hay 2001

Evidence statement Q3.3d

There is evidence from 2 good quality (++)[1,2] studies, 1 of which is from the UK, and 6 moderate quality (+) studies[3–8], 2 of which are from the UK, to suggest that people who inject drugs are not a homogeneous group: there are different cultures, some of whom disapprove of others' drug using behaviours and some of whom are more affluent than others. Fear of being caught and publicly exposed as a drug user (to police [USA studies], neighbours or family [UK studies]) is a prominent theme and can impact upon use of needle and syringe programmes and other services, with some people who inject drugs preferring secondary distribution for this reason.

[1] Matheson 1998

[2] Strenski 2000

[3] Buchanan 2003

[4] Murphy 2004

[5] Neale 1998

[6] Spittal 2003

[7] Strike 2005

[8] Voytek 2003

Evidence statement Q3.4a

There is evidence from 2 moderate quality (+) UK studies[1,2] of gender differences in patterns of equipment sharing and use of services. Women are less likely than men to share equipment with friends, preferring to share only with their sexual partner. Women are also more likely to have negative feelings about using pharmacy-based needle and syringe programmes and to obtain equipment by secondary distribution, particularly with their sexual partner.

[1] Barnard 1993

[2] Neale 1998

Evidence statement Q3.4b

There is evidence from 3 good quality (++)[1–3] and 1 moderate quality (+) study[4] to suggest that a range of harm reduction interventions (referrals to drug treatment and other services, HIV testing, medical care) in addition to needle and syringe programmes were accessed and valued by people who inject drugs.

[1] Long 2004

[2] Power 1996

[3] Porter 2002

[4] Phillips 2007

Evidence statement Q3.4c

There is evidence from 3 good quality (++)[1–3] studies, 1 of which is from the UK, and 6 moderate quality (+)[4–9] studies, 1 of which is from the UK, that secondary distribution is a valued method for obtaining sterile syringes because it is convenient and relieves the fear of exposure.

[1] Finlinson 2000

[2] Power 1996

[3] Moore 1995

[4] Voytek 2003

[5] Grund 1992

[6] Miller 2001

[7] Murphy 2004

[8] Neale 1998

[9] Snead 2003

Evidence statement Q3.5a

In 2 UK studies (1 good quality [++][1] and 1 moderate quality [+][2]), people who inject drugs obtained oral methadone prescriptions from the same pharmacy they used for needle and syringe exchange. A need for privacy when collecting needles and taking oral methadone was expressed.

[1] Clarke 2001

[2] Matheson 1998

Evidence statement Q3.6a

There was evidence from 1 good quality (++)[1] US study and 2 moderate quality (+) studies[2,3], 1 of which was from the UK, that the general public, particularly religious

groups, had concerns about the ethics or morality of providing syringes and needles to injecting drug users, with some stating that it was helping them (people who inject drugs) to harm themselves; others were more concerned that it discouraged people who inject drugs from taking personal responsibility for their drug use.

[1] Springer 1999

[2] Lawrie 2005

[3] Shaw 2006

Evidence statement Q3.6b

There was evidence from 3 moderate quality (+) studies[1–3], 1 of which was from the UK, that the general public and people who inject drugs themselves had some concerns about the environmental and health consequences (for example, discarded needles and increased crime) of fixed site needle and syringe programmes. In some cases direct opposition came from a vocal, more affluent, minority.

[1] Lawrie 2005

[2] Shaw 2006

[3] Tempalski 2007

Evidence statement U1a: Needle and syringe coverage and injection risk behaviours

There is evidence from 2 moderate quality (+) cross-sectional studies about the association between individual levels of syringe coverage and injection risk behaviours among people who inject drugs. One study[1] reported that a level of 60% syringe coverage may be sufficiently adequate to effectively reduce injection risk behaviours among people who inject drugs. The other study[2] found that despite a high level of coverage among the overall sample, inadequate syringe coverage was associated with syringe re-use (Adjusted Odds Ratio [AOR] 0.56, 95% confidence interval [CI] 0.42–0.74). This evidence is only partially applicable to the UK as these 2 studies were conducted in Australia where needle and syringe availability is likely to be higher than may be commonly found across the UK.

[1] Bryant et al. 2012

[2] Iversen et al. 2012

Evidence statement U1b: Proximity to needle and syringe programme and injection risk behaviours

There is evidence from 5 moderate quality (+) cross-sectional studies about the association between geographical proximity to needle and syringe programmes and injection risk behaviours. The evidence about the association is based on studies conducted in diverse settings. One study[1] found that a temporal increase in access to needles and syringes was associated with greater odds of injecting with a sterile syringe at least 75% of the time (needle and syringe programme: AOR 1.23, 95% CI 1.01–1.52; pharmacy: AOR 1.15, 95% CI 1.03–1.27). Further studies[2,3] showed that this association was undermined by drug-related arrests. Another study[4] found that distances between 4 locations used by people who inject drugs in purchasing and using drugs were associated with injection risk behaviours. A fifth study[5] found that the association between distance to needle and syringe programmes and high-risk injection behaviour was non-linear and that proximity to a needle and syringe programme was associated with high-risk injection behaviour. This evidence is only partially applicable to the UK. Four studies[1–4] were from the USA, where needles and syringes are sold over the counter in pharmacies and in settings where needle and syringe programmes may have formerly been illegal. One further study[5] was conducted in a setting where needle and syringe availability is likely to be higher than may be commonly found across the UK.

[1] Cooper et al. 2011

[2] Cooper et al. 2012a

[3] Cooper et al. 2012b

[4] Williams and Metzger 2010

[5] Bruneau et al. 2008

Evidence statement U2b: Profile of people who inject drugs who use vending machines

There is moderate evidence from 5 (4 [+] and 1 [−]) cross-sectional studies[1–5] about the characteristics and risk behaviour profiles of people who inject drugs who use needle and syringe vending machines (NSVM). There was evidence from 4 studies[1–4] to suggest that people who inject drugs who use NSVM tend to be younger[1–4] and have a shorter history of injecting drug use than users of other types of needle and syringe programmes[1,3]. There was further evidence from 5 studies[1–5] to suggest that sharing behaviours among NSVM users did not differ significantly from users of other types of needle and syringe programmes. This evidence is partially applicable to the UK because although studies were conducted across a range of settings, none were directly applicable to a UK context.

[1] Islam et al. 2008a

[2] McDonald 2009

[3] Moatti et al. 2001

[4] Obadia et al. 1999

[5] Stark et al. 1994

Evidence statement U2c: Profile of people who inject drugs who use outreach and mobile outlets

There is moderate evidence from 1 (++) cohort study[1] and 4 (2 [++] and 2 [+]) cross-sectional studies about the characteristics and risk behaviour profiles of people who inject drugs who use outreach and mobile outlets. There was evidence from 5 studies[1–5] to suggest that people who inject drugs who use outreach and mobile outlets have different characteristics to users of fixed-site and pharmacy needle and syringe programme services, and represent a high-risk group of people who inject drugs. There was mixed evidence from 3 studies[3–5] about sharing behaviours among outreach and mobile users. Two studies[3,5] did not identify an association, but 1 study[4] reported an association between using a needle that had already been used by someone else and use of a mobile van needle and syringe programme. This evidence is partially applicable to the UK as although studies were conducted across

a range of settings, none were directly applicable to a UK context. Four studies[1–3,5] were conducted in a setting with a high proportion of cocaine injectors among people who inject drugs and a significant proportion of participants in the fifth study[4] was African American.

[1] Deering et al. 2011

[2] Hayashi et al. 2010

[3] Miller et al. 2002

[4] Riley et al. 2000

[5] Wood et al. 2003

Evidence statement U2e: needle and syringe programme policy changes

There was moderate evidence from 2 (+) cohort studies[1,2] that examined associations between changes in needle and syringe programme policies and needle and syringe programme user status[1], and injection risk behaviours[2]. One study[1] found that changes to the cap on the number of needles and syringes that could be exchanged did not have a direct impact on needle and syringe programme use but increased secondary distribution. Another study[2] found that a significant change in needle and syringe programme policy and diversification of services was associated with reductions in injection risk behaviours. This evidence may only be partially applicable to the UK because needle and syringe programme policies in 1 study[1], which was conducted in the USA, were more restrictive in comparison to policies in the UK and in the second study[2] were likely to be more liberal than may commonly be found across services in the UK.

[1] Green et al. 2010

[2] Kerr et al. 2010

Evidence statement U3a: Uptake of injection paraphernalia and sharing of equipment

There is moderate evidence from 1 (+) cross-sectional study[1] about the association between the uptake of injection paraphernalia (specifically filters, spoons or sterile

water) from needle and syringe programmes and sharing of such equipment among people who inject drugs. There is evidence from this study to suggest that a shortfall in injecting paraphernalia among people who inject drugs is associated with increased odds of sharing (for example, shortfall of more than 10 filters: AOR 1.55, 95% CI 1.12–2.14). In addition, evidence from this study suggests that uptake of injecting paraphernalia from needle and syringe programmes is associated with reductions in sharing (for example, uptake of at least 1 spoon: AOR 0.61, 95% CI 0.45–0.82). This evidence is directly applicable to the UK.

[1] Allen et al. 2012

Evidence statement U3b: Crack kit distribution

There is weak evidence from 1 (−) repeat cross-sectional study[1] to suggest that distribution of crack kits from needle and syringe programmes may reduce the frequency of injecting drug use among people who inject drugs by facilitating the transition to other routes of administration (for example, from injecting to smoking). This evidence is only of limited applicability to the UK because the setting in which the study was conducted included a high proportion of crack smoking among people who inject drugs.

[1] Leonard et al. 2008

Evidence statement U3c: Drop box presence

There is moderate evidence from 1 (+) study[1] based on a time series approach and 1 (+) controlled before and after study[2] about the association between the installation of drop boxes and changes in the quantity of discarded needles. One study[2] of 4 drop boxes did not find a change in the number of discards but a second study[1] found that the presence of an outdoor drop box was associated with reduction of discards within 25 m (98%), 50 m (92%), 100 m (73%) and 200 m (71%) buffer zones. This evidence is only partially applicable to the UK because both studies were conducted in cities in North America; in addition, 1 study[1] was conducted in a city where cocaine (associated with frequent daily injection) was the drug of choice among people who inject drugs.

[1] de Montigny et al. 2010

[2] Riley et al. 1998

Evidence statement U5: Pharmacies

Five studies[1–5] (all [+]) examined views and perspectives on, and experiences of, pharmacies as a setting for needle and syringe distribution and exchange. Two studies[1,2] identified convenience and accessibility as the main reasons for people who inject drugs accessing needle and syringes from pharmacies. Three studies[1,3,4] identified that people who inject drugs had encountered both positive and negative experiences in pharmacies. A theme relating to the need for mutual respect among people who inject drugs and pharmacy staff was identified in 2 studies[1,5] This evidence is directly applicable to a UK context.

[1] Trealoar et al. 2010

[2] Vorobjov et al. 2009b

[3] Lutnick et al. 2012

[4] Mackridge et al. 2010

[5] Mackridge and Scott 2009

Evidence statement U6: Needle and syringe vending machines

Two studies[1,2] (both [+]) explored views and perspectives on vending machines. Although participants in both studies reported a general acceptance of the benefits of NSVMs, the potential ease of access of needles and syringes from vending machines was raised as a major potential public health and safety issue. However, in 1 study[1] there was a consensus among participants (who were people who inject drugs and drugs workers) that making needles and syringes more accessible from vending machines would not encourage people to start injecting drugs. This evidence is likely to be directly applicable to the UK.

[1] Dodding and Gaughwin 1995

[2] Philbin et al. 2009

Evidence statement U7: Additional harm reduction services

Five studies[1–5] (all [+]) reported views and perspectives on, and experiences of, additional harm reduction services offered by specialist needle and syringe programmes and pharmacies. Two studies[1,2] identified that trusting relationships between people who inject drugs and needle and syringe programme staff were felt to be key to facilitating engagement in additional harm reduction services in specialist needle and syringe programme settings. Two studies[3,4] explored the potential for additional harm reduction services to be delivered by pharmacies. Expansion of services was desired by both people who inject drugs and pharmacy staff. However, barriers to expansion were identified including the need to tackle negative attitudes towards people who inject drugs by some pharmacy staff, and the need to identify private spaces for the delivery of such services. One study[5] acknowledged that opportunities for disseminating information to users of NSVMs were limited but participants in this study did not feel that this was a major concern. This evidence is directly applicable to the UK.

[1] Parker et al. 2012

[2] MacNeil and Pauly 2011

[3] Mackridge at al. 2010

[4] Lutnick et al. 2012

[5] Dodding and Gaughwin 1995

Evidence statement U8: Drop boxes and drug-related litter bins

Four studies[1–4] (1 [++] and 3 [+]) explored views and perspectives on, and experiences of drop boxes and drug-related litter bins. Two studies[1,3] identified that discarded needles were a concern for both community members and people who inject drugs. Two studies[3,4] that explored the views of community members identified mixed responses to drop boxes; with 1 study[3] finding that many fears and concerns within the community may be unfounded. Three studies[2–4] identified general support for drop boxes among people who inject drugs. However, significant barriers to their use were identified in all 4 studies[1–4]. One UK study[2] identified that the correct environmental and geographical positioning of drop boxes was crucial. In all

4 studies[1–4], participants expressed that the fear of being arrested for possession of injection paraphernalia was a barrier to the use of drop boxes. In 1 UK study[2], experience of arrest after the use of a drop box led to the adoption of unsafe injection practices. The evidence is likely to be applicable to the UK.

[1] Miller 2001

[2] Parkin and Coomber 2011

[3] Smith et al. 1998

[4] Springer et al. 1999

Evidence statement Y5: Prevalence of injecting risk behaviours

There is strong evidence from 4 controlled studies (3 [+][1–3] and 1 [++][4]) and 2 cohort studies (both [++][5,6]) to suggest that more than 25% of young people who inject drugs inject with a used needle or syringe. In Ireland among a sample aged less than 25 years, 56% reported ever sharing needles or syringes[4]. In San Francisco 52% of young people who inject drugs (less than 30 years) reported this behaviour in the past month[7]. In the USA 37% of young people who inject drugs aged between 12 and 18 years had ever injected with a used needle or syringe and in Moldova 13% of a similar age range (15–17 years) had shared injecting equipment in the past month[3,4]. High prevalence (39%) of sharing needles or syringes (time frame not specified) were reported in Dublin among young people who inject drugs (median age 18) and 31% in New York (median age 23)[1,3].

[1] Diaz et al. 2001

[2] Cassin

[3] Chan et al. 2011

[4] Busza et al. 2013

[5] Miller 2002

[6] Miller 2007

[7] Kral et al. 2000

Evidence statement Y6: Differences in injecting risks by age

Three controlled studies (2 [+][1,2], 1 [++][3]) and 2 cohort studies (both [++][4,5]) suggested no difference in injecting risk behaviours by age. However, there is moderate evidence from a study in the USA that compared differences in risk between 12–15 and 16–18 year olds. Among the younger group, 37% had ever injected with a used needle compared with 45% of their older peers. Among the younger group 26% re-used a needle compared with 45% of the older group, suggesting injecting risk increased with age among this very young population (1 controlled study [+][6]). Overall, there is strong evidence from some of the above studies[2,4,5] and an additional controlled study (++)[7] that younger people who inject drugs more consistently reported being injected by someone else compared with their older counterparts.

[1] Diaz et al. 2001

[2] Cassin

[3] Busza et al. 2013

[4] Miller 2002

[5] Miller 2007

[6] Chan et al. 2011

[7] Kral et al. 2000

Evidence statement Y13: Factors associated with use of needle and syringe programmes among young people who inject drugs

There is moderate evidence from another US controlled study (+) that younger age (19–25) was associated with inadequate syringe coverage (odds ratio [OR]=6.3, 95% CI 1.2–32.0) compared with those aged over 45 years (1.0). Other factors associated with inadequate coverage included being homeless (OR=1.6, 95% CI 1.0–2.5), being male (OR=1.6, 95% CI 1.0–2.6), injecting in a public place (OR=1.9, 95% CI 1.2–3.0) and ethnicity: black/African–American (OR=3.0, 95% CI 1.5–6.2) or Latino/Hispanic

(OR=2.5, 95% CI 1.3–4.8) compared with being white. Inadequate coverage was defined as obtaining fewer needles or syringes than the number of times injected in the past month[1].

[1] Heller et al. 2009

Evidence statement Y14: Use of pharmacies

There is evidence from one Moldovan controlled study (++)[1] to suggest that in Eastern Europe young people who inject drugs use pharmacies more than needle and syringe programmes and that use of pharmacies or needle and syringe programmes rather than informal sources is associated with reduced odds of sharing injecting equipment (Romania OR=0.18, 95% CI 0.68–0.49; Moldova: OR=0.33, 95% CI 0.12–0.93; Serbia: OR=0.28, 95% CI 0.10–0.81).

[1] Busza et al. 2013

Cost effectiveness

The analyses for the original guidance estimated that needle and syringe programmes used as a channel for treating injecting drug users for chronic hepatitis C were cost effective. They can reduce the costs for society of drugs misuse by:

- improving the health of people who inject drugs
- ensuring the disease cannot be passed on after treatment.

The modelling showed that if only health costs and benefits are counted, then an needle and syringe programme (NSP) that increased coverage by 25% in a city with high-incidence of hepatitis C virus (HCV) was cost effective (estimated ICER = £11,400); however, an increase in coverage by 12.5% was not cost effective (estimated ICER = £31,600). For a low-incidence city, the estimated ICER for an increase in coverage of 25% was £11,800, whereas for an increase of 12.5% the ICER was estimated as £26,100.

If the costs to the criminal justice system are included, the modelling showed that a 12.5% increase in coverage for a high-incidence city was not cost effective (estimated ICER = £38,700) but if coverage increased to 25%, the estimated ICER

fell to £19,900. For a low-incidence city, for a 12.5% increase in coverage the ICER was £29,300, and for 25% increase in coverage the ICER was £12,300.

Needle and syringe programmes can also help to reduce the number of people who are injecting drug users by acting as a 'gateway' to opiate substitution therapy (OST). In so doing, NSP may help reduce the costs of drug-related crime. When these indirect ('gateway') effects were modelled, it showed that a 13.5% increase in the rate of referral to opiate substitution therapy (OST) resulted in ICERs of between £11,000 and £17,000, depending on prevalence.

The modelling found that overall, it is cost effective to give users more than one free needle per successful injection, if the cost of reaching them is not excessive and if use of this service increases by more than about 25% as a result.

For further details, see Assessing the cost-effectiveness of interventions linked to needle and syringe programmes for injecting drug users: an economic modelling report.

There were no additional analyses undertaken for the updated guidance.

10 Gaps in the evidence

The Public Health Advisory Committee (PHAC) identified a number of gaps in the evidence related to the programmes under examination, based on an assessment of the evidence. These gaps are set out below.

1. There is a lack of evidence about how many people inject drugs within different subgroups. This includes a lack of evidence about the number of young people who inject drugs and the number of people who inject performance and image-enhancing drugs.

2. There is a lack of evidence about the injecting behaviours of different subgroups of young people and users of performance and image-enhancing drugs. There is also a lack of evidence on how these groups use needle and syringe programmes and the effectiveness and cost effectiveness of providing needle and syringe programmes to these groups.

3. There is a lack of UK-based research on how best to target and tailor needle and syringe programmes to meet the needs of particular groups (such as young people who inject drugs, people who inject performance- and image-enhancing drugs and people who have recently started injecting drugs). For example, there is a lack of data on the effectiveness of using any of the following approaches with these groups: needle and syringe vending machines, specialist clinics, outreach or detached schemes.

4. There is a lack of evidence on how people who inject drugs perceive needle and syringe programmes and what encourages or discourages them from using the services.

5. There is a lack of evidence on how to prevent people who are at high risk of injecting drugs (for example, those who smoke drugs) from moving from non-injecting to injecting drug use. This includes a lack of information about their needs and views.

6. There is a lack of evidence about the effectiveness (or otherwise) of providing needle and syringe programmes to children and very young people who are injecting drugs. This includes a lack of evidence about their specific needs.

7. There is a lack of evidence about the likelihood of children living with people who inject drugs becoming regular injectors themselves.

8. There is a lack of UK-based research on how the carers and families of people (including young people) who inject drugs and people who inject performance and image-enhancing drugs view needle and syringe programmes. This includes a lack of evidence on how to get them involved with the programmes.

9. There is a lack of evidence about related behaviours that may occur among people who inject performance and image-enhancing drugs, for example, poly-drug use or increased sexual activity.

10. There is a lack of UK-based research on the effectiveness and cost-effectiveness of prison-based needle and syringe programmes.

11. There is a lack of UK-based research into the potential unintended consequences of needle and syringe programmes. For example, there is a lack of evidence on whether or not they encourage people to inject more frequently.

12. There is a lack of standardised outcome measures for needle and syringe programmes in relation to safe injecting practices and the incidence and prevalence of blood-borne viruses, overdoses and wound infections. In particular, there is a lack of information regarding young people who inject drugs and people who inject performance and image-enhancing drugs.

13. There is a lack of evidence on whether drug users who are referred to opioid substitution therapy programmes from needle and syringe programmes continue to attend after the first meeting.

14. There is a lack of evidence on the effectiveness of peer interventions that aim to prevent risky injecting practices and encourage people to use needle and syringe programmes.

15. There is a lack of evidence to determine whether secondary distribution increases risky injecting behaviour, and whether it increases or decreases the likelihood of people who inject coming into contact with a needle and syringe programme.

16. There is a lack of evidence on whether needle and syringe programmes encourage people to switch to safer injecting practices

17. There is a lack of evidence about the impact that training needle and syringe programme staff can have on its effectiveness

11 Membership of the Public Health Advisory Committee (PHAC) and the NICE project team

Public Health Advisory Committee

NICE has set up several Public Health Advisory Committees (PHACs). These standing committees consider the evidence and develop public health guidance. Membership is multidisciplinary, comprising academics, public health practitioners,

topic experts and members of the public. They may come from the NHS, education, social care, environmental health, local government or the voluntary sector. The following are members of PHAC A:

Chair

Susan Jebb, Head of Diet and Population Health, Medical Research Council Human Nutrition Research unit, Cambridge

Core members

Amanda Sowden Deputy Director, National Institute for Health Research (NIHR) Centre for Reviews and Dissemination, University of York

Chris Packham Associate Medical Director, Nottinghamshire Healthcare NHS Trust

Joyce Rothschild Independent Education Consultant

Lucy Yardley Professor of Health Psychology, University of Southampton

Mireia Jofre Bonet Professor of Health Economics, City University, London

Toby Prevost Professor of Medical Sciences, King's College London

Alison Lloyd Community Member

Topic members

Adam Mackridge Senior Lecturer in Pharmacy Practice, Liverpool John Moores University

Fortune Ncube Consultant Epidemiologist and Head of Bloodborne Viruses Section, Health Protection Agency

Paul Wells Peer Reviewer, Healthcare Inspectorate Wales Substance Misuse Peer Review Team; Former General Manager, Coventry and Warwickshire Partnership NHS Trust

Tony Margett Substance Misuse Manager, East Riding of Yorkshire Council

Vicky Fenwick Public Health Programme Manager, West Sussex County Council; Planning Group member, National Needle Exchange Forum

April Wareham Community Member

Expert co-optees

Joseph Kean Steroid Project Lead, Lifeline; Senior Trainer, Nine Zero Five

NICE project team

Mike Kelly Director, Centre for Public Health

Simon Ellis Associate Director

Chris Carmona Lead Analyst

James Jagroo Analyst

Suzi Peden Analyst (until July 2013)

Louise Millward Analyst (from July 2013)

Alastair Fischer Technical Adviser Health Economics

Emma Doohan Project Manager

Rukshana Begum Coordinator

Sue Jelley Senior Editor

Rebecca Boucher and **Susan Burlace** Editors

12 About this guidance

Why is this guidance update being produced?

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health.

In 2007, the Department of Health (DH) asked the then National Institute for Health and Clinical Excellence (NICE) to produce guidance to encourage the optimal provision of needle exchange schemes amongst injecting drug misusers. In 2009, NICE published Needle and syringe programmes, NICE public health guidance 18.

Following a review of the guidance in 2012, the National Institute for Health and Care Excellence (NICE) decided to update the guidance.

The updated guidance should be implemented alongside other guidance and regulations (for more details see Implementation and Related NICE guidance respectively).

How was this guidance update developed?

The recommendations are based on the best available evidence. They were developed by the Public Health Advisory Committee (PHAC).

Members of the PHAC are listed in Membership of the Public Health Advisory Committee and the NICE project team.

For information on how NICE public health guidance is developed, see the NICE public health guidance process and methods guides.

What evidence is the guidance based on?

Original guidance

The evidence used to develop the original guidance included:

- Evidence reviews:
  - 'Injecting equipment schemes for injecting drug users: qualitative evidence review'
  - 'A review of the effectiveness and cost-effectiveness of needle and syringe programmes for injecting drug users'.
- Economic modelling:
  - 'Assessing the cost-effectiveness of interventions linked to needle and syringe programmes for injecting drug users: an economic modelling report'.

Updated guidance

The evidence that the PHAC considered for the updated guidance included:

- Evidence and policy reviews:

- Review 1: 'Update of NICE guidance PH18 on needle and syringe programmes: qualitative and quantitative review updates', was carried out by Liverpool John Moores University. The principal authors were: Lisa Jones, Geoff Bates and Jim McVeigh.
- Review 2: 'Update of NICE guidance PH18 on needle and syringe programmes: PIEDs review', was carried out by Liverpool John Moores University. The principal authors were: Geoff Bates, Lisa Jones and Jim McVeigh.
- Review 3: 'Injecting drug use among young people – risk, harm and factors affecting access to services: a systematic review of the evidence' was carried out by the London School of Hygiene and Tropical Medicine. The principal authors were: Lucy Platt, Bethan McDonald, Neil Hunt, Adam Fletcher and Tim Rhodes.
- Policy review and consensus development exercise: 'Analysis of national and local policy and protocols on the delivery of needle and syringe programme services to young people under 18: policy review and consensus development exercise', was carried out by the London School of Hygiene and Tropical Medicine. The principal authors were: Neil Hunt and Lucy Platt.

In some cases the evidence was insufficient and the PHAC has made recommendations for future research.

Status of this guidance update

This is the draft guidance update. The recommendations made in section 1 are provisional and may change after consultation with stakeholders (listed on our website) and fieldwork.

This document does not include all sections that will appear in the final guidance update. The stages NICE will follow after consultation (including fieldwork) are summarised below.

- The Committee will meet again to consider the comments, reports and any additional evidence that has been submitted.

- After that meeting, the Committee will produce a second draft of the guidance update.
- The draft guidance update will be signed off by the NICE Guidance Executive.

The key dates are:

Closing date for comments: 5 November 2013.

Next PHAC meeting: 22 November 2013.

Implementation

NICE guidance can help:

- Commissioners and providers of NHS services to meet the requirements of the NHS outcomes framework 2013–14. This includes helping them to deliver against domain one: preventing people from dying prematurely.
- Local health and wellbeing boards to meet the requirements of the Health and Social Care Act (2012) and the Public health outcomes framework for England 2013–16.
- Local authorities, NHS services and local organisations determine how to improve health outcomes and reduce health inequalities during the joint strategic needs assessment process.

NICE will develop tools to help organisations put this guidance into practice. Details will be available on our website after the guidance has been issued.

Updating the recommendations

This section will be completed in the final document.