An up to date measure of the extent of Pharmacy Based Needle Exchange in England

Jamila Pishori, Amy Lavery, Upveer Manro, Stephanie Tyler and Jenny Scott (supervisor). Department of Pharmacy & Pharmacology, University of Bath, Claverton Down, Bath. BA2 7AY tel: 01225 385775 email: j.a.scott@bath.ac.uk

Project summary

This work was undertaken for a final year Masters of Pharmacy group project between October 2011 and January 2012. Four students designed and implemented the methods, each conducting an equal share of the data collection. They pooled their results and analysed them individually for the purposes of their assessment. Their work was supervised by their academic tutor J Scott. This document presents a summary of the work and its key findings, prepared by J Scott, for the purpose of disseminating the findings to those who participated and other interested parties.

Aim:

The primary aim of this study was to calculate a current (end of 2011) figure for the extent to which community pharmacies in England provide needle exchange. This was last done in 2005 by the National Treatment Agency (Abdulrahim et al, 2006). However, since this time, the National Institute for Health and Clinical Excellence has introduced guidance on best practice in needle exchange (NICE, 2009). A secondary aim was to establish what influence, if any, respondents perceive that the NICE guidance has had on pharmacy based needle exchange locally.

Design:

A short semi-structured telephone questionnaire was piloted then conducted across all 9 regions (151 Drug (& Alcohol) Action Teams) in England. Initial contact was made with the Joint Commissioning Manager (JCM) named on the NTA website. In some cases the JCM then referred the call to the person they considered most appropriate to answer the questions. An email version of the questionnaire was sent to those who were not contactable by telephone. The project received ethical approval from the University of Bath.

Response:

From the NTA website, 159 DATs* were identified, but on contact it was established that 151 operate as separate commissioning units for Pharmacy needle exchange. Contact was made with someone able to provide information on local pharmacy based needle exchange (PBNX) schemes for 74% of DATs (n= 111/151). Out of the non-responders, 1% *(n=2/151)* were unreachable and 25% *(n=38/151)* were contacted but were unable to participate. Of the responses received, 15% (n=17/111) were sent via e-mail.

*The abbreviation DAT includes DAATs

Findings:

Extent of PBNX in England

Respondents reported a total of 10,732 community pharmacies in their regions, of which 2,342 were reported to provide NX. This gives an average percentage of NX provision of approximately 22% for England *(n=2342/10732)* amongst those who responded. A breakdown of data for individual regions can be seen in Table 1:

Region	Total Number of Pharmacies identified (n)	Number of pharmacies providing needle exchange identified (n)	**Percentage of pharmacies that provide needle exchange (%)**
South East	1452	370	**25**
South West	1011	257	**25**
East Midlands	803	191	**24**
East	1242	288	**23**
West Midlands	1037	237	**23**
North West	1648	344	**21**
London	1871	376	**20**
Yorkshire and Humber	1079	197	**18**
North East	589	82	**14**

Table 1: *The percentage of the total number of pharmacies providing NX in each region in England.*

Large variations in the provision of NX across England were identified at DAT level, ranging from one DAT having 79% of pharmacies involved to another having no PBNXs. Every DAT had community pharmacies within it.

100 hour pharmacies

A total of 594 100-hour pharmacies were identified from respondents (n=100) and local Pharmaceutical Needs Assessments published online (n=35), of whom 173 were reported to provide PBNX (29%). This represents 7% of the total number of PBNXs identified. Table 4 shows the data regionally.

*The abbreviation DAT includes DAATs

Region	Total Number of 100 hour Pharmacies identified	Number of 100 hour pharmacies providing needle exchange identified	**Percentage of pharmacies that provide needle exchange (%)**
West Midlands	58	30	**52**
Yorkshire and Humber	71	35	**49**
East	57	26	**46**
South West	62	21	**34**
South East	73	22	**30**
East Midlands	45	10	**22**
London	69	13	**19**
North West	114	12	**11**
North East	45	4	**9**
Total	**594**	**173**	**29%**

Table 2: *This table shows the percentage 100 hour pharmacies providing PBNX*

Perceptions on the influence of NICE PH118

When asked whether the NICE guidance on needle exchange (PH118) was perceived to have impacted on PBNX locally, 20% of respondents thought that the NICE guidance had influenced an increase in the number of PBNXs locally. They also described an improvement in quality of PBNX attributed to the implementation of NICE guidance. A further 18% reported the number of PBNXs had increased locally since the NICE guidance were introduced but they did not perceive this influence to be due to the introduction of the guidance. In many cases the plan to increase numbers was in place before NICE PH118 was published. The majority of respondents (54%) perceived there to be no change in the number or operation of PBNXs locally since the introduction of NICE guidance. Many said they felt their services met the NICE standards before they were introduced, so had not made any direct changes because of NICE. However they often reported being reassured that they were implementing best practice when they compared their service standards

*The abbreviation DAT includes DAATs

with NICE guidance. Eight percent of respondent were unsure or did not know if the NICE guidance had impacted on PBNX locally.

Equipment given out by PBNXs

The majority of respondents said their PBNX scheme gave out needle exchange packs (68%). A further 20% gave out both packs and 'pick and mix', with 9% reporting 'pick and mix' only. The remainder (3%) did not know.

Form of payment made for PBNX

'Retainer plus per transaction' payment was reported by 41% of respondents to this question (n=42, 8 missing). 'Per transaction' was closely followed by 39% (n=40). Payments for packs varied extensively, from 50 pence to £1.79 and most commonly £1 per pack distributed. On top of transactions, many paid either an annual or quarterly retainer fee (ranging from £500 to £2000 per annum). The banded/sliding payment method was the least popular across England, with only 7% (n=7/103) reporting. Some areas reported payments for returns including 25 pence, 50 pence and £1 per sharps bin returned. A couple of DATs said that they cannot afford to pay per transaction and only pay an annual retainer for the service due to minimal funding available.

Methods used to encourage pharmacies to join the needle exchange scheme

This was an open question, providing qualitative data that was analysed using thematic analysis. Most respondents reported a combination of methods used in recruitment. A common theme that arose was making training available to pharmacies ahead of signing up to the scheme. One DAT reported paying for pharmacists to undertake the Royal College of General Practitioners (RCGP) level 1 certificate and another reported paying for both the level 1 and level 2 RCGP training. Financial incentives were also a key player and deciding factor as to whether a pharmacy would agree to participate in the NX scheme. Many respondents suggested financial incentives were key in recruiting PBNXs. However one said their DAT was unable to give financial incentives because funding available for NX within their locality being minimal. Some DATs reported to have such a high demand for uptake of the service by pharmacies that they have to refuse either due to adequate provision already in the locality, or lack of financial capacity to support the service. The provision of support was also a key theme. Many DAT/PCTs ensure someone liaises with the pharmacist and their staff and deals with the promotional aspects of the service and troubleshooting.

This document has summarised the key findings from this project. It is planned to submit a paper to an academic journal for consideration for publication. This paper will discuss the implications of the findings and make comparisons with previous related work.

*The abbreviation DAT includes DAATs