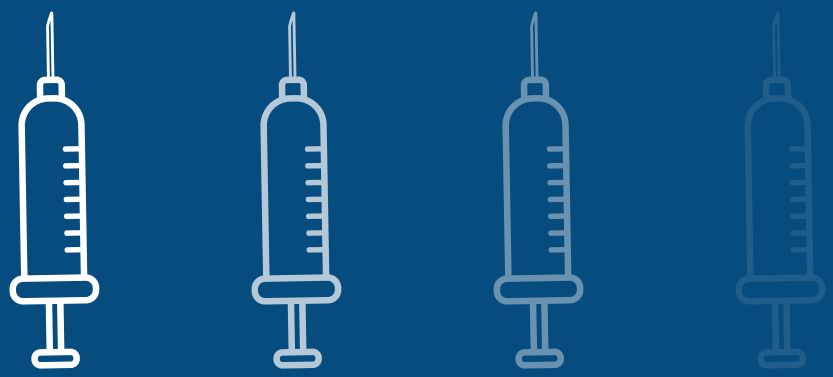
OUT OF REACH

Declining Access to Needle and Syringe Programmes in England and the Threat to Public Health



THE HEPATITIS C TRUST

Acknowledgements

The Hepatitis C Trust would like to thank the many individuals and organisations that contributed to this project. In particular, we are grateful to our staff and volunteers who undertook the mystery shopping exercise and shared their time, expertise and lived experience to inform its design. We thank the local services and commissioners who responded to requests for information, and the academic and public health experts who provided advice on the study design. We also thank those commissioners who contributed to the consultation that informed the Freedom of Information process, and colleagues across partner organisations who supported the project. Their contributions made this work possible.

Following the fieldwork for the report, the Hepatitis C Trust, the UK Health Security Agency, and NHS England sent a joint letter of gratitude to all pharmacies providing NSP, recognising and thanking them for delivering this vital service and highlighting the important contribution that community pharmacy makes towards England's efforts to eliminate hepatitis C as a public health threat. Now we are publishing the findings, we would like to reiterate our thanks to all those providing this vital service.

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About The Hepatitis C Trust

The Hepatitis C Trust is a charity dedicated to eliminating hepatitis C in the UK by 2030. We champion the right of every person at risk of hepatitis C in the UK to receive effective testing, treatment and care.

We achieve this by empowering people with lived experience, influencing policy and practice, and working with healthcare and treatment services to deliver support and raise awareness about hepatitis C.

The Hepatitis C Trust is a registered charity (Scotland SC039914, England and Wales 1104279) and a company limited by guarantee (no. 05069924).

Get in touch

Following the fieldwork on this project, The Hepatitis C Trust met with many local authorities and health leaders to share the detail of the data for their local areas.

If you would like to be given a report on the data for your local authority area please get in touch with us at stuart.smith@hepctrust.org.uk

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Executive Summary

Needle and Syringe Programmes (NSP) are one of the most effective public health interventions for preventing the transmission of infections, including hepatitis C, hepatitis B and HIV, among people who inject drugs. These conditions can be life-threatening, and come at a significant cost to the health system. Between 2002 and 2021, for example, there were 92,303 hospital admissions for injection-associated bacterial infections,[1] and England has spent nearly £1billion in its efforts to eliminate hepatitis C.[2] NSP is one of the UK's quiet public health success stories, helping to prevent thousands of infections and reducing the long-term costs associated with blood-borne viruses, drug harms and premature mortality. Yet despite its proven effectiveness, NSP provision in England is increasingly neglected, and its benefits poorly understood.

The Hepatitis C Trust is a national charity delivering peer-led healthcare to people facing exclusion, in particular people who inject drugs, experience homelessness, and/or have experience of the criminal justice system. In recent years, our frontline staff and networks have been raising increased concern about the closure of NSP services, leaving potentially insufficient provision to meet need, with people having to travel many (unaffordable) miles to access basic services.

Responding to these concerns, The Hepatitis C Trust conducted a national mapping and mystery shopping exercise across England's pharmacy-based NSP services in 2025. We set out to map the availability of pharmacy-based NSP, the most widely commissioned form of NSP provision across England, and to understand what services are being offered. Our findings point to a system with no clear ownership, little accurate data and limited understanding of local provision. Services are closing, but the absence of a national or local reporting framework makes this difficult to clearly evidence. We also identified significant quality challenges, with provision in many instances not meeting national quality guidelines.

Key findings

Local authorities' knowledge of NSP services in their area is often limited. The vast majority of local authorities do not have an adequate picture of NSP coverage in their area. Only 26% of the local authorities responding to our Freedom of Information requests met our criteria for having a "strong" understanding of NSP provision.

Local information on pharmacy NSP services is inaccurate. Local intelligence on NSP availability – from online directories, drug and alcohol services, and other resources – was inaccurate, with only 47% of pharmacies identified by these local sources as providing NSP actually doing so.

Provision is declining. Out of the pharmacies we contacted in both our 2025 and 2023 NSP mapping exercises, a third (323/1,002) said they had stopped providing the service since the 2023 study.

Provision is not in line with recommended standards. Our research identified widespread quality issues with NSP services, where national guidance was not being followed. Of the pharmacies we found to be providing NSP and were able to answer each question on service quality, 70% had restrictions on the amount of injecting equipment that could be dispersed and 22% required used equipment to be returned in order to access new supplies without limit.

Recommendations

NSP is a well-understood and effective intervention with a long and successful history in the UK. With additional leadership and prioritisation, it can continue to play its essential role into the future. To this end, we recommend:

- Local authorities should include data collection on NSP as part of the core data set that they use for contract monitoring for all drug contracts, drawing on the examples set out in the Office for Health Improvement and Disparities' (OHID) commissioning quality standard for alcohol and drug treatment and recovery,[3] to ensure that commissioning is effective and equitable.

- OHID should commission a comprehensive national evaluation of NSP provision to inform national and regional level planning, at the earliest possible opportunity. This should seek to capture both current provision and the rate of service closure, as well as understanding the reasons for this.

- OHID should work with the UK Health Security Agency (UKHSA) to develop and embed a robust national data reporting system for NSP. This work should build on work by UKHSA to pilot NSP monitoring to support hepatitis C elimination, and the Department of Health and Social Care (DHSC) should support this being rapidly scaled up.

- The National Institute for Health and Care Excellence (NICE) should review its 2014 NSP guidelines (PH52) to ensure they fully reflect changing drug use, including increasing injecting of cocaine and other new substances, and evolving evidence in new approaches to NSP such as postal services and peer-led interventions.

- DHSC should set out a clear long-term vision for NSP in the context of the elimination of hepatitis B and C, and elimination of HIV transmission, including clear resourcing to implement and safeguard this.

Introduction:
The role of Needle and Syringe Programmes

Injecting drug use can cause a range of serious harms. Beyond overdose, people who inject drugs can contract skin or blood infections (such as HIV, hepatitis B, and hepatitis C) and sustain vein damage. These can be life threatening, and come at a significant cost to the health system. For instance, between 2002 and 2021, there were 92,303 hospital admissions for injection-associated bacterial infections,[4] and England has spent nearly £1billion in its efforts to eliminate hepatitis C.[5]

Many of the risks associated with injecting drug use can be substantially mitigated with safer consumption practices, particularly the use of new, sterile equipment for each injection. To this end, health systems commission needle and syringe programmes (NSP) to provide a free and accessible supply of injecting equipment. 93 countries around the world operate these services, including every EU member state,[6] and they form a critical part of preventative public health infrastructure. The World Health Organisation describes NSP as "one of the most effective, cost-efficient, straightforward public health interventions for reducing the harm associated with injecting drug use".[7]

NSP is mainly delivered face to face through established community services, particularly pharmacies – the principal delivery channel in England – and drug and alcohol services. These familiar, locally based settings provide reliable access during regular opening hours, without availability being determined solely by demand for injecting equipment. Other delivery models include mobile outreach units, dedicated harm reduction hubs, online and home-delivery services, and NSP vending machines. This provision is vital, often bringing specialist, peer-led expertise and credibility into settings that can reach people who may otherwise struggle to access support. However, community pharmacy provision is unique in its scale: more than 10,000 pharmacies operate across England, dispensing more than a billion prescription items each year.[8] In England, an estimated 70% of NSP is provided by pharmacies.[9]

NSP is highly cost effective, with one 2019 study concluding that UK "needle and syringe programmes are a highly effective low-cost intervention to reduce hepatitis C virus transmission, and in some settings they are cost-saving",[10] whilst a 2016 analysis found that NSP delivered through community pharmacies in England made an overall contribution to wider society worth £655.1 million, of which £140.8 million would have been expected to accrue in the short term.[11]

> "Needle and syringe programmes (NSPs) are often the first point of contact with marginalized people who inject drugs. As a core intervention for harm reduction, they are highly effective in preventing HIV and HCV transmission, reducing the incidence of skin and soft tissue infections and providing an entry point for prevention of overdoses and broader health support.
> In the absence of such programmes, these populations may remain entirely out of reach, allowing epidemics of infections such as HIV, HCV and tuberculosis (TB) to spread unchecked."
>
> *World Health Organisation, Needle and syringe programmes for people who inject drugs: Operational guide (2025)* [12]

NSP in England

History

The UK was a pioneer in NSP,[13] opening the first needle distribution service in 1986 in the midst of the HIV crisis. A series of pilot sites were then introduced by the Government in 1987.[14] Employing a 'user friendly' approach, these services operated on a policy of no waiting lists, a requirement of minimal personal information from clients, and no need to stop using drugs.[15] By 1997, 96% of Health Authorities in the UK (not including Northern Ireland) delivered a form of needle exchange.[16] This model continued to expand into the 2010s, both in number of settings providing this service,[17] and in scope, with many beginning to offer sexual health provision, as well as vaccines and testing for blood-borne viruses.[18]

This period saw the sharing of injecting equipment decline, but this progress has now stalled.[19] In 2026, the UK Health Security Agency (UKHSA) reported "the highest proportions for both direct and indirect sharing over the last 10 years", highlighting higher rates of direct sharing among women and young people.[20] In 2023, 25% of people who inject drugs reported directly sharing needles and syringes, and 44% had shared other injecting equipment.[21] These rises have occurred in the context of a decreasing presence of community pharmacy, and significant funding cuts to drug and alcohol services in England.[22]

NSP coverage is not routinely monitored in England, but estimates place England as providing 240 needles and syringes per person who injects drugs per year.[23] This is below the World Health Organisation's programmatic target for elimination of hepatitis C, which is set at 300, a threshold widely regarded as a minimum rather than an optimal level of provision.[24]

Policy context

Under the Health and Social Care Act 2012, local authorities are responsible for commissioning drug and alcohol services as part of their wider remit to improve the health of people in their area, with little specification as to the provision and accessibility of these services.[26]

Under current national policy, direction for these services is very limited. Whilst the Government's 2021 drugs plan did provide a funding increase for drug and alcohol services,[27] the plan itself contained limited focus on the provision of harm reduction.[28]

Guidance for Combatting Drugs Partnerships (the multi-agency local fora established as part of the delivery of the 2021 plan) does not cover needle and syringe programmes.[29] Whilst the National Combating Drugs Outcomes Framework has set reducing drug-related deaths and harms as one of its three key outcomes, many of its supporting metrics either rely on limited datasets or have a particularly strong focus on immediate harms, such as deaths from drugs misuse, rather than indicators able to directly demonstrate accessible, effective harm reduction services.[30]

Similarly, guidance on service provision does exist, but it predominantly focuses on service

> "(NSPs) have been a huge success story in the UK, and are credited with helping HIV rates among people who inject drugs to be as low as 1%. This is one of the lowest rates in the world and compares very favourably to many countries, including the US at 11% and Spain at 33%."[25]
>
> *Health matters: preventing drug misuse deaths (2017)*

design rather than impact. The Office for Health Improvement and Disparities (OHID) national commissioning quality standard for local authority drug and alcohol treatment and recovery services,[31] for example, encourages services to offer 'a full range of evidence-based support,' including the provision of injecting equipment.[32] This guidance also recommends commissioners collect data that monitors NSP provision as part of an integrated system approach.

Similarly, NICE guidance on NSP is comprehensive, but it has not been updated since 2014. This therefore does not reflect changes to drug use, including increasing poly-drug use and injecting of cocaine, nor evolving harm reduction practice and evidence over the past decade, such as the growing emphasis on peer-led services, postal services and online provision. While the NICE guidance provides an important benchmark for service quality, there is no statutory requirement for local services to be routinely assessed against its recommendations.

The origins of this report

The Hepatitis C Trust is a national charity working with people who use drugs, have experienced homelessness, and/or have experience of the criminal justice system. Our staff work in communities and prisons across England, delivering peer-led services for people who face significant barriers to accessing health and care services. We engage more than 100,000 of these people each year, many of whom have current or recent experience of injecting drugs.[33]

Over 90% of hepatitis C transmission in England occurs through injecting drug use, and comprehensive and accessible NSP is central to preventing new infections. In recent years, our frontline staff and networks have been raising increasing concern about the closure of NSP services, leaving potentially insufficient provision to cover need. Similarly, staff have witnessed mixed service quality, including instances where patients have faced stigmatising attitudes from pharmacy staff.

In England, there is no national data collection system to monitor the availability, accessibility or quality of NSP. National data shows a 9% decline in the number of community pharmacies operating in England in the ten years to 2026, with more than 1,000 pharmacies ceasing to trade during that period.[34]

Concerns about limited remuneration for the service are also widespread; pharmacies providing NSP may be paid an annual retainer fee of up to £500, and then an amount per transaction, often in the range of £1 to £3.[35] These payments compare unfavourably to what is offered to pharmacists for other services under the Pharmacy First scheme.[36]

This study set out to provide a clear, current picture of NSP services being provided through community pharmacy in England. Much of the work was delivered by trained volunteers. To support this, the information collected was limited to a small, core dataset judged sufficient to provide insight into the availability and key components of pharmacy NSP delivery.

Investigating the provision and quality of pharmacy NSP

To gain a clearer understanding of some of the challenges outlined above, the Hepatitis C Trust undertook a mapping exercise of community pharmacy NSP in England. This follows a similar exercise we did in 2023.

How did we map pharmacy NSP?

Preliminary list

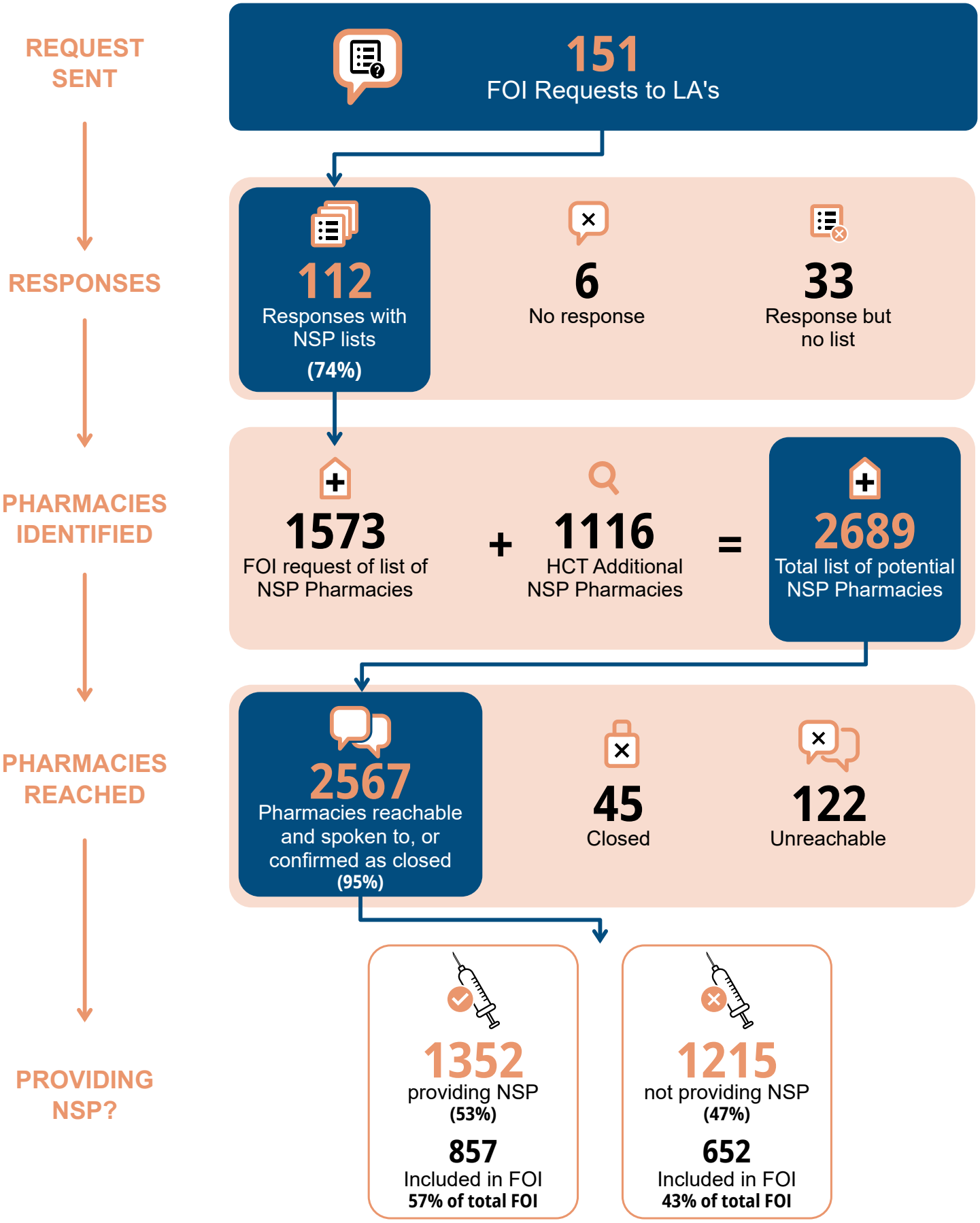
We began this exercise by sending a Freedom of Information request (FOI) to local authorities, asking for the names and addresses of all pharmacies that are contracted to provide NSP.

To supplement these lists (or where we did not receive a response) we conducted an additional mapping exercise, contacting drug and alcohol providers at local authorities' request and drawing on other data sources, such as online lists from local substance misuse services and Pharmaceutical Needs Assessments, which are published every three years by local public health teams.

Mystery shopping

We then attempted to make a phone call to every pharmacy on this combined list. We'd ask if they provided NSP. If they did, we asked the following questions relating to the quality of service provided:

- Can I get a mix of different types of syringes or are they pre-made packs?
- Is there a limit to the amount of injecting equipment I can get?
- Do I need to bring in used equipment to access new syringes?


REQUEST SENT
151
FOI Requests to LA's
RESPONSES
112
Responses with NSP lists
(74%)
6
No response
33
Response but no list
PHARMACIES IDENTIFIED
1573
FOI request of list of NSP Pharmacies
+
1116
HCT Additional NSP Pharmacies
=
2689
Total list of potential NSP Pharmacies
PHARMACIES REACHED
2567
Pharmacies reachable and spoken to, or confirmed as closed
(95%)
45
Closed
122
Unreachable
PROVIDING NSP?
1352
providing NSP
(53%)
857
Included in FOI
57% of total FOI
1215
not providing NSP
(47%)
652
Included in FOI
43% of total FOI

Key findings

1. Local authorities' knowledge of NSP services in their area is often limited

The vast majority of local authorities do not have an adequate picture of NSP coverage in their area. Only 26% of the local authorities responding to our FOI met our criteria for having a "strong" understanding of NSP provision.[i]

We asked 151 local authorities for a list of the community pharmacies providing NSP in their area, through a Freedom of Information (FOI) request. We received responses from 145 local authorities.[ii] 112 provided a list of pharmacies commissioned to deliver NSP, 30 informed us that another organisation held this data, and 3 reported no commissioned pharmacies in their area.

A total of 1,573 pharmacies were included as providing NSP in the lists provided directly from the local authorities. We were able to confirm the status of 1,509, and of these, just 57% (857) confirmed that they provided an NSP service when we contacted them. Our additional mapping found a further 495 pharmacies that provide this service, but were not on the lists provided by local authorities. [iii]

2. Local information on pharmacy NSP services is inaccurate

Local intelligence on NSP availability – from online directories, drug and alcohol services, and other resources – was inaccurate, with only 47% of pharmacies identified by these local sources as providing NSP actually doing so.

We compiled a full list of pharmacies delivering NSP by combining lists provided by local authorities with information requests to local drug and alcohol services and other resources (see above figure). In total, we identified 2,689 pharmacies that were listed as providing NSP in at least one local source.

Trained staff and volunteers called each pharmacy, posing as someone who wanted to access NSP using a 'mystery shopping' methodology, confirming the status of 2,567 of the 2,689 pharmacies (95%). Half of these pharmacies (1,352, 53%) confirmed that they provided an NSP service. 47% were not providing the service.

Beyond the pharmacies that were provided through FOIs, we found 1,116 that were listed as providing NSP in another source. From these, we were able to confirm the status of 1060. Only 495 (47%) provided NSP.

i Our criteria for a local authority having a "strong" understanding of pharmacy NSP is one where both:
1) 75% of pharmacies found to be providing NSP in an area were on the local authority's FOI list and
2) 75% of pharmacies on a local authority's list were found to be providing NSP.
For an explanation as to why both criteria are needed, see Annex 2.

ii There are 153 upper-tier local authorities in England. We were unable to contact two local authorities due to incorrectly following their request procedure. Six local authorities did not respond to our request.

iii 43 (9%) of the 495 pharmacies we found to be providing NSP but not on FOI lists were from local authorities we didn't receive a response from.

3. Provision is declining

Out of the pharmacies we contacted in both our 2025 and 2023 NSP mapping exercises, a third (323/1,002) said they had stopped providing the service since the 2023 study.

In 2023, HCT conducted a similar, smaller study of pharmacy NSP. Although direct comparisons cannot be made, the rate of closures indicated by this is striking. As part of our 2025 exercise, we contacted 1,002 pharmacies we knew to be providing NSP in 2023. 323 (32%) were no longer providing the service; almost one third in just two years.

4. Provision is not in line with recommended standards

Our research identified widespread quality issues with NSP services, where national guidance was not being followed. Of the pharmacies we found to be providing NSP and were able to answer each question on service quality, 70% had restrictions on the amount of injecting equipment that could be dispersed and 22% required used equipment to be returned in order to access new supplies without limit.

NICE guidance sets out clear quality standards for NSP services. It recommends that needle and syringe programme providers should "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." Additionally, it recommends that providers "make needles available in a range of lengths and gauges, provide syringes in a range of sizes". [37]

We found common quality issues in our research. From the responses we received, we found[iv]:

- 70% had restrictions on the amount of injecting equipment that could be dispersed.
- 15% required used equipment to be returned in order to access new supplies, and an additional 7% placed a limit on how much new equipment could be acquired if there was no return.
- 67% of pharmacies (884) provided only pre-made packs, 23% (298) offered a mix of different syringe types, and 10% (134) offered both.

iv Not every pharmacy that we confirmed to be providing NSP answered every question. Limits on equipment: 1,341 responses, requirements for returns: 1,272 responses, what packs are available: 1,307 responses.

Discussion

This mapping exercise raises significant concerns about both the availability and oversight of needle and syringe provision in England, including the speed at which these services may be closing. Most importantly, it highlights that local authorities often do not have a reliable picture of where NSP is available in their area. Only 26% of responding local authorities met our criteria for having a strong understanding of local NSP provision, and only half of pharmacies identified through local authority lists as providing NSP confirmed that they were currently providing the service. Many services were also not operating in line with NICE guidance.

Whilst this study did not capture the provision of specialist harm reduction services or needle and syringe programmes operating outside of pharmacies, these findings add to wider concerns about access to NSP, alongside UKHSA data showing increases in the sharing of injecting equipment in recent years and estimates of access to 'adequate' NSP stalling at just 60%.[38]

Conclusions and recommendations

NSP services were developed in the UK more than forty years ago to support efforts to prevent the transmission of blood-borne viruses. Since that time, we have seen the significant additional benefits these services can bring, facilitating early BBV testing and diagnosis, linking people into drug treatment, and providing access to basic health and care services when they are most in need of support. As we near the 2030 goals to eliminate hepatitis B and C, and to bring HIV transmission to zero, the prevention and early intervention that NSP provides is becoming increasingly critical.

With no consistent national system for monitoring community pharmacy NSP provision in England, changes in provision—including services closing, reducing their offer or introducing access restrictions—may go undetected at both a local and a national level. **A national monitoring system should therefore be established to provide an up-to-date picture of NSP provision, including where services are operating, the type and quantity of equipment available, and key aspects of service accessibility and quality. A pilot system is currently being run by UKHSA to support national hepatitis C elimination; this mapping exercise highlights the urgency with which this must be rolled out nationally.**

Given the scale of the gaps identified through this exercise, we also recommend a **national review of NSP provision in England**. This should assess whether current provision is sufficient, equitable and accessible, identify areas where provision has declined or disappeared, and establish what is required to ensure that people who inject drugs can access appropriate injecting equipment wherever they live. Regular national monitoring, alongside a comprehensive review of provision, would provide a stronger basis for identifying and addressing gaps before they translate into increased risk of blood-borne virus transmission and other injecting-related harms.

NSP is a well-understood and effective intervention with a long and successful history in the UK. With additional leadership and prioritisation, it can continue to play its essential role into the future. To this end, we recommend:

- Local authorities should include data collection on NSP as part of the core data set that they use for contract monitoring for all drug contracts, drawing on the examples set out in OHID's Commissioning quality standard for alcohol and drug treatment and recovery,[39] to ensure that commissioning is effective and equitable.
- OHID should commission a comprehensive national evaluation of NSP provision to inform national and regional level planning, at the earliest possible opportunity. This should seek to capture both current provision and the rate of service closure, as well as understanding the reasons for this.
- OHID should work with UKHSA to develop and embed a robust national data reporting system for NSP. This work should build on work by UKHSA to pilot NSP monitoring to support hepatitis C elimination, and DHSC should support this being rapidly scaled up.
- NICE should review its 2014 NSP guidelines to ensure they fully reflect changing drug use, including increasing injecting of cocaine and other new substances, and evolving evidence in new approaches to NSP such as postal services and peer-led interventions.
- DHSC should set out a clear long-term vision for NSP in the context of the elimination of hepatitis B and C, and elimination of HIV transmission, including clear resourcing to implement and safeguard this.

Annex 1:
Research methods and limitations

This project employed a **mixed-methods service mapping and mystery shopping design** to assess the availability and accessibility of pharmacy-based needle and syringe programmes (NSP) in England. The work was conducted in two sequential phases: (1) **service mapping** to establish a comprehensive database of pharmacies potentially providing NSP, and (2) a **mystery shopping exercise** to test the accuracy of reported coverage and assess compliance with national guidance on NSP delivery.

Research approach

Service Mapping

The initial mapping sought to generate a comprehensive list of pharmacy-based NSPs. Upper-tier Local Authorities in England were sent Freedom of Information (FOI) requests (n=151), asking for a list of names and addresses of all contracted pharmacies that provide NSP. We were unable to contact two local authorities due to incorrectly following their request procedure. The responses were collated into a central document.

This data was split up to match the geography of the 24 Hepatitis C Operational Delivery Networks (ODN) in England, with each being assigned a local NSP mapping lead. Supported by a peer volunteer, they coordinated data collection within their area to supplement the lists obtained through FOIs. Data sources included:

- **Local substance misuse services (SMS)** and harm reduction leads, often via lead pharmacists, who maintain operational lists of NSPs.
- **Publicly available documents**, including Pharmaceutical Needs Assessments (PNAs) published every three years, Local Pharmaceutical Committee (LPC) records, and provider directories.
- **Service user knowledge** to validate accuracy and timeliness of the data.
- **Pharmacies delivering NSP in 2023** when HCT's initial pharmacy NSP mapping was undertaken

Mapping leads consolidated this information into a standardised spreadsheet (name, address, telephone number) for each pharmacy, which was subsequently merged with FOI responses to create a master dataset for each ODN area.

Mystery Shopping

To test this mapped dataset, a structured telephone-based mystery shopping exercise was undertaken. This was piloted in two ODN areas (Newcastle and Wessex) before being rolled out nationally. Peer volunteers were trained to conduct the calls using a standardised questionnaire, which included four core questions:

1. Do you provide sterile needle and syringe provision?
2. Can I get a mix of different types of syringes or are they pre-made packs?
3. Is there a limit to the amount of injecting equipment I can get?
4. Do I need to bring in used equipment to access new syringes?

Responses were recorded in real time on a structured spreadsheet, alongside space for qualitative notes on the interaction (e.g., whether staff were approachable or knowledgeable).

Training and Ethical Considerations

Mystery shoppers received training on ethical practice, objectivity, and confidentiality prior to data collection. They were instructed to:

- Keep calls brief to minimise burden on pharmacies.
- Avoid revealing their role as evaluators.
- Report only factual information.
- Record aggregated rather than individual-level data.

No personal identifiable information was collected, and no audio/video recording took place. Data were anonymised at the point of reporting, consistent with **Market Research Society (MRS) ethical guidelines** for mystery shopping.

Data Analysis

Data from the mapping and mystery shopping phases were merged into a single database. Analysis involved descriptive statistics to quantify:

- The proportion of pharmacies actually providing NSP services.
- Variations in provision (pack-only vs. mixed syringes, limits imposed, requirements for returns).
- Geographic variation across ODN areas.

Qualitative notes were used to contextualise findings, particularly around staff knowledge, accessibility, and service-user experience.

Limitations

While this project represents the most comprehensive attempt to map pharmacy-based NSP provision across England to date, several limitations should be acknowledged:

- This work does not amount to a fully complete map of all pharmacies in England that provide NSP. The initial list of pharmacies provided through the FOI exercise was of low quality, and the exact approach used by each regional team to build on these lists will naturally have varied. Likewise, this mapping does not account for how much equipment each pharmacy will be providing. Factors like the size of pharmacies, or how well NSP is advertised will vary greatly. Similarly, we are not able to make assertions about the overall coverage for an area, given this exercise did not map NSP provided through other models, such as through mobile units or those hosted in drug and alcohol services.
- Telephone survey limitations: While most pharmacies were successfully contacted (95%), responses often depended on which staff member answered the call. Differences in knowledge and confidence could have affected how accurately service availability was described.
- Temporal changes in provision: NSP coverage is dynamic. Pharmacies may close, withdraw from provision, or experience temporary stock shortages. The findings therefore represent a snapshot in time (2025) rather than a permanent state of provision.
- Decline since 2023, but extent uncertain: The comparison with 2023 data confirms that some pharmacies previously delivering NSPs are no longer doing so in 2025. However, the scale of decline cannot be precisely determined, as new sites may have been commissioned that were not captured, and alternative delivery models are expanding.

Annex 2:

Our criteria for what "**strong**" local authority understanding of NSP looks like

We opted to use a combination of two criteria to assess the fidelity of local authorities' freedom of information request responses. To meet our definition of a **strong** understanding of pharmacy NSP coverage in their jurisdiction, a response needs to meet the following thresholds:

1. 75% of pharmacies found to be providing NSP in an area were on the local authority's FOI list.
2. 75% of pharmacies on a local authority's list were found to be providing NSP.

Both criteria are needed to ensure lists reflect the reality of service coverage because:

- A local authority could feasibly meet criteria 1) but not 2) by providing an overly large list that also contained a lot of pharmacies that don't provide NSP. For example, an FOI list could contain 50 pharmacies – which included every pharmacy that provided NSP, but also 25 that don't. A local authority could in fact pass criteria 1) just by providing a list of every single pharmacy in their area.
- A local authority could feasibly meet criteria 2) but not 1) by providing a very limited list. For example, an FOI list could contain 5 pharmacies, all of which actually do provide NSP, but they could have missed an additional 10 in the area that also do.

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