Alcohol Identification and Brief Advice in South London: Recommendations for Action

Author
Rod Watson
Senior Project Manager
Health Innovation Network
www.hin-southlondon.org
January 2015
# Table of Contents

Abbreviations .................................................................................................................. 3  
Executive Summary ......................................................................................................... 4  
Recommendations ............................................................................................................. 5  
  Recommendations to support commissioning of IBA .................................................. 5  
  Recommendations to support delivery of IBA .............................................................. 5  
Background and Context .................................................................................................. 6  
Methodology ...................................................................................................................... 9  
  Review of evidence ........................................................................................................ 9  
  Interviews with Local Authority Commissioners of IBA in South London .................. 9  
Review of IBA Guidance and IBA in various settings ...................................................... 9  
  IBA in community health settings .............................................................................. 10  
  IBA in a hospital-based setting .................................................................................. 11  
  IBA in a sexual health setting ...................................................................................... 12  
  IBA in a community pharmacy setting ...................................................................... 12  
  IBA in social services’ settings .................................................................................. 13  
  IBA in homeless settings ............................................................................................ 14  
  IBA in criminal justice settings .................................................................................. 15  
  Follow-up (all settings) ............................................................................................... 15  
  Other London-based evidence ..................................................................................... 15  
Key points from stakeholder interviews ......................................................................... 16  
Discussion .......................................................................................................................... 19  
  Primary care ................................................................................................................ 19  
  Hospital-based CQUIN for alcohol IBA ..................................................................... 20  
  Data returns ................................................................................................................. 20  
  Training and ongoing support ..................................................................................... 20  
  IBA Direct .................................................................................................................... 21  
References ......................................................................................................................... 22  
Appendix 1 ......................................................................................................................... 24
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUDIT</td>
<td>Alcohol Use Disorder Identification Test</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CLAHRC</td>
<td>Collaboration for Leadership in Applied Health Research &amp; Care</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>DES</td>
<td>Directly Enhanced Service</td>
</tr>
<tr>
<td>FAST</td>
<td>Fast Alcohol Screening Test</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HIN</td>
<td>Health Innovation Network</td>
</tr>
<tr>
<td>IBA</td>
<td>Identification and Brief Advice</td>
</tr>
<tr>
<td>LAMP</td>
<td>London Alcohol Misuse Prevention</td>
</tr>
<tr>
<td>M-SASQ</td>
<td>Modified Single Alcohol Screening Questionnaire</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>PAT</td>
<td>Paddington Alcohol Test</td>
</tr>
<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
</tr>
</tbody>
</table>
Executive Summary

- The Health Innovation Network (HIN) is the Academic Health Science Network for South London. This report describes the process and results of a scoping exercise on alcohol Identification and Brief Advice (IBA) activities across the 12 boroughs of South London. The report is aimed at commissioners of alcohol IBA. The aims of the scoping exercise were to:
  
  - Identify gaps and opportunities in the planning, commissioning, delivery and monitoring of alcohol IBA training and activities.
  - Propose recommendations that will lead to an increase in delivery of alcohol IBA across all South London boroughs.

- The methodology used for the scoping exercise was two-fold:
  
  - A review of alcohol IBA Guidance documents and recent evidence reviews of IBA delivery in various settings.
  - Face to face, semi-structured interviews with local authority Commissioners of alcohol IBA in all 12 South London boroughs.

- Findings from the scoping exercise highlighted a range of IBA training and interventions in a large range of settings, and much consistency in the approach to IBA commissioning across South London boroughs.

- Gaps and opportunities were identified in different settings. In Primary Care, a consistent theme was a lack of activity data being returned to commissioners; therefore actual activity wasn't known in most boroughs. This applies to almost all settings in which IBA is delivered/thought to be delivered but particularly in the Primary Care setting. Some respondents mentioned not knowing whether brief advice was provided after a patient completed an alcohol tool or written information/leaflets were provided or nothing was provided at all.

- There was variability across the Boroughs in the commissioning and delivery of IBA activities in other settings and for training on IBA. Opportunities to share learning from good practice and to collaborate on training programmes were proposed.

- All respondents expressed a desire to take part as a pilot area on an initiative or to collaborate with the Health Innovation Network where they had the capacity to do so.
Recommendations

The Health Innovation Network will work collaboratively with responsible officers from across South London to deliver the following recommendations arising from this scoping exercise. Many of the findings and recommendations may be generalisable beyond South London. Spread and adoption of some initiatives can be expected to occur beyond South London; perhaps nationally.

Recommendations to support commissioning of IBA

- Develop a toolkit to support commissioning of IBA in different settings. The alcohol IBA commissioning toolkit will be an electronic resource and shall include:
  - Summary of the evidence base on alcohol IBA
  - Links to Guidance documents
  - Potential returns on investment scenarios
  - Best practice examples in a range of different settings
  - Sample service specifications
  - Advice on inclusion of data collection within contracts

- Work with the LAMP (London Alcohol Misuse Prevention) to develop guidance to support commissioning and delivery of IBA training. This could include spread and adoption of Royal College of General Practitioners (RCGP) and Royal College of Nursing (RCN) online training packages as follow-up refresher training 6 months after face to face training.

Recommendations to support delivery of IBA

- Work with a selection of Primary Care practices from a number of different Boroughs across South London to understand current local barriers and drivers to IBA delivery and to facilitate improvements in the number and quality of IBA delivered. This would include consideration of electronic application of IBA. Following this, develop a Standard for Primary Care practices on alcohol IBA. The Standard could provide guidance on best practice and minimum requirements for GPs to deliver and record IBA.

- Work with the South London Collaboration for Leadership in Applied Health Research and Care (CLAHRC) to develop and pilot an innovative direct-to-population approach to alcohol IBA in one or more South London boroughs via a smartphone app.
Explore options for open-access, cross-Borough alcohol IBA training on a regular cycle. The training should incorporate strategies to evaluate maintenance of IBA delivery over a given period of time (eg. 6 months). Training of IBA champions in various settings may also be explored. All participants of IBA training shall be encouraged to join the London IBA Network.

Establish a system for sharing good practice on IBA initiatives among South London commissioners and providers eg. using the Health Innovation Network’s collaboration portal. Also, explore interest in an annual one-day “show-case” seminar where good practice initiatives and examples of effective commissioning can be presented.

Work with 1 or 2 Boroughs on a Workplace pilot: form a small working group to develop and pilot a web-based IBA intervention for staff in a workplace setting eg. staff of a Council department, with support materials. It could be delivered as part of a broader healthy workplace initiative.

Background and Context

The Health Innovation Network is one of 15 national Academic Health Science Networks, licensed by NHS England, with a membership that includes all health and social care organisations and higher education institutes across all 12 boroughs of South London. There are 5 clinical areas: Alcohol, Dementia, Diabetes, Musculoskeletal and Cancer; and the following innovation themes: Industry partnership (wealth creation), Patient and Carer experience, Informatics, Education and Training, Research and Evaluation. Initial priority areas for Alcohol were identified as Alcohol-related Hospital Frequent Attendees and Identification and Brief Advice. This report focuses on a scoping exercise undertaken to propose recommendations for action for the IBA element of the Alcohol programme. The report is aimed at commissioners of alcohol IBA across South London; the recommendations may be generalisable more widely. The aims of the scoping exercise were to:

- Identify gaps and opportunities in the planning, commissioning, delivery and monitoring of alcohol IBA training and activities.

- Propose recommendations that will lead to an increase in delivery of alcohol IBA across all South London boroughs.

Alcohol Identification and Brief Advice is simple, structured and brief advice given to a person after completing a validated alcohol screening tool. It is a preventative approach aimed at identifying and providing brief advice to increasing and higher-risk drinkers. It is not a treatment and it is not aimed at dependent drinkers. The advice includes feedback on the individual’s score from the identification tool and information about harm from alcohol; aimed at motivating risky drinkers to reduce
their alcohol consumption to lower risk levels. Written information may also be provided.

The evidence base for the effectiveness of IBA is strong. The World Health Organisation and the Department of Health have both acknowledged over 50 peer reviewed, academic studies that demonstrate IBA is both effective and cost-effective in reducing the risks associated with drinking. On average, 1 in 8 drinkers who receive this type of support from a healthcare professional will reduce their drinking to lower-risk levels. However, this may be an underestimation of the benefits, as some may reduce their drinking but not to lower-risk levels. This compares with 1 in 20 smokers who benefit from stop smoking advice. (Babor and Higgins-Biddle, 2001; Raistrick, et. al., 2006).

In terms of the need for IBA (and other interventions) in London, a review of evidence in Evidence of Effectiveness: Case for Decision-makers (Alcohol Concern, 2014) highlighted the following characteristics about alcohol and Londoners:

On the surface the level of alcohol use and alcohol related harm in London is around or slightly below the national average.

- 13% of adults in London are likely to have drunk on five or more days in the previous week – exactly the national average.
- 15% of adults drank in London more than 8 units (if male) or 6 units (if female) on their heaviest drinking day in the last week. Again this was the national average.
- The proportion of adults likely to exceed 4/3 units on their heaviest drinking day is 28% in London. The national average is 31%.
- Alcohol specific mortality rates for both men and women are slightly below the national average
- Alcohol specific hospital admissions are also slightly below the national average for both genders.

However, this data conceals as much as it reveals. It is estimated that areas with average levels of alcohol related harm will experience a considerable impact from alcohol. A London borough of about 250,000 people would have:

- **38,000** Increasing Risk Drinkers
- **9,500** Higher Risk Drinkers
- **5,000** Dependent Drinkers
- **21,500** Binge Drinkers
A borough with an average level of harm would be likely to experience the following:

<table>
<thead>
<tr>
<th>Effect</th>
<th>Borough with 250,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people admitted to hospital with an alcohol-related condition (per annum)</td>
<td>5,000</td>
</tr>
<tr>
<td>Victims of alcohol-related violent crime(per annum)</td>
<td>2,500</td>
</tr>
<tr>
<td>11-15 year olds will be drinking (weekly)</td>
<td>1,000</td>
</tr>
<tr>
<td>Costs to health service of alcohol related harm (per annum)</td>
<td>£14,100,000</td>
</tr>
<tr>
<td>Costs of alcohol related crime (per annum)</td>
<td>£47,100,000</td>
</tr>
<tr>
<td>Costs of drink-driving (per annum)</td>
<td>£2,400,000</td>
</tr>
<tr>
<td>Drink-driving deaths (per annum)</td>
<td>2</td>
</tr>
<tr>
<td>Alcohol-related sexual assaults (per annum)</td>
<td>90</td>
</tr>
<tr>
<td>Victims of alcohol-related /domestic violence (per annum)</td>
<td>1700</td>
</tr>
<tr>
<td>Costs to economy of alcohol related absenteeism, deaths and lost working days (per annum)</td>
<td>£30,200,000</td>
</tr>
<tr>
<td>Working days lost due to alcohol related absence (per annum)</td>
<td>66,000</td>
</tr>
<tr>
<td>Children affected by parental alcohol problems (per annum)</td>
<td>4,400</td>
</tr>
</tbody>
</table>

More importantly, these average rates of harm across London conceal communities with much higher levels of harm. For example:

- Alcohol dependence in London is higher than in most other parts of the country. This is probably due to the urban environment attracting heavier drinkers.

- Non-white ethnic groups consume less alcohol than white British, white Irish and other white groups. Therefore, the large non-white populations (40.2% as against 14.6% in England) across London may statistically conceal the impact of alcohol on white populations.

- The mean age of the London population (35.6 years) is lower than the England average (39.3 years). If this reflects a pattern of people moving outside London as they grow older, it may result in harm being “exported”.

Above all, although health problems may be lower, alcohol related crime is particularly high in London. Alcohol attributable crime generally, and attributable
violent and sexual crimes specifically, are not only above average in the London region but are all at the highest level of any of the nine regions in England.

Methodology

Review of evidence

Several projects have been commissioned over recent years on alcohol IBA in different settings in London and the key points from the project reports and their recommendations are presented below.

Interviews with Local Authority Commissioners of IBA in South London

An initial email invitation was sent out to commissioners of alcohol services in South London in late June 2014. Meetings with commissioners were organised to gain a better understanding of IBA being delivered across South London and whether there was interest and scope to build upon this work. An interview schedule comprising key questions for discussion was attached to the email. A copy of the interview schedule is attached at Appendix 1.

Review of IBA Guidance and IBA in various settings


National guidance has supported and recommended the rollout of IBA for many years. A strong case has been made for investing in NHS services and social services to deliver IBA in a range of settings.

- National alcohol strategies from 2004 onwards have highlighted primary care and hospitals as key locations for screening and brief intervention.

- The Department of Health’s High Impact Changes to reduce alcohol related harm identify appointing an Alcohol Health Worker in hospital and rolling out IBA as two of the key changes required at the local level.

- Guidance from the National Institute for Health and Care Excellence (NICE) in 2010 recommends that health professionals should routinely carry out alcohol screening as an integral part of their practice.

- The 2004 national strategy flags up models such as St Mary’s Hospital in Paddington which applies a customised questionnaire to all entrants and
refers those with problems to an alcohol misuse worker. This message is repeated in the 2012 strategy.

- The Royal Pharmaceutical Society of Great Britain recognises that community pharmacy has a potential role to play in alcohol screening.

- NICE Guidance recommends that screening for alcohol-use disorders should include people with relevant mental health problems such as anxiety, depression or other mood disorders or at risk of self-harm.

- NICE Guidance on Psychosis and substance misuse emphasises the importance of alcohol training for mental health staff.

- A position statement from the Royal College of Surgeons of England (2010), endorsed by the Royal College of Nursing, recommends brief, cognitive advice delivered by nursing staff as part of care for conditions resulting from alcohol misuse.

- Health First: an evidence-based alcohol strategy for the UK (2013) recommends All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.

- The Delivering Better Oral Health guidance document identifies the risks to oral health caused by alcohol and recommends tailored feedback to patients to reduce the risks of oral cancer and dental erosion.

IBA in community health settings

Alcohol Concern (2014) reviewed the international and national evidence base for IBA in a report which made the case for the delivery of IBA in a number of community health settings, including:

- Primary care
- Midwifery and health visiting
- Mental health services
- Drug services

Minimum standards for staff working in each of the settings were developed. This included which Alcohol Use Disorder Identification Tool (AUDIT) to use and who to target with the tool. Guidance on how to initiate IBA with a client and how to deliver advice was also included in the minimum standards.

- Primary care practitioners should not limit IBA to new registrants but also offer it to people in the following target groups: people with heart disease, people with diabetes, people who have recently attended Accident and Emergency, men over 45 and all smokers. It can also be undertaken with patients where there is a suggestion of an underlying alcohol issue, for example, indigestion, poor sleeping and incontinence.
Midwives and health visitors. Although both TWEAK (a five item-scale developed to test for risky drinking during pregnancy) and T-ACE (another tool developed to identify risky drinking during pregnancy) are appropriate alcohol identification tools to use with pregnant women, AUDIT-C was found to have the best sensitivity and specificity with this target group. The tool should be used with all patients at their first face to face meeting.

Mental health service staff include staff working in inpatient and community settings for statutory, third sector and commercial organisations. The full AUDIT tool should be used with all adult mental health patients. For maximum coverage, the tool should be used at first assessment but it is recognised that this may not always be possible. The first care planning or key working sessions are suitable alternatives. If the patient is an inpatient, the IBA can be administered prior to discharge.

Drug services’ staff should use the full AUDIT tool with all of their adult clients at first assessment, care planning or key working session. If the person is an inpatient, staff can use the full AUDIT prior to discharge.

**IBA in a hospital-based setting**

There is a strong evidence base for the delivery of IBA in hospital-based settings also. Emergency staff, hospital inpatient staff and outpatient staff can all play a role. In the hospital setting, IBA information should be included in an intervention package for staff, such as a folder with the chosen identification tool and patient leaflets.

Hospital emergency department staff, including doctors, nurses and healthcare assistants can use a variety of identification tools such as FAST (Fast Alcohol Screening Test), Paddington Alcohol Test (PAT), Modified Single Alcohol Screening Questionnaire (M-SASQ) and AUDIT-C. It is recommended that one of the tools can be used at any point during contact with a patient. Each emergency department will need to decide who is best placed to administer the tool eg doctor or triage nurse, and at which point in the process it should be used. When considering the best time to use the identification tool, it is recommended that patients who are intoxicated are unlikely to benefit and sufficient time is available to give brief advice.

Hospital inpatient staff. The recommendation is that one of the shorter identification tools is used initially and if the patient is found to be positive, the rest of the questions that make up the full AUDIT are then asked. The identification tool can be used with all patients or it can be targeted to specific at-risk groups, such as:

- Maxillofacial injuries
- Fractures
- Mental health problems
- Liver disease
- Heart disease
- Diabetes
- Sexual health issues
- A recent attendance at the emergency department
- Men over 45
- Smokers
- Patients where alcohol was likely to be a contributory factor, eg indigestion, poor sleeping and incontinence

- Hospital outpatient staff. If time allows in this setting, the full AUDIT tool is recommended; otherwise the FAST tool can be used. As with hospital inpatient staff above, the identification tool can be used with all patients or with those specific at-risk groups listed immediately above.

**IBA in a sexual health setting**

The report by Alcohol Concern (2014) recommends the full AUDIT tool should be used for all sexual health clients, including 16-17 year olds (younger people can also be screened but it is recommended that a joint approach with young people’s substance misuse services is taken) presenting for a variety of needs.

An evaluation of a pilot project by Alcohol Concern and Brook sexual health services in Lambeth, Southwark and Camden found increased delivery of IBA by staff after training. However, turnover of staff and high workloads were challenges to further delivery of IBA. Some staff were quite reluctant to deliver IBA as they felt they already had too much on without taking on another piece of work (Alcohol Concern, 2014a).

**IBA in a community pharmacy setting**

Although a literature review of papers published up to 2007 did not find any empirical evidence for effectiveness of community pharmacy-based services for alcohol misuses, it did find the setting to be feasible and recommended it be considered as part of a larger strategy to address alcohol consumption. The NICE Public Health Guidance on preventing harmful drinking (NICE, 2010) also recommends pharmacies as one of a number of appropriate settings for alcohol screening.

Community Pharmacies are best suited to deliver alcohol intervention and brief advice for the reasons outlined below (NHS Health Scotland):

- Community Pharmacies are the most accessible health professionals, with pharmacies open daily including evenings and weekends.

- Community Pharmacies have the potential impact on health inequalities as they are located across the country including in areas of high deprivation.

- Community Pharmacies have the potential to increase access to hidden and hard-to-reach groups who may not necessarily engage with other healthcare professionals.
• Community Pharmacies are in the unique position of attracting both those who are unwell, but also those who have no medical complaint.

• Pharmacists are also well placed to identify and target vulnerable populations for whom alcohol presents an increased risk for poor prognosis of drug interaction e.g. older people, drug users (Watson and Blenkinsopp, 2008; Sheridan et al., 2011; Watson et al., 2011)

An evaluation of IBA delivered in community pharmacies in North-west England supports the feasibility of the intervention in a community pharmacy setting, demonstrated the intervention reaches relevant sections of the population and is regarded by key stakeholders as desirable (Gray, NL, et al, 2012).

Alcohol Concern (2014) set out minimum standards for delivery of IBA in pharmacies as follows. The pharmacy setting provides the opportunity to offer either opportunistic or targeted identification. The AUDIT tool could be used with:

• People who come in to purchase medications where there is an interaction with alcohol e.g. antihistamines, sedating cough mixtures

• Those who purchase over the counter medications to manage symptoms of alcohol misuse, such as gastrointestinal remedies and pain killers

• People who present with prescriptions who are prescribed medications for chronic conditions such as heart disease, diabetes, depression/anxiety, or gastro-intestinal disease. Especially chronic conditions which are adversely affected by alcohol misuse

• People receiving a medicines use review service

• People prescribed medications where there is an interaction on contraindication with alcohol

• Those receiving emergency hormonal contraception service

• People during a smoking cessation consultation, health check or weight management service

A private consultation area will be necessary for IBA in a pharmacy setting.

**IBA in social services’ settings**

NICE Guidance supports the delivery of IBA by social workers, as does the British Association of Social Workers. Staff targeted for delivery of IBA in this setting are: social workers and other care workers working in children and family services and,
social and other care workers working in adult social care, people with learning disabilities, physical disabilities and vulnerable adults.

- Children and family services. All children and family services staff should be able to deliver IBA and all parents/adults involved with children and families should receive alcohol IBA. Alcohol Concern’s guidance (2014) is aimed at adult clients; however:
  
  - The drinking of teenagers and possible pre-teens should be considered, because children in the looked-after system will be vulnerable to alcohol related harm
  
  - AUDIT is a validated tool for assessing 16 and 17 year olds
  
  - Tools exist for screening younger age groups; however, it is best to agree a joint approach to identification with this age group with local young people’s substance misuse services

Given the high incidence of alcohol misuse in child protection cases, the topic should be raised as part of all assessments. It should certainly be used in cases of people at risk of, or perpetrating, domestic abuse. If AUDIT is not included as part of a general assessment, it should be used as part of an initial care planning session or review, or at the end of a short care intervention.

- Adult services. All adult social care staff should be using the full AUDIT tool with all of their clients other than those with serious learning difficulties or cognitive impairment. Given that social workers will regularly come into contact with people misusing alcohol, the topic should be raised at all assessments to determine a client’s support needs. However, it can also be target at clients with higher support needs such as:
  
  - People at risk of, or perpetrating, domestic abuse
  - People with physical disabilities resulting from their alcohol use
  - Clients with mental health problems

AUDIT is effective whether it is used as part of a general assessment, before a break or change in care and at the end of a short care intervention.

**IBA in homeless settings**

In an evaluation of a small-scale IBA and EBI pilot intervention in homeless settings (Luger, 2013), the AUDIT tool and IBA were found to be useful by clients and staff alike. Some AUDIT questions were deemed less suitable than others due to the nature of many homeless clients’ dependence on alcohol. Although the small sample size prevented strong statistical effectiveness of IBA and EBI, the author recommended IBA be integrated into the client booking-in process or ongoing assessment process. Training of hostel staff in IBA was also recommended.
IBA in criminal justice settings

Alcohol Concern (2014) set out minimum standards for delivery of IBA in criminal justice settings aimed at probation staff, police custody staff and other custody staff such as detention officers, custody nurses and arrest referral workers. There are numerous national guidance documents recommending IBA in these settings and AUDIT to be used as the tool for delivery. As police stations are busy and time can be limited, AUDIT-C and FAST were suggested as suitable alternative tools. If positive results are returned, those who are positive should ideally be screened with the full tool.

In probation settings, staff should be using the full AUDIT tool with all of their adult clients. The AUDIT tool should be in the pre-sentence report pack and the licence pack, along with a client information leaflet. It should be administered at the earliest possible point.

- AUDIT should be used in both fast delivery reports and standard delivery reports
- If time pressures do intervene at the pre-sentence report stage, the focus should be on clients where alcohol was an aggravating factor in the offence
- It is important to record AUDIT scores on the Delius system in order to report accurate data to commissioners and to identify need

Although offending behaviour is strongly related to alcohol use, IBA can impact on increasing and higher risk drinking in offenders even if alcohol is not related to the offending behaviour.

Follow-up (all settings)

Alcohol Concern (2014) recommends that clients are followed up in all settings. Where the client is seen regularly in a particular setting, ongoing monitoring of their progress is recommended. Offer praise where suitable and ongoing support where necessary. Referral to specialist support may be an option for some clients.

Other London-based evidence

Question Time was a survey of more than 7,500 residents of London on alcohol consumption, spending patterns, impact on health and attitude towards a number of alcohol related issues. More than half of respondents believed that employers should play a larger role in access to advice on alcohol. The survey also provides evidence that many people feel communities should have a bigger role, with just over half of respondents believing they could reduce local problems if involved in making decisions around managing alcohol issues.
The survey also highlighted the important role that GPs and local hospitals have in terms of supporting people to find help with alcohol problems.

Key points from stakeholder interviews

Meetings with stakeholders from all 12 South London boroughs were held separately from July – September 2014. The majority of interviewees were Alcohol leads based within the Public Health Department or Alcohol Commissioners based within Local Authority Commissioning teams. Primarily as a public health preventative activity, IBA is mainly commissioned by local authorities. However, the alcohol enhanced service in primary care is funded centrally by NHS England. Some Clinical Commissioning Groups (CCGs) may commission some activity also; such as IBA within Hospital settings. Information on these activities was requested as a part of discussions with the local authority commissioners.

The following paragraphs comprise information collated from across the 12 boroughs.

Commissioning of IBA across South London varies widely between boroughs. Some boroughs have been commissioning IBA for many years and they continue to invest in it whereas other boroughs have minimal resources to allocate to alcohol prevention programmes. The centrally funded alcohol Directly Enhanced Service (DES) has enabled IBA delivery in the primary care setting for specific groups (new registrations and those eligible for NHS Health Check). Some boroughs had commissioned IBA for other patients not covered by the DES or NHS Health Checks. A few boroughs had initiated pilot projects which made use of an IBA worker based in selected practices or reception staff handing out AUDIT-C scratchcards to patients in the waiting room. Preliminary results from these pilots indicate an increase in reported IBA activity at the selected practices; however, it was not clear what level of intervention was offered. A consistent theme arising from the meetings was a lack of activity data being returned to commissioners; therefore actual activity wasn’t known in most boroughs. (This applies to almost all settings in which IBA is delivered/thought to be delivered but particularly in the Primary Care setting). Some respondents mentioned not knowing whether brief advice was provided after a patient completed an alcohol tool or written information/leaflets were provided or nothing was provided at all.

Although some pharmacies from all 12 South London boroughs participated in the Pharmacy Scratchcard project in 2012-13, fewer than 50% of boroughs in South London now have alcohol IBA activity in a pharmacy setting. Where it is being delivered, it is usually as part of a wider public health initiative with pharmacies covering a number of other ‘Living Well’ issues (eg diabetes, tobacco control and sexual health initiatives).

Some Commissioners noted that a CQUIN (Commissioning for Quality and Innovation) relating to IBA was in place at some hospitals. There may be an opportunity to collect learning from the experiences of implementing a CQUIN for alcohol IBA in hospital settings and share this with hospitals in which there currently isn’t a CQUIN. Many sexual health services across South London have
already integrated alcohol IBA into practice, although data on activity and how consistent it was being delivered was thought to be patchy.

Probation services was a setting raised consistently in which respondents said training had taken place with frontline staff. However, it was generally not known whether that had translated into IBA activity as data returns were not being received.

Training of frontline staff on IBA was being undertaken in almost all Boroughs. Some boroughs had a rolling programme of training that had been going for a number of years. Some respondents said this was necessary due to the high turnover of staff across all settings as well as a need to provide information on local services for staff to refer to.

There were mixed views about how far and wide the net should be cast to staff from various frontline services. For some, training in IBA should cover as many frontline providers as possible. This is consistent with the Department of Health’s ‘Make Every Contact Count’ initiative. Others felt that frontline staff were already overworked and couldn’t fit anything more into their role. Cut backs were putting further pressure on these staff.

Some boroughs had already invited frontline staff from young people’s services and social workers to IBA training. Others were considering broadening it to housing staff, care home staff, job centre plus staff and school nurses. Respondents mentioned the advantage of having support from senior staff for this and also from the local CCG.

An issue which was consistently raised was how commissioners could prevent motivation to deliver IBA from waning after training had been completed. Are there strategies that could be integrated into the training or post-training that would keep IBA as a priority for front-line workers?

There was a high level of interest across the board from stakeholders in digital technologies as a way of directly reaching residents. Two boroughs have developed websites aimed at screening for alcohol and providing information and signposting to local services. User numbers are currently low (on one of the sites) and efforts are being made to increase traffic to it. The interface is being adapted to make it more smartphone-friendly. A third borough has a young person’s smartphone app in development. Another borough was very interested in looking at developing a website; an opportunity for shared learning is available here.

Various health promotion activities were delivered year round to raise awareness of services and to deliver IBA direct to the local population. Many of these were targeted at specific populations, for instance, students via Fresher Fairs, Council and Hospital staff at Health and Wellbeing days. Dry January and Alcohol Awareness Week were also used by almost all boroughs for delivering prevention activities. Increasingly, scratchcards are being used as a direct-to-population approach during these events.

Some commissioners spoke about a need to demonstrate to senior staff and local members the return on investment for commissioning IBA. Toolkits exist for some other health issues that outline this. Several commissioners requested something similar for alcohol IBA.
Resourcing of alcohol IBA had been committed across all of South London. Borough alcohol leads were enthusiastic about collaborating with the Health Innovation Network on new initiatives and to explore opportunities to further develop their alcohol prevention strategy. Given the current climate of fiscal constraint, the availability of new funding was limited; however, all respondents expressed a desire to take part as a pilot area on an initiative or to collaborate with the Health Innovation Network where they had the capacity to do so. Financial information regarding spend on IBA did not present a clear picture. Six of the 12 boroughs returned information on the amount of funding allocated to IBA and this ranged from £15,000 to £47,000. A breakdown of how the funding is allocated across activities and whether the DES is included in the figure was difficult to establish.
Discussion

Primary care

Primary care was a focus of many of the discussions as it is one of the areas that is funded to deliver IBA. However, even where IBA is being delivered, the quality of the content is being questioned by some commissioners. This claim is supported by evidence from a study by Khadjesari et al (2013) where only 9% of patients with alcohol screening data in a primary care setting were recorded as completing a validated screening questionnaire. Also, it is thought there is a heavy reliance on identification using questions on consumption and less emphasis on brief advice.

On 30 September 2014, NHS Employers and the General Practitioners Committee of the British Medical Association announced changes to the GMS Contract in England for 2015-16: the alcohol enhanced service will end on 31 March 2015. “The alcohol enhanced service will cease and the associated funding will be reinvested in global sum. It will be a contractual requirement for all practices to identify newly registered patients aged 16 or over who are drinking alcohol at increased or higher risk levels.” This change may further affect the delivery and monitoring of IBA in primary care.

To assist commissioners and providers of alcohol IBA to improve IBA delivery, the Health Innovation Network could look at developing a London Standard for Primary Care Practices on alcohol IBA training and delivery. The Standard could provide a minimum practice for GPs to deliver and record IBA, and to ensure they feel supported and equipped to do so. A pilot project would aim for the introduction of technological innovations such as digital sources of IBA to facilitate IBA delivery and monitoring. Given the changes to the alcohol DES at the end of March 2015, developing robust methods for monitoring delivery of IBA in Primary Practice is essential.

Pharmacy-based alcohol IBA is recommended by NICE and several UK projects (Khan 2013, Davies 2013, Gray 2012) have demonstrated the pharmacy setting to be suitable to deliver the service. A selection of Pharmacies from all South London boroughs participated in the 2012 London-wide pharmacy Alcohol Awareness campaign, which used scratchcards to engage customers to complete AUDIT-C. Although the evaluation found this pilot to be successful, very few pharmacies in South London continue to provide the service. Some boroughs have indicated an interest in commissioning IBA in pharmacies, under a Health Living Pharmacy Scheme, while others were not considering this area at all. There is a Healthy Living Pharmacy ‘Health Champions’ programme rolling out across South London. Health Champions are members of the pharmacy team (usually counter-staff) who are trained and accredited to provide customers with health and wellbeing information and to signpost customers to services. Training pharmacy Health

2. The Healthy Living Pharmacy Scheme is a nationally recognised concept enabling pharmacies to help reduce health inequalities within the local community, by delivering high quality health and wellbeing services, promoting health and providing pro-active health advice. Services can include smoking cessation, healthy weight and alcohol IBA. www.npa.co.uk/Documents/HLP/HLPOverview_12.11.pdf
Champions to deliver alcohol IBA is being considered by a couple of boroughs. There is potential for this model to be adopted in other areas if boroughs were considering commissioning alcohol IBA in local community pharmacy settings.

Hospital-based CQUIN for alcohol IBA

The evidence base for alcohol IBA in hospital Accident and Emergency settings shows some favourable results using simple feedback or provision of a patient information leaflet (Drummond, 2014). However, it was not clear whether all hospitals had a CQUIN specifically applying to IBA or, if they did, whether they would continue after this financial year. Learning from the experiences of those hospitals that have implemented a CQUIN for IBA could be undertaken with responsible officers if there was interest in developing this for other hospitals. Although this did not appear to be a priority at this stage, it could be addressed at another point, if required.

Data returns

Receipt of DES data was patchy across the Boroughs. Indeed, receipt of much alcohol IBA data from providers was inconsistent. In some cases, this is because some providers have attended training on IBA but they are not necessarily commissioned to deliver it. Therefore, in many cases, there isn’t a system set up for monitoring of any IBA delivered, although the understanding is that providers are doing it.

Return on investment data is increasingly becoming requested by locally elected members. How to demonstrate a return on investment was a specific request raised by several stakeholders. Many have invested funding in alcohol prevention activities over many years and, with limited data returns, were struggling to demonstrate what had been achieved for this investment. The Health Innovation Network can undertake to review this area and develop an evidence-based toolkit that shows financial savings for alcohol IBA as a return on investment.

Training and ongoing support

There was a considerable amount of training on alcohol IBA being delivered. A review of the minimum standards in different settings indicates IBA to be useful and of benefit in a number of front line services. Greater use could be made of the e-Learning programmes on Public Health England’s Alcohol Learning Resources website www.alcohollearningcentre.org.uk/eLearning/IBA/. There are 3 e-learning courses, aimed at IBA in Primary Care, IBA in Community Pharmacy and IBA in Hospital Settings.
There may be some value in running training jointly across neighbouring boroughs. There is also an opportunity here for trainers to encourage staff to join the London IBA Network. The Network currently provides regular updates via email, online support and occasional meetings for members to problem-solve and share good practice.

However, there will be challenges faced by frontline staff in juggling workloads and priorities. As was found by the Alcohol Concern and Brook pilot in 3 sexual health services, some staff will be reluctant to engage in IBA delivery (Alcohol Concern, 2014a). Strategies to address this will need to be considered. Thom, et al (2014) found barriers to implementation of alcohol IBA among workers in both health and non-health settings arise from:

- Professional feelings of lack of role adequacy and role legitimacy, lack of knowledge and skills
- Patient/client/staff reluctance to engage – in some circumstances because of concerns about confidentiality
- Lack of strategic and organisational commitment to implementing IBA

These issues should be addressed directly as part of a training programme.

Consideration also needs to be given to ongoing support to staff in frontline service roles to prevent motivation from waning. Strategies could include writing performance indicators on IBA into the contract, identifying an IBA champion within the team to motivate and support staff, set targets and monitor returns. IBA could be added to the agenda of monthly supervision sessions with the service manager also.

**IBA Direct**

Direct-to-population approaches of alcohol IBA are already being delivered across South London (and in many other parts of London and England). Although there are no studies on the effectiveness of these approaches, it is fair to assume that they are doing no harm and they may be, at least, raising awareness of one's alcohol consumption. The South London CLAHRC has been funded to evaluate the population-level impact of IBA implementation via a mobile phone app and to compare this with conventional IBA implementation in primary and secondary care. This initiative will add to our understanding of optimal methods of implementation of evidence based alcohol interventions. Careful consideration will need to be given to how this pilot is implemented; so that it complements existing and developing technology-based initiatives in various South London boroughs. At the same time, the Health Innovation Network would like to optimise those developing and existing initiatives by assisting to promote them and share learning from them with other boroughs.

---

3 The IBA Network’s status is currently unclear. The newsletter is continuing and resources may soon be available. James Morris, Personal communication.
References


Alcohol Concern, Evidence of effectiveness: Case for decision makers, 2014.

Alcohol Concern, Alcohol and Sexual Health Project: An evaluation report, 2014a.


Department of Health, Alcohol Ready Reckoner. www.alcohollearningcentre.org.uk


Appendix 1  Interview schedule for key stakeholders

Alcohol IBA Workstream

Discussion with Alcohol Commissioners

Thank you for your time today. The following trigger questions are simply to focus our discussion on one of the key workstreams of the Alcohol theme: Identification and Brief Advice. Notes will be taken and collated with responses from interviews with other south London alcohol commissioners. Information will be written into a report with recommendations for action on this workstream. The report will be circulated for comment.

1. In which settings is IBA delivered in your borough?
2. Where is it working well and where is it not working so well? What do you think are the reasons for IBA working well/not well in those settings?
3. Are there other settings locally in which you think IBA could be developed and delivered?
4. How can we work with key senior people to influence them towards adoption and rollout of IBA with their departments/staff teams?
5. Are you aware of any alcohol IBA apps? What are the best elements about the app that we can learn from?
6. Are you aware of any initiatives that have targeted the public directly with an alcohol IBA intervention? What can we learn from those initiatives?
7. What opportunities may exist to develop and commission IBA in new settings in your borough?
8. What support would you need for new initiatives to get off the ground?
9. Are you aware of any funding sources or opportunities that can be tapped into to further this programme of work in your borough?
10. Any further comments?