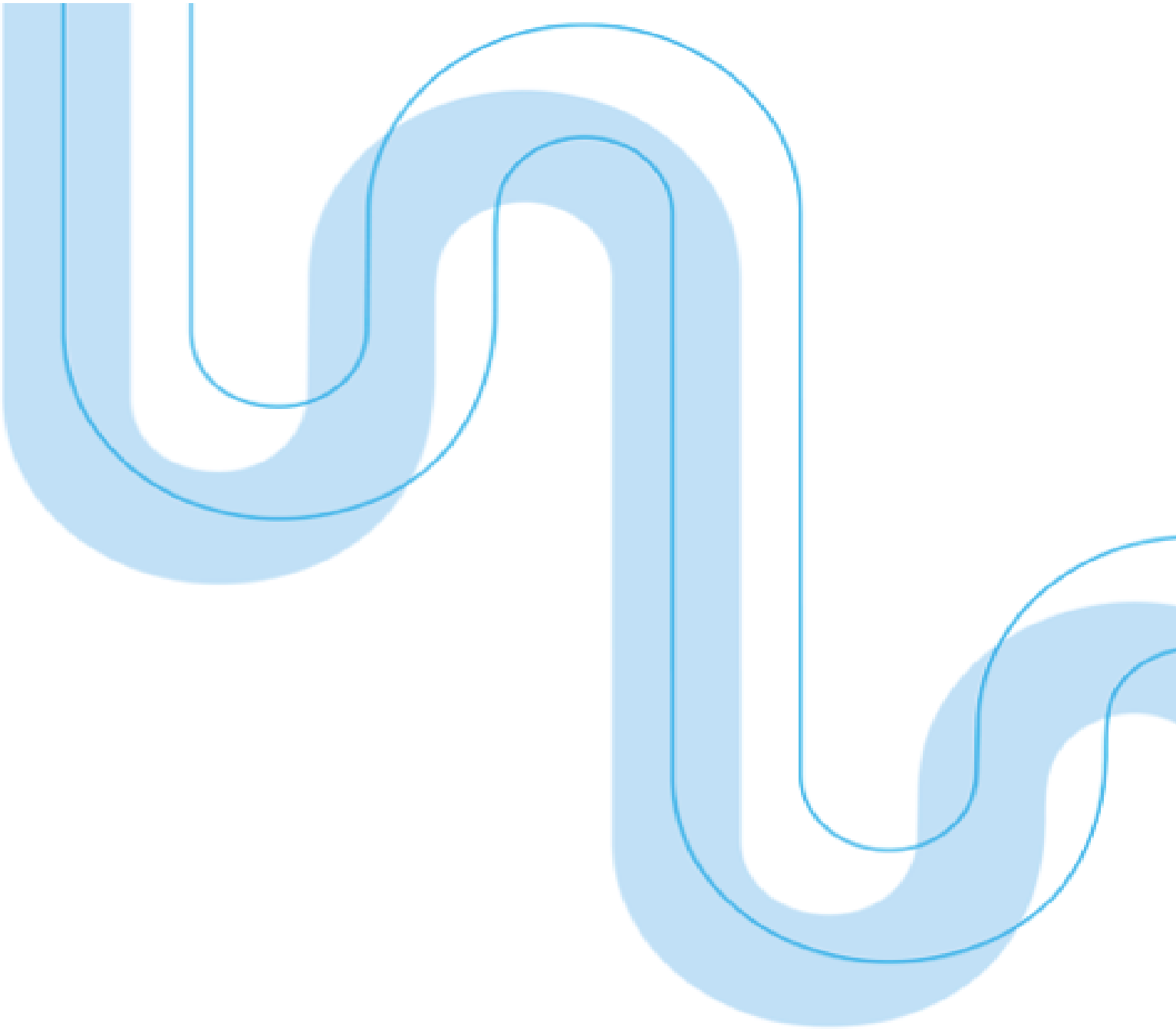

Implementing Alcohol Awareness Programmes in Workplaces: An evaluation

Report of findings

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The project was funded by Health Education South London (HESL). The work was undertaken by the Health Innovation Network in partnership with Safe Sociable London Partnership.

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Abbreviations

AHSN	Academic Health Science Network
AUDIT	Alcohol Use Disorder Identification Test
CFIR	Consolidated Framework for Implementation Research
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
EAP	Employee Assistance Programme
HESL	Health Education South London
HIN	Health Innovation Network
IBA	Identification and Brief Advice
LAMP	London Alcohol Misuse Prevention
NHS	National Health Service
NICE	National Institute for Health and Care Excellence

Executive summary

Background

Alcohol misuse is one of the leading risk factors for ill health and early mortality. More than 10 million people in the UK consume alcohol at harmful levels, costing the NHS an estimated £3.5 billion each year (Public Health England, 2016). Alcohol Identification and Brief Advice (IBA) has been shown to be effective at reducing alcohol-related harm. Consisting of a brief screening to assess risk of harm, followed by brief, tailored advice, IBA enables individuals to make more informed choices about their drinking, motivating at-risk drinkers to reduce their alcohol consumption to safer levels. Whilst normally completed within a Primary Care setting, IBA has also been completed in the workplace. Given 74.8% of the population are in employment, this would allow high population reach and access to those who may not use Primary Care services. Addressing alcohol misuse could bring benefits to the workplace through improved productivity and extended working lives. Traditionally a face to face, or paper based intervention, digital tools bring new opportunity. This would allow IBA to be delivered anonymously, at scale and in a standardised way, for substantially less cost.

Aims

This project aims to introduce digital IBA within the workplace as part of an alcohol awareness programme, to evaluate the processes by which organisations can successfully implement and embed this within their systems and practices.

Methodology

Organisations were recruited from the South London locality, and 10 took part in the project. The inclusion criteria were that they were in the locality, had a commitment to implement alcohol awareness and had an alcohol policy in place. Organisations were asked to nominate staff to lead on the implementation who then attended a 2 - 3 hour free training session. The training consisted of education on alcohol-related harm and the potential impact on the workplace. Staff were introduced to tools used to raise awareness of alcohol issues and were given details of digital IBA providers. Within the workshops staff completed two activities, one to explore organisational culture regarding alcohol, and one to develop an implementation plan for their workplace.

Support was offered throughout the implementation process, and staff completed data collection sheets during this time. After three months, staff were interviewed using a semi-structured interview guided by implementation science tools. Quantitative data was gathered on IBA completion, alongside

qualitative data on implementation barriers and facilitators. Themes were then analysed to explore strategies, barriers and facilitators to implementation.

Results

In total, 10 organisations participated in the project: six public sector companies, two charities, one higher education institute and one private company.

Evaluation data was obtained from eight, with five interviews completed. At the time of writing, three had implemented IBA in their workplace, and five were planning to do so. From those who implemented, 358 employees were known to have accessed the tool, and of those completing it over 50% were drinking at risk levels. Several organisations had also made changes to policy or procedures following the project, indicating sustainability.

From the analysis of the implementation, 19 implementation strategies were identified, alongside 14 factors which had potential to be barriers or facilitators to implementation. The strategies used to implement alcohol awareness and IBA included adapting to intervention to the context, developing stakeholder relationships, training and education on alcohol-harm and IBA, engaging staff, using financial strategies and changing infrastructure. Factors found to be important when implementing alcohol IBA were: Intervention Characteristics (evidence strength and quality, relative advantage, adaptability, complexity and design quality, cost); Outer Setting (peer pressure, external incentives, wider culture); Inner Setting (structural characteristics, organisational culture, organisational structure, tension for change and relative priority, readiness for implementation, characteristics of individual); Process (planning, engaging).

Conclusion

Alcohol awareness and IBA were successfully implemented within several organisations, showing the potential for using alcohol IBA within the workplace. Health and financial benefits are discussed, alongside recommendations for future implementation.

Introduction

The Health Innovation Network (HIN) is the Academic Health Science Network (AHSN) for South London, and is one of 15 AHSNs across England. The role of the AHSN is to connect NHS and academic organisations, local authorities, the third sector and industry. It acts as a catalyst to create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients. The AHSNs are uniquely placed to identify and spread health innovation at pace and scale; driving the adoption and spread of innovative ideas and technologies across large populations.

The HIN works across a huge range of health and care services through each of their clinical and innovation themes, to transform care in diabetes, musculoskeletal disease, alcohol and healthy ageing, accelerating digital health uptake into the NHS. Within the alcohol theme, work is focused on partnership working with a wide range of stakeholders to implement innovative ways of preventing alcohol-related harm and supporting people with alcohol dependency.

Background

Alcohol misuse is one of the leading risk factors for ill health and early mortality, bringing substantial cost to society (Public Health England, 2016). There are more than 10 million people in the UK who consume alcohol at harmful levels, costing the NHS an estimated £3.5 billion each year in preventable illness (Public Health England, 2016; Health and Social Care Information Centre, 2017).

Alcohol Identification and Brief Advice (IBA) has been shown to be an effective tool in addressing alcohol-related harm (Public Health England, 2016). The tool consists of a screening questionnaire to assess risk of harm followed by brief, structured advice. The screening uses the Alcohol Use Disorders Identification Test (AUDIT; Appendix I) which is a well-validated, 10-item self-report questionnaire developed by the World Health Organization (2001). The advice given is tailored to the individual's score on the questionnaire. Through the questions and advice offered, individuals can make more informed choices about their drinking, which can motivate at-risk drinkers to reduce their alcohol consumption to safer levels. The tool can also identify those who may require additional support, signposting them to appropriate services as needed (National Institute for Health and Care Excellence, 2010). Alcohol IBA has the potential to increase quality of life by reducing the health and social impacts of alcohol harm, bringing cost savings to the NHS in the longer term.

Alcohol IBA is most commonly delivered in Primary Care and has a strong evidence base with over 50 peer reviewed academic papers demonstrating both clinical and cost effectiveness. Despite this evidence base, implementation rates are relatively poor and of varying quality (Khadjesari et al., 2013; O'Donnell et al., 2014).

Alcohol IBA has also been used within the workplace. Given 74.8% of people in the UK are currently in employment (Office for National Statistics, 2017), addressing alcohol in this setting could have high population reach. Alcohol also features as a standard within the London Healthy Workplace Charter which aims to help employers build good practice in health and wellbeing. The inclusion of alcohol in the charter and workplace health within the Five Year Forward View (NHS England, 2014) shows the importance of considering this within the workplace. Alcohol can impact on the organisation through lost productivity due to absenteeism, presenteeism, inappropriate behaviour, accidents and poor performance, as well as leading to shorter working lives (British Medical Association, 2016). Using alcohol IBA in this context has potential to bring tangible benefits to employers through improved productivity; to employees through improved health; and to the NHS through prevention of disease and cost saving. Whilst alcohol IBA has been delivered in the workplace, little is known about what works, highlighting the need for further work in this area.

Typically, alcohol IBA is completed face-to-face, however the use of digital tools can offer a potentially valuable opportunity. Using a digital format, the intervention could be completed anonymously and in the individual's own time. This brings a clear advantage to those who may not want to disclose the full extent of their alcohol use to others, enabling more accurate advice to be given. It also has the advantage of being able to be delivered at scale, in a standardised way. This has the potential to increase access to alcohol IBA and improve the quality of the intervention offered. Again, whilst there is some evidence digital alcohol IBA can be effective, the factors involved in successful implementation have not been explored thoroughly (Dedert et al., 2015).

Scope

This project forms part of a wider programme of work which aims to increase the spread and adoption of alcohol IBA across South London, to reduce alcohol-related harm. Within this project, digital alcohol IBA was to be implemented in the workplace as part of an alcohol awareness programme. Due to the time and resources available, 10 organisations in South London tool part. It was expected that this number would allow the results to be reasonably representative and would enable saturation to be reached in the thematic analysis.

Aims and objectives

The aim of this project was to introduce digital alcohol IBA in the workplace as part of an alcohol awareness programme, and evaluate the processes by which organisations can successfully implement and embed this within their systems and practices. The key objectives were to:

- Engage and deliver alcohol IBA training to 10 South London organisations
- Assist the organisations in designing an implementation plan for alcohol IBA
- Observe and map the methods, processes, barriers and facilitators involved
- Produce recommendations to facilitate implementation of alcohol IBA in future organisations

Methodology

The engagement of organisations and staff training was completed by Ghazaleh Pashmi from Safe Sociable London Partnership. The evaluation of the implementation of alcohol IBA was completed by Kate Daley from the Health Innovation Network.

Engagement

Organisations were recruited via an invitation letter (Appendix III) which was sent out to 36 organisations in the South London locality. The intention was to recruit organisations of varying sizes from a range of sectors. In total, 10 organisations expressed interest in participating and were followed up by telephone (details can be found in the results section, and Appendix II). To take part in the project, organisations were required to have a base within the locality, to be committed to implement alcohol awareness in their workplace and to have an alcohol policy in place. All 10 organisations met these inclusion criteria.

Training of Staff

The organisations were asked to nominate staff members who would lead on the implementation. The nominated staff were then invited to attend a free training session, which was between two and three hours in duration. Prior to the training, attendees were sent some pre-reading and the materials were approved by the project team. The training consisted of education on alcohol-related harm and the potential impact in the workplace. It also introduced attendees to tools they could use to raise alcohol awareness in the workplace, and details of digital alcohol IBA providers who were again approved by the project team. Within the training session, attendees also completed two activities: one to explore the organisational culture regarding alcohol, and one to develop an implementation plan for their

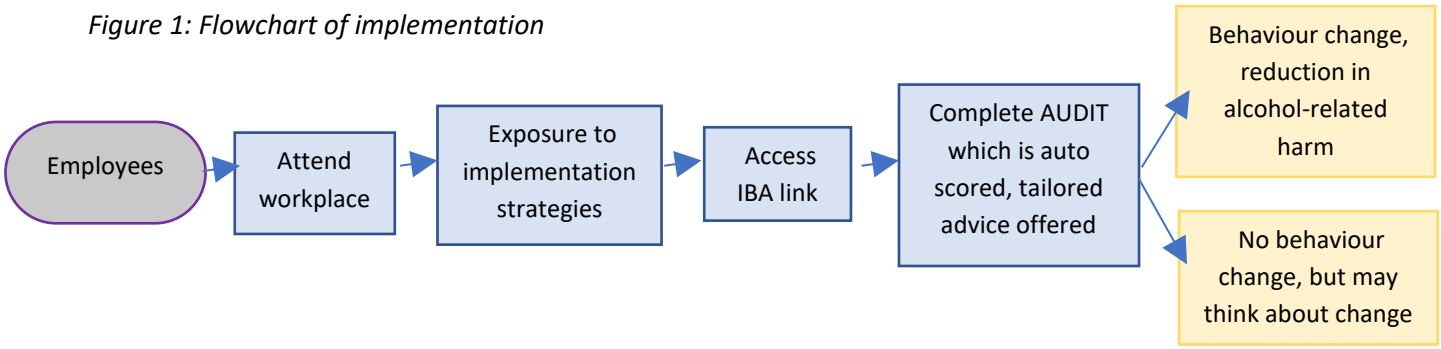
workplace. These discussions were recorded and formed part of the evaluation. All resources are available on request.

Implementation of alcohol IBA

Implementation plans were devised by each organisation at the training session and were developed over the course of the project. The recommendation was for an iterative, cyclical process whereby strategies were planned, implemented, observed and evaluated. Support and guidance was offered to organisations throughout the process to facilitate successful implementation, building on the learning from each organisation.

The organisations all used the same overarching model to implement alcohol IBA (figure 1), however the specific strategies differed for each organisation. Some strategies were imposed by the project design (e.g. attending training) and others were selected by the organisation (e.g. newsletters).

Figure 1: Flowchart of implementation



Evaluation methodology

The evaluation was divided into two sections. The first was an evaluation of the training session in terms of how beneficial staff found it (completed by Ghazaleh Pashmi, SSLP), and the second was an evaluation of the implementation in terms of how many alcohol IBA's were completed and the barriers or facilitators encountered (completed by Kate Daley, HIN).

Evaluation of training

The evaluation of the training involved a post-training evaluation questionnaire completed immediately after the training, and repeated at three month follow up (Appendix V). Rating scores were analysed alongside qualitative feedback.

Evaluation of implementation of IBA

Implementation was measured using outcomes of adoption (e.g. the intent to implement or actual implementation of intervention) and penetration (e.g. number accessing the intervention) which included qualitative and quantitative data. Appropriateness and acceptability were not directly evaluated due to resources and time scales, but were inferred through penetration.

Quantitative data was collected on access (e.g. number of people opening IBA link), completion (e.g. number of people completing the AUDIT and receiving brief advice), and levels of risky drinking (e.g. scores on the IBA tool). In cases where a free tool was used, it was agreed that the link would be sent to staff in a way that enabled access to be recorded anonymously to maximise hard data collection.

Implementation Science[1] was then used to evaluate the implementation process. Qualitative data was captured during the training session and through the implementation using discussions and a data collection sheet (Appendix VII) and a semi-structured interview was completed with staff at three month follow up (Appendix VIII). Staff attending the training chose a lead who would take part in the evaluation on behalf of the organisation. For those unable to complete the interview, information was obtained by email. Data was analysed and themes identified, highlighting the strategies and implementation factors that were involved in successful implementation.

The Consolidated Framework for Implementation Research (CFIR) was used in the design of the interview schedule (Appendix VIII) and to guide the analysis. The CFIR offers a menu of defined factors taken from research areas which have shown them to be associated with effective implementation (Damschroder et al., 2009). It organises the factors into five domains covering intervention characteristics, outer setting, inner setting, characteristics of individuals and process. A pre-defined list of implementation strategies (Waltz et al., 2015) was also used to guide the implementation and analysis. Strategies refer to the methods or techniques used to implement or sustain an intervention. Factors refer to the barriers or facilitators to consider when implementing the intervention.

[1] Implementation Science is the study of methods to promote the integration of research findings and evidence into healthcare policy and practice. It seeks to understand the behaviour of healthcare professionals and other stakeholders as a key variable in the sustainable update, adoption and implementation of evidence based interventions.

Results

Implementation of alcohol IBA

In total, 10 organisations participated. This included six public sector organisations, two charities, one higher education institute and one private company. The sizes ranged from 50 to 15,000 employees, four were classified as medium size organisations, six as large[2]. Further details can be found in appendix I.

A total of 45 staff attended the training, with between one and 15 people attending from each organisation. Staff typically worked in Human Resources or Occupational Health Departments, and/or had a special interest in staff wellbeing. All organisations opted for the training to be completed in-house due to convenience and time commitments.

Feedback from training

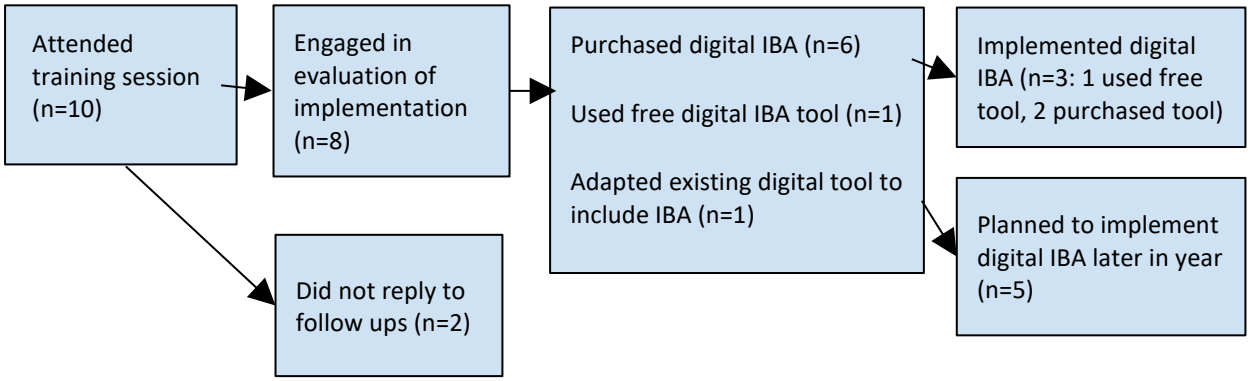
Thirty-eight staff completed the post-training evaluation form. 97% agreed that the training helped them understand how alcohol awareness can be important in the workplace, and understood the benefits of using IBA tools. 84% agreed that they felt confident in explaining IBA to stakeholders, and 95% felt confident to initiate an alcohol awareness project in the workplace. 92% also agreed that the information and resources would help them in setting up the project, and 95% agreed that examples were useful in understanding the practicalities of alcohol awareness projects. The most helpful elements of the training were reported to be: Seeing active tools and explanation of options, open and honest discussions, pre-reading, practical examples, information giving, self-completion of the AUDIT questionnaire. It was suggested going online to look at the tools and a follow up session offering full IBA training would be helpful improvements to consider.

Numbers implementing alcohol IBA

Figure 2 illustrates the number of organisations who took part and implemented (or planned to implement) digital alcohol IBA as part of an alcohol campaign. Of the 10 organisations, information was returned from eight, three of whom had implemented digital alcohol IBA and five who were planning on doing so later in the year. No information was obtained from the two who did not respond to follow up, however at the last contact they did state that their intent was to implement.

[2] Small-sized businesses, 10-49 employees; medium-sized businesses, 50-249 employees; large-sized businesses, 250+ employees - whilst some small businesses were approached the total staff count moved them into the medium size category

Figure 2 – Outcome of Implementation



Numbers completing alcohol IBA

Details of the organisations who had implemented alcohol IBA at the time of writing are summarised in table 1 below. Organisation A and B used a paid-for digital tool which offered data on completion and risk levels, whilst organisation C opted for a free digital tool.

Table 1 - Summary of access to digital alcohol IBA[3]

	Organisation A	Organisation B	Organisation C
Sector, no. of employees	Local Authority, 1400 employees (large organisation)	Higher Education Institute, 2700 employees (large organisation)	Charity, 74 employees (medium organisation)
Key strategies	Email, internet, business cards on desks	Email, internet, wellbeing day, business cards in payslips	Email, electronic newsletter
Access	153 (11%)	194 (7%)	11 (15%)
Completion	104 (7%)	134 (5%)	Unknown
Proportion drinking at risk levels	52 (50%)	69 (52%)	Unknown

NB: numbers may increase given the implementation is ongoing.

As highlighted above, rates of access ranged from 7% to 15%, and completion from 5% to 7%. In organisations A and B where information is available, gender was evenly distributed and there was a range of age, ethnicity and professional grouping which suggested the intervention appeals to a diverse mix of staff. It is not clear whether those who did not access the tool were not interested in

[3] As implementation is an ongoing process and the tool was only recently launched, these numbers will increase

assessing their alcohol use, or if they did not see the messaging. This would be something to explore with employees directly.

Levels of risk identified

In terms of levels of alcohol-related harm, both organisation A and B had similar proportions of employees scoring in each risk category (figures 3 and 4), with at least 50% of respondents from each organisation drinking at risky levels (a total of 121 employees in total). These results appear to show use of digital alcohol IBA is acceptable to some employees in this context, and is completed by the intended population (e.g. those who are drinking at-risk levels).

Figure 3 - Organisation A - Levels of risk of alcohol harm

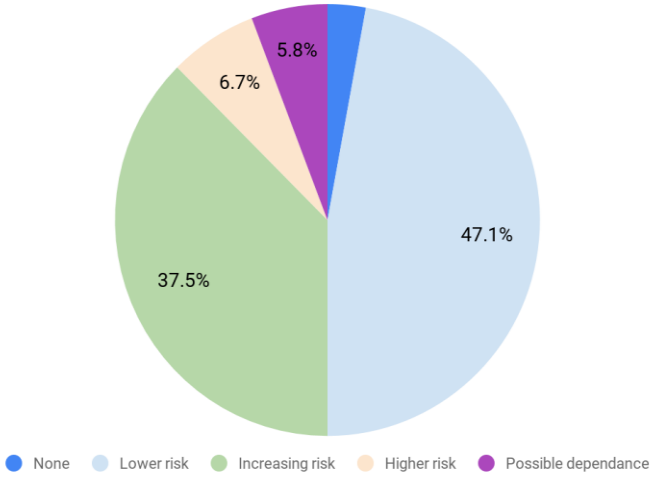
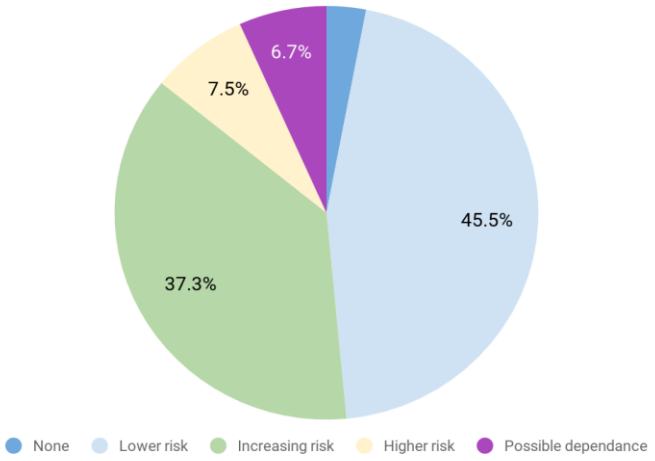


Figure 4 - Organisation B - Levels of risk of alcohol harm



The proportion of people drinking at increasing (AUDIT scores 8-15), higher (AUDIT scores 16-19) and possible dependent (AUDIT scores 20+) levels of alcohol-related harm appear higher than in the literature (16.6% at increasing risk, 1.9% at higher risk, 1.2% possible dependent; Adult Psychiatric Morbidity Survey, 2014). This may be due to this being a self-selected sample, or the method of data collection (e.g. anonymous vs face to face questioning).

Impact: Individuals

It is possible that all individuals benefited in some way from completing the tool, but the literature would predict that 15% would reduce alcohol consumption to safe levels (Public Health England, 2016). Using the numbers so far this would equate to 18 employees, which will increase as the implementation progresses. This would bring clear benefits to physical and mental health, in addition to improved productivity.

Impact: Cost Saving

In terms of financial impact, Public Health England (2016) estimate that the net saving to the NHS for each person receiving alcohol IBA could be on average £27 per year, over a period of 4 years. Quanbeck (2010) estimate that savings to employers would be $771 (approx. £621) for each employee who received IBA over a 4-year period. Using the figures above, for organisation A and B, we would estimate the project has saved the NHS approximately £6426 and saved the organisations a collective £147,798. This is a conservative estimate given this data is based on only two out of 10 organisations who took part in the project, one of which was only recently launched. It shows however a clear business case for organisations to use the tool, and illustrates clear benefits to the NHS which, if funded by the organisations, could come at zero cost to the public.

Impact: Sustainability

In addition to implementing alcohol awareness and IBA, several organisations had made changes to their policies and procedures following the project. For example, adding Alcohol IBA to staff induction and adding a section in their alcohol policy about prevention (rather than just focusing on treatment and dependence). It is likely that due to these changes, gains could be sustained beyond the licence period of the tool and would not rely on current champions to remain in role.

Evaluation of implementation

An evaluation of the implementation was completed with eight of the organisations. Interviews were completed with five, and three provided information by email. Qualitative data was analysed using the

CFRI framework. From this, 19 implementation strategies and 14 implementation factors were identified, matching those cited in the literature (Waltz et al., 2015). The strategies refer to how the programme was administered, and the factors are the facilitators and barriers faced in implementation.

Implementation strategies

Table 2 summarises the 19 implementation strategies that were identified. All organisations combined multiple strategies, with some being imposed by the project and others being selected by the organisation themselves.

Table 2 - Implementation Strategies

Area	Implementation Strategy
Evaluative and iterative strategies	Assess for readiness, identify potential barriers and facilitators to implementation*
	Develop a formal implementation blueprint which includes the aim, scope, time frame and who will complete each task*
	Purposefully re-examine the implementation and refine as needed
Adapt and tailor to context	Tailor strategies and promote adaptability as appropriate
Develop stakeholder inter-relationships	Identify and prepare wellbeing champions
	Organise implementation meetings with key stakeholders
	Inform local opinion leaders and involve executive boards
	Obtain formal commitment to implement, e.g. as an objective or deliverable
Train and educate	Conduct training*
	Provide consultation* as needed
	Develop and distribute educational materials, booklets, presentations
Engage staff	Involve staff members, e.g. focus groups, team meeting discussions
	Intervene to increase uptake, e.g. increase awareness of tool at wellbeing days, lunch and learns, business cards in payslips / desk drops, posters, outreach, scratch cards
	Communication plan, e.g. structured task list with time scales, to link in with wider campaigns such as alcohol awareness week or general wellbeing days
	Use media channels, e.g. emails, bulletins, newsletter, website, Twitter, Facebook, portals, blogs, to increase awareness and call to action
Utilise financial strategies	Access new funding
	Fund and contract the intervention
Change infrastructure	Change physical structure, or equipment, e.g. add to induction / portal, use digital methods of IBA
	Policy changes, e.g. adding prevention element

**Those imposed by the project design*

When engaging employees, a range of strategies were used to raise awareness of alcohol related harm. All organisations had or were developing alcohol awareness programmes, which were used as

a vehicle to drive traffic to the alcohol IBA. This meant alcohol IBA was not launched or completed in isolation, it was instead embedded in an awareness raising or educational programme.

Implementation Factors

In total, 14 factors were identified as being important in the implementation of alcohol IBA in the workplace. Each will be discussed below, categorised by domains as set out in the CFIR.

Intervention Characteristics

This domain looks specifically at the key attributes of the alcohol IBA tool that could influence implementation success.

Evidence strength and quality

Staff reported that having academic studies which detail the effectiveness of the intervention was valuable, alongside having specific statistics they could use to predict the potential savings to the organisation. This was noted to be crucial in securing organisational buy-in and financial support, specifically to provide a business case for implementation.

> ***"It was useful to know the tool worked, and to have some facts and figures… I used that to make our business case" Case G***

Having the project endorsed by a quality source (e.g. the National Health Service, or Public Health England) was also noted to be key in the organisations decision-making process around whether to engage in the project. They believed that the innovation would have the desired outcome due to the perceived validity of the evidence source.

> ***"It helped that it was an NHS organisation that approached us, it gave credibility" Case D***

Relative advantage

None of the organisations were using alcohol IBA routinely, although many had current alcohol awareness campaigns or had delivered them in the past. Many did have an Employee Assistance Programme (EAP) which included support for substance misuse, but this did not contain digital alcohol IBA as far as we were aware.

> ***"From the training, we realised that we could be doing more prevention, our focus had been on helping those who were drinking at the highest end, we didn't have the questionnaire so this was something we could add" Case H***

As the alcohol IBA could offer something extra to the current package, it appealed to staff. Many explained that the tool had the advantage of taking a population level, prevention approach which differed to their existing individual level, alcohol-dependence focus. They reported that this enabled them to see more need for the intervention and increased engagement.

Staff noted that using digital tools also brought a relative advantage over alternative solutions. This was because it enabled confidentiality to be gained and took less time to administer when compared to face to face interventions.

> ***"We liked that it was anonymous and confidential, this was really important for us, and so the digital tool appealed more than the paper one" Case A***

Adaptability

For many of the organisations, the ability to adapt the intervention to suit their needs was crucial. Adapting the strategies was also important, alongside embedding implementation into existing processes.

Some organisations wanted their own branding added to the tool, whilst others were clear that they wanted the tool to retain external branding. This decision appeared to be linked to beliefs about how staff would react to the messaging and so they wanted to adapt the tool accordingly.

> ***"It was important for us to have distance from the tool, we have a zero-tolerance policy on alcohol, and so didn't want them to think this was something we were driving for that reason" Case H***

> ***"We wanted to have it as part of our wellbeing strategy and would have been happy to use our branding so staff would know it was something we were endorsing" Case B***

The tool itself is a validated measure and so advice was given not to modify the AUDIT aspect of the questionnaire. All organisations reported to be happy with this and so adaptability in this context was not required.

Complexity and design quality

All organisations reported that the digital alcohol IBA tool appealed as it was quick to administer and feedback was immediate. It was not particularly disruptive or intricate to implement.

> ***"What we liked about it was that it was so simple and quick to use… it only took 5 minutes to complete… we really emphasised that to staff" Case C***

"I liked that it was user-friendly, it had the right feel for our organisation" Case D

When choosing between the IBA tools, design was considered important in the decision-making process. Staff reported that when selecting the tool, they wanted one which was simple, user-friendly and appealing to staff; one which looked professional and was easy to navigate. All staff reported that the tools in the project all met these criteria, and so this was not a differentiating factor.

The confidentiality and anonymity of the tool was also discussed by all organisations, alongside the data security of any tool which collects data from employees.

Cost

The cost of the intervention was described in all but one organisation as the most important barrier to implementation.

"We didn't have a budget, so it needed to be done at zero cost" Case C

The costs related primarily to the digital tool, but also included the time for staff to attend the training and run the implementation programme. There was also time cost for staff completing the tool, but as this was only five minutes none of the organisations viewed this as a barrier. For the organisation where funding was not mentioned as an issue, they had a pre-existing budget which could be used to fund this work. In circumstances where cost was noted to be an initial barrier, having statistics to illustrate potential return on investment was an important facilitator.

"The biggest hurdle was funding, we had to make a good business case" Case G

Cost was also an important factor when deciding which IBA tool to use, some of the organisations opted for a free tool and the others for the one which was offered at lowest cost.

"When deciding which tool we looked at what we could afford, how easy it was to use and liked that it has been used by other people before" Case B

Staff noted that they looked at cost, design and adaptability when choosing which tool to use, and information regarding who else had used the tool was considered to help ascertain quality or reputation.

Outer Setting

This domain looks at issues external to the organisation which can impact upon it. Not many staff discussed these factors, but those who did, reported that peer pressure or external incentive would be most relevant.

Peer pressure and external incentives

Where there was some competition between industries, the organisations competitor using alcohol IBA was noted to be a driver for the decision to implement. The London Healthy Workplace Charter was also an external incentive as all organisations had achieved this or were working towards it, and alcohol fitted into their objectives.

> ***"… having the charter shows it's a good place to work and a focus on staff wellbeing can be an advantage in recruitment" Case G***

This factor is likely to have enabled engagement which was the first step in the implementation process. Whilst there is no direct financial reward to be obtained from the Healthy Workplace Charter award, recognition as being a 'healthy workplace' was noted to be a driver for some organisations.

Wider culture

Whilst not included in the CFRI framework, one of the biggest implementation barriers appeared to be societal culture or beliefs around alcohol. Alcohol consumption was often discussed as a part of British culture, and staff worried that offering advice on this could be perceived as being "nanny state" or controlling, and were concerned that the organisation could be judged negatively for this.

> ***"My worry would be that staff think we're trying to control them, they might think it's none of our business or wonder why we're asking the questions" Case D***

Stigma in relation to alcohol was dominant in the staff narrative, and many viewed alcohol as only a problem in dependant drinkers.

> ***"Alcohol isn't really an issue in our organisation, we don't really get many referrals from people looking for support with that" Case H***

Concern about how the organisation would be viewed by others was also raised as a barrier.

> ***"People might think we're doing this because we have problems with drinking, rather than seeing it as something that would be helpful for everyone, or most people… we need to be careful things don't impact our reputation, unless positively" Case D***

Staff worried that if they were to address alcohol, those outside the organisation may believe this was due to them having problems with alcohol in their workforce, in terms of dependency or a "boozy culture". Many staff cited the example of how a bank was recently portrayed by the media when announcing a change to their alcohol policy. This led to some resistance in publicising the alcohol

awareness initiatives, and in some cases, sign off for the project. This factor appeared more evident in public sector organisations where there was more perceived scrutiny from political parties and members of the public. It was less of an issue where alcohol IBA was presented as a wellbeing initiative which could benefit everyone, suggesting this could be a facilitator to implementation or buffer this concern.

Inner Setting

This domain addresses issues within the organisation which may have impacted on the success of implementation.

Structural characteristics

Organisations who were set up with more access to computers and internet were perhaps unsurprisingly more able to implement a digital tool. In cases without good access, having one base was an important facilitator as awareness raising was easier with smaller resources. Where there were multiple bases and staff had low resources, they highlighted this as a barrier as they were unable to complete high levels of awareness raising across the organisation and were limited in the number of strategies they could use.

> ***"Everyone technically has access to computers but they don't always have the time to use them so it would be good to use other ways to get the message out" Case A***

> ***"We have quite a few bases, I haven't the resources to go to each one, but could send out emails or posters they could put up in each place" Case C***

Size of organisation could also influence strategies used, although medium and large sized organisations both implemented alcohol IBA. Medium organisations could use personal connections and relationships to facilitate completion, whereas larger organisations could obtain a bigger budget and so access more engagement tools.

> ***"Yes (I've met most of the staff), so maybe that helps. I'm not their Manager" Case C***

Having a rigid, formal hierarchical structure appeared a barrier as senior leaders or external bodies (e.g. unions, trustees) were required for sign off.

> ***"The biggest barrier to getting going was getting the senior team to sign off the project. It is hard to get a meeting with them, and to get them truly on board" Case G***

"It is part of my well-being role so I can champion it but it needs to be signed off by the Directors" Case G

"We also needed to run it by our Communications and External Relations Team" Case D

Having an informal, networked power structure appeared to be a useful facilitator, and having the key stakeholders on board

"It was great having a project team, we had involvement at all levels and across the organisation which seemed important" Case D

It also helped when those involved in the project had wellbeing as part of the job description. Staff noted it was more likely to slip down the priority list if it was additional to their core role.

"Having this as part of my job description helps, I'm able to put time aside for it" Case B

Organisational culture

An organisational culture which values new ideas, is open to change, friendly and questioning (e.g. whether they could consider whether staff could be drinking at risky levels) was helpful in implementation. Having staff wellbeing as an organisational value or company ethos was also useful, as the organisation was more ready to engage with the intervention. Perceived presence of an alcohol culture in the workplace was also a barrier where staff did not see the need for the intervention or worried staff would reject it seeing their alcohol use as 'normal'.

"Staff might think we are interfering, but guess it is good to raise awareness as they might not know they are drinking at these risk levels, my score surprised me" Case C

Beliefs appeared to be shifted through the training session and self-completion of the tool. The move to include prevention within the organisation culture was also important, particularly in organisations were the focus was on compliance.

"It was great to be able to add this to our policy, our focus had been on the compliance and disciplinary side of things as we have a zero tolerance to alcohol at work, but hadn't included anything outside of this so we now cover all aspects" Case H

Tension for change and relative priority

Organisations all reported to struggle with having a tension for change as they had not identified alcohol issues in the workplace, and so stakeholders did not consider the intervention as immediately necessary.

"It slipped down the priority list… we had to concentrate on our core business" Case H

This factor impacted through the re-prioritisation of implementation. Placing implementation as a key objective and presenting this as a key wellbeing initiative appeared to mitigate this. Implementation was prioritised when it was viewed as something that could benefit a large proportion of employees, even when the organisation did not identify staff as having alcohol issues. Where the alcohol IBA tool was seen to be compatible with the organisations values (e.g. a focus on being a healthy workplace), the climate appeared more primed and amenable to implementation.

In cases where organisations struggled to implement their plans, a key barrier was that other tasks had arrived unexpectedly. Resources were re-allocated to 'core business' meaning less resource was available for the alcohol IBA implementation. Whilst competing priorities were present across all organisations, those who viewed the intervention as important were less likely to allow this to slip down their agenda.

"We wanted to do this as part of the wellbeing offer to staff, it was an important component of our wellbeing strategy" Case B

Setting deadlines and goals to review progress were noted to be an important facilitator in this context, in addition to having this as an objective or performance target with specific roles allocated.

Readiness for implementation

Having the available resources (e.g. computers, staff, information, tools) was key, alongside engagement with leaders or stakeholders. Having people who were committed, involved and accountable was key, and those who had the power to sign off the project. Attending the training also offered education and information to staff groups which acted as a trigger for the project, and prepared them for the implementation. Many staff noted that it is unlikely they would have implemented alcohol IBA had they not been approached by the project team.

"We might not have done it, certainly not in this timescale, this if we weren't approached to take part" Case H

This appeared a key facilitator and should be considered when considering sustainability.

Three of the organisations noted that they were developing their substance misuse policies or strategy which assisted with stakeholder engagement and sign off.

"… linked to the development of a substance misuse strategic framework we have been able to identify the resources… the significant strategic buy in has been the key critical success factor" Case A

Characteristics of individual

Characteristics of the individual leading the project in the organisation was also important to timely implementation. Qualities that were noted to be important were a passion for wellbeing, motivation to complete projects, self-efficacy, perseverance and an ability to make decisions or push things forward due to personality and position or seniority in organisation.

"I'm quite impatient, and was perseverant, I think that is what you need to be sometimes to get these things done!" Case B

The barrier faced by many organisations was having the right person to lead the project, not having the power to make final decisions or sign off led to delays or additional obstacles.

"Not having the ability to sign this off definitely slowed things down" Case G

Process

This domain related to the processes by which alcohol IBA was implemented. It includes stages of planning, engaging, executing, reflecting and evaluating.

Planning

All organisations were given the opportunity to plan their implementation within the training session. Organisations who made detailed plans and allocated actions to staff members tended to be most successful. Those who could reflect and revise their plans also had greater success in terms of rolling out alcohol IBA within the time scale.

"Having an action plan and deadlines definitely helped us" Case D

A lack of a strategic plan was reported as a barrier, and early identification of champions seen as a facilitator. The importance given to planning was also highlighted as a crucial facilitator in this process.

Engaging

Organisations who engaged health and wellbeing champions tended to be most successful in terms of getting staff to complete the IBA.

"It was great to have a project team, and for us to be able to run with the project, wellbeing is something we're all passionate about here so I think that helped" Case E

The opportunity to foster ownership and confidence was noted to be important, and having formally appointed leaders to drive things forward. Lack of engagement with opinion leaders was seen to be a barrier, and champions to overcome any indifference or resistance were useful.

"With hindsight, we should have made sure the senior leaders were fully engaged at the start as it might have speeded things up" Case G

Given the project was either at the executing or planning stages, elements of reflection and evaluating were not present in any of the staff narratives. This is likely to appear later in the implementation process and so would be something to consider further down the line.

Considering these factors and range of domains when implementing alcohol awareness and IBA would be important in future success.

Dissemination

The project was presented at the Tackling Alcohol Misuse for Prevention and Treatment Joint HIN and CLAHRC Conference in May 2017. The project report and a 'how to' guide will be disseminated through the HIN partners and the AHSN network.

Discussion

The project aimed to introduce digital alcohol IBA in the workplace as part of an alcohol awareness programme, and to evaluate the processes by which organisations can successfully implement and embed this within their systems and practices.

In total 10 organisations were trained in alcohol IBA, and eight took part in the evaluation. In terms of adoption, three organisations had started to implement at the time of writing, and five planned to do so by the end of this year. For penetration (e.g. number accessing the intervention), 4775 employees had the potential to be exposed to alcohol IBA (rising to 29,475 if all organisations implement), 358 had accessed it, and 121 had completed it. Of those who completed the tool, over 50% were drinking at 'at-risk' levels. This would suggest that alcohol IBA is acceptable and appropriate for completion in the workplace, at least to some employees, and can target the right people (e.g. those drinking at 'at-risk' levels). It is however unclear whether those who did not access the IBA tool did so because they were not interested in assessing their alcohol use, or whether they had not seen the promotion of the tool or did not have time to complete it. The project brought cost savings to both the NHS and the

organisations who took part, illustrating the financial case for using IBA, alongside the benefits to health and wellbeing. This fits with the Five Year Forward View (NHS England, 2014) and NICE guidelines (NICE, 2010).

In addition to impact of the project, methods and processes were mapped to evaluate the implementation itself. This led to the identification of 14 implementation strategies, which included evaluative strategies, adapting innovation to context, developing stakeholder relationships, training and education, engaging staff, using financial strategies and changing infrastructure. All organisations were found to use multiple strategies, tailoring them to their own workplace in terms of size and structure.

When exploring the facilitators and barriers to implementation, 19 factors were identified. Factors included the following domains: Intervention Characteristics (evidence strength and quality, relative advantage, adaptability, complexity and design quality, cost); Outer Setting (peer pressure, external incentives, wider culture); Inner Setting (structural characteristics, organisational culture, organisational structure, tension for change and relative priority, readiness for implementation, characteristics of individual); Process (planning, engaging). This highlights aspects that should be considered in any future implementation. As noted from the evaluation, implementation was challenging in many of the organisations, perhaps reflected in only three having implemented within the time scale discussed at the outset. Considering the barriers and how these could be overcome could be helpful in promoting more successful implementation programmes. The findings fitted with the implementation science literature, and provided additional support for the CFRI framework, developing the evidence base in this area.

Conclusion

This suggests that implementation of alcohol awareness and IBA in the workplace is acceptable to employees, and can target the right population.

Key Recommendations

Learning from the project indicates that there are some key factors to consider when organisations are considering implementing alcohol awareness or IBA. These are:

- **Assess readiness for intervention:** Consider resources (do you have staff time and funding?); organisation vision and objectives (does staff wellbeing feature in your organisations vision or objectives?); attitudes and motivation conducive to change (what is the culture around alcohol and change within the organisation?). If organisation does not appear ready,

complete education or training on the need for the intervention and review policies or strategies to ensure they are up to date and include a prevention element.

- **Engagement through education and training:** Consider delivering training or offering education to key stakeholders, covering the impact of alcohol-harm to both the individual and organisation, the benefits gained from completing alcohol IBA, and what this offers above what the organisation currently has (e.g. evidence based, digital intervention focused on prevention). Linking this to Public Health England, the NHS or the World Health Organisation may also be helpful.
- **Develop blueprint for implementation**: This should include clear objectives and time frames. Tasks should be allocated to specific individuals, ideally with a project team made up of staff from across the organisation, and an appropriate leader with enough influence to drive implementation forward. This should be co-designed where possible to maximise engagement and success.
- **Use a range of implementation strategies:** Implementation strategies should be used to engage staff members and increase awareness. The strategies should be tailored to the organisations structure, size and learnings from any previously successful campaigns. Communication should be neutral and emphasise wellbeing and prevention. It should also, emphasise the confidential and anonymous nature of the tool.
- **Engagement through developing stakeholder relationships:** Identify and prepare wellbeing champions, organise meetings with key stakeholders, inform local opinion leaders. Obtain formal commitment to implement an alcohol awareness programme within the organisation. The Healthy Workplace Charter could be used to increase interest in the project.
- **Select a tool**: This should fit with organisations values and ethos, it should be easy and quick to use, and offer confidentiality and data security. The tool should be piloted with a group of staff prior to roll out to ensure it is viewed as user-friendly and acceptable to employees.
- **Write a business case:** If funding is not available, a business case should be developed. This would include cost of the tools, resources and staff time, alongside the benefits this can bring to the employee and organisation in terms of wellbeing and cost saving (see cost saving above). This can be modelled based on previous research and literature.
- **Consider changed to infrastructure:** For sustainability of the project, it would be helpful to consider changes to policy or processes, for example adding IBA to the staff induction or agenda for yearly wellbeing events, linking into other initiatives.

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Appendices

Appendix I – Alcohol Use Disorders Identification Test (AUDIT)

AUDIT	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL SCORE	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

Appendix II – Summary of Organisations

Table: Summary of organisations participating in project, as of July 2017

Organisation	Approximate number of employees	Size of organisation	Sector of organisation	Number attending training session	Implementation outcome
A	2000	Large	Public	1	Implemented
B	2700	Large	HEI	6	Implemented
C	75	Medium	Charity	2	Implemented
D	800	Large	Public	5	Planned to implement
E	50	Medium	Public	2	Planned to implement
F	150	Medium	Public	2	Planned to implement
G	1500	Large	Public	4	Planned to implement
H	7000	Large	Private	6	Planned to implement
I	15,000	Large	Public	1	No follow up info
J	200	Medium	Charity	15	No follow up info

Appendix III - Engagement Letter

Dear XXX,

Re: Workplace Alcohol Awareness Programme

I am writing to you to invite you to take part in a pilot project to support and improve workplace health and wellbeing through an Alcohol Awareness raising programme, including support for delivering an evidence based intervention to reduce alcohol related harm – alcohol Identification and Brief Advice. This pilot project is part of the Health Innovation Network's Alcohol Programme, and is supported by Health Education South London and the Darzi Fellowship Programme.

Impact of alcohol on workplaces

Misuse of alcohol by employees can have major impacts on their health and wellbeing, their productivity and occasionally on safety in the workplace. The Department of Health has estimated that over a third of the cost of alcohol misuse nationally falls on employers. This is through absenteeism, lower productivity where employees are suffering the after effects of alcohol misuse (sometimes termed 'presenteeism'), and workplace accidents.

What is alcohol Identification and Brief Advice?

Alcohol Identification and Brief Advice (IBA) is an evidence based intervention that has been proven to prevent and reduce alcohol related harm. The intervention consists of a short questionnaire (of 3-10 questions) which has been researched widely and validated by the World Health Organization; and a brief five-minute provision of advice. A wide range of research studies have shown that: alcohol IBA helps those at risk of harm from their drinking to significantly reduce this risk; reduces overall consumption by 15%; and can help hose with dependence issues be identified and provided with appropriate support.

Digital applications of IBA have been shown to be effective in reducing alcohol related harm, and they provide a unique opportunity for workplaces to roll out IBA in a simple, effective and anonymous way.

What is this pilot project?

This pilot project is aimed at Human Resources and Health and Safety staff within a workplace to be trained and supported to implement a programme of alcohol IBA training and/or alcohol IBA implementation within the workplace. To support this, we will provide:

- A training session for nominated staff on how to raise awareness of alcohol related issues in

the workplace and to deliver digital alcohol IBA to employees within your workplace;
- Support for the nominated staff to plan and deliver a programme of alcohol IBA implementation through alcohol awareness activities and digital IBA; and,
- Signposting to a range of tools to support this implementation, with detailed discussion of the best tools to support workplaces.

What are the benefits of being involved?

There are a range of benefits for your workplace of being involved in this project. As outlined alcohol misuse is a major burden on the economy and a major impact on the health and wellbeing of employees. Some of the benefits include:

- Improved staff health and wellbeing;
- Improved productivity because of fewer days worked with reduced productivity due to the side effects of alcohol misuse;
- Fewer days absent from work due to the side effects of alcohol misuse; and,
- Making a significant contribution to meeting the Healthy Workplace Charter through improving staff health and wellbeing in terms of responsible alcohol use.

What are we asking of you?

We are asking you to nominate 1 or more staff members who are involved in Human Resources, Health and Safety or Line-Management to take part in the training process. This will include:

- Reading preparation materials provided by us to outline the background, basic information and basic skills to take part in the training;
- Taking part in one half-day training course to ensure the appropriate understanding and skills to implement a programme of workplace alcohol awareness and digital IBA;
- Time and support to implement a digital alcohol IBA programme for staff within your workplace; and,
- Some time to be surveyed and interviewed for the evaluation of the project.

We are also asking for your commitment and support for this project. This might include communicating to staff management support for the project and providing appropriate time for those involved to take part.

Time frame and time commitment

We are intending to work with participants during November and December 2016 with the aim to implement training in December 2016 and January 2017. We would be providing support during this period and after the training in February and March 2017. The evaluation of the project would be taking place in January – March 2017.

In terms of time commitment, we would estimate that this might involve 3-4 days of the two-nominated staff to prepare, be trained and implement. It would also involve a small amount of time

for wider staff to undertake the alcohol IBA, for most this would be 5 minutes or less. We are keen to discuss this opportunity with you or one of your team. Please do not hesitate to contact:

- Dr Ghazaleh Pashmi - ghazaleh.pashmi@safesocaible.com
- Dr Kate Daley – katedaley@nhs.net

Yours sincerely,

Dr Ghazaleh Pashmi

Safe Sociable London Partnership on behalf of the Health Innovation Network

Appendix IV - Training Outline

Alcohol Awareness in the Workplace: Training Agenda

Time	Session
5 minutes	Welcome and introductions
5 minute	Overview and objectives for the day
15 minutes	Pre-reading • Alcohol and its impact • Why use IBA *Activity: Impacts of alcohol in your workplace*
25 minutes	IBA in practice • Identification and how it works • Identification as assessment • Evidence of effectiveness • AUDIT questionnaire • What is brief advice • When to use it
45 minutes	Resources • Outlining intervention pack/tools available and how they can be used • Discussion of the online IBA packages available • Additional resources and awareness raising tools
15 minutes	Evaluation project
35 minutes	*Activity: How will you apply this in your workplace* • Discussion about options, opportunities, barriers to applying an alcohol awareness programme in your workplace
25 minutes	Our support • Outline the support that will be provided by the project team • Asking what support attendees might need • Contact points • Time for questions
5 minutes	Thank you and close

Appendix V – Evaluation Forms

Alcohol awareness in the workplace Training Evaluation Form

The following form asks questions relating to the knowledge and information provided in this training session. Please assess the statements in questions 1 - 9 as per the text boxes and provide any further comment you have for questions 10 and 11.

1. I understand how alcohol awareness can be important in the workplace

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

2. I feel confident to initiate an alcohol awareness project in my workplace

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

3. I feel that I understand the purpose and benefits of using IBA tools to support an alcohol awareness in the workplace campaign

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

4. I feel that I understand how I can use an IBA screening tool as part of an alcohol awareness project

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

5. I feel confident to explain identification and brief advice to stakeholders in my workplace and the place it has in an alcohol awareness project

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

6. I felt that the trainer explained alcohol awareness and Identification and Brief Advice in an easy to understand and useful way

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

7. I felt the examples and discussions were useful and helped me understand the practicalities of alcohol awareness projects

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

8. The information, materials and resources provided will help me in setting up an alcohol awareness project in my workplace

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

9. "I feel confident to develop and deliver an alcohol awareness project in my workplace"

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

10. The things I found most useful about the training were:

11. The training could be made stronger by:

Alcohol awareness in the workplace Training Evaluation Form (3 month follow up)

The following form asks questions relating to the knowledge and information provided in the training session you attended in December 2016. Could you please assess the statements in questions 1 - 5 as per the text boxes and provide any further comment you have for questions 6-7.

1. I feel that the training allowed me to develop a successful alcohol awareness project in my workplace

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

2. I feel that I can explain the benefits of the project to senior managers and employees clearly

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

3. I feel that I understand the IBA tool that we are using in my workplace and how it has an impact

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

4. I feel that the training prepared me for aspects of implementing an alcohol awareness project in my workplace

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

5. I would recommend a similar alcohol awareness project to other workplaces

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

6. The things I have found most useful from the training:

7. What I now know I would have liked to learn more about in the training:

Appendix VI – Implementation Evaluation Plan

Approach organisations, interested in taking part

Yes

No - record number & reasons

Engagement meeting to ensure eligible

Yes

No - record number & reasons

Arrange training session, invite appropriate staff

Training session, discuss implementation, use contextual factors as guidance to troubleshoot and select implementation strategies*

Support offered during implementation, amended if needed, complete data collection form

Interview with staff post implementation, discuss implementation outcomes

No – record reasons

Evaluation

Appendix VII – Data Collection Sheet

Organisation (name, sector, size, description - number of bases, type of staff group): **Date of IBA training:** **Job titles of attendees:**
Sign up: Why did you and / or the organisation want to take part in this project? Any motivators? Incentives? Drivers?
Implementation: Which strategies do you plan to use to implement alcohol IBA in the workplace *(e.g. email staff the IBA, newsletter, engage champions, getting senior buy in)*? Which IBA tool was chosen and why?
Barriers: Have there been any barriers or obstacles, anything which slowed things down, any amendments to original plan? **Facilitators:** Any factors which helped implementation move forward or aided its success so far?
Wording of messaging: Attach any examples of email communication, posters etc.
Estimated cost (if known): What has been the estimated cost of the project? Costs of the tool, staff time?
IBA completion (if known): Number of IBA's completed, number identified as drinking at risk levels (e.g. a score of 7+ on the AUDIT)
Other: Any other notes which would be helpful for us knowing what works / challenges faced, that other organisations could learn from if they were to do something similar?

Appendix VIII – Interview Template

Adapted from the CFIR Framework - http://www.cfirwiki.net/guide/app/index.html#/

I. Innovation Characteristics	Questions for training / interview	Answers
Innovation Source Perception of key stakeholders about whether the innovation is externally or internally developed.	Who developed the intervention / decided to implement What is your opinion of them How was decision made to implement	
Evidence Strength & Quality Stakeholders' perceptions of the quality and validity of evidence supporting the belief that the innovation will have desired outcomes.	What evidence is there that it will work in your setting What supporting evidence needed to get staff on board Is this evidence high quality and valid	
Relative Advantage Stakeholders' perception of the advantage of implementing the innovation versus an alternative solution.	How does this compare to existing programmes Advantages and disadvantages compared to these How compares to alternatives you've considered, Any other interventions that people would rather implement, and why they may prefer these	
Adaptability The degree to which an innovation can be adapted, tailored, refined, or reinvented to meet local needs.	What changes do you think you'll need to make it effective in your setting Do you think you'll be able to make these changes and why Who will decide whether changes are needed How will you know if appropriate to make changes Any components that should / shouldn't be altered	
Trialability The ability to test the innovation on a small scale in the organization, and to be able to reverse course (undo implementation) if warranted.	Will the intervention be piloted prior to implementation What plans do you have for this Do you think it would be possible to pilot first, why and would this be helpful	
Complexity Perceived difficulty of the innovation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement.	How complicated is the intervention (*not the implementation*). Consider duration, scope, intricacy, number of steps and whether reflects clear departure from previous practices	
Design Quality & Packaging	What is your perception of quality of supporting materials What supports such as marketing, online resources are	

Perceived excellence in how the innovation is bundled, presented, and assembled.	available, how do you access How will materials affect implementation in your setting
Cost Costs of the innovation and costs associated with implementing including investment, supply, and opportunity costs.	What costs will be incurred What costs were considered
II. Outer Setting	
Needs & Resources of Those Served by the Organization The extent to which the needs of those served by the organization (e.g., patients), as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization.	To what extent are you aware of needs and preferences of employees in organisation / extent their needs are considered when deciding to implement intervention Will anything be changed to meet their needs How do you think the employees will respond to the intervention What barriers might they face to participating Have you elicited information from participants regarding their experiences, what are their perceptions, what kind of specific information have you heard
Cosmopolitanism The degree to which an organization is networked with other external organizations.	To what extent do you network with others outside of the organisation, what information if any do you exchange Are you encouraged to network outside of the organisation
Peer Pressure Mimetic or competitive pressure to implement an innovation, typically because most or other key peer or competing organizations have already implemented or are in a bid for a competitive edge.	Can you tell me what you know about other organisations that have implemented IBA, to what extent are they implementing the intervention Did this information influence your decision to implement To what extent would implementing provide an advantage for your organisation compared to others in your area, is there a competitive advantage
External Policy & Incentives A broad construct that includes external strategies to spread innovations including policy and regulations (governmental or other central entity), external mandates, recommendations and	What kind of local / national performance measures, policies, regulations, guidelines influenced your decision to implement the intervention (if any) How will implementing affect the organisations ability to meet these measures, are there any relevant policies What kind of financial or other incentives influenced the

guidelines, pay-for-performance, collaboratives, and public or benchmark reporting.	decision to implement How will the intervention affect the organisations ability to get the incentives
III. Inner Setting	
<u>Structural Characteristics</u> The social architecture, age, maturity, and size of an organization.	How infrastructure of organisation (age, social architecture, maturity, physical layout) affects implementation of the intervention How will infrastructure facilitate / hinder implementation of intervention How will you work around those structural challenges Do you need any changes in scope of practice, formal policy, information systems Is it a one off intervention or part of wider initiative What approvals needed, who will need to be involved What are the processes needed to make the changes
<u>Networks & Communications</u> The nature and quality of webs of social networks, and the nature and quality of formal and informal communications within an organization.	Can you describe working relationships with your colleagues Any times have worked with them to implement an intervention in the past To what extent to you get together outside of work, how often you meet, what are the working relationships like with leaders and influential stakeholders, do you meet regularly as a team, how often, how many of you How do you find out about new information on initiatives, staff changes, when you need to get something done who are your go to people
<u>Culture</u> Norms, values, and basic assumptions of a given organization.	How would you describe the culture of the organisation and your own setting How do you think the culture (beliefs, values) will affect implementation To what extent are new ideas embraced & used to make improvements in your organisation Would you describe the culture as: (*prompt*) ● Team: Friendly workplace, leaders like mentors, value on team and development

	● Hierarchical: Structured, formal, leader as coordinator, value on doing things right ● Entrepreneurial: Dynamic workplace, leaders that stimulate intervention, value doing first ● Rational: Competitive workplace, leaders like producers or competitors, value on short-term performance and doing things fast Does this change through the intervention
Implementation Climate The absorptive capacity for change, shared receptivity of involved individuals to an innovation, and the extent to which use of that innovation will be rewarded, supported, and expected within their organization.	What is the general level of receptivity in organisation to implementing the intervention
Tension for Change The degree to which stakeholders perceive the current situation as intolerable or needing change.	Is there a strong need for this intervention, why / why not, do others see a need for it How essential is the intervention to meet employees needs How do people feel about current practices that are related to the intervention Extent current programmes fail to meet existing needs, will the intervention meet these
Compatibility The degree of tangible fit between meaning and values attached to the innovation by involved individuals, how those align with individuals' own norms, values, and perceived risks and needs, and how the innovation fits with existing workflows and systems.	How well does intervention fit with your values and norms, and those within organisation How well does it fit with existing practice and processes, likely issues that may arise How will it be integrated into current practices, how interact or conflict with other practices Will it replace or compliment current programme, in what ways Health and wellbeing policy
Relative Priority Individuals' shared perception of the importance of the implementation within the organization.	Activities that have highest priority for you and organisation, pressure to do this, from who Extent implementation may take back seat to other initiatives How important implementation compared to other priorities to you and others

	How will you juggle competing priorities, what are the other priorities
Organizational Incentives & Rewards Extrinsic incentives such as goal-sharing, awards, performance reviews, promotions, and raises in salary, and less tangible incentives such as increased stature or respect.	What kind of incentives to help insure implementation is successful What is your motivation for making this successful Any recognition or rewards planned, what are they, who for
Goals & Feedback The degree to which goals are clearly communicated, acted upon, and fed back to staff, and alignment of that feedback with goals.	Have you set goals related to the implementation, what are they To what extent does your organisation set goals, how communicated, examples To what extent are goals monitored for progress Do you get any feedback reports about your work, how helpful, how often, who from Does implementation align with organizational goals
Learning Climate A climate in which: 1. Leaders express their own fallibility and need for team members' assistance and input; 2. Team members feel that they are essential, valued, and knowledgeable partners in the change process; 3. Individuals feel psychologically safe to try new methods; and 4. There is sufficient time and space for reflective thinking and evaluation.	Recent quality improvement or implementation programme Describe it, major accomplishments, key players, your involvement, happy with outcome If you saw a problem what would you do, recent example To what extent do you feel you can try new things to improve work process Do you have time and energy to think about new ways of improving things What role did leaders plan, what actions did they take, did you feel valued / respected
Readiness for Implementation Tangible and immediate indicators of organizational commitment to its decision to implement an innovation.	See below
Leadership Engagement Commitment, involvement, and accountability of leaders and managers with the implementation of the innovation.	What level of endorsement / support have you seen from leaders What level of involvement had with the implementation Do they know about it, who are they, how do attitudes vary, support given you to

	What support you can expect from them to make implementation a success Can you think of any barriers they may create
Available Resources The level of resources organizational dedicated for implementation and on-going operations including physical space and time.	Do you have sufficient resources to implement intervention, what are they, which can't you How do you expect to procure the resources, who involved, what challenges expect
Access to Knowledge & Information Ease of access to digestible information and knowledge about the innovation and how to incorporate it into work tasks.	What training is planned for you or colleagues, do you feel prepared for what is expected What kinds of information have you had already, copies of materials, personal contact Who do you ask if you have any questions, how available are they What kind of information about intervention is planned for your setting
IV. Characteristics of Individuals	
Knowledge & Beliefs about the Innovation Individuals' attitudes toward and value placed on the innovation, as well as familiarity with facts, truths, and principles related to the innovation.	What do you know about the intervention / implementation Do you think it will be effective, why / why not How do you feel about the intervention being used, and implementation At what stage of implementation is the intervention at, how do you think it's going and why
Self-efficacy Individual belief in their own capabilities to execute courses of action to achieve implementation goals.	How confident are you that you will be successful at implementation, what gives you that How confident you will be able to use it How confident do you think colleagues feel about intervention and implementation What gives them that level of confidence / lack of confidence
Individual Stage of Change Characterization of the phase an individual is in, as s/he progresses toward skilled, enthusiastic, and	How prepared are you to use the intervention: Knowledge: Knowledge of key aspects – pre-contemplation Persuasion: Like it, discuss it with others, buy in, positive view – contemplation

sustained use of the innovation.	Decision stage: Intend to seek additional information – preparation Implementation: Acquire additional information, use and continue to use – action Confirmation stage: Recognize benefits, integrated intervention into routines – maintenance
Individual Identification with Organization A broad construct related to how individuals perceive the organization, and their relationship and degree of commitment with that organization.	May pick this up goals and feedback
Other Personal Attributes A broad construct to include other personal traits such as tolerance of ambiguity, intellectual ability, motivation, values, competence, capacity, and learning style.	Locus of control, health or organizational psychology concepts
V. Process	
Planning The degree to which a scheme or method of behavior and tasks for implementing an innovation are developed in advance, and the quality of those schemes or methods.	What have you done / plan to do to implement intervention Describe plan – how detailed, who knows, realistic, feasible, your role, who else involved, how engaged are they, do you plan to track progress, what if have to modify plan due to barriers, errors, mistakes What role has your plan for implementation played during implementation – was it used to guide implementation, compared planned and actual, revisions or refinements, plan shared / reviewed by others and how often
A. Engaging	See below
Opinion Leaders Individuals in an organization that have formal or informal influence on the attitudes and beliefs of their colleagues with respect to implementing the innovation.	Who are key influential individuals to get on board with implementation What are they saying about the intervention, who are they to what extent will they influence

Formally Appointed Internal Implementation Leaders Individuals from within the organization who have been formally appointed with responsibility for implementing an innovation as coordinator, project manager, team leader, or other similar role.	How did your organisation become involved in implementation of the intervention Were you involved in the decision-making process, who else participated Who will lead it Who else involved
Champions "Individuals who dedicate themselves to supporting, marketing, and 'driving through' an [implementation]", overcoming indifference or resistance that the innovation may provoke in an organization.	Other than the formal leader, anyone who is likely to champion – formally appointed or informal role, position in organisation, how they will help Can you describe people's perception of the champion, to what extent you respect them What kind of behaviour or actions do you they think they will exhibit