


# Commissioning Alcohol Identification and Brief Advice

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Health Innovation Network South London

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# Foreword

**The Health Innovation Network is one of 15 Academic Health Science Networks (AHSN) across England. We are a membership organisation focused on spread and adoption of lasting system-wide improvements in patient and population health, strengthening relationships and capitalising on teaching and research strengths across South London.**

As the AHSN for South London, our work prioritises health challenges for local communities across a number of clinical areas; including diabetes, dementia, musculoskeletal and alcohol. Our work incorporates cross-cutting innovation themes to generate wealth and increase the quality of care in our communities.

Our Alcohol Identification and Brief Advice (IBA) Commissioning Toolkit brings together the evidence base and guidance for alcohol IBA, including tips for commissioning across a range of different settings, a framework for ensuring quality elements are considered in the commissioning process and case studies to illustrate topics, all in one easy-to-use online resource.

# Why a toolkit?



**Alcohol Identification and Brief Advice (IBA) is early identification and intervention of increasing-risk and higher-risk drinking**

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# Why a toolkit?

## Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England commission alcohol Identification and Brief Advice (IBA) to provide early identification and intervention of increasing-risk and higher-risk drinking.

The purpose of the toolkit is to provide Commissioners with information that will assist in developing IBA pathways, which form part of an effective alcohol harm reduction system.

### Who is this toolkit aimed at?

Whether you are new to commissioning alcohol IBA or you're an experienced commissioner, there should be something in this toolkit for you! Specifically, this toolkit is for:

- Substance Misuse Commissioning Managers
- Mental Health Commissioning Managers
- Acute Commissioning Managers
- Public Health Consultants
- Public Health Principals and Specialists
- Probation Substance Misuse Leads
- Community Safety Managers and those that lead on Drug Interventions Programme (DIP) and arrest referral schemes

## Purpose of the toolkit

This toolkit aims to bring all the best practice and most up to date knowledge about IBA and commissioning of IBA into one toolkit. This includes step-by-step guidance on all the key aspects of commissioning and some further exploration of how to commission strategically and on commissioning to improve quality of IBA delivery.

## Using the toolkit

Links to many useful resources can be found in this toolkit. These include links to web-based training, a return on investment tool and studies on the effectiveness of alcohol IBA in different settings.

The toolkit should support commissioners in a number of ways.
For example, it provides:

- Information on a number of different settings in which IBA can be commissioned, including a whole system approach which maximises funding to reach as many people as possible in your population.
- Suggestions for indicators that commissioners can use to monitor the quality of their current local services and identify improvements that can be made.
- Case studies and examples of good practice are used throughout the Toolkit to illustrate some topics.
- Samples of contracts that may be used to commission an IBA service are also presented throughout the toolkit.


> Commissioners should ensure their plans include screening and brief interventions for people at risk of an alcohol related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers). This includes people from disadvantaged groups

National Institute for Health and Care Excellence (NICE) Guidelines PH24

# Alcohol in the UK



**In addition to health costs, alcohol misuse also contributes to crime and lost productivity.**

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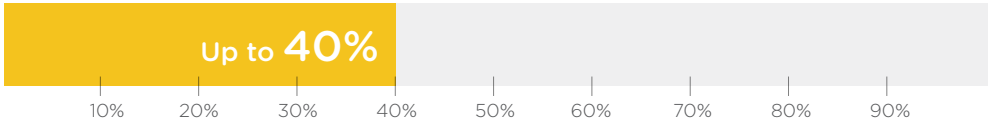
# Alcohol in the UK

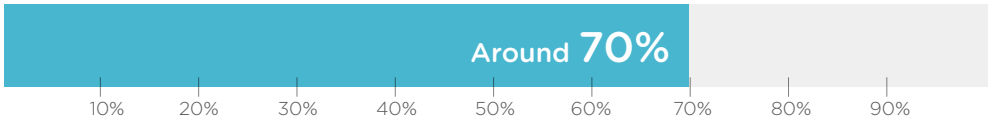
The cost of alcohol misuse in the UK is substantial. Alcohol related harm is estimated to cost the NHS in England £3.5 billion per year at 2009-2010 costs.[1] Alcohol misuse is a major cause of attendance at Accident & Emergency and of hospital admissions. Up to 40% of all Accident & Emergency admissions are estimated to be alcohol-related.[2] Between midnight and 5 am on weekends, around 70% of Accident & Emergency attendances are estimated to be alcohol-related.[3]

Drinking patterns at hazardous levels increases the risk of physical and psychological problems. Several diseases are linked to alcohol misuse, including heart disease, stroke, liver disease and cancer. In 2012 in England, 21,485 people died from alcohol related causes.[3]

**A&E admissions that are estimated to be alcohol-related.**




**A&E attendances between midnight and 5am on weekends that are estimated to be alcohol-related.**




## Alcohol in the UK

In addition to health costs, alcohol misuse also contributes to crime and lost productivity. Crime statistics from the Crime Survey for England and Wales 2013-2014 reported 64% of stranger violence incidents were alcohol related and that victims perceived the offender to be under the influence of alcohol in 53% of all violent crime.[4] Crime related to alcohol costs £11 billion a year (2010-2011). Lost productivity due to alcohol is estimated to cost the UK £7.3 billion per year (2009-2010).[5]

Much of the harm from alcohol use can be attributed to drinking habits of non-dependent drinkers. In England, around 9 million adults drink at levels that pose some risk of harm to their health and 2.2 million adults drink at a higher risk levels.[3]

**IBA has been shown to be an effective intervention to reduce alcohol consumption and alcohol related problems in non-dependent drinkers.**

## Alcohol data and where to find it

Public Health England is responsible for producing the Local Alcohol Profiles for England, which include the rate of alcohol–related hospital admissions locally, regionally and nationally. Data on mortality from alcohol is also presented and this can be viewed at local authority and CCG level and compared with other areas.
www.lape.org.uk

Alcohol Concern has produced a map of England with up to date data by local authority or Clinical Commissioning Group for a range of alcohol related issues, such as:

- The number of people drinking at unsafe levels
- The number of alcohol related hospital admissions
- Alcohol related healthcare costs
- Alcohol related deaths


The map can be found here

Commissioners should consider any information or data relating to alcohol misuse in any existing needs assessment documents. Locally, the Joint Strategic Needs Assessment (JSNA) is the most robust local needs assessment available to local Commissioning leads.

The JSNA data set provides indicators to establish current and future health needs of the population and in turn supports better targeting of interventions to reduce health inequalities. Local healthcare and treatment providers possess a wealth of data, some of which should be captured within the JSNA.

Public Health England has published (September 2015) a guidance document to support the JSNA process specific to alcohol prevention and treatment. It contains a section on good practice prompts for planning IBA interventions.

Find the full guidance document here

Specific local data on alcohol IBA however, may be difficult to obtain. Refer to the section entitled 'Ensuring quality of delivery' for tips on ensuring commissioned services are recording and reporting on IBA activity.

# What is Alcohol IBA?



**Alcohol Identification and Brief Advice (IBA) is early identification and intervention of increasing-risk and higher-risk drinking.**

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## What is Alcohol Identification and Brief Advice?

Alcohol IBA 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. IBA is usually delivered by a trained health professional in a health-related setting. However, it does not need to be limited to this setting. Non-health professionals have been trained and delivered IBA in a variety of settings including probation services, housing and youth services. Use of apps and web-based programmes linking individuals direct to IBA is becoming increasingly popular. IBA is an opportunity to reach and educate a wide range of people who may not be aware of the role of units, lower risk drinking limits and the risks associated with alcohol.[6]

**A sample alcohol pathway using AUDIT-C as the initial screening tool is attached here.**

A unit of alcohol is defined as 8g (or approximately 10ml) of ethanol. Proposed new guidelines[34] set by the Department of Health were released in January 2016. These guidelines accepted recommendations in the following 3 areas, summarised below:

## 1. A weekly guideline on regular drinking.

**For both men and women, the guideline is that:**

- You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.
- If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries.
- The risk of developing a range of illnesses (including, for example, cancers of the mouth, throat and breast) increases with any amount you drink on a regular basis.
- If you wish to cut down the amount you're drinking, a good way to help achieve this is to have several drink-free days each week.

## 2. Advice on single episodes of drinking.

**Men and women who wish to keep their short term health risks from a single drinking occasion to a low level are advised that they can reduce these risks by:**

- Limiting the total amount of alcohol you drink on any occasion.
- Drinking more slowly, drinking with food, and alternating with water.
- Avoiding risky places and activities, making sure you have people you know around, and ensuring you can get home safely.

## 3. A guideline on pregnancy and drinking.

- If you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.
- Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

**A summary document of the proposed new guidelines can be downloaded here**





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## A strong evidence base

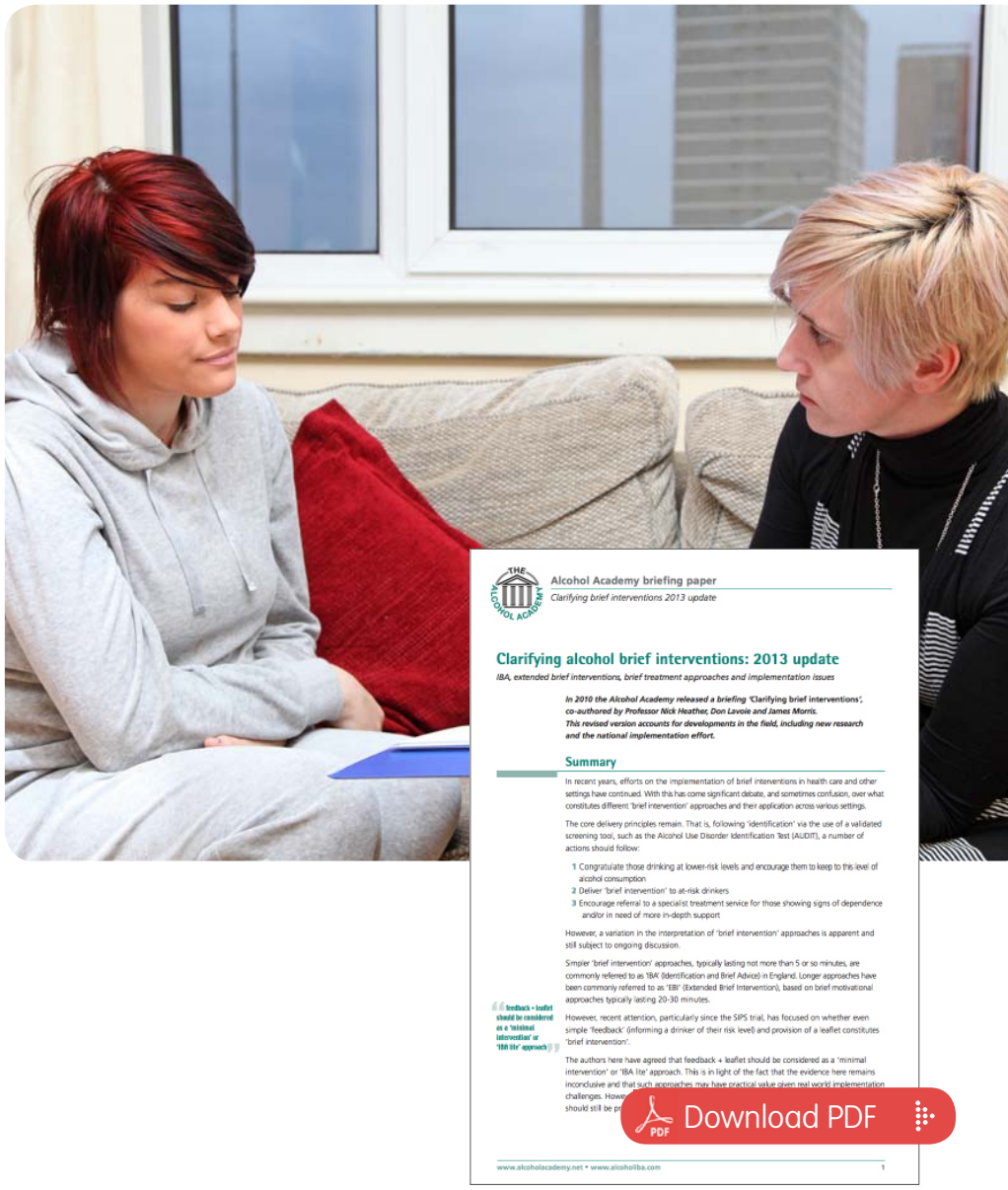
The evidence base for the effectiveness of IBA is strong. The World Health Organisation and the Department of Health have both acknowledged over 50 peer reviewed, academic studies that demonstrate IBA is both effective and cost effective in reducing the risks associated with drinking. On average, 1 in 8 drinkers who receive this type of support from a health care professional will reduce their drinking to the lower-risk levels.[8] 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.[9]

There is a growing evidence base that use of electronic IBA is also effective in reducing levels of drinking. A systematic review and meta-analysis of 23 studies found that electronic IBA is effective in reducing alcohol consumption in follow-up periods that range from less than 3 months to less than 12 months.[10]

## IBA approaches and screening tools

For an excellent summary of alcohol brief intervention approaches, some tools used and clarification of some of the key components between the approaches, please download this Briefing Paper published in 2010 (updated 2013) by the Alcohol Academy.

View a selection of IBA screening tools such as AUDIT, AUDIT-C and **FAST** at the Alcohol Learning Centre



## Further reading

A concise summary of the evidence for alcohol IBA, called the Alcohol Matrix has been published by the **Drug and Alcohol Findings Effectiveness Bank**. It is an excellent site for broadening your knowledge on a number of areas relating to IBA. It is divided into 5 bite-sized sections containing online links to key research, reviews and guidance documents. The 5 section headings are:

- Alcohol: Screening and Brief Interventions
- Practitioners: Screening and Brief Interventions
- Management/supervision: Screening and Brief Interventions
- Organisational functioning: Screening and Brief Interventions
- Treatment Systems: Screening and Brief Interventions


**...a year would reduce their drinking levels from higher-risk to lower-risk through implementation of IBA nationally.[11]**

# Commissioning Alcohol IBA

Ensuring rigorous implementation of IBA can be a significant challenge for Commissioners.

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## Commissioning alcohol IBA

Ensuring rigorous implementation of IBA can be a significant challenge for Commissioners. It is not an intervention that is mandated to be commissioned locally in any setting (with the exception of NHS Health Checks) and there are no statutory levers for guaranteeing minimum levels of coverage or quality.

One of the challenges of commissioning is around embedding high quality IBA routinely in settings other than Primary Care, where much of the initial focus has been, and widening this focus to other health, criminal justice, workplace and social care settings; or direct to the population via web- or app-based programmes. More information on the various settings in which IBA can be commissioned can be found in **Settings**. The importance of support for front-line professionals cannot be emphasised enough in the commissioning of services. Local Commissioners, managers of services and health champions can play a significant role in providing support and inspiration to frontline workers.

**Local Commissioners, managers of services and health champions can play a significant role in providing support and inspiration to frontline workers.**

## Who are commissioners?

People with the responsibility for commissioning services across a wide range of housing, criminal justice, health and social care areas should consider commissioning alcohol IBA.

Local Authority Adult Social Care Teams and Children's Social Services teams should consider ways in which to embed IBA in practice, adding IBA as a tool in a toolkit of approaches/ interventions. The Public Health team has a role in advising how to establish these systems in practice and this advisory role should also be considered a useful local resource.

Time and capacity must be considered when embedding an IBA system with little or no financial resources. Although the Commissioner might understand the logic of Children's Social Services or Mental Health Practitioners carrying out IBA, there are often time and capacity issues cited by these groups as a barrier to implementing IBA in their areas.

**Time and capacity must be considered when embedding an IBA system with little or no financial resources**





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## Mechanisms for Commissioning

There are incentive frameworks that Commissioners may implement, with the appropriate level of local health buy-in, which can operate as a vehicle for IBA in certain settings such as Commissioning for Quality and Innovation **(CQUIN)** schemes.

Financial resources can be a key barrier or facilitator to commissioning a local IBA system and without some level of financial incentive available to do IBA some contractual levers would need to be considered.

**Commissioning for Quality and Innovation (CQUIN)**

The CQUIN payment framework enables NHS commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals. A number of CQUINs have been developed in the development of schemes to reduce alcohol-related harm and in particular embed alcohol IBA.

CQUIN frameworks have been used by NHS Commissioners with:

- Provider: Foundations Trusts, Community Healthcare NHS Trusts
- Deliverer: Acute hospital staff, Community Healthcare staff
- Target Group: Alcohol-related presentations to psychiatric liaison, frontline community health care staff trained

The CQUIN is mainly made of an indicator that relates to a quality domain. It must contain a numerator, denominator, rationale, data source, frequency of collection, baseline, indicator value and rules for achievement upon which the payment is calculated.






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**Not a treatment intervention, alcohol IBA can be commissioned innovatively to respond early to those patients considered at risk**

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### Quality, Innovation, Productivity and Prevention (QIPP)

The Quality, Innovation, Productivity and Prevention (**QIPP**) is an NHS initiative designed to make efficiencies in the health economy whilst at the same time improve quality of treatment and care. Alcohol IBA has a strong evidence base and is very cost effective. Not a treatment intervention, it can be commissioned innovatively to respond early to those patients considered at risk particularly in settings such as Accident & Emergency, Primary Care, Pharmacy and Dental surgeries. However, the involvement of the **QIPP** lead in the local area is key to making the case and for the implementation of **QIPP** related IBA being adopted.





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### NHS Health Check

From 1 April 2013, local authorities took over responsibility for the national NHS Health Check programme. The provision of NHS Health Check risk assessments is a mandatory requirement for local authorities.

Legal duties exist for local authorities to make arrangements:

- for each eligible person aged 40-74 years to be offered a NHS Health Check once in every five years and for each person to be recalled every five years if they remain eligible
- so that the risk assessment includes specific tests and measurements
- to ensure the person having their health check is told their cardiovascular risk score, and other results are communicated to them
- for specific information and data to be recorded and, where the risk assessment is conducted outside the person's GP practice, for that information to be forwarded to the person's GP.
- Local authorities are also required to seek continuous improvement in the percentage of eligible individuals taking up their offer of a NHS Health Check. Further information on these provisions is provided in this document.

From 2013-14, alcohol risk assessment has been included in the NHS Health Check. The provider of the Health Check is required to carry out screening with a validated tool such as **AUDIT** or **FAST** and deliver brief advice or referral to a specialist treatment service.

**Further commissioning guidance on the NHS Health Check programme can be found here**

## Principles of Commissioning[12]

- The commissioning process is a continuous cycle through three key stages: strategic planning, procuring services and monitoring and evaluation. Commissioning should be a dynamic process that is about identifying and prioritising need and apportioning resources to meet those needs and achieve positive outcomes in a spiral of continuous improvement.
- The Joint Strategic Needs Assessment process should be used to establish local patterns of need and, in partnership with other stakeholders, agree local priorities for investment and development and decommissioning where necessary – taking account of service re-design, changing service models and practice, and ensuring the provision of an appropriately skilled and experienced workforce.
- Ensure there is an appropriate range of providers that are able to meet demand. Work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes, and monitor delivery, effectiveness, outcomes and costs.





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Public Health England has published (September 2015) a guidance document to support commissioning of alcohol prevention and treatment, which includes a section on IBA. The document aims to support the JSNA process and includes a range of prompts to assist local areas to consider key actions. Public Health England suggests the following questions are asked to ensure best practice is being followed:

1. Does the partnership have an integrated plan that sets out the partners' agreed roles and responsibilities, including for workforce development, in rolling out IBA in a range of settings, and is there a system in place to monitor activity?
2. Do the services that deliver IBA collect, analyse and report data to demonstrate the level of delivery?
3. Does local 'making every contact count' (**MECC**) activity include evidence-based alcohol IBA?
4. Are there any specific interventions to raise awareness of the harms of drinking for specific at-risk groups, such as pregnant women, older people and those with existing long-term conditions or mental health issues?
5. Do the NHS Health Check programme and GP new-registrations procedures include evidence-based alcohol IBA in line with regulations and guidance?
6. Is there IBA delivery across a range of adult local authority services, criminal justice and health settings?
7. Are there clear pathways to specialist assessment for those who may be dependent?


**These points above have been incorporated into a sample service specification. The sample service specification is an editable document that can be adapted to any setting within which face-to-face alcohol IBA may be commissioned.**





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# Settings for delivery of alcohol IBA

A 'whole system approach' is one that recognises the contribution that all parts or partners make to the delivery of high quality care.

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# Settings for delivery of alcohol IBA

## Whole System Approach

The previous section discussed the elements involved to effectively commission alcohol IBA. A 'whole system approach' is one that recognises the contribution that all parts or partners make to the delivery of high quality care. For alcohol IBA to be effective in reducing an individual's high risk alcohol consumption to within recommended limits, patient, staff and organisational factors need to be considered when designing the delivery and reporting of alcohol IBA.

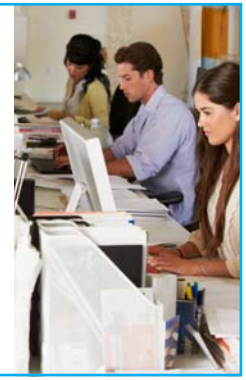
The whole system is not simply a collection of organisations that need to work together, but a mixture of different people, professions, services and sites. Multiple 'groups' are involved to provide a whole system approach. For example, different agencies are required to screen and support individuals. Commissioning a number of different settings where IBA can be delivered will maximise reach. Making each part of the system aware of its role within the whole system of care is essential to adequately ensure that the pathway achieves its aims of being a preventative approach to alcohol related harm and not merely a standalone screen.

A local partnership may typically include representatives from the CCG, local authority, local hospital, substance misuse services, criminal justice services and patient/public involvement. A lead Commissioner should be identified in a local partnership that is responsible for:

- Utilising the local JSNA data for the planning of an Integrated IBA Service system so that the most appropriate service model is in place for reducing alcohol-related harm
- Identifying resources to deliver the model
- Ensuring that the Alcohol IBA component of the NHS Health Check meets quality standards
- Ensuring that any **CQUINs** are delivered to quality standards and explore opportunities for the development of them
- Creating a single point of data collection for IBA related activity in forming an IBA coverage map highlighting areas of innovative practice and/or need.
- Maximising IBA opportunities across the health system and "making the case" using local data to Health and Wellbeing Boards
- Ensuring training is available for practitioners expected to deliver IBA in various settings
- Recruiting local IBA champions – team leaders or managers who can champion IBA with their frontline staff

> Effective local systems will be those that are coherently planned by local government, NHS and criminal justice partners to provide clear, integrated policies and pathways through levels of intervention based on identified need.
> **Public Health England, September 2015**

Alcohol harm prevention, treatment and recovery for adults: joint strategic needs assessment (JSNA) support pack







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## Settings in which commissioning alcohol IBA should be considered

National guidance has supported and recommended the rollout of IBA for many years. A strong case has been made for investing in NHS services, social services and the criminal justice service to deliver IBA in a number of settings. In addition to these, the icons (right) present a range of other settings for consideration. Click on each icon for information and tips about commissioning IBA in that setting. Unless otherwise stated, the guidance comes from Alcohol Concern, Evidence of effectiveness: Case for decision makers, 2014.[13] Consideration should also be given to support mechanisms for frontline workers expected to deliver IBA; for instance, training opportunities and organisational commitment from management or IBA champions.






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## Primary care

Primary care is a key access and contact point to healthcare and health promotion for the wider population. As such, it is a key setting from which IBA should be delivered. It is also Primary Care settings that have the strongest evidence of effectiveness of alcohol IBA.

From 1 April 2015, alcohol-related risk reduction enhanced services ceased and the associated funding was reinvested in the global sum. The current requirements were embedded in routine general practice and became a core contractual requirement of primary care services. All practices are required under the contract to identify newly registered patients aged 16 years or over who are drinking at increased or higher risk levels. Practices are expected to enable collections of anonymised data or provide associated anonymised data to assist commissioners in monitoring contractual performance[14].

Primary care practitioners should not limit IBA to new registrants but also offer it universally to people aged 16 years and over.

NICE PH24 guidelines[7] recommend carrying out screening:

- At new patient registrations
- During screening for other conditions
- When promoting sexual health
- Antenatal appointments
- When treating minor injuries

Incentives, especially when combined with training and support, were the most effective implementation strategies found in the Optimising Delivery of Healthcare Interventions (ODHIN) study, leading to significant modelled cost savings[15]. The implication is that a more robust approach to training and support and financial incentives are the most powerful strategies for furthering Primary Care IBA.

Download Case Study 1 | Download Case Study 2

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## Midwives and health visitors

Although **TWEAK** (a five item-scale developed to test for risky drinking during pregnancy) is an 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.

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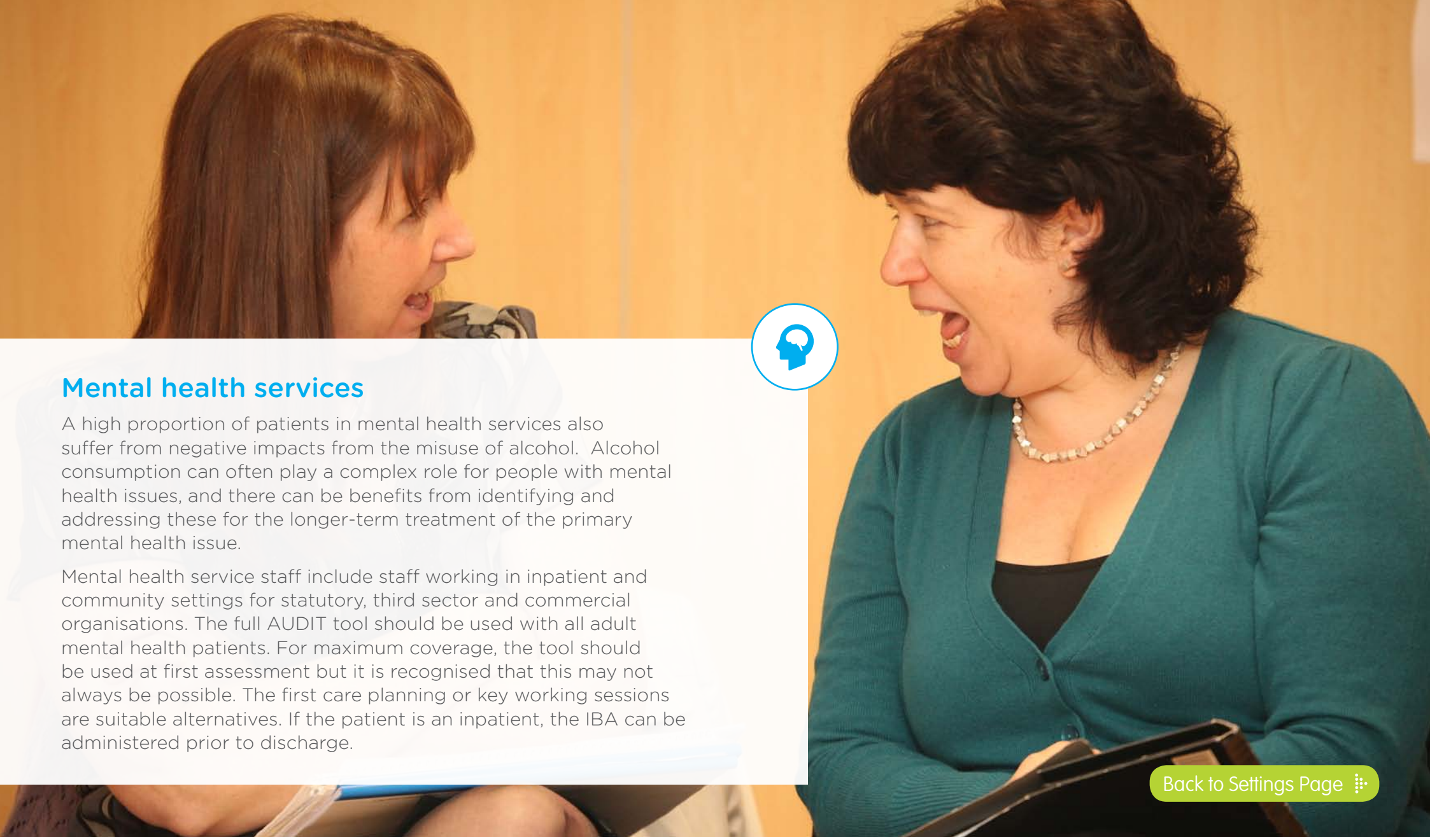

## Mental health services

A high proportion of patients in mental health services also suffer from negative impacts from the misuse of alcohol. Alcohol consumption can often play a complex role for people with mental health issues, and there can be benefits from identifying and addressing these for the longer-term treatment of the primary mental health issue.

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.

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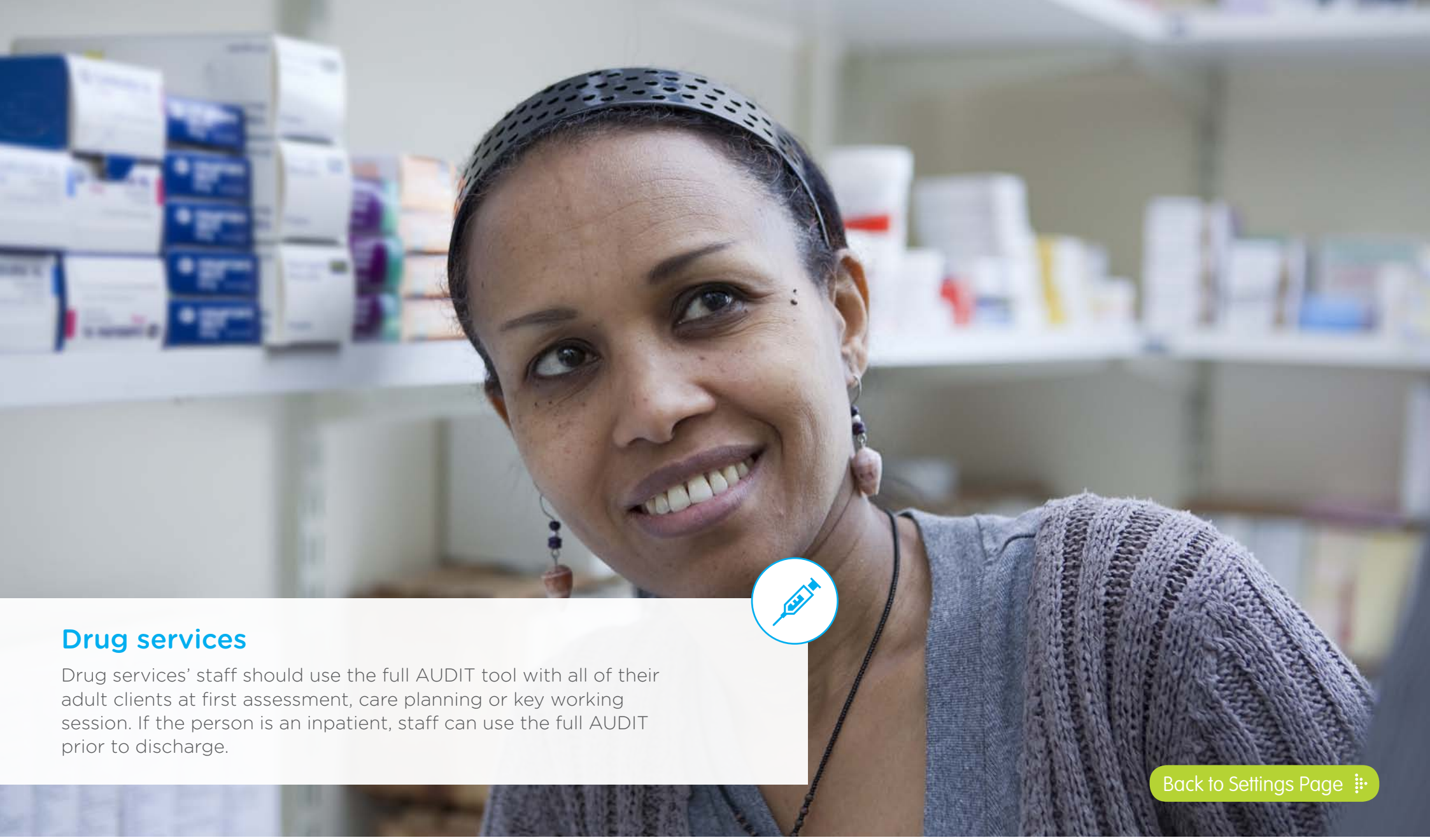

## Drug services

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.

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## Hospital

There is a strong evidence base for the delivery of IBA in hospital-based settings. 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 issues
- 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.

Download Case Study 3

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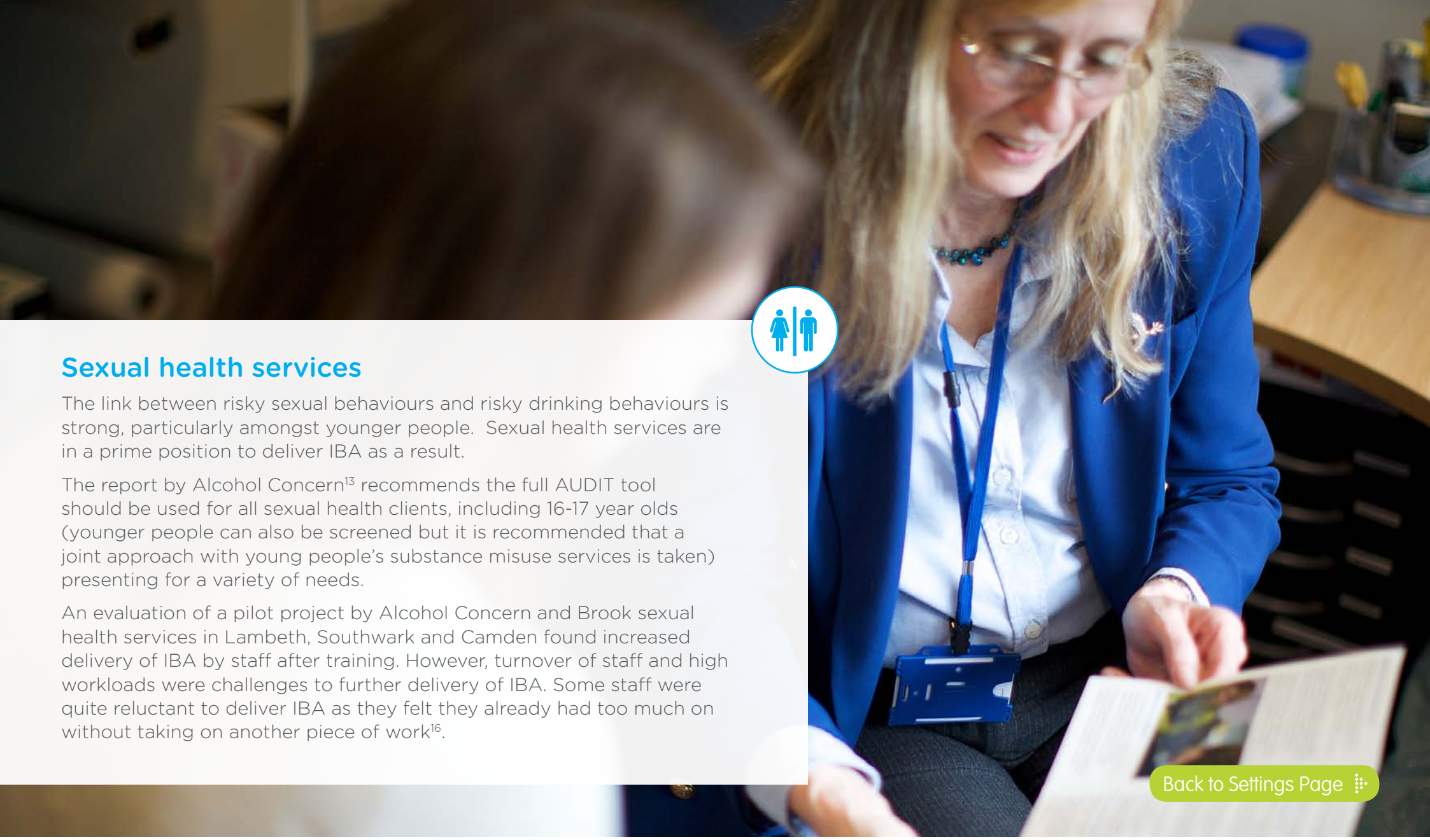

## Sexual health services

The link between risky sexual behaviours and risky drinking behaviours is strong, particularly amongst younger people.  Sexual health services are in a prime position to deliver IBA as a result.

The report by Alcohol Concern[13] 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[16].

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## Community pharmacy

Community pharmacy is another setting that has a wide range of contact with the local population. Community pharmacies have shown an interest and willingness in offering IBA to their clients in recent years.

Community Pharmacies are best suited to deliver alcohol intervention and brief advice for the reasons outlined below:[18 38]

- 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

A review of the literature by Watson and Blenkinsopp[35] found little empirical evidence for effectiveness of community pharmacy-based services for management of alcohol misuse. This finding was supported by a randomised-controlled trial by Dhital and colleagues in 2015, and further research to assess if IBA could be effective when delivered in community pharmacy was recommended[36]. However, a number of studies have supported the community pharmacy setting to be feasible and recommended it be considered as part of a larger strategy to address alcohol consumption.

Continued on following page





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## Community pharmacy (continued)

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[19]. A pan-London pharmacy alcohol awareness campaign using scratchcards also demonstrated feasibility and practicality of screening people in this setting[37].

The NICE Public Health Guidance on preventing harmful drinking[17] also recommends pharmacies as one of a number of appropriate settings for alcohol screening.

Alcohol Concern[13] 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.**

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## Social services

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[13] 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.

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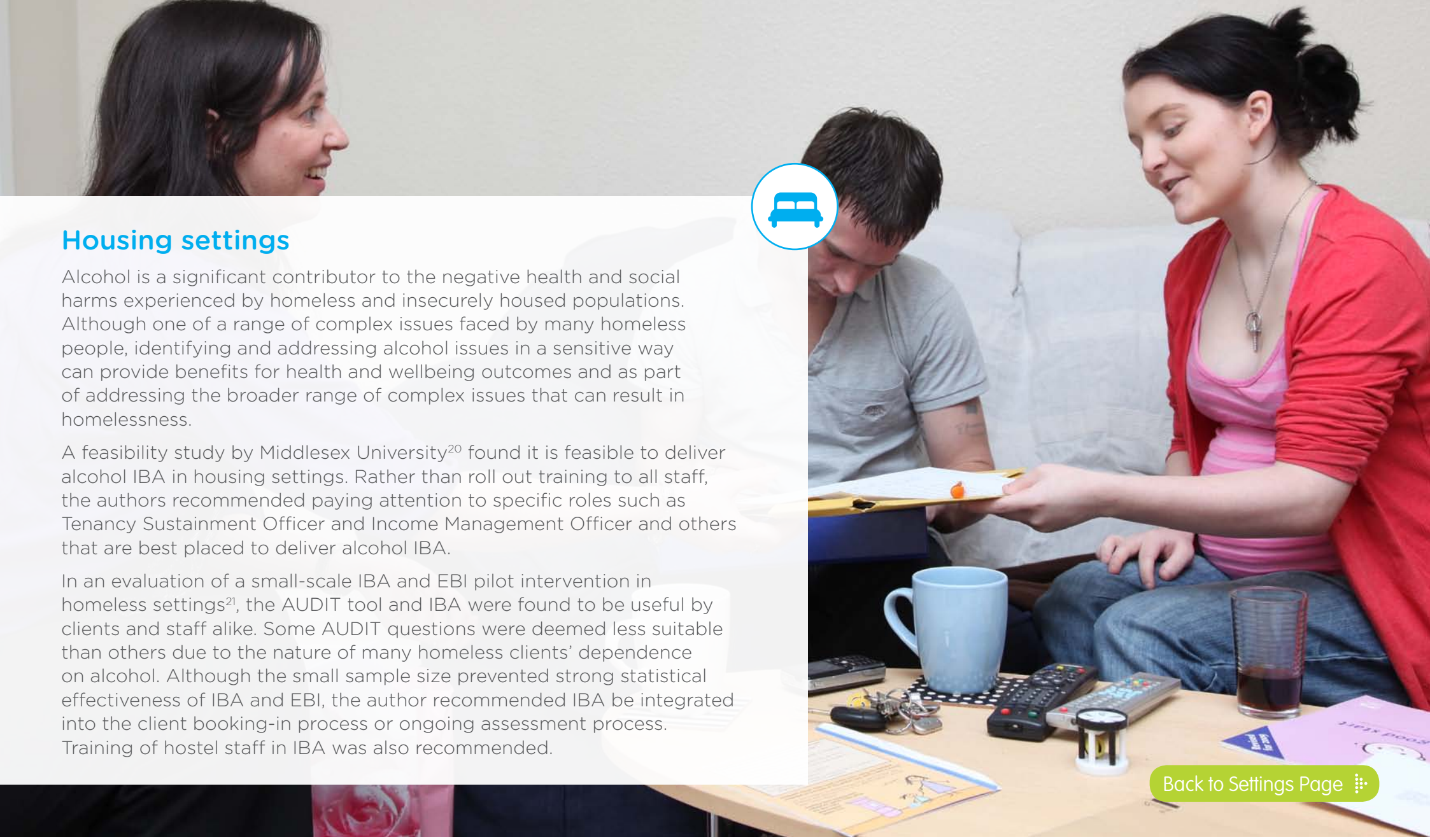

## Housing settings

Alcohol is a significant contributor to the negative health and social harms experienced by homeless and insecurely housed populations. Although one of a range of complex issues faced by many homeless people, identifying and addressing alcohol issues in a sensitive way can provide benefits for health and wellbeing outcomes and as part of addressing the broader range of complex issues that can result in homelessness.

A feasibility study by Middlesex University[20] found it is feasible to deliver alcohol IBA in housing settings. Rather than roll out training to all staff, the authors recommended paying attention to specific roles such as Tenancy Sustainment Officer and Income Management Officer and others that are best placed to deliver alcohol IBA.

In an evaluation of a small-scale IBA and EBI pilot intervention in homeless settings[21], 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.

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## Criminal justice

Alcohol Concern[13] 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.

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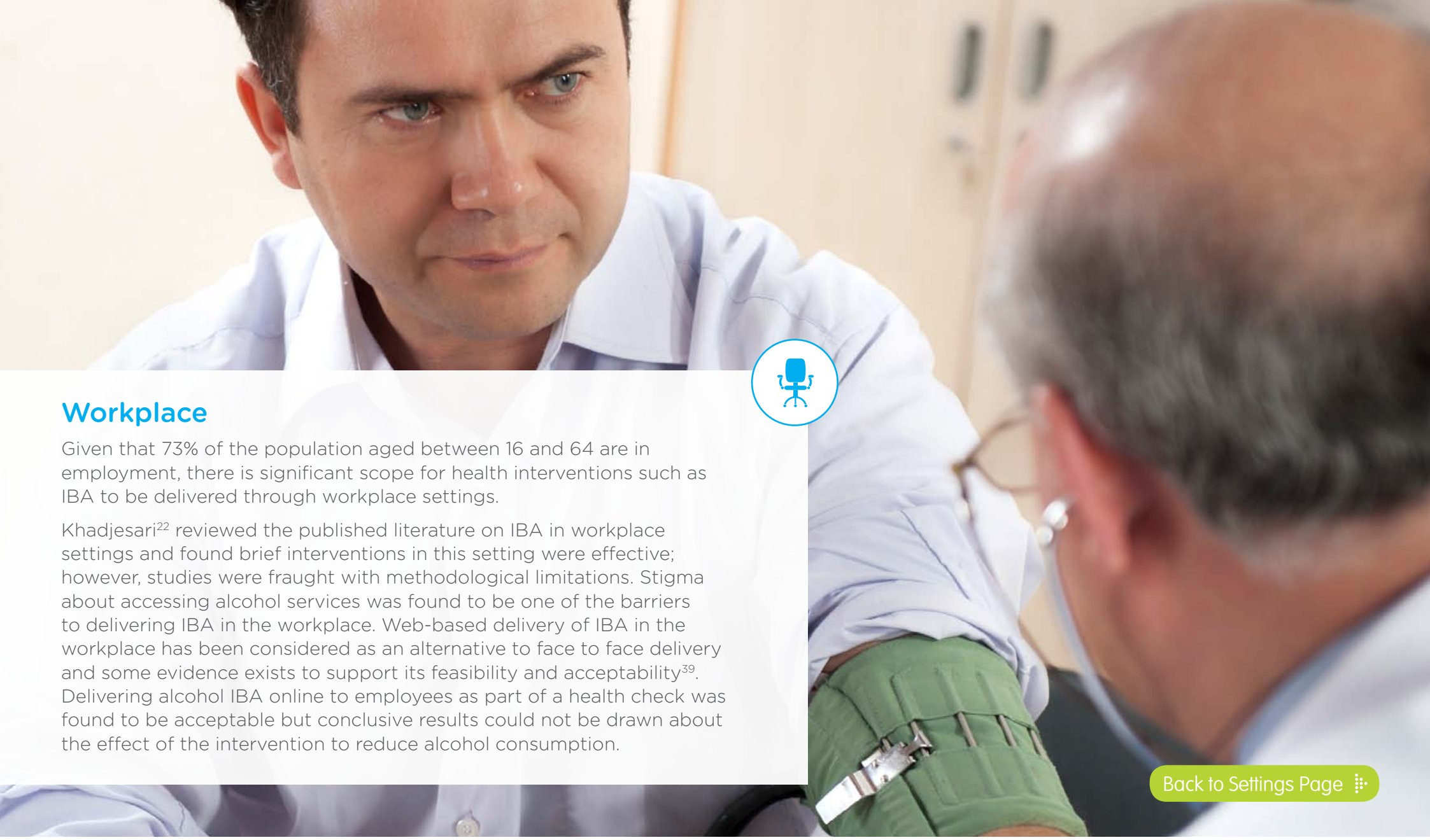

## Workplace

Given that 73% of the population aged between 16 and 64 are in employment, there is significant scope for health interventions such as IBA to be delivered through workplace settings.

Khadjesari[22] reviewed the published literature on IBA in workplace settings and found brief interventions in this setting were effective; however, studies were fraught with methodological limitations. Stigma about accessing alcohol services was found to be one of the barriers to delivering IBA in the workplace. Web-based delivery of IBA in the workplace has been considered as an alternative to face to face delivery and some evidence exists to support its feasibility and acceptability[39]. Delivering alcohol IBA online to employees as part of a health check was found to be acceptable but conclusive results could not be drawn about the effect of the intervention to reduce alcohol consumption.

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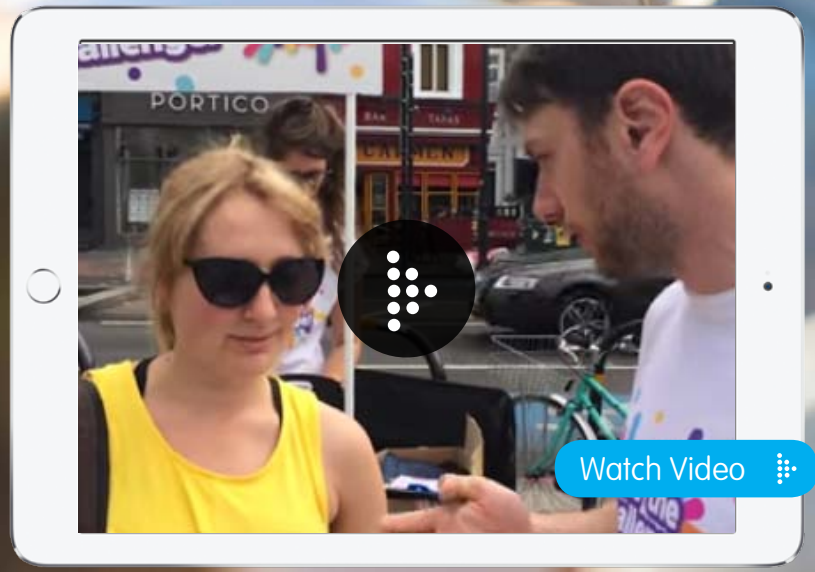
## Direct to population

A project undertaken in the London Borough of Lambeth over 3 days in August 2015 found IBA delivered by non-health professionals to be feasible and acceptable to passers-by on the high street. Trained staff set up a stand and offered passers-by a free mocktail drink in exchange for completing full AUDIT[23]. 'IBA Direct' was also found to be effective in targeting particular groups of at-risk drinkers less likely to visit healthcare settings.

In addition to settings such as pharmacy, primary care and custody suites, IBA scratchcards have also been used in an outreach setting. A scratchcard has AUDIT-C questions only. They provide a useful tool for undertaking IBA, are cheap and can be administered with minimal training required. Although they can be useful in an outreach setting as an engagement tool, there is no evidence that they should be used as an alternative to a trained practitioner delivering full IBA.

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## Digital: online and apps

The scope for delivering brief health promoting interventions through digital and online platforms is large and growing. The lower cost of delivering IBA digitally and the easier access to it for the broader population makes digital IBA likely to be an effective intervention if enough of the population can be persuaded to use it online.

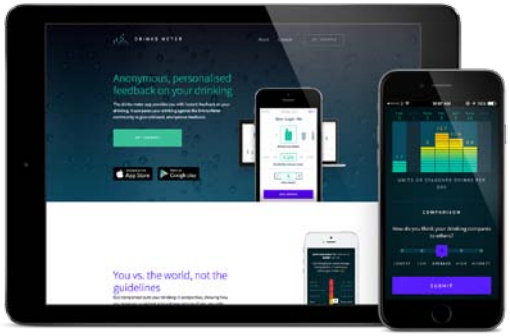
Donoghue[10] published a systematic review of the effectiveness of electronic screening and brief intervention to reduce alcohol consumption. This review found a significant reduction in weekly alcohol consumption was demonstrated between 3 and 12 months follow-up but not beyond 12 months.

There are a number of sites on the internet where users can complete alcohol IBA. A selection of them can be found opposite. The full AUDIT is used by Kingston e-checker and Don't Bottle it Up. This is followed by provision of information based on AUDIT score. Details of service providers are also given.


**e-drink check** Visit website


**Don't bottle it up** Visit website


**Change4Life** Also available as a smartphone app Visit website




**Drinks Meter** Also available as a smartphone app Visit website

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# Workforce development

Online and app-based training is available to support IBA in primary care, community pharmacy and hospital settings.

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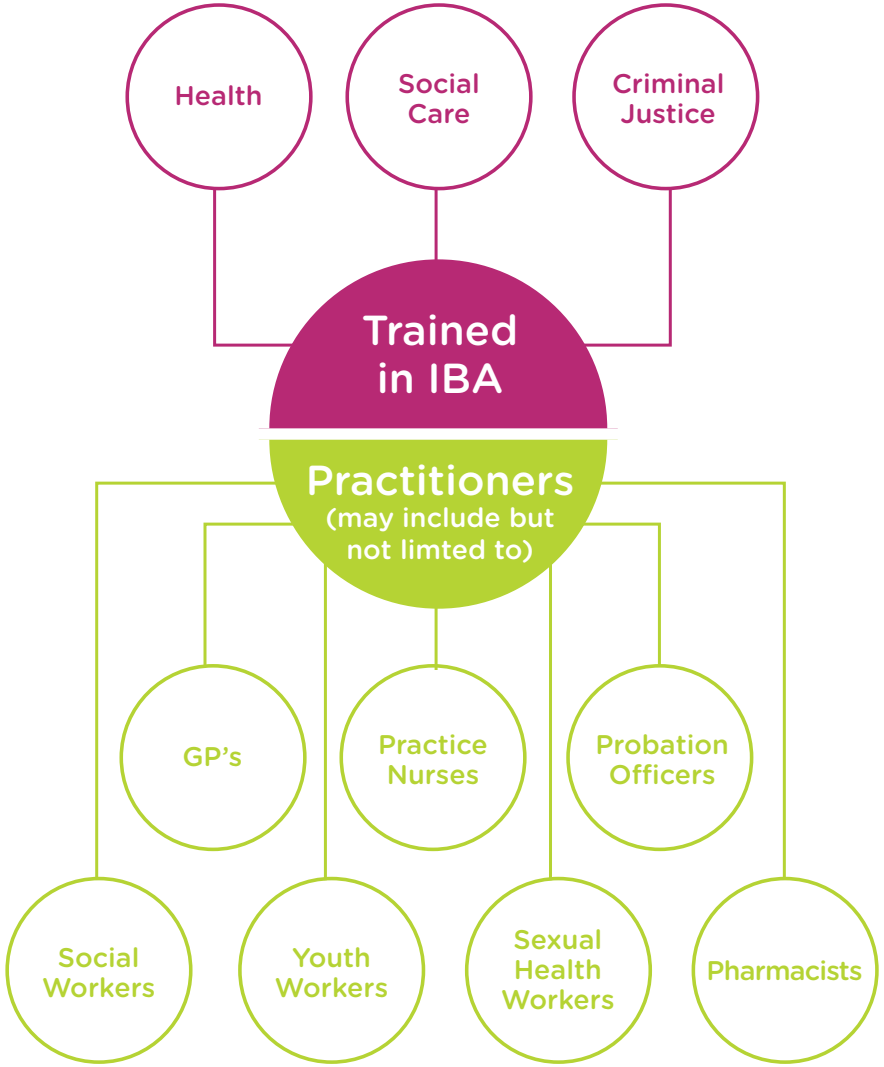
## Commissioning IBA Training

The effectiveness of IBA relies on delivery of the intervention by a trained practitioner. In order for effective IBA to be delivered successfully, commissioning IBA training needs to be considered carefully. Here we are considering IBA training as activities that involve the facilitation of key knowledge and skills to equip, motivate and encourage practitioners to undertake opportunistic IBA.

Workers in a wide variety of fields, such as health, social care and criminal justice can be trained in IBA. Practitioners may include but are not limited to GPs, practice nurses, probation officers, social workers, youth workers, sexual health workers and pharmacists. IBA training most commonly occurs via:

- Face-to-face training utilising a lead facilitator or trainer
- Online e-learning modules
- Informal training such as experiential learning or from peers



## Face-to-face training

Face to face training may be considered optimal since it will typically allow content to be delivered via a number of learning styles to suit different participants. For instance, most people learn best by 'doing', rather than reading or listening. As such, face-to-face training sessions may involve interactive tasks to deliver key learning points, such as units or understanding of different risk groups. Additionally, role-play style 'skills practice' can allow participants to familiarise themselves with the key elements of IBA.

## E-learning

E-learning modules have the significant benefit of being easy to access and typically free at the point of use. However, whilst e-learning may be suited for those who respond well to audio or visual information, the limits to interactivity are significant in comparison to face-to-face learning.



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## Experiential or peer-learning

With regards to experiential or peer learning, there has been little to assess the effectiveness in relation to other styles. Those learning to do IBA because their role requires it, for instance a practice nurse delivering a health check, will quickly become used to asking about alcohol which may address fears or reluctance to do so. On the other hand, those delivering IBA without being aware of key principles may be offering ineffective or possibly counter-productive interventions.

Training can be provided by external trainers or through cascade training. In cascade training, one or two staff members disseminate training to colleagues after attending longer training sessions. Cascade training requires support through written or on-line materials.

It is recommended that commissioners' commission training that is competency-based and can demonstrate learning outcomes. Training should be relevant to the setting in which the IBA service will be delivered. Commissioners may also want to consider the pros and cons of half-day versus full-day training and face-to-face versus online training. Again, these issues will relate closely to the setting in which the service is delivered.

There are a variety of resources for IBA available from the **Alcohol Learning Centre.** These tools, validated by the World Health Organisation, have been tailored by the Department of Health to fit the context of alcohol in the UK. Screening tools, advice tools and training resources are **available to download**

The Alcohol Learning Centre states that commissioners may want to consider the **IBA training workbook** as a starting point for specifying training. However, the workbook is a guide only and commissioners should consider other factors, such as participant skills and time constraints when developing course design. A list of key elements to consider when developing an IBA training course is listed on the **Alcohol Learning Centre website**.

Further information on commissioning IBA training can also be found in the document, **Guidelines for commissioning of Identification and Brief Advice training.**

## Electronic-based training (Online and app based)

The **Alcohol Learning Centre**, part of PHE's alcohol learning resources, offers **online IBA training** to support IBA in primary care, community pharmacy and hospital settings. The course offers five e-learning sessions followed by a sixth assessment session. Each session should take around 20 minutes to complete and teaches users how to use World Health Organisation validated tools to identify patients at risk and intervene in an appropriate manner.

The beginning sessions of the course covers facts about alcohol, the purpose of IBA and how to determine the number of units in a drink. Further sessions also cover tools for identifying alcohol misuse, including the different versions of the **AUDIT** tool that can be delivered, such as **AUDIT-C** and **FAST**. The training also discusses the importance of the **FRAMES** approach: 6 essential elements in the provision of brief advice. To determine the best approach to deliver brief advice, the modules show how to identify how motivated a patient may be to change his or her behaviour and gives strategies. The modules include videos and questions for participants to assess their knowledge of practicing brief advice. Finally there is an assessment at the end to complete the certificate.

This course is accredited by the Royal College of Nursing and is supported by the Royal College of General Practitioners (RCGP) and Royal College of Physicians. The RCGP offers the RCGP Certificate in the management of alcohol problems in primary care to users that combine the online training with the RCGP workbook and face-to-face training.

# Ensuring quality of delivery

The factors that affect how the IBA pathway is enacted (in practice) need to be considered, monitored and efforts made to improve them.

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## Ensuring a quality IBA service: interactions that change behaviour

Central to alcohol IBA being effective at improving the health of individuals at risk of alcohol related harm or those drinking at higher than recommended levels is the relationship between the individual and the staff member delivering the IBA. Equipping staff with the knowledge, skills and appropriate attitudes to provide brief advice, engage in motivational interviewing, reflect on their own practice and encourage self-efficacy will directly impact on how the individual thinks about changing their alcohol consumption. High quality staff training and support should be a central component of all IBA commissioning decisions.

Assuring a quality service should be an integral and core component when commissioning, re-configuring or evaluating IBA in any setting. To explain how this could be achieved the set of recommendations that follow are split into 3, based on Juran's Quality Trilogy[24]. This framework recognises the distinct components that need to be addressed for continuous quality, they are:

### Quality planning

### Quality control

### Quality improvement

These guidelines are appropriate for commissioners, Public Health alcohol leads and also frontline staff who are keen to develop and improve their local practices. The approach and learning is expected to have resonance in most settings, although some indicators may be more relevant to some, rather than other, areas.





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## Quality planning

**To meet a patient or service user's needs, the design of a pathway of care needs to be specific to their requirements. Specific populations that are intended to benefit from IBA need to be identified and the social systems that they are a part of should be explored and understood if interconnections between how the IBA pathway fits within other services are to be made[25].**

The IBA commissioning process is explained in the section entitled Commissioning alcohol IBA. Firstly, commissioners or clinical leads need to understand which groups are of concern in their borough or county. IBA intends to improve the health outcomes for individuals who are drinking at an increasing or higher risk level[17]. Using reports such as the Joint Strategic Needs Assessment alongside tools like the Public Health Profiles[26] and Local Alcohol Profiles[27], quantified measures of alcohol consumption and harm can be better understood and data utilised to inform planning of commissioned health services.

For example, in primary care practice, individuals who attend for an NHS Health Check or New Patient Check (both examples of consultations where IBA is mandated) tend to be more health conscious and self-select their involvement. Finding and developing other 'IBA hooks': whether during other consultations, locations or using innovative approaches could be more effective. Understanding the links between raised alcohol consumption and other social determinants of health and wellbeing should be made. Quality planning is essential for developing local initiatives that advance the reach and intended effect of alcohol IBA.

Alongside quantifying the local population's needs, community engagement and networks should be called upon, where appropriate, to understand which aspects of alcohol behaviour are of concern for the local population. These insights can be used to focus service commissioning decisions.

This guidance is not meant to deter efforts to provide a universal IBA service, such as those already commissioned in many GP surgeries and pharmacies, but instead recognise that complex social systems exist which create inequalities in access to health assessments that include IBA. Social context and systems need to be understood and worked within if a universal IBA approach is to be actualised by all groups of a community.





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## Quality control

**Measures, both quantitative and qualitative, need to be in place to benchmark services delivering IBA. Quality control is required to inform both the staff delivering services and those commissioning them about deviations from expected outcomes and the potential need for reassessment or development of services.**

It is recommended that any service that is commissioned to provide IBA should collect and report data quarterly so that the delivery of the whole IBA pathway can be monitored. Information about the following stages is regarded as "essential" to collect:

1. Total number of individuals within a locality eligible for alcohol IBA
2. Number of individuals screened using AUDIT-C/ FAST questionnaires
3. Number of individuals AUDIT-C/ FAST positive when screened with the full AUDIT questionnaire
4. Number of individuals AUDIT positive (with a score of 8+) and have received brief advice or brief intervention
5. Number of individuals AUDIT positive (score 20+) and referred to specialist services

Additionally, age and gender of individuals receiving each part of the pathway should also be collected. Use of this data alongside other previously mentioned profiles and health needs' reports could help determine whether specific populations of concern that are being targeted have been reached.





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# Quality control

**In order to establish quality control, the three required checks are:**

**Are enough people being screened?**
Is IBA being delivered to a high enough proportion of the total eligible population to ensure a universal service is achieved?

**Are enough people being followed through the pathway?**
In absolute terms are enough individuals being screened to provide confidence that the numbers recorded at stages 3, 4 and 5 are representative of the service being provided?

**Does this line up with expectations?**
If the previous check is above threshold, are the numbers reported at stages 3, 4 and 5 in line with those expected as per national averages?[28]

Printable version

The aim of these checks is to establish which aspect of the IBA pathway is not being fulfilled and will inform quality improvement approaches (please see the next section).

In conjunction, engaging with patient or service user groups, regularly and routinely, to obtain feedback on qualitative aspects of consultations where alcohol has been discussed should be implemented. This can provide vital insight into the efficacy of the quality control checks.

**Example**

In primary care practice, read code data is used to monitor the delivery of different services. In other settings where IBA is commissioned, electronic systems need to be set up or adapted to make delivery reporting a standard part of the service.

## Quality improvement

**Analysing performance and making systemic efforts to innovate and improve the delivery of the IBA pathway is an iterative and ongoing process. It requires engagement and close working between commissioners and service providers.**

Quality improvement refers to making healthcare safe, effective, efficient and patient-centred. It is about making changes that will lead to:

- Better outcomes for patients
- Better professional development for staff
- Better system performance

Commissioners play a critical role in quality improvement across these three areas as they can influence them through the commissioning process by ensuring quality indicators are written into contracts.

In relation to IBA specifically, very little is known about whether recorded activity is reflective of genuine alcohol brief intervention. For instance, is 'brief advice' always being offered to at-risk drinkers, and does the delivery fall in line with key principles such as **FRAMES.** Significant questions are being asked about the extent to which reported IBA activity is actually reflective of genuine brief intervention. As such, finding systemic ways to ensure IBA quality may be considered crucial.

## A framework for IBA quality assurance and improvement

**In order to systematically understand all the factors that affect the quality of alcohol IBA delivery and reporting, the SHEL model (shown in the diagram to the right) has been adapted[29].**

Central to quality assurance and improvement of the IBA pathway are the frontline staff delivering the service: it is for this reason that this group are placed in the middle of the model. In the following pages particular indicators and metrics that can be built into contracts to better understand, measure and improve the interfaces between the different parts of the IBA process are recommended[24].

The role of partnership working (between commissioners and providers) is strongly encouraged for improving service provision. Additionally, it may be worthwhile exploring the use of peer review methodologies to monitor and improve IBA quality however this approach is not covered in this toolkit.


Diagram of the SHEL model[30]



# Service Providers and the Software

**To assure and improve IBA providers' evidence based knowledge of the pathway and understanding of national guidelines.**

| Indicators to consider to assure and improve IBA could include: | Measures to use to help determine extent to which indicators are being considered: |
|---|---|
| • All staff trained to deliver and report IBA understand the national policy, procedures, local level pathways and evidence base of alcohol IBA and these are made relevant to their individual role.<br>• Commissioners invest in IBA training programmes, locally, that are evidence based and support providers to attend them.<br>• Local policies and pathways explicitly reflect national policy and are up to date.<br>• Standard Operating Procedures (SOPs) are developed and shared with and across multiple agencies to ensure that each service involved in the local authority or CCG IBA pathway are known to each other and their roles and responsibilities are easily apparent.<br>• Local alcohol reduction campaigns and resources that are used alongside the IBA pathway are evidence based and provide easy access into the IBA pathway. | • All staff trained to deliver and report IBA understand the national policy, procedures, local level pathways and evidence base of alcohol IBA and these are made relevant to their individual role.<br>• Commissioners invest in IBA training programmes, locally, that are evidence based and support providers to attend them.<br>• Local policies and pathways explicitly reflect national policy and are up to date.<br>• Standard Operating Procedures (SOPs) are developed and shared with and across multiple agencies to ensure that each service involved in the local authority or CCG IBA pathway are known to each other and their roles and responsibilities are easily apparent.<br>• Local alcohol reduction campaigns and resources that are used alongside the IBA pathway are evidence based and provide easy access into the IBA pathway. The number of staff, their role and the level/ type of training they have received to deliver IBA in each commissioned service is reported. Regular updates of training (possibly yearly) are mandated.<br>• Contracts with providers includes the details of how to access and attend locally recommended (and where possible accredited) IBA training programmes.<br>• Other core training programmes are mandated to include evidence based IBA training e.g. NHS health checks.<br>• The local IBA pathway (see below) is shared with training programme attendees.<br>• Contracts reference (and are structured around) NICE guidelines for IBA delivery and reporting.<br>• The SOP/ IBA pathway is developed by the multi-agencies that are involved, locally, in providing IBA, brief intervention and treatment services. Up to date contact details for each different agency is displayed.<br>• A representative from each of the different services involved in the IBA pathway signs the SOP/ IBA pathway. The sign off is displayed, alongside the date on the pathway document which is shared across all services. This is reviewed and updated in each commissioning cycle.<br>• It is mandated that all campaign materials and resources reference up to date guidelines and provide links to local services. |

**Example**

A patient attends the GP practice for a blood pressure check. The healthcare assistant takes the BP and it is found to be very high so the patient is asked about any lifestyle factors that may be affecting it. The Alcohol IBA pathway is commenced when the patient is found to be AUDIT C positive. The healthcare assistant feels confident to provide appropriate advice and liaise directly with other services in the pathway because he knows who they are, where they are located and whether they are relevant for this particular patient.





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# Service Providers and the Hardware

**To assure and improve IBA providers' ability to deliver the pathway, tools such as electronic templates, leaflets and scratch cards are developed to optimise the effectiveness of their use.**

| Indicators to consider to assure and improve IBA could include: | Measures to use to help determine extent to which indicators are being considered: |
|---|---|
| • The readability and usability of the tools, such as scratch cards and leaflets is assessed and reviewed regularly. Iterations are made as required and version controls maintained.<br>• Information is written in the language and style appropriate for the intended user.<br>• A 'unit' of alcohol is simply defined and this is universally used on all leaflets, templates and scratch cards.<br>• The usability of templates and reports for recording IBA in each commissioned setting are checked and the design optimised to encourage the pathway to be followed.<br>• The process to report on IBA activity from provider to commissioner is simple and well defined. Services are given feedback on their reporting within a predefined time frame.<br>• Technology used to administer training to staff is evaluated for their usability and ease prior to being disseminated and reviewed regularly. | • All scratch cards and leaflets provided by local public health teams for use in commissioned services are assessed to have a suitable reading age and provided in languages appropriate for the local population.<br>• A single visual representation and definition of a 'unit' of alcohol is used on all locally produced resources.<br>• Service providers provide example images of the IBA recording template to the commissioners. Templates are reviewed and optimised as part of the contract agreement.<br>• Dates for reporting metrics on IBA delivery (as per **quality control**) are predefined and shared with all service providers and written into the service specification.<br>• Dates within which service providers will expect feedback from commissioners are written into the service specification.<br>• Technology used to administer IBA training to staff or IBA to a population is tested with a sample of the expected users and assessed for its usability prior to being commissioned. |

**Example**

A pharmacy assistant is talking to a customer about their alcohol consumption. She uses a scratch card to deliver the screen and this contains pictures depicting what a unit of alcohol is. After completing IBA, information about the consultation is recorded on an electronic form which is simple to access and split into sections that directly correspond to the process she has just completed.





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# Service Providers and the Environment

**To assure and improve IBA providers' ability to deliver the pathway, the environment in which IBA occurs is optimised to meet staff needs, which helps to improve the experience of individuals receiving screening and advice.**

| Indicators to consider to assure and improve IBA could include: | Measures to use to help determine extent to which indicators are being considered: |
|---|---|
| • The environment that IBA is being delivered in promotes individuals to feel comfortable about sharing information and engaging with the process.<br>• Individuals that are delivering IBA are given adequate time to complete the process with service users or patients.<br>• The environment that IBA is being delivered in is health promoting (e.g. includes posters and leaflets etc. to support other health improvements).<br>• The training environment for staff providing IBA is suited to the individual group's needs.<br>• Patient or service user feedback about consultation spaces is used to shape where improvements can be made. | • Campaign materials are shared with local IBA service providers and advice about how to display them in the environment is given.<br>• Individuals delivering IBA have protected and adequate consultation time with service users or patients to provide comprehensive IBA or follow up (this is in keeping with smoking cessation appointments).<br>• Feedback from patients/ service users about their alcohol related consultations is regularly collected and includes questions about the environment and its effect. |

**Example**

A meeting of practice nurses from 5 different medical centres happens fortnightly. As it is difficult for this professional group to attend face-to-face IBA training courses at CCG offices, IBA commissioners liaise with the meeting lead and set up training at these sessions instead.



# Service Providers interactions with Commissioners, Service Users and the local population

**Connecting individuals to appropriate health services is the central aim of the IBA pathway. To assure and improve IBA providers' ability to achieve this, the relationships between different groups involved needs to be robust and each person's role well understood.**

| Indicators to consider to assure and improve IBA could include: | Measures to use to help determine extent to which indicators are being considered: |
|---|---|
| • Face to face training is delivered by service appropriate individuals who can provide ongoing support to frontline staff; whether administrative or clinical.<br>• Relationships between commissioners and providers are strong with regular meetings to inform commissioning direction.<br>• The effect of the IBA process on all staff groups is considered in the service commissioning plan.<br>• Patients/ service users are informed, where appropriate, prior to consultations about the IBA questions they will be asked so that time in the appointment is more productive for both clinical staff and the individual. | • Contracts with providers includes the details of how to access and attend locally recommended (and where possible accredited) IBA training programmes.<br>• The effectiveness and relevance of training programmes commissioned by the public health team are evaluated by the course attendees using a formal feedback approach.<br>• A representative from each of the different services involved in the IBA pathway signs the SOP/ IBA pathway. The sign off is displayed, alongside the date on the pathway document which is shared across all services. This is reviewed and updated in each commissioning cycle.<br>• Dates for reporting metrics on IBA delivery (as per quality control section) are predefined and shared with all service providers up to 12months in advance and written into the service specification.<br>• Dates within which service providers will expect feedback from commissioners are predefined up to 12 months in advance and written into the service specification.<br>• Invites to patients, either by letter or email, for health checks which have a manndatory IBA component include information about the process and the AUDIT questionnaire. |

**Example**

An advisor in the job centre, responsible for submitting the report on IBA delivery, is having difficulties uploading the document. However, he has previously met the IBA commissioner and so feels confident to call her up and ask for advice and support.

Download a sample Service Specification, the Indicators and Measures tables presented on the previous pages and a sample alcohol IBA pathway.

## Sample Service Specification

This is an editable document that can be adapted to any setting within which face-to-face alcohol IBA may be commissioned.

Download Word Doc


Service Providers and the Software

| Indicators to consider to assure and improve IBA could include: | Measures to use to help determine extent to which indicators are being considered: |
|---|---|
| • All staff trained to deliver and report IBA understand the national policy, procedures, local level pathways and evidence base of alcohol IBA and these are made relevant to their individual role.<br>• Commissioners invest in IBA training programmes, locally, that are evidence based and support providers to attend them.<br>• Local policies and pathways explicitly reflect national policy and are up to date.<br>• Standard Operating Procedures (SOPs) are developed and shared with and across multiple agencies to ensure that each service involved in the local authority or CCG IBA pathway are known to each other and their roles and responsibilities are easily apparent.<br>• Local alcohol reduction campaigns and resources that are used alongside the IBA pathway are evidence based and provide easy access into the IBA pathway. | • The number of staff, their role and the level/ type of training they have received to deliver IBA in each commissioned service is reported. Regular updates of training (possibly yearly) are mandated.<br>• Contracts with providers includes the details of how to access and attend locally recommended (and where possible accredited) IBA training programmes.<br>• Other core training programmes are mandated to include evidence based IBA training e.g. NHS health checks.<br>• The local IBA pathway (see below) is shared with training programme attendees.<br>• Contracts reference (and are structured around) NICE guidelines for IBA delivery and reporting.<br>• The SOP/ IBA pathway is developed by the multi-agencies that are involved, locally, in providing IBA, brief intervention and treatment services. Up to date contact details for each different agency is displayed.<br>• A representative from each of the different services involved in the IBA pathway signs the SOP/ IBA pathway. The sign off is displayed, alongside the date on the pathway document which is shared across all services. This is reviewed and updated in each commissioning cycle.<br>• It is mandated that all campaign materials and resources reference up to date guidelines and provide links to local services. |

Service Providers and the Environment

| Indicators to consider to assure and improve IBA could include: | Measures to use to help determine extent to which indicators are being considered: |
|---|---|
| • The environment that IBA is being delivered in promotes individuals to feel comfortable about sharing information and engaging with the process.<br>• Individuals that are delivering IBA are given adequate time to complete the process with service users or patients.<br>• The environment that IBA is being delivered in is health promoting (e.g. includes posters and leaflets etc. to support other health improvements).<br>• The training environment for staff providing IBA is suited to the individual group's needs.<br>• Patient or service user feedback about consultation spaces is used to shape where improvements can be made. | • Campaign materials are shared with local IBA service providers and advice about how to display them in the environment is given.<br>• Individuals delivering IBA have protected and adequate consultation time with service users or patients to provide comprehensive IBA or follow up (this is in keeping with smoking cessation appointments).<br>• Feedback from patients/ service users about their alcohol related consultations is regularly collected and includes questions about the environment and its effect. |

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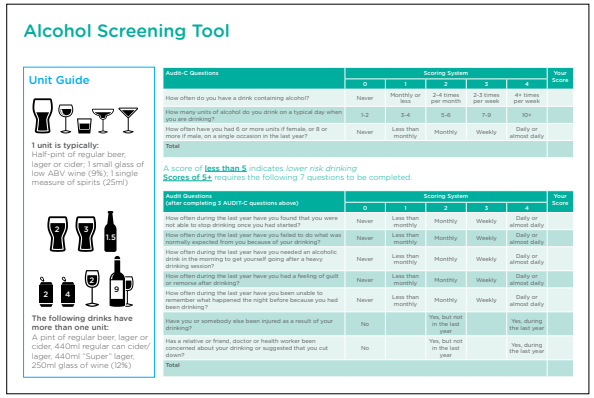

Alcohol Screening Tool

Unit Guide

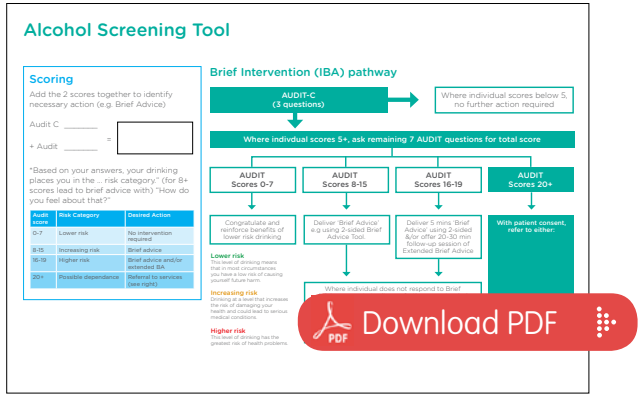
1 unit is typically:
Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:
A pint of regular beer, lager or cider, 440ml regular can cider/ lager, 440ml "Super" lager, 250ml glass of wine (12%)

| Audit-C Questions | Scoring System 0 | 1 | 2 | 3 | 4 | Your Score |
|---|---|---|---|---|---|---|
| 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? | 1-2 | 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 | |
| Total | | | | | | |

A score of less than 5 indicates *lower risk drinking*
Scores of 5+ requires the following 7 questions to be completed.

| Audit Questions (after completing 3 AUDIT-C questions above) | Scoring System 0 | 1 | 2 | 3 | 4 | Your Score |
|---|---|---|---|---|---|---|
| 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 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 | | | | | | |


Alcohol Screening Tool

Scoring
Add the 2 scores together to identify necessary action (e.g. Brief Advice)

Audit C _____
+ Audit _____ =

"Based on your answers, your drinking places you in the ... risk category." (for 8+ scores lead to brief advice with) "How do you feel about that?"

| Audit score | Risk Category | Desired Action |
|---|---|---|
| 0-7 | Lower risk | No intervention required |
| 8-15 | Increasing risk | Brief advice |
| 16-19 | Higher risk | Brief advice and/or extended BA |
| 20+ | Possible dependence | Referral to services (see right) |

Brief Intervention (IBA) pathway

AUDIT-C (3 questions) → Where individual scores below 5, no further action required

Where indivdual scores 5+, ask remaining 7 AUDIT questions for total score

AUDIT Scores 0-7 | AUDIT Scores 8-15 | AUDIT Scores 16-19 | AUDIT Scores 20+

Congratulate and reinforce benefits of lower risk drinking

Deliver 'Brief Advice' e.g using 2-sided Brief Advice Tool.

Deliver 5 mins 'Brief Advice' using 2-sided &/or offer 20-30 min follow-up session of Extended Brief Advice.

With patient consent, refer to either:

Where individual does not respond to Brief

Lower risk
This level of drinking means that in most circumstances you have a low risk of causing yourself future harm.

Increasing risk
Drinking at a level that increases the risk of damaging your health and could lead to serious medical conditions.

Higher risk
This level of drinking has the greatest risk of health problems.

Download PDF

# Return on investment

Being able to clearly demonstrate the economic, health and wellbeing benefits of IBA are important parts of the commissioning process.

READ MORE »





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Being able to clearly demonstrate the economic, health and wellbeing benefits of IBA are important parts of the commissioning process.

As an "invest to save" measure, NICE Guidance[7] states that Chief Executives of the NHS and local authorities should prioritise alcohol-use disorder prevention. Investing in alcohol and drug interventions can promote public health and social care outcomes, reduce crime and improve community safety. A study commissioned by Health England estimated that brief interventions delivered in GP surgeries resulted in a cost savings of £123 per person[31].

### Public Health England's Return on Investment Tool

Public Health England recently released a set of products as part of their Value for Money programme to help local authorities make informed decisions and demonstrate the positive outcomes possible through investment in drug and alcohol interventions. These tools include a cost calculator, a families' toolkit, a social return on investment (**SROI**) tool and a commissioning tool. These tools are available via ndtms.net or by emailing health.economics@phe.gov.uk.

The cost calculator assists commissioners to split local global substance misuse spend into that on tier 3 and 4 services and tier 1 and 2 interventions (such as IBA).

The **SROI** tool uses primary and secondary care data to help local areas make the case for investment using crime, health, and quality-adjusted life year (**QALY**) benefits.

The families' toolkit is aimed at assisting commissioners in collecting data for use in the **SROI** tool to show the benefits of investment in drug and alcohol treatment from the perspective of a family.

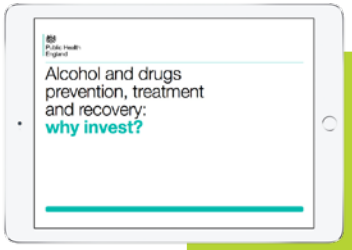
The commissioning tools evaluate the cost-effectiveness of different interventions for varying cohorts of clients within a local treatment system.

| Tool | Description |
|---|---|
| **Cost calculator** | Calculator to help alcohol and drugs commissioners split local global substance misuse spend into that on alcohol and drugs specialist (tier 3 and 4) services and tiers 1 and 2 (e.g. IBA) interventions. |
| **Families toolkit** | A workbook and paper aimed at helping commissioners collect local data for use in the forthcoming **SROI** tool to demonstrate the benefits of investment in alcohol and drugs treatment from the perspective of the family. |
| **Social Return on Investment Tool** | Alcohol and drug social return on investment tool using primary and secondary data to help LAs make the case for investment. The tool presents estimates of mainly, crime, health and **QALY** benefits. |
| **Commissioning tool** | Assesses the cost-effectiveness of different interventions for varying cohorts of clients (opiate users, non-opiate users and alcohol) within a local treatment system. |

**Further information on social return on investment can be found here**

## NICE Return on Investment Tool

NICE has also released an alcohol return on investment (**ROI**) tool developed using evidence from the NICE Guidance. The tool allows local areas to compare the **ROI** of different packages of alcohol interventions. The tool is pre-populated with 22 interventions including 3 screening and brief interventions for the adult population and 1 brief intervention for under 18s. The allocation (the percentage of the population that receives the intervention), the effect of the intervention, and the cost of the intervention are used as variables to calculate the **ROI**. While the effect and cost are pre-populated by NICE, the local manager inputs the allocation data of the interventions they wish to compare. Further information on the NICE **ROI** tool, including user guide and a technical guide, can be found on **their website**




Download Pack

**Public Health England updated the following slide pack in October 2015 with infographics illustrating the case for local investment in alcohol and drug prevention, treatment and recovery.**

**Commissioners are in the business of securing social value that is delivered by third parties. The mechanisms by which that value is secured may differ but, by measuring that value, better decisions can be made. SROI can be used at three points in the commissioning process:**

- Programme/pre-procurement – forecast **SROI** analyses can be used at the strategic planning stage to decide how to set up a programme, for market testing and to determine scope and specification of contracts.
- Application/bidding – forecast **SROI** analyses can be used to assess which applicant or bidder is likely to create the most value. (Where applicants or bidders are already delivering the intervention that is being commissioned, evaluative **SROI** can be used at the application/bidding stage).
- Monitoring and evaluation/contract management – evaluative **SROI** analyses can be used to monitor the performance of a successful contractor.

**The SROI Network**[32]





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## Similarities and differences

There are differences in the methodology of the PHE Value for Money tools and the NICE alcohol **ROI** tool. One area to note is that the interventions included in the NICE tool are based upon the clinical guidelines published by NICE and not all of the common types of treatment received by alcohol patients are included. The NICE tool gives local areas the option to include additional treatment interventions in the tool using local data. These common types of treatment will be covered within the PHE Value for Money programme tools.

Furthermore the PHE Value for Money programme uses treatment data from the national drug treatment monitoring system so that local areas can have their data on alcohol and drugs in-treatment population, time spent in treatment, the types of interventions received and resulting outcomes. The treatment data can also be matched with crime data from the Ministry of Justice to monitor how offending changes for the treatment population over time. PHE is able to track treatment population to see if they are re-admitted to treatment services or criminal justice services for alcohol-related crime.

**the PHE Value for Money programme uses treatment data from the national drug treatment monitoring system**





Health Innovation Network South London

# Appendices







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# Glossary

| ITEM | ACRONYM | DETAIL |
|---|---|---|
| **Alcohol Learning Centre** | **ALC** | Part of Public Health England; provides training resources and guidance to support frontline practitioners and commissioners. **www.alcohollearningcentre.org.uk** |
| **Alcohol Use Disorder Identification Test** | **AUDIT** | A ten-item alcohol screening test developed by the World Health Organisation and considered the gold standard alcohol screening test. |
| **Alcohol Use Disorder Identification Tool - Consumption** | **AUDIT-C** | A three-item version of the full AUDIT which asks questions on consumption only. |
| **Commissioning for Quality and Innovation** | **CQUIN** | A payment framework that encourages providers of services to share and continually improve how the service is delivered and to achieve overall improvement in healthcare. **www.england.nhs.uk/wp-content/uploads/2015/03/9-cquin-guid-2015-16.pdf** |
| **Extended Brief Intervention** | **EBI** | An intervention usually lasting 20-30 minutes, using a motivational interviewing technique. More than 1 follow-up session may be agreed by the practitioner and service user. |
| **Fast Alcohol Screening Test** | **FAST** | A four-item alcohol screening test. |
| **Feedback Responsibility Advice Menu Empathy Self-efficacy** | **FRAMES** | Brief intervention has been defined as having six essential elements described by Miller and Sanchez[33] using the acronym FRAMES. **https://www.nice.org.uk/guidance/ph24/chapter/glossary#frames** |

# Glossary

| ITEM | ACRONYM | DETAIL |
|---|---|---|
| **Identification and Brief Advice** | **IBA** | 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. |
| **Making Every Contact Count** | **MECC** | An initiative which encourages frontline workers to have conversations with members of the public based on behaviour change methodologies (such as brief advice) to improve health. **www.england.nhs.uk/wp-content/uploads/2014/06/mecc-guid-booklet.pdf** |
| **Modified Single Alcohol Screening Questionnaire** | **M-SASQ** | A single item screening test, developed to screen people for alcohol-related problems in a busy clinical setting. |
| **Paddington Alcohol Test** | **PAT** | Designed to screen people for alcohol-related problems in an Accident & Emergency setting. |
| **Quality Adjusted Life Years** | **QALY** | A generic measure of disease burden, including the quality and quantity of life lived. It is used to assess the value for money of an intervention. |
| **Quality Innovation Productivity Prevention** | **QIPP** | A programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested in the NHS. |
| **Return on Investment** | **ROI** | The benefit to the investor resulting from an investment of a resource. |

# Glossary

| ITEM | ACRONYM | DETAIL |
|---|---|---|
| **Screening and Brief Intervention** | **SBI** | Used as an umbrella term to refer to both Identification and Brief Advice and Extended Brief Intervention. |
| **Social Return on Investment** | **SROI** | A principles-based method for measuring social, environmental and economic value relative to resources invested. |
| **TWEAK** | | A five-item scale developed to assess risky drinking in pregnant women. The acronym prompts the questions to be asked to the service user. **http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/74_TWEAK.pdf** |

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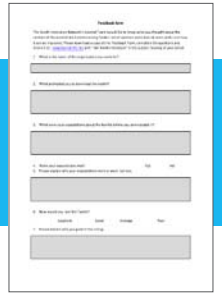
**Members of the London Alcohol Misuse Prevention Project**

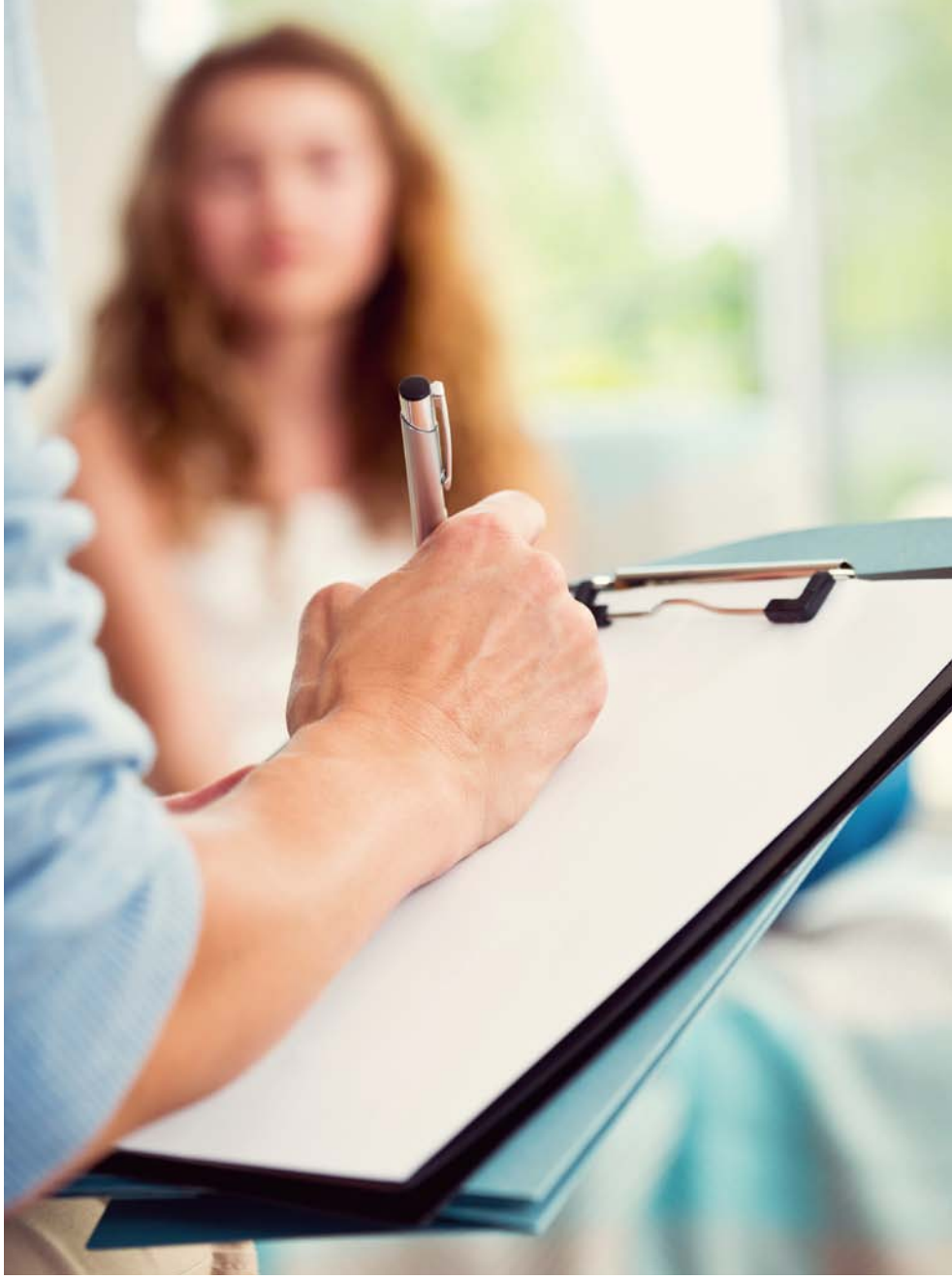
# Feedback Form

The Health Innovation Network's Alcohol Team would like to know what you thought about the content of the Alcohol IBA Commissioning Toolkit: which sections were most & least useful and how it can be improved.

Please download a copy of the Feedback Form, complete the questions and return it to: rodwatson@nhs.net with "IBA Toolkit Feedback" in the subject heading of your email.



**An editable* Feedback Form can be found here**



* The editable Feedback Form is an interactive PDF. It is best opened in either an **Explorer**, **Chrome** or **Safari** browser window. Your browser must be fully up-to-date or you may not be able to fill in the form. Alternatively, save the PDF to your desktop and open it in Acrobat.