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**LOCAL DELIVERY PLAN STANDARD: ALCOHOL BRIEF
INTERVENTIONS**

NATIONAL GUIDANCE: 2019-20

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Alcohol Brief Interventions

Purpose

This note sets out national guidance for the Alcohol Brief Interventions (ABI) Local Delivery Plan (LDP) standard for 2019-20. **NHS Boards and ADPs should continue to fully embed ABI delivery into routine practice.**

The guidance outlines what should be considered to ensure appropriate planning and delivery of ABIs, and the related reporting requirements for NHS Boards and their Alcohol and Drug Partnership (ADP) partners.

Background

The long term aim of the ABI programme has always been to sustain and embed ABI delivery so that it becomes part of the standard offer of NHS Scotland, as well as developing the evidence base. The delivery and embedding of ABIs remains a priority for 2019-20 as per action 17 in the new Alcohol Prevention Framework (2018).

The 2019-20 LDP standard will strengthen the continued aim of embedding ABIs into core NHS business, i.e. that ABIs are part of the day-to-day practice of health professionals and others, not an add-on to their role.

ABI and LDP Standard definitions

The ABI LDP Standard for 2019-20 states that:

NHS Boards and their Alcohol and Drug Partnership (ADP) partners will sustain and embed alcohol brief interventions in the 3 priority settings of primary care, A&E and antenatal and broaden delivery in wider settings.

Nationally, the delivery figure for ABIs under the LDP standard in 2019-20 remains 61,081 ABIs from 1 April 2019. It is expected that at least 80% of delivery (i.e. a minimum of 48,865 ABIs) will continue to be delivered in the priority settings.

The remainder can be delivered in wider settings in accordance with this guidance. NHS Boards and their ADP partners are encouraged to evaluate ABI delivery where possible.

Local targets remain the same in 2019-20 and are attached at **Annex A**.

While there is no formalised definition of a brief intervention, it can be described as:

a short, evidence-based, structured conversation about alcohol consumption with a patient/client that seeks in a non-confrontational way to motivate and support the individual to think about and/or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm.

The key components of an ABI are described in detail in **Annex B**. **It should be noted that simply raising the issue of alcohol does not constitute a brief intervention for the purposes of this standard.** Screening is an integral part of the ABI process and an ABI should be delivered, if appropriate, thereafter.

ABIs are an effective and cost effective intervention¹. Delivery should be evidence-informed and based on the NICE Public Health Guidance² and reviews such as those through Cochrane³.

A checklist outlining what should be considered when planning, delivering and evaluating ABIs is included in **Annex C**.

UK Chief Medical Officer (CMO) - Low Risk Drinking Guidelines

The [UK CMO Low risk Drinking Guidelines](#) were published in August 2016. Health professionals play an important and active role in promoting these.

The national social marketing campaign, [Count 14](#), was published in March 2019 and aims to increase public awareness of the CMO's low risk guideline limit of 14 units alcohol consumption per week for men and women. The new materials can be utilised by practitioners to help form the basis of a conversation with an individual.

ABI Screening Tools

Our ABI screening tools are internationally validated and are designed to give clinicians a consistent way to screen for alcohol problems. In the main these screening tools ask about drinking behaviours with the number of units as the first question in FAST which can quickly identify those who would benefit from an ABI. These tools remain appropriate. NHS Health Scotland has updated their online ABI resources to reflect the CMO guidelines and is available here: <http://www.healthscotland.scot/publications/alcohol-brief-intervention-resources>.

¹ *Evidence for the effectiveness and cost effectiveness of interventions to reduce alcohol related harm*, World Health Organization, 2009

http://www.euro.who.int/_data/assets/pdf_file/0020/43319/E92823.pdf

Best Preventative Investments for Scotland – what the evidence and experts say, NHS Health Scotland, 2014

<http://www.healthscotland.com/uploads/documents/24575->

[Best%20Preventative%20Investments%20For%20Scotland%20-](#)

[%20What%20The%20Evidence%20And%20Experts%20Say%20Dec%202014.pdf](#)

² NICE Public Health (PH) Guideline 24 *Alcohol use disorders – preventing harmful drinking* (June 2010, updated in 2014): <http://www.nice.org.uk/PH24>

³ McQueen J, Howe TE, Allan L, Mains D, Hardy V (August 2011) Brief interventions for heavy alcohol users admitted to general hospital wards: http://www.cochrane.org/CD005191/ADDICTN_brief-interventions-heavy-alcohol-users-admitted-general-hospital-wards

ABIs – Priority and Wider settings

This guidance sets out the definitions for both priority and wider settings for the delivery of ABIs in order to maintain and develop delivery for the ABI LDP standard.

Appropriate screening and ABIs in the priority settings should ideally be delivered opportunistically as part of a face to face clinical consultation following routine history taking, rather than requiring a separate visit.

Priority settings

Primary Care

Interventions within Primary Care are delivered by doctors and nurses in the general practice setting. Interventions associated with health promotion checks (such as Keep Well) conducted out with the practice, but delivered by doctors and nurses in line with the guidance set out in this note, can be considered as part of the standard.

At an ABI Leads network event (January 2015) delegates identified a number of potential ways to develop delivery in Primary Care including improving engagement with GP practices and making full use of areas such as Keep Well, Pharmacy and Community Nursing. Full details of the event can be found through the [summary report](#)⁴ and the [presentations](#)⁵ on the NHS Health Scotland website.

Current evidence suggests that an ABI is effective in primary care for up to 12 months after delivery, however if after that time an individual is drinking at a hazardous or harmful level, then a repeat ABI would be appropriate. These 'repeat' ABIs can be considered and recorded as part of the standard if they are in line with this guidance.

NHS Boards and their ADP partners should also ensure systems are in place to detect double counting – i.e. where an individual receives an intervention within a single setting or in more than one setting over the course of a 12 month period.

A&E Care

Interventions within A&E are delivered by doctors and nurses as part of a patient's care initiated by their attendance at A&E, minor injury unit/department and community-based minor injury clinic. The intervention can be delivered in the A&E department, minor injury unit/department or community-based minor injury clinic as part of the clinical consultation. It may also be delivered during follow on care from an A&E or minor injury attendance in the acute setting, such as an outpatient fracture clinic or in a hospital ward following an admission from A&E. ABIs are most effective if delivered within 48 hour of initial contact.

Two ABI Leads network events held in 2013 identified a number of common challenges and potential solutions for delivery of ABIs in A&E. Using a Learning Set approach, Leads have been able to work collaboratively and support each other; findings from one such process are summarised in **Annex D** as an illustration. It may be useful for NHS Boards and their ADP partners to consider these in relation to local delivery and, as part of

⁴ABI Event 22 January 2015 (Primary Care) – Summary Report:

<http://www.healthscotland.com/documents/24934.aspx>

⁵ABI Event 22 January 2015 (Primary Care) – Presentations:

<http://www.healthscotland.com/documents/24890.aspx>

embedding, leads and relevant acute setting colleagues may wish to consider self-sustaining these approaches informally in the future.

There is still a need to maintain and embed ABI delivery in A&E, strengthen links to the wider health and social care settings as well as continuing to maintain workforce development. Annual HPHS Performance Reporting has been revised and will not include performance measures for ABIs. This information is now captured through ADP Annual Reporting. Please note that it is only reporting that has been reduced and not the delivery of all HPHS actions.

Antenatal Care

Interventions within antenatal care are delivered by midwives or obstetricians in a primary care, community or hospital based setting. It is anticipated that the intervention will be delivered as part of the booking appointment and should be in line with the Chief Medical Officer for Scotland's advice: *'avoid alcohol when pregnant or contemplating pregnancy, no alcohol means no risk.'* The gathering of information on pre-pregnancy alcohol consumption is considered good practice and enables a fuller understanding of a woman's alcohol consumption. However, only interventions delivered during pregnancy alcohol consumption can be considered as part of the standard.

Wider settings

The LDP standard for 2019-20 continues to allow for **20% of ABIs** to be delivered in wider settings. This supports the approach ADPs have been taking: increasingly leading on ABI delivery and innovating new routes of delivery.

NHS Boards and their ADP partners are encouraged to consider delivery of ABIs in wider settings where there is an identified need, ensuring staff are appropriately trained.

Annex C outlines the requirements for the appropriate planning and delivery of ABIs in wider settings, reinforcing the importance of evaluating such approaches in order to develop the evidence base and inform future service delivery. Information and findings from evaluation should be fed back to Scottish Government and also shared widely with partners.

ABIs delivered out-with the priority settings, by any trained professional, will constitute as wider setting delivery. Any delivery in the priority settings by a professional other than doctors, nurses and midwives will also be considered as wider setting delivery. Likewise, an ABI delivered to an individual under 16 in any setting will also constitute wider setting delivery, although **it should be noted that there is currently no evidence to support ABIs with individuals under 16 as research has not been undertaken.**

The [NICE Public Health \(PH\) Guideline 24⁶](#) *Alcohol use disorders - preventing harmful drinking* (June 2010) considers the delivery of brief interventions in wider settings. It highlights that Chief Executives of NHS and local authorities, commissioners of NHS healthcare services, commissioners from multi-agency joint commissioning groups (i.e. ADPs) and managers of NHS-commissioned services should all take action to screen and provide brief interventions where professionals have contact with those aged over 16.

⁶NICE Public Health (PH) Guideline 24 *Alcohol use disorders – preventing harmful drinking* (June 2010): <https://www.nice.org.uk/guidance/PH24>

Furthermore, it recommends that commissioners should include formal evaluation within the commissioning framework so that alcohol interventions and treatment are routinely evaluated and followed up. **Annex E** outlines the recommendations of this Guideline which should be considered by NHS Boards and their ADP partners for ABI delivery in wider settings.

Through broadening delivery in wider settings and also through existing delivery in the priority settings, NHS Boards and their ADP partners are asked to consider ways to increase the focus on communities where deprivation is greatest.

Criminal Justice

Evidence suggests that there is a strong link between alcohol and crime, particularly violent crime. In 2016/17, 29% of the total of 77 persons accused in homicide cases were reported to have been under the influence of alcohol and/or drugs at the time of the homicide⁷.

People who enter the criminal justice pathway also tend to have high levels of multiple health problems as well as below average engagement with health and other services.⁸

Screening and alcohol brief interventions that target those in justice settings have the potential not only to help with the reduction of reoffending, but also health inequalities that some prisoners face, given that alcohol related harm is disproportionately higher in those from more deprived areas.

The transfer of healthcare to NHS Boards in prisons in 2011 and police custody in 2014 continue to provide opportunities for delivery of ABIs in justice settings. ABIs should only be considered for those in police custody who are considered as crime suspects. It would **not** be appropriate to screen those who are a potential victim of crime or those who have been taken to police custody as a place of safety. The Scottish Prisoner Healthcare Network has published guidance⁹ for the delivery of substance misuse services which includes recommendations for the delivery of ABIs in prison. The Police Care Network also developed guidance on Substance Misuse in April 2017 outlining recommendations for the delivery of ABIs¹⁰. The Quality and Outcome Framework developed to assess the quality of care in police custody also includes an indicator on the delivery of ABIs.

In November 2016 the Scottish Government published a National Strategy for Community Justice¹¹. This strategy sets out a vision where people are rightly held to account for their offending, but are supported to be active and responsible contributors to their community through the use of a preventative and person-centric approach to reduce crime and the number of future victims of crime.

⁷ <https://www.gov.scot/publications/homicide-scotland-2016-17-9781788512367/>

⁸ Prison Health in Scotland – A Health Care Needs assessment
<http://www.ohrn.nhs.uk/resource/policy/scottishPrisonHealthNeeds.pdf>

⁹ Drugs, Alcohol and Tobacco Health services in Scottish Prisons: Guidance for Quality Service Delivery, February 2016
<http://www.knowledge.scot.nhs.uk/media/11318713/20160226%20nphn%20substance%20misuse%20report%20final%20v1.0.pdf>

¹⁰ <http://www.policecare.scot.nhs.uk/groups/healthcare-service-delivery-group/substance-misuse/>

¹¹ National Strategy for Community Justice <http://www.gov.scot/Resource/0051/00510489.pdf>

ABI delivery and recording in justice settings

It would be helpful if the recording of ABIs in justice settings was undertaken as consistently as possible across Scotland and recorded as a 'wider setting' with delivery described by justice setting e.g. prison/police custody/criminal justice social work. If your NHS Board area records ABI delivery in police custody/prison in a different setting (e.g. Primary Care) it would also be helpful if you could specify the number of ABIs delivered in police custody within this setting. This information will be of interest to your Alcohol and Drug Partnerships (ADPs) and Community Justice Partnerships who are required to complete [annual reporting](#), demonstrating local performance against a set of core outcomes and indicators. These include outcomes for community safety, often reliant on reducing alcohol related offending. Since the passing of the Community Justice Act 2016, this will strengthen links across key local partners with a statutory responsibility for people within the justice system.

Training

Full guidance on competencies required to deliver ABIs are outlined in the [Delivery of Alcohol Brief Interventions Competency Framework](#)¹² available on the NHS Health Scotland website and will be considered as part of the review of the ABI training programme. This framework clarifies the required knowledge, skills and approaches used in order to raise the issue of alcohol, assess and screen the extent of the problem, to offer an ABI and to signpost/refer on appropriately.

This should be used in conjunction with [The Health Behaviour Change Competency Framework](#)¹³ which highlights the transferable skills needed to support change across a range of health topics. It reinforces the focus on person centred approaches and the need for partnership working to ensure the seamless referral of individuals to a wide range of services. In response to this change NHS Health Scotland created a suite of Health Behaviour Change (HBC) training resources. The training consists of face to face learning sessions and e-modules designed to support staff across a range of settings and roles in raising the issue, assessing the problem, carry out interventions and referring/signposting on, if appropriate. It is recommended staff undertake generic HBC learning in addition to alcohol topic specific learning. The suite of [e-modules](#) and resources can be accessed by all practitioners but it is recommended that this is through the guidance and support of local trainers in health behaviour change.

We would urge ABI leads to communicate with each other to highlight any training events they are arranging, to encourage learning and also opportunities for other Boards to attend if possible.

To support embedding, the expectation is that NHS Boards and their ADP partners will continue to identify and support an appropriately trained individual to coordinate training and will ensure they have sufficient and appropriately trained staff in post to help support them to deliver ABIs quickly and effectively. Further information on what to consider before training is offered is also outlined in **Annex C**, as part of *implementing the service*.

An ABI Leads event, held in September 2014, focused on Workforce. The event included discussion on a wide range of workforce-related issues which have implications for embedding ABIs. The top five issues discussed were consistency vs flexibility, leadership, meeting workforce needs, tracking impact and ensuring clear pathways/effective systems. A copy of the [report](#)¹⁴ and the [presentations](#)¹⁵ from the event can be accessed through the NHS Health Scotland website. NHS Boards and their ADP partners are encouraged to consider the findings of the event and how they may apply to local issues.

¹²Delivery of Alcohol Brief Interventions: A Competency Framework; NHS Health Scotland, March 2010: <http://www.healthscotland.com/documents/4120.aspx>

¹³The Health Behaviour Change Competency Framework, NHS Health Scotland, December 2010: <http://www.healthscotland.com/documents/4877.aspx>

¹⁴ ABI Workforce Event – report, September 2014: <http://www.healthscotland.com/documents/24255.aspx>

¹⁵ ABI Workforce Event – presentations, September 2014: www.healthscotland.com/documents/24207.aspx

Data Collection

Mandatory data reporting requirements – 2019-2020

The mandatory reporting requirement and performance measure for the ABI LDP standard in 2019-20 is **the total number of alcohol brief interventions delivered by setting in each quarter** in accordance with this guidance.

NHS Boards should coordinate local arrangements with their ADP partners to ensure the capture and reporting of data for the purposes of the ABI LDP standard and the ADP national core outcomes/ indicators.

NHS Boards and ADPs will be aware that the [guidance for ADP Planning and Reporting](#) includes the following national core indicators for ABI delivery:

National Outcome 4: CAPSM/FAMILIES

- **Indicator:** Proportion of positive ABI screenings in ante-natal setting

National Outcome 7: SERVICES

- **Indicator:** The number of screenings (using a validated screening tool) for alcohol use disorders delivered and the percentage screening positive with the breakdown of:
 - i) % eligible for ABI and
 - ii) % eligible for referral to treatment services.
- **Indicator:** The number of alcohol brief interventions delivered in accordance with the LDP standard guidance.

It is expected that data for all of the above indicators is collected and fed into your ADP, for the Performance Framework element of ADP Delivery Plans and Annual Reports.

Collection of these indicators will help to provide an overall picture of activity, identifying those with alcohol use disorders as well as the potential demand for services.

Plans (which can include any relevant risks) for local delivery of ABIs and indicative figures for quarterly delivery will be agreed through the LDP process. NHS Boards are expected to work with their ADPs - as the strategic leads for tackling alcohol misuse at local level - in this planning in order to assess wider delivery for 2019-20.

Given the need to closely monitor the standard, NHS Boards will report levels of delivery, by individual setting, directly to ISD on a quarterly basis. NHS Boards should continue to use the same reporting template. All reported ABI delivery will require to be in accordance with the ABI LDP standard guidance.

Scottish Government will monitor the delivery in all settings to ensure it accords with the planned national guidance.

Timescales for mandatory reporting

Quarterly returns should be submitted by email to Martin Moench (Health Improvement Team, ISD) at martin.moench@nhs.net by the following dates:

Quarter	Dates	Deadline
1	1 April to 30 June 2019	Friday 26 July 2019
2	1 July to 30 September 2019	Friday 25 October 2019
3	1 October to 31 December 2019	Friday 31 January 2020
4	1 January to 31 March 2020	Friday 24 April 2020

In addition, the **total number of alcohol brief interventions** delivered during **2019-20** for the LDP standard (1 April 2019 – 31 March 2020) should be submitted by email to Martin Moench: martin.moench@nhs.net at Information Services Division (ISD) no later than **Friday 8 May 2020**.

Only ABIs delivered between 1 April 2019 and 31 March 2020 can be reported for the purposes of the LDP standard. Any retrospective data subsequently determined for ABIs delivered under the previous LDP standard (between 1 April 2018 and 31 March 2019) **cannot** be included in returns for 2019-2020.

Publication of data

As part of the LDP standard, ISD will publish an annual figure of ABI delivery. This information will be made available on the [ISD website](#)¹⁶ and Scottish Government's [Scotland Performs website](#)¹⁷.

The information will be broken down by NHS Health Board, delivery in each of the three priority settings (primary care, A&E and antenatal; listed as a % of the Board's expected level of delivery) and a fourth data category which will aggregate all delivery in 'wider settings'.

Screening data is also requested however this is to aid internal planning and information gathering and is shared with NHS Boards on a management information only basis. Screening data and any other additional data provided by NHS Boards, and their ADP partners, will not be published.

Further information about data collection and the potential links to capturing the reach of ABIs and impact on health inequalities can be found at **Annex F**.

¹⁶ISD Website – Latest Publications:

<http://www.isdscotland.org/Publications/index.asp>

¹⁷Scottish Government – Scotland Performs website:

<http://www.gov.scot/About/Performance/scotPerforms/NHSScotlandperformance/ABI-LDP>

Support

Scottish Government, in partnership with NHS Health Scotland and ISD, will continue to support NHS Boards and their ADP partners in their delivery of ABIs throughout the course of the LDP standard. This will include supporting data collection, maintenance of resources and encouraging the sharing of good practice to build the evidence base.

In line with the long term aim of the ABI programme to embed ABI delivery in routine practice, NHS Boards and ADPs are encouraged to develop local and regional support networks to share mutual learning by linking with areas of good practice and sharing learning. Leads are encouraged to sustain this to facilitate ongoing discussion of challenges and potential local solutions. This could for example, include continuation of the Action Learning Sets as previously facilitated by NHS Health Scotland at a number of ABI Leads events.

Links to resources can be found in **Annex G**.

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NHS BOARD TARGETS 2019-20

National ABI Target: **61,081**

It is expected that at least 80% of delivery (i.e. a minimum of 48,865 ABIs) will continue to be delivered in the priority settings. The remainder can be delivered in wider settings in accordance with this guidance.

NHS Board Targets

ABI LDP Standard 2019-20	Target delivery
Ayrshire & Arran	4,275
Borders	1,312
Dumfries & Galloway	1,743
Fife	4,187
Forth Valley	3,410
Grampian	6,658
Greater Glasgow & Clyde	13,085
Highland	3,688
Lanarkshire	7,381
Lothian	9,757
Orkney	249
Shetland	261
Tayside	4,758
Western Isles	317
Total	61,081

KEY COMPONENTS OF AN ABI

The following elements can be considered key components of an ABI:

Short

In practice, ABIs can take as little as 5 to 10 minutes to complete, and even a single session with a patient/client can be effective. There is good evidence that longer sessions are no more effective than briefer interventions¹⁸.

The length of the intervention will depend on a variety of factors, including what the patient/client wants, the skills and confidence of the practitioner, the level of drinking involved, the interaction between the client and practitioner and the time available for both patient/client and practitioner.

Evidenced-based

The ABI programme was originally based on the national clinical guideline, SIGN74 Guideline, which was published in 2003. The Guideline recommended the delivery of ABIs for harmful and hazardous drinkers in primary care and also highlighted the potential for delivery in A&E and antenatal settings.

Structured conversation

ABIs involve more than just giving advice. They typically use specific techniques to help people to change their behaviour. Key components of an ABI include the use motivational interviewing approaches, being person centred and using techniques to enhance the abilities of individuals to make changes for themselves.

Even short ABIs (sometimes referred to in the literature as 'brief advice') have a structure and style that distinguishes them from simply advising a person to drink less.

The first part of the structured conversation is focused on obtaining an accurate picture of the client's alcohol consumption, pattern of drinking and personal circumstances to assess whether they are suitable for an ABI, whether they should be signposted to another service, or if no action is required. Screening tools appropriate to specific settings provide an objective and validated way of assessing whether a client is a hazardous, harmful or a dependent drinker.

Screening is an important part of delivering ABIs and this alone may help the client recognise that they have a problem and start the process of thinking about change, or provide the motivation to change.

¹⁸ Scottish Intercollegiate Guidelines Network (2003). Guideline 74. The management of harmful drinking and alcohol dependence in primary care. Scottish Intercollegiate Guidelines Network, Edinburgh.

Motivational interviewing

This is a collaborative style of conversation that practitioners can use to help clients explore and resolve their mixed feelings about changing their behaviour in a way that enhances their motivation and ability to make changes.

Techniques to support health behaviour change

Further information exploring the evidence for motivational interviewing can be found in this evidence review:

<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0204890>

Evidence suggests that different techniques are more effective in supporting change depending on the individual's circumstances and their motivation to change. The [HBC competency framework \(December 2010\)](#)¹⁹ highlights techniques that focus on enhancing confidence and motivation to change, action planning to support taking steps towards change and ways to restructure the environment to make change easier.

¹⁹Health Behaviour Change Competency Framework, NHS Health Scotland, December 2010:
<http://www.healthscotland.com/documents/4877.aspx>

MANAGEMENT AND DELIVERY OF ABIs AT LOCAL LEVEL:

CHECKLIST OF GOOD PRACTICE REQUIREMENTS TO CONSIDER WHEN PLANNING THE DELIVERY AND EVALUATION OF YOUR SERVICE

Scottish Government and NHS Health Scotland have developed a 'checklist of good practice requirements' to ensure appropriate delivery of ABIs in practice. This takes into account the findings from the ABI national evaluation '[An evaluation to assess the implementation of NHS delivered Alcohol Brief Intervention](#)' (September 2011)²⁰, as well as evidence papers, scoping exercises, the evaluation of the national ABI training programme and the nationally funded ABI pilots.

The checklist outlines what should be considered when planning, delivering and evaluating ABIs in order to help support the implementation of effective interventions and to develop and strengthen the ABI evidence base. It is therefore applicable to all ABI delivery. **Any ABIs delivered out-with the priority settings and/or by trained professionals other than doctors, nurses and midwives should give particular attention to the monitoring/evaluating section of this checklist.**

It is recommended that no wider setting delivery should be undertaken unless this checklist is first considered. This checklist can also be used to support continued implementation in the priority settings.

1) PLANNING THE SERVICE

Who are you aiming to reach?

- Which groups/populations do you want to target and why?
- What benefit will there be to these groups?
- On what evidence is your decision based e.g. local needs assessments?
- Is ABI the most appropriate intervention for this group?

What outcomes are you hoping to achieve through the delivery of ABIs?

- In the short term e.g. increased reach to target group, increased identification of hazardous and harmful drinkers with referral of harmful and dependent drinkers where appropriate, increase in the knowledge and skills of the workforce
- In the medium term e.g. reduction in individual and population levels of alcohol consumption
- In the longer term, prevention e.g. reduction in alcohol related illness, reduction in alcohol-related crime

What other organisations, agencies or groups will be involved in helping you to achieve these outcomes?

- What other organisations, agencies or groups within the ADP are involved in the planning and implementation process? Which staff groups and patient/client groups have been consulted as part of the planning and development process?

²⁰An evaluation to assess the implementation of NHS delivered Alcohol Brief Intervention, September 2011: <http://www.healthscotland.com/documents/5438.aspx>

- If working between NHS services and systems, or between NHS and non NHS services and systems, is there full understanding of joint aims, accountability, roles, expectations and responsibility?

How will you reach these target groups or populations?

- In what settings will the intervention be delivered? What evidence is there that these settings are the most effective for reaching the target groups/populations?
- What evidence is there that the delivery of the interventions in these settings would be feasible e.g. is acceptable to clients of the service, would not damage the professional relationship between professionals and their service users, is seen by staff delivering the intervention as an appropriate and manageable part of their job?
- Is there evidence for the effectiveness (including cost effectiveness) of delivery of these activities in these settings to achieve the desired outcomes?
- If there is no evidence, are there plans for systematically collecting this evidence?

What are you aiming to do to help you achieve these outcomes?

- Raise the issue of alcohol (for referral on as appropriate)
- Screen for hazardous and harmful patterns of consumption and refer on as appropriate
- Screen and deliver an ABI (i.e. for hazardous and harmful drinkers and delivered as defined in SIGN 74)
- Follow up after delivery of a screen and/or intervention

What tools will be used to screen for and deliver an intervention in these settings?

- What validated screening and delivery tools will be used for these interventions?
- Is there evidence supporting the use of these tools in these settings?

2) IMPLEMENTING THE SERVICE

Who/which staff groups will deliver the intervention and what are their training needs?

- Why these staff groups? What evidence is there that these are the most appropriate staff groups for reaching the target groups/populations and delivering the intervention? [Consider [ABI Competency Framework \(March 2010\)](#)²¹]
- Is there a local workforce strategy or policy setting out the role of these staff groups in delivering the intervention?
- Has there been local scoping/needs assessment to assess the learning needs of this group?

What do the staff groups delivering the intervention need to support them?

- Is training (and co-ordination of training) available for staff on those aspects of delivery of the intervention relevant to their post?
- Are relevant staff given the time to attend training?
- To maintain staff skills and confidence how will you: minimise the time lag between staff being trained and being able to deliver the intervention; ensure that staff have sufficient hands-on experience to maintain their skills?
- Will time be available for staff to deliver an intervention in the course of their normal practice?

²¹ Delivery of Alcohol Brief Interventions: A Competency Framework, NHS Health Scotland, March 2010: <http://www.healthscotland.com/documents/4120.aspx>

- Is there an appropriate physical space in which to deliver a confidential intervention?
- Is there appropriate line management and supervision to support staff to deliver the intervention?
- What 'practice level' co-ordination will be in place to encourage implementation and support on-going monitoring?
- What care/referral pathways will be in place to ensure that staff are able to appropriately refer people to the agencies or services where additional and/or more specialist support is required? Will this be in place prior to the roll out of training?
- Is there recognition that supporting this new ABI development is a valid and legitimate part of staff's professional role?

3) MONITORING AND EVALUATING THE SERVICE

How will you know who has been reached by the intervention and with what impact?

- How and by whom will data on delivery of the screening and alcohol brief intervention be recorded?
- If using an electronic data recording system does it have the required functionality? Do all staff delivering the intervention have the skills and physical access to computing facilities? If not, what alternative systems will be in place to ensure delivery is recorded?
- How will you monitor consistency, accuracy, and timeliness of recording?
- Follow up is strongly encouraged. If people are being followed up after delivery of an intervention, when will this take place? Who will undertake the follow up and how will this be recorded?
- How are you going to monitor delivery and evaluate the process of implementation? How will these data be used as part of continuous service improvement to inform ongoing delivery? For example, measuring the extent of adoption/delivery by staff and reach to potential beneficiaries.
- How are you going to evaluate impact (at local level)?
- How will you measure cost effectiveness?

DELIVERING ABIs IN A&E

This approach employs the Case Consultation methodology that has been used by the Scottish Government as part of its Leadership Development and Change Management Programmes. The process provides a structured way to surface new interpretations, areas of activity and improvement plans that could not be realized in a traditional meeting or conversation. The process is best used on what many have called “wicked issues” – situations where there is no clear solution and where even the nature of the problem may be unclear.

This method has been used on a number of occasions with ABI Leads, including once in partnership with Health Promoting Health Service colleagues and resulted in collation of a number of common challenges and potential solutions. This is illustrated below however is not intended as an exhaustive list, instead reflecting the challenges and potential solutions that have been identified so far.

Strategic Challenges:

- *Senior management/clinical buy in*
- *Gap in screening/ABI delivery in A&E for patients who are “walk-in” discharges*
- *ABI is only one of a number of competing priorities within A&E e.g. 4 hours waiting time, child protection, unscheduled care etc*
- *Culture and behaviours towards alcohol*
- *Practicalities of incorporating screening and ABI into core work and embedding*
- *Developing effective care pathways*
- *Need for national and local evidence of effectiveness*

Operational Challenges:

- *Access to staff for training purposes*
- *Organisation of training delivery*
- *Staff acceptance of the concept and model and part of their role*
- *Time/Competing pressures*
- *Staff confidence*
- *Data recording*
- *Maintaining momentum and enthusiasm*
- *Patient resistance*

Potential Solutions

- *Agree key delivery areas (wider than A&E)*
 - *Admission Assessment Units (AAU)*
 - *Medical Assessment Units (MAU)*
 - *Medical Receiving Wards (MR)*
- *Robust training programme which includes wider context*
- *Universal data recording system*
- *Find a ‘local champion’ to model behaviour and be local advocate.*
- *Additional investment in staff*
- *Link ABIs into wider priorities and evidence effectiveness to support funding*

CONSIDERATION FOR ABI DELIVERY IN WIDER SETTINGS

The following outlines recommendations from the [NICE Public Health \(PH\) Guideline 24 Alcohol use disorders - preventing harmful drinking](#) (June 2010)²² may be considered by NHS Boards and ADPs for ABI delivery in wider settings.

For screening adults, the following settings are suggested for those professionals in NHS and non-NHS who regularly come into contact with people who may be at risk of harm from the amount of alcohol they drink:

- health and social care
- criminal justice
- community and voluntary sector

NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. This includes people:

- with relevant physical conditions (such as gastrointestinal or liver disorders)
- with mental health problems (such as anxiety, depression or other mood disorders)
- who have been assaulted
- at risk of self-harm
- who regularly experience accidents or minor traumas
- who regularly attend GUM clinics or repeatedly seek emergency contraception.

Non-NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and people who have alcohol-related problems. For example, this could include those:

- at risk of self-harm
- involved in crime or other antisocial behaviour
- who have been assaulted
- at risk of domestic abuse
- whose children are involved with child safeguarding agencies
- with drug problems.

Adults who have been identified as drinking a hazardous or harmful amount of alcohol and who are attending NHS or NHS-commissioned services or services offered by other public institutions, should receive brief advice from professionals who have received the necessary training and work in:

- primary healthcare
- emergency departments
- other healthcare services (hospital wards, outpatient departments, occupational health, sexual health, needle and syringe exchange programmes, pharmacies, dental surgeries, antenatal clinics and those commissioned from the voluntary, community and private sector)
- the criminal justice system
- social services
- higher education other public services.

²² National Institute for Health and Clinical Excellence (2010). Guideline 24. Alcohol use disorders - preventing harmful drinking. London: National Institute for Health and Clinical Excellence: <http://www.nice.org.uk/PH24>

CORE MINIMUM DATASET

As part of national support for the implementation of the original ABI HEAT target (2008-2011), the Information Services Division of National Services Scotland produced, in consultation with NHS Boards, a core minimum dataset.

The dataset, including definitions, guidance notes and data standards where applicable, is available through the [NHS Health Scotland website](#)²³.

This enables NHS Boards, with their ADP partners, to collect and report on the implementation and delivery of ABIs in a consistent manner. Please note that this is a minimum dataset only (as NHS Boards and their ADP partners may wish to gather additional information) and is **not** mandatory.

Data Collection

NHS Boards and their ADP partners have a responsibility to develop appropriate IT systems and reporting of delivery in line with the requirements of the LDP standard and ADP core indicators.

In developing the ABI Programme NHS Boards, the Scottish Government and the ABI HEAT Delivery Support Team (DST) recognised the benefits of capturing data beyond the mandatory reporting requirements outlined below, in helping to develop the evidence base.

The collection of ABI data, along with any supplementary data, enables NHS Boards and their ADP partners to track progress at local level and feed into the continuous improvement of local services. Capturing information on the investment of resources for tackling alcohol misuse (including, but not limited to, delivery for the ABI LDP standard) can act as an aid to future planning and development of policy and strategy.

Capturing the reach of alcohol brief interventions and their impact on health and health inequalities

The collection of supplementary data from the core minimum dataset, in addition to the mandatory reporting requirements, will improve understanding of who is receiving ABIs and how effective they are. For example, monitoring data can be used to assess whether ABIs are being delivered across the geographical area or population groups as expected, or whether any areas or demographic groups do not seem to be receiving ABIs. Reasons, implications for health inequalities, and remedial action, if necessary, can then be explored. Similarly, follow-up data will help assess what impact, if any, alcohol brief interventions are having on health and health inequalities.

If an NHS Board or ADP decides to collect supplementary data for a given ABI Setting (or Service within that setting), and is able to analyse the data in sufficient detail, the Board can submit these data to ISD and ISD can offer demographic analysis, depending on the level of detail of what has been submitted. These results can help NHS Boards and ADPs with planning, delivery and assessment of the impact and reach of alcohol brief interventions.

²³ Core Minimum Dataset, December 2008:
<http://www.healthscotland.com/documents/3207.aspx>

RESOURCES

As part of national support for the implementation of ABIs by NHS Boards, reference material on screening and ABIs is maintained by NHS Health Scotland. NHS Health Scotland have updated their ABI resources to reflect the new CMO guidelines on low risk drinking levels. Online versions of the updated materials can be found here:

<http://www.healthscotland.scot/publications/alcohol-brief-intervention-resources>

Evidence papers have been developed by NHS Health Scotland to support planning and delivery in priority and wider settings. This includes settings such as A&E, antenatal, dentistry, pharmacy and young people. Links to these papers are available through the NHS Health Scotland ABI WebPages:

[<http://www.healthscotland.com/topics/health/alcohol/evidence-and-research.aspx>]

Additional resources you may find helpful:

- ABI Event Series Summary Report
<http://www.healthscotland.com/documents/25095.aspx>
- Outcomes Framework and Logic Model:
<http://www.healthscotland.com/OFHI/alcohol/content/tools.html>
- ScotPHO Profiles – Online Profiles Tool
<http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool>
- MESAS Final Annual Report and Infographics:
<http://www.healthscotland.com/documents/26884.aspx>
- MESAS Evaluation Support Page
<http://www.healthscotland.com/scotlands-health/evaluation/support/index.aspx>