

Identification and Brief Advice (IBA) Alcohol Evaluation

Cruddas Park Practice

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1. Summary of Pilot

Last year, West Newcastle Clinical Commissioning Group (CCG) identified 'improving community alcohol services' as one of their top priorities within their prioritisation plan. Prior to this (2012), a Rapid Process Improvement Workshop (RPIW) was held with stakeholders, including both Newcastle CCGs, to understand the pathway. The intention was to explore whether the services were cost effective and sufficient to meet the needs of Newcastle population; this was to assist in providing a clear steer on the gaps and duplication in the system to inform future commissioning intentions.

Prior to the event, there was variable practice in Newcastle aimed at systematically targeting patients for alcohol screening, brief advice and onward referral, should the client require additional support. Whilst there are pockets of good practice, to have an impact on the health of the population, alcohol screening and brief advice needs to be rolled out on an industrial scale across primary care as a priority area for delivery.

From this event, Cruddas Park volunteered to be the champion practice to lead the development of a systematically applied alcohol pathway in primary care. It was agreed that they would introduce a pilot pathway and learning from this was to be shared with West CCG practices. The intention was to assess whether the adult alcohol care pathway is viable for roll out across Newcastle practices.

The aim of this pilot was to assess the effectiveness of an adult alcohol care pathway prior to roll out across West CCG practices. It would evaluate an intervention with patients who would receive alcohol screening and brief advice as part of their GP, Practice Nurse or Health Care Assistant (HCA) appointment. The pilot aimed to assess the practicality of implementing Identification and Brief Advice (IBA) into a busy GP practice - both Cruddas Park and Hills view Avenue practices took part.

This pilot was introduced for 13 weeks between 1 November 2012 and 31 January 2013. During this period, nine members of staff (2 x health care assistants, 2 x practice nurses and 5 GPs) undertook IBA to patients. Prior to the pilot, all staff participating received training to ensure they all had a consistent approach in undertaking the IBA, including an understanding of the AUDIT tools and the agreed referral pathway.

2. Rationale

When reviewing the full adult alcohol care pathway there was no clear pathway defined across the city. From opportunistic and/or routine alcohol screening of the whole population through to structured alcohol treatment there was a lack of clarity amongst service providers regarding who was operating across the pathway. As a consequence, differing thresholds for referral have been applied by different organisations and with clients being referred to a variety of organisations depending on the level of knowledge and understanding of providers across the pathway.

Furthermore, it was identified that there is little robust data on the numbers and demographic profile of the population using alcohol services across Newcastle. This is a significant knowledge gap resulting in commissioning decisions being made without a full understanding of the health needs of the population.

Studies have estimated that 20-30% of patients who routinely present in primary care are hazardous or harmful drinkers.¹ Hazardous drinking is defined as a repeated pattern of drinking that increases the risk of physical or psychological problems.² Harmful drinking is defined by the presence of physical or psychological problems.³

Alcohol consumption has been linked with the development of 60 diseases including high blood pressure, coronary heart disease, some cancers and liver disease.⁴ After tobacco and hypertension, alcohol consumption is the third highest contributor to the burden of disease in developed countries.⁵ Evidence suggests that costs of implementing schemes to increase screening and brief interventions for alcohol-use disorders may be offset by long term savings.⁶ Screening for alcohol consumption among patients carries many potential benefits. It provides an opportunity to educate patients about low risk consumption levels and risks of excessive alcohol use. Screening also offers the opportunity for practitioners to take preventative measures in reducing alcohol related risks as well as appropriately signposting or referring patients to specialist alcohol services if necessary.

NICE guidance, *Preventing Harmful Drinking* (PH 24), recommends that:

“Health and social care staff opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice” (quality statement 2)

This guidance identifies key professional groups that should be delivering alcohol screening and brief advice. As the main gatekeeper to services and the central point of contact for patients within the NHS, primary care is integral to reducing the impact of alcohol on our population. The strongest evidence base for the delivery of alcohol screening and brief advice sits in primary care.

NICE takes the view that this approach is likely to contribute to the overarching outcome of reducing alcohol-related harm and alcohol-related hospital admissions by:

- targeting the delivery of screening and brief interventions to selected populations at an appropriate time and in an appropriate setting
- reducing alcohol consumption in those drinking at hazardous and harmful levels by providing brief advice or extended brief interventions

- improving identification and referral to specialist treatment of people with alcohol dependence and harmful drinkers who have not responded to brief interventions.

A NICE Evidence Update⁷ re-affirms that simply asking questions about drinking does not seem to affect drinking behaviour but that universal alcohol screening may result in more people being asked about alcohol use than consultation-based targeted screening. However, it does take the view that neither screening system seems to consistently identify people with risky alcohol-use who should then receive brief intervention. However, universal screening may detect risky drinking at an earlier stage than consultation-based screening.

A survey of GPs carried out by Balance⁸ showed that GPs found that, particularly in urban areas with high levels of deprivation, alcohol was a big issue for their practice. They referred to the increase in alcohol specific conditions in the under 40s and that alcohol was linked to many other conditions such as CVD, anxiety and depression, gut disorders and hypertension. Respondents from CCGs also saw a need to develop a preventative strategy to reduce the numbers of A&E attendance and hospital admissions related to alcohol.

The survey found that GPs were typically tackling alcohol opportunistically, in response to clinical indicators, rather than routinely. Time pressures and competing priorities were the recurring reasons offered for this. The survey was primarily aimed at GPs but the findings revealed that Nurse Practitioners have an active role delivering routine alcohol screening in many practices. In response to the time pressures on GPs – and the perceived synergy between a Nurse Practitioner’s role and alcohol screening – targeting future initiatives and support at Nurse Practitioners was felt to be effective. There may also be scope to use Nurse Practitioners to deliver alcohol clinics, similar to those delivered for smoking and diet.

3. Brief intervention and AUDIT Tools

The WHO manual for the use of brief interventions in primary care defines brief interventions as:

"Those practices that aim to identify a real or potential problem and motivate an individual to do something about it"⁹

A brief intervention is a short, evidence-based, structured conversation about a health issue with a service user. It seeks in a non-confrontational and non-judgemental way to motivate and support the individual to think about and/or plan behaviour change. A large number of randomised controlled trials have shown that opportunistic screening and brief intervention is effective and cost-effective in reducing excessive alcohol consumption in primary care.^{10,11,12}

The aims of brief interventions are to:

- reduce the burden of alcohol related injuries and disease on the NHS and society
- inform service users of the health risks associated with drinking
- determine which service users health could be improved by reducing drinking
- encourage service users to think more carefully about how their drinking might adversely affect their client journey

The main features of a brief intervention are that they are opportunistic, last between 5-15 minutes and based on advice – they should never be confrontational. They are considered flexible and may or may not have any formal follow-up. However, it is not specialist counselling nor a route to abstinence and it should not be used to treat service users who are alcohol dependent.

The Alcohol Use Disorders Identification Test (AUDIT) is a tool to identify people with hazardous and harmful patterns of alcohol consumption. The tool was developed by the World Health Organization (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment. It can help in identifying excessive drinking as a cause of the presenting illness. Its aim is to assist practitioners identify whether a patient has hazardous drinking, harmful drinking or alcohol dependence.¹³

The full AUDIT tool comprises 10 questions and was revised in 2008 so that the first 3 questions could be used as a screening tool. The Alcohol Use Disorders Identification Test – Consumption (AUDIT-C) is a validated, shortened version of the full ten question AUDIT and is recommended by NICE guidance as a screening tool.

The aim of AUDIT-C is to help identify people who are hazardous drinkers or have active alcohol abuse or dependence. To score AUDIT-C positive a patient must score 5 or more on the first three questions (see Appendix 2). Although it does not indicate alcohol dependence it does indicate whether an individual is potentially drinking at increasing or higher risk levels.

For the full AUDIT, scores between 8 and 15 are most appropriate for simple advice focused on the reduction of hazardous drinking. Scores between 16 and 19 suggest brief counselling and continued monitoring. AUDIT scores of 20 or above clearly warrant further diagnostic evaluation, e.g. referral to specialist services for alcohol dependence. This is based on a drinker typology (see Appendix 3).

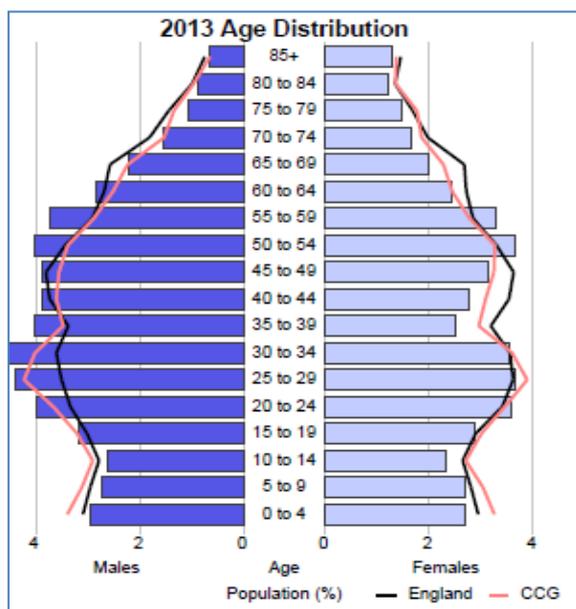
4. Cruddas Park practice population

The Practice

The practice comprises Cruddas Park surgery and North Kenton branch surgery. Across the two surgeries, the practice has 6 GPs, 3 nurses and 2 health care assistants. In addition they have a practice manager, 4 admin staff, 10 receptionists and 2 apprentices.

Practice demography

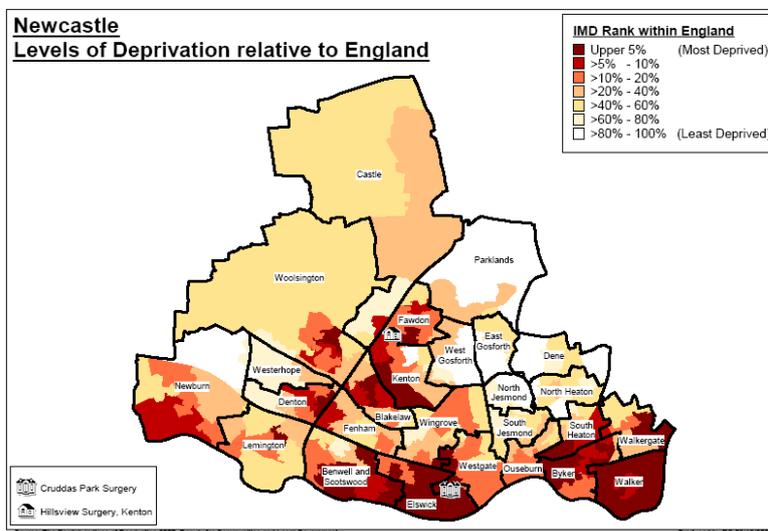
The surgeries are located in the west of the city and have 9,550 patients registered which is higher than the Newcastle West CCG average (7,347) and England average (7,041).¹ The Practice age profile broadly reflects the CCG population and is distributed as follows:



Source: National General Practice Profiles (2013)

Deprivation

Cruddas Park surgery is located in an area that ranks amongst the 5% most deprived areas in England, as defined by the Index of Multiple Deprivation (IMD) 2007.¹⁴ The North Kenton branch surgery is also located in an area surrounded by pockets of extreme deprivation.



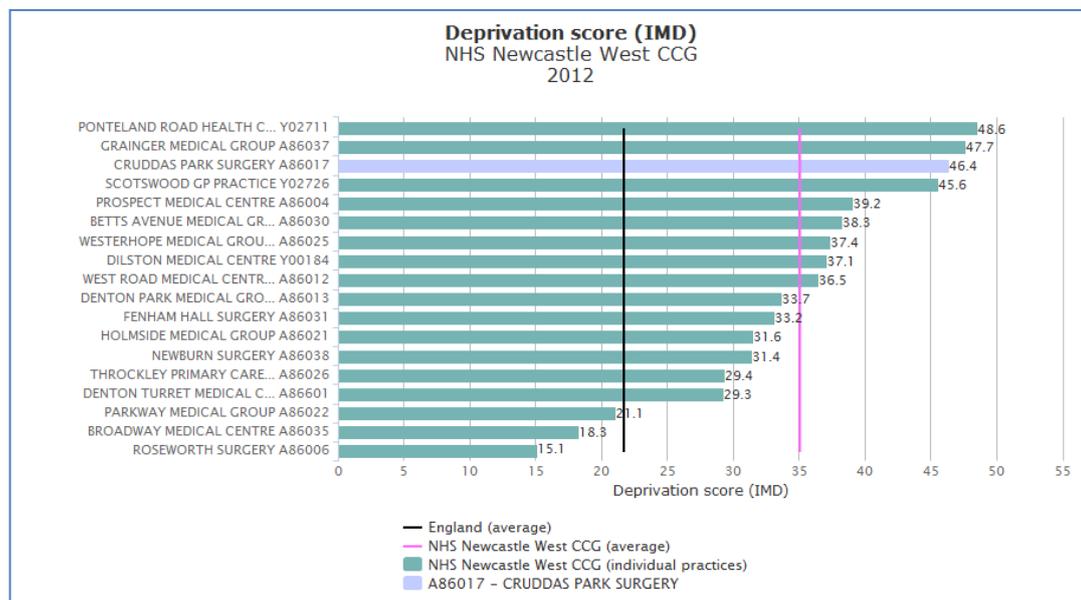
Historical data from 2008 indicated that almost 46% of the patients registered with the practice lived in areas that rank amongst the 5% most deprived in the whole of England and a total of 80.5% of the patients are resident in areas that are amongst the most deprived 20% in the country (see Table 3).

Table 1: Practice List by level of deprivation (Aug 2008)

Position within England	No. of patients	%	Cumulative %
Upper 5% (Most Deprived)	4,552	45.7%	
>5% - 10%	1,111	11.2%	56.9%
>10% - 20%	2,353	23.6%	80.5%
>20% - 40%	1,050	10.5%	91.1%
>40% - 60%	482	4.8%	95.9%
>60% - 80%	314	3.2%	99.0%
>80% - 100% (Least Deprived)	95	1.0%	100%
Total List size	9,957	100%	

Source: Exeter system download 12/08/2008

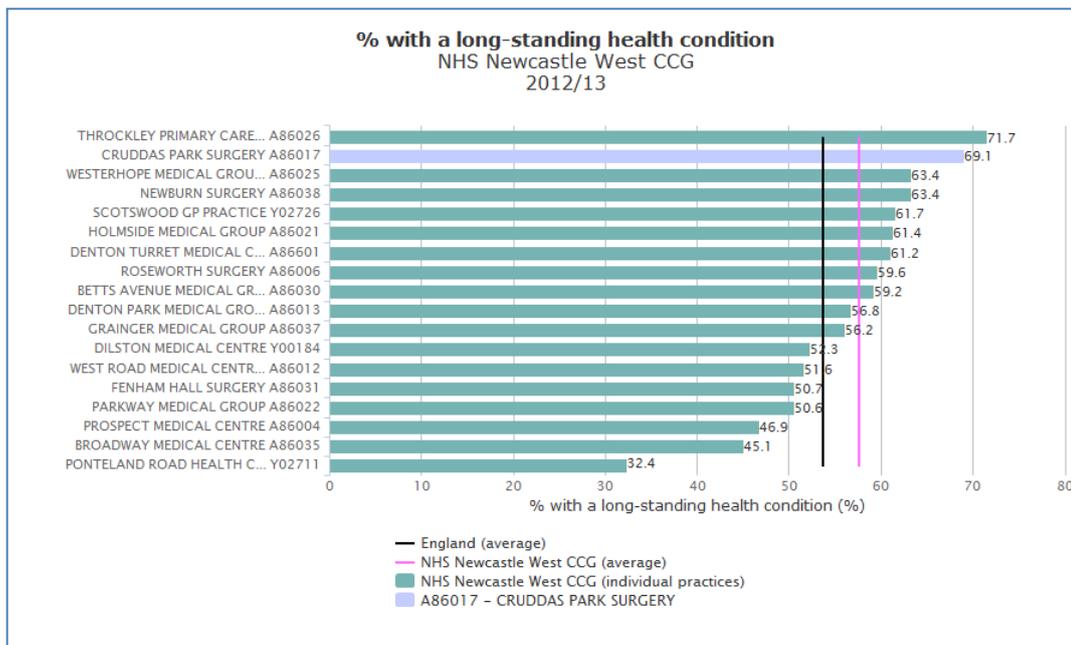
In comparison with other GP practices in the city (see below), Cruddas Park has the third highest IMD deprivation score in the city with 46.4 compared to Newcastle West CCG average of 34.9 and the England average of 21.5.



Source: National General Practice Profiles (2013)

Long-standing health conditions

According to the GP Practice Survey, across Newcastle West CCG, Cruddas Park has the second highest percentage of patients with a long-standing health condition. In the practice 69.1% of patients were found to have a long-standing health condition compared with 57.4% for the CCG average and 53.5% for the England average.



Source: National General Practice Profiles (2013)

However, these figures should be considered with some caution as this was based on a relatively small sample with only 127 patients answering this question (1.3% of the practice list).¹⁵ Of those answering this question in the practice, the CCG and England as a whole, their health conditions were listed as follows:

Table 2: Self-reported medical conditions of patients

Medical Condition	Practice		West CCG		England	
High blood pressure	38	31 %	514	26 %	226419	26 %
Arthritis or long-term joint problem	30	24 %	447	23 %	160587	19 %
Another long-term condition	23	19 %	261	13 %	117263	14 %
Long-term back problem	22	18 %	259	13 %	103510	12 %
Diabetes	17	14 %	195	10 %	84935	10 %
Asthma or long-term chest problem	16	13 %	272	14 %	97728	11 %
Angina or long-term heart problem	12	10 %	176	9 %	63324	7 %
Long-term mental health problem	10	8 %	99	5 %	34974	4 %
Deafness or severe hearing impairment	9	7 %	116	6 %	46950	5 %
Cancer in the last 5 years	8	7 %	89	5 %	37245	4 %
Kidney or liver disease	5	4 %	44	2 %	17550	2 %
Long-term neurological problem	5	4 %	42	2 %	18090	2 %
I would prefer not to say	4	3 %	51	3 %	15176	2 %
Epilepsy	2	2 %	20	1 %	9504	1 %
Learning difficulty	2	2 %	23	1 %	7935	1 %
Alzheimer's disease or dementia	0	0%	11	1%	6197	1%
Blindness or severe visual impairment	1	1%	28	1%	11889	1%
None of these conditions	27	22 %	594	31 %	295035	34 %
	123		1947		866796	

Source: The GP Patient Survey¹⁶

Patients from the practice were also asked about their confidence in managing their own health and the majority of practice patients (89%) were very or fairly confident in managing their health which is slightly lower than in the CCG responses and England as

a whole. This reflects the view amongst practice patients who responded that more are lacking in confidence in managing their own health.

Table 3: Patient confidence in managing their own health

	Practice		West CCG		England	
Very confident	51	40 %	888	43 %	395904	43 %
Fairly confident	62	49 %	1002	49 %	464675	50 %
Not very confident	12	10 %	143	7 %	57784	6 %
Not at all confident	1	1 %	26	1 %	12450	1 %
	126		2059		930813	

Source: The GP Patient Survey¹⁷

Life Expectancy

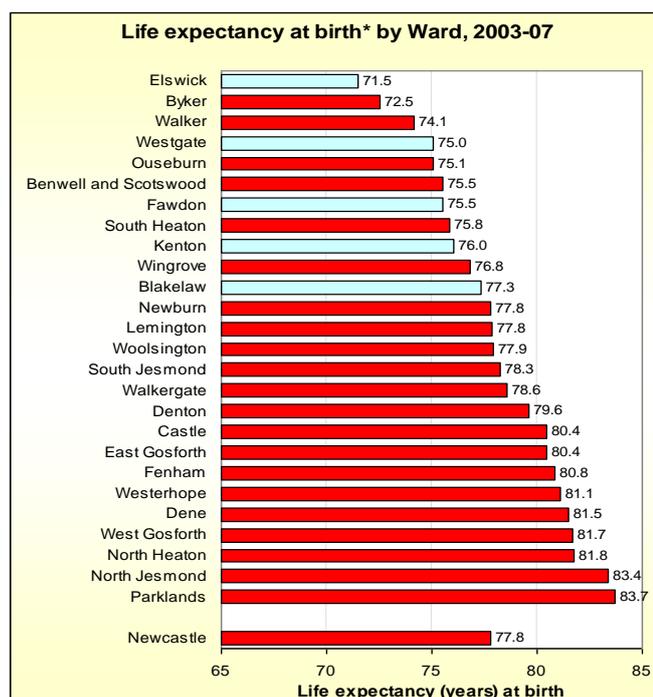
The link between deprivation and poor health has long been recognised; people living in areas with higher levels of deprivation tend to have poorer health and die younger than those living in more affluent areas. Life expectancy at birth¹⁸ is a measure of overall quality of life and where the practice surgeries are located reflects this. The life expectancy across the practice is lower than both Newcastle and England averages:

Table 4: Life expectancy at birth

	Cruddas Park ¹⁹	Newcastle	England
Women	78.9	81.2	82.9
Men	73.8	77.2	78.9

Source: Newcastle Health Profile 2013

Previous data suggests that over 77% of the patients registered with the practice live in the five wards of Westgate, Fawdon, Kenton, Blakelaw and Elswick. Life expectancy in all these areas is below the Newcastle average.



Mortality rates

Mortality rates are not routinely available for individual GP practice populations but are available for geographical areas such as wards and Lower Super Output Areas (SOAs).¹ The chart in Appendix 4 shows the mortality rate for all causes of death, for all 173 Lower SOAs in Newcastle between 2002 and 2006. Approximately 70% of the patients registered with Cruddas Park practice live in the areas highlighted in “red” on the chart. Whilst the mortality rates in the red areas are very variable, there is a concentration at the higher end of the spectrum.

Lifestyle and risk factors

The health of individuals and populations is associated with a variety of factors and many of the chronic health issues which affect people are linked to lifestyles yet there is limited, good quality data on the prevalence of health behaviours for alcohol use. Nevertheless, adults are defined as drinking to excess (‘binge’ drinkers) if they reported drinking 8 or more units of alcohol if they were a man, or 6 or more units of alcohol if they were a woman, on any one day or more in the last week.

For Cruddas Park practice, the estimated prevalence of drinking to excess varies significantly across the practice’s geographical area - in one area it is above the Newcastle average, in another it is below it. In two areas it is expected to be similar to the Newcastle average (see Appendix 1). The proportion of people who are estimated to drink to excess in Newcastle and the areas where the majority (72%) of the practice’s patients live are highlighted in green

Costs of Alcohol

Public Health England has estimated that for every 5,000 patients screened in primary care, it may prevent 67 Accident and Emergency (A&E) visits and 61 hospital admissions. In financial terms they have calculated that it cost of this is £25,000 with savings of £90,000. Similarly, for every 100 alcohol-dependent people treated can prevent 18 A&E visits and 22 hospital admissions. This highlights that alcohol screening in primary care can be cost effective.

In 2012/13, based on Hospital Episode Statistics for Newcastle upon Tyne Hospitals, admissions which were partially or wholly attributable to alcohol cost almost £16 million²⁰. When looking at this by GP practice population, this equates to a cost of £765,077 for Cruddas Park Practice.

5. Identification and Brief Advice (IBA) Pilot Proposal

Aim

To undertake a three month pilot of IBA in both Cruddas Park and Hills view Avenue surgeries with the aim of identifying patients who would receive alcohol screening and brief advice as part of their GP, Practice Nurse or Health Care Assistant (HCA) appointment. The intervention was to be piloted with an expectation that, if successful, the intervention could be rolled out across West CCG practices.

Objectives

The main objectives of the pilot were to:

- Evaluate the effectiveness of an adult alcohol care pathway
- Assess the practicality of implementing IBA into a busy GP practice
- Set up an electronic data template to capture patient outputs and outcomes for the pilot and any future roll out.

Methods

For the duration of the pilot, all new patients and patients from priority groups (see below), having a consultation at either of the two practices, to be asked about their current alcohol consumption via AUDIT-C. The priority groups identified were people from the following categories:

- NHS Health Checks
- Long Term Conditions (LTC)
- Sexual health/Family planning
- Mental health presentation
- Pregnant women
- Opportunistic screen

Staff was to be trained to use the AUDIT-C tool to make an initial assessment then to follow the Newcastle Adult Alcohol Pathway (see Appendix) which recommends:

- a) Offer AUDIT-C to all new patients or patients in a priority group
- b) If AUDIT-C taken,
 - score of 0-4: no further action
 - score of 5 or above: offer a full AUDIT
- c) If full AUDIT taken,
 - scores of 8-15: brief advice given in the practice by a trained health professional
 - scores of 16-19: patients signposted to other services and/or referred to tier 2 services (e.g. open access facilities and outreach that provide alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm)
 - scores of 20: clearly warrant further diagnostic evaluation, e.g. referral to specialist services for alcohol dependence

Data collection and analysis

In the project outline a wide range of process, output and outcome data were identified as being useful to collect and analyse. This included:

- baseline data around current practice, current AUDIT scores and onward referrals
- Output measures relating to AUDIT scores
- Outcome measures including reduction of AUDIT scores
- the role of training for staff
- staff knowledge, confidence and practice before and after the pilot

A full list of data identified in the proposal is included in Appendix 2.

Outcomes

It was identified that the evaluation of the pilot would assess two main outcomes, namely:

1. Patient output measures relating to AUDIT scores, including possible reductions
2. Staff attitudes, confidence and competence to delivering IBA across the alcohol care pathway

Outputs

In addition to the main outcome measures, the proposal identified that the evaluation should also assess a range of process issues:

1. patients AUDIT scores across the 7 priority groups
2. patients referred and attending structured treatment for alcohol issues
3. effectiveness of training for practice staff
4. agreed electronic template (pathway embedded in the local system)
5. a clear and effective care pathway for primary care

6. Results of Pilot

Key points

- ❖ 365 AUDIT-Cs undertaken
- ❖ 126 full AUDITs undertaken (35% of AUDIT-Cs)
- ❖ Of 126 full AUDITs, 64 were positive with a score of more than 8
- ❖ 5 patients were referred to specialist services
- ❖ Most IBA was undertaken by HCAs (61%) and practice nurses (36%)
- ❖ All staff felt the training was important and beneficial
- ❖ Time to do IBAs was an issue for some staff
- ❖ All practice staff surveyed considered it feasible to roll-out IBA into other practices

Data sources

The data on which this evaluation rests is drawn from a number of different sources in an attempt to fully explore the effectiveness of the introduction of a structured approach to addressing patient issues of alcohol use.

EMIS search

In August 2013, data was extracted from the Practice's EMIS record system on the basis of a number of search criteria including those patients having an AUDIT-C; patients who subsequently had a Full Audit; patients who had been referred to specialist services and patients who had received a 6 monthly review audit. Altogether, 365 records were identified and while this data is an extremely useful description of the pilot work it should be noted that the numbers involved are too small to make any statistical inferences from the data.

Baseline data

It was not possible to collect any baseline data on the use of any alcohol audit tools prior to the pilot. As part of the Direct Enhanced Service (DEA) in the practice, however, audits were undertaken on new patients. This data was not available for this evaluation but further evaluation could include this.

Prior to the audit, no audit score triggered any referral in its own right but it would have acted as an alert to getting new patients to see a doctor to discuss issues and options.

Manual audit

To obtain more detailed data, the records of all those patients identified in the database searches with a Full Audit score of more than 8 were manually audited for a number of outcomes and outputs, including:

- age
- gender
- audit scores

- alcohol consumption
- priority group
- use of leaflets
- process issues around the Audits
- health professional undertaking the Audits

This detailed analysis led to the identification of 7 patients who, through data entry errors, had been incorrectly assigned to the “more than 8” group rather than the “less than 8” group.

Questionnaires

Five practice health professionals (2 x GPs, 2 x HCAs and 1 Practice Nurse) from a total of 11, completed a questionnaire that also explored their knowledge of alcohol issues, their experience of doing IBAs and what would be required to roll out IBA across the CCG area.

One-to-One interviews

The two Health Care Assistants (HCAs) responsible for undertaking the majority of the assessments were interviewed individually to explore their views of undertaking IBA, including their knowledge of alcohol issues as well as the process issues of the intervention. These were tape-recorded and notes made of the main issues discussed.

Results: Electronic template

Prior to the start of the pilot, the practice incorporated AUDIT-C and AUDIT into a protocol that fitted with their electronic recording system, EMIS LV. The result of this was that when health professionals undertook an Audit, the patient’s score was entered and the system provided prompts to ensure that the right outcome - brief advice, extended IBA or specialist referral – was followed.

The general view from practice staff was that this system worked well. However, the practice no longer uses this patient record system as EMIS Web and System One are now used. This means that a similar protocol will need to be incorporated into their new systems.

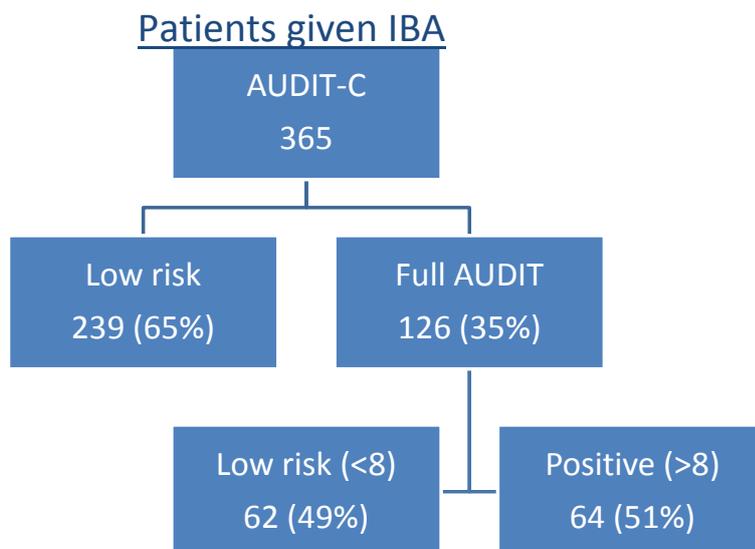
Recommendation

Protocols should be developed for practice electronic patient record systems to ensure that health professionals are prompted to the appropriate outcome once a patient’s score is entered.

Results: Patients receiving IBA

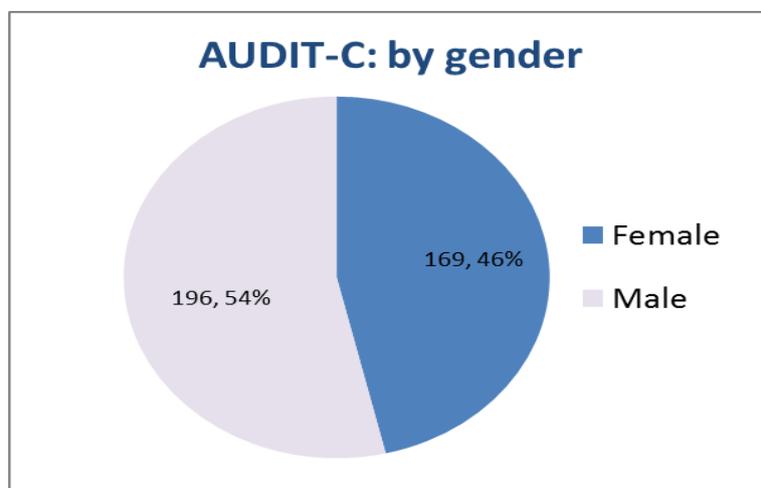
In the 13 week period between 1 November 2012 and 31 January 2013, 365 patients (3.8% of the practice population) were given brief advice around alcohol use. Of these, 126 (35%) scored 5 or more on the AUDIT-C so were assessed with the full AUDIT. This resulted in 71 people having a positive score of 8 or more. Those patients found to have a full AUDIT score of more than 8 equates to 18% of all the AUDIT-Cs and 51% of all the

full AUDITs. This would suggest that from the AUDIT-C the full audit was picking up a substantial number of patients with hazardous drinking. The full breakdown of results was:



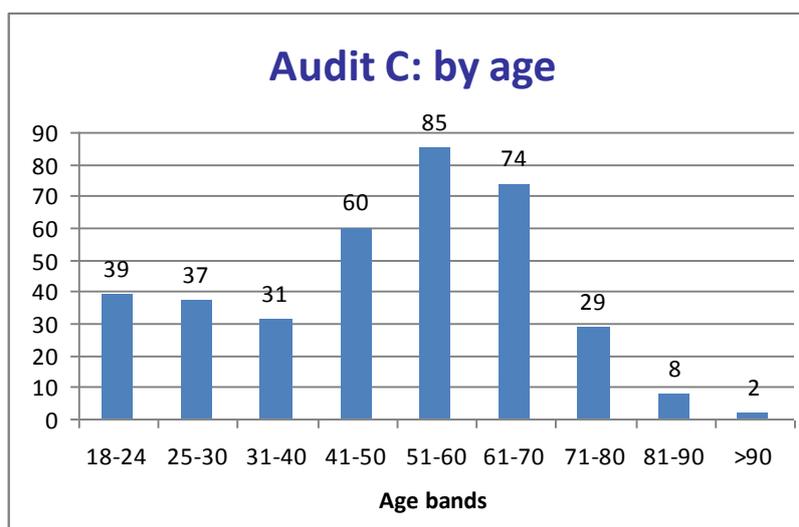
Results: AUDIT-C

365 patients across the two Cruddas Park practices were screened with the AUDIT-C tool. More men than women were assessed with 196 (54%) men compared to 169 (46%) women undertaking an AUDIT-C.



There was a considerable spread of ages across these patients (see chart below) – from 18 to 98 years of age – although over half, 60%, were aged between 41 and 70 years. In the younger age groups, those spanning 18-30 years accounted for over 20% of those screened; 11% in the 18-24 years category and 10% in the 25-30 years age group.

All ages were calculated as at the end of the pilot on 31.1.13 and the full age breakdown for age was as follows:



In terms of AUDIT-C scores, over two-thirds of all patients screened (248, 68%) were identified as low risk with a score of less than 5. However, 117 (32%) patients were assessed as having a score of 5 or more, placing them in the high risk category. The table below illustrates the AUDIT-C scores across each age band. It is worth noting that 9 cases originally categorised as being <5, on further investigation were >5 but <8, so accounting for the discrepancy between those identified as being <8 and >8 and the original AUDIT-C scores.

Table 5: AUDIT-C scores by age

Age range	<5		5+		total
	n	%	n	%	
18-24	33	13	6	5	39
25-30	24	10	13	10	37
31-40	21	8	10	8	31
41-50	35	14	25	20	60
51-60	51	21	34	27	85
61-70	47	19	27	21	74
71-80	20	8	9	7	29
81-90	6	2	2	2	8
>90	2	1	0	0	2
Total	239	100	126	100	365

Results: Full Audit

From the AUDIT-C, 126 (35%) patients accepted the offer to have a Full Audit. This resulted in 64 patients having a score of more than 8 and 62 patients having a score of less than 8.

In terms of the time patients had to wait between their initial consultation and IBA completed, only one of the 64 patients had to wait more than 28 days and 8 (12.5%) patients had to wait less than 16 days.

At the end of the pilot period there was limited data around the number of follow-up IBAs undertaken as it was too soon after the pilot. However, four patients were identified as

having a follow-up IBA and, of these, two had reported a reduction in weekly units consumed. This was reflected in no increases in the Full Audit scores in any of these patients, with reduced scores for three and a maintenance of their score in one patient.

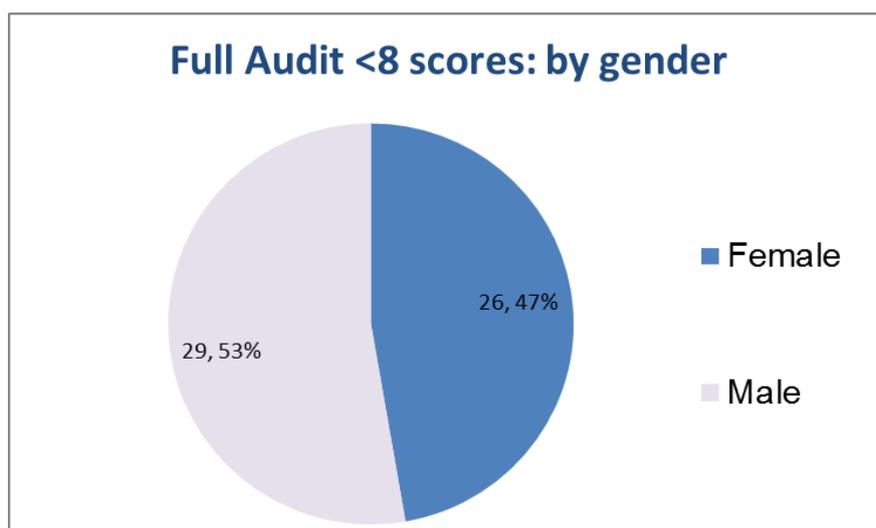
The table below provides a complete breakdown of the Full Audit scores:

Table 6: Full Audit scores

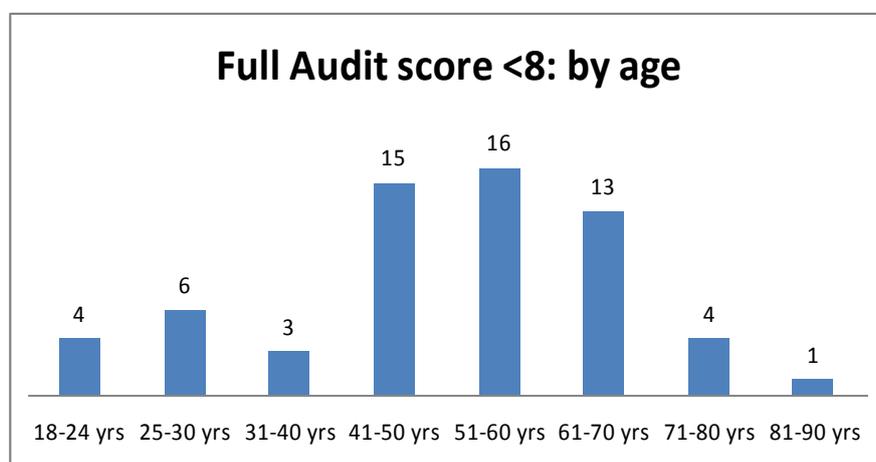
Score	<i>n</i>
1-7	62
8-15	60
16-19	1
20+	2
Not stated	1
Total	126

Scores<8:

62 patients were identified by the Full Audit as having a score of less than 8 but an AUDIT-C score of more than 5. The gender split is generally in proportion to the number of patients assessed by AUDIT-C with 53% male and 47% female (see chart below).



Similarly, the age spread of this group of patients is broadly comparable to the AUDIT-C group:



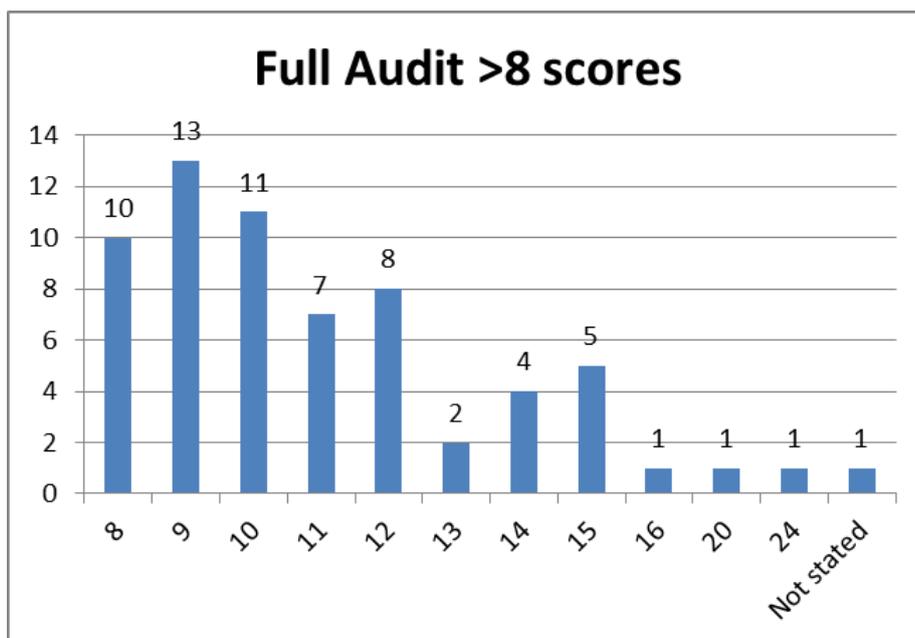
Although we have not considered this group of patients in detail, it is worth considering whether we can do more to provide general advice. Current guidance advises that their scores are recorded and they are offered a leaflet but no further action is taken in relation to brief advice. Given that this group comprises almost half (49%) of those taking a Full Audit it may be worth making some consideration about whether any other intervention should be provided for this group of patients around alcohol use as a part of a wider preventative approach.

Recommendation

Consideration should be made about what intervention, if any, is offered to patients who score 5+ on AUDIT-C but who have a score of <8 in the Full Audit.

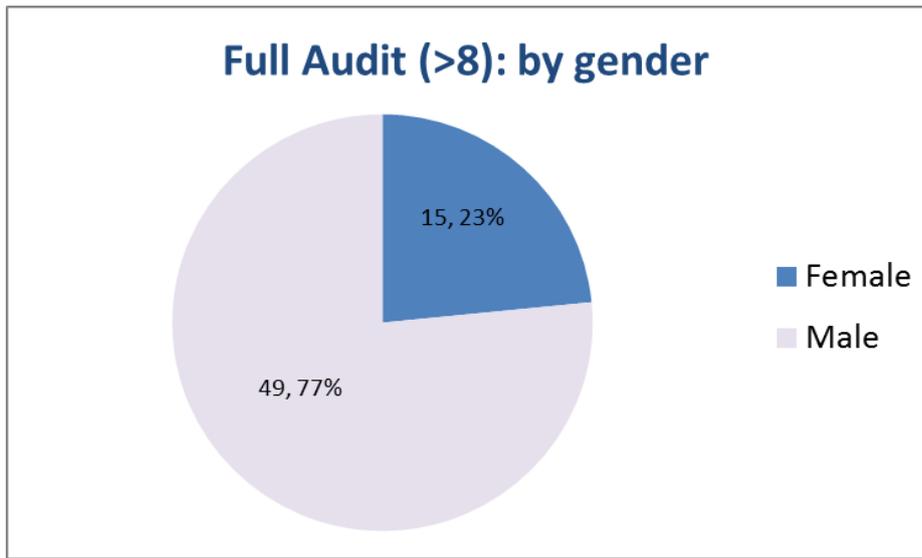
Scores>8:

From the Full Audit, 63 patients had a score of 8 or more and their scores ranged between 8 and 24 with a median score of 10. The vast majority of patients, 60 (94%), had a score of 8-15, precisely the group of patients that are most likely to benefit most from brief advice. The full spread of scores is shown below:

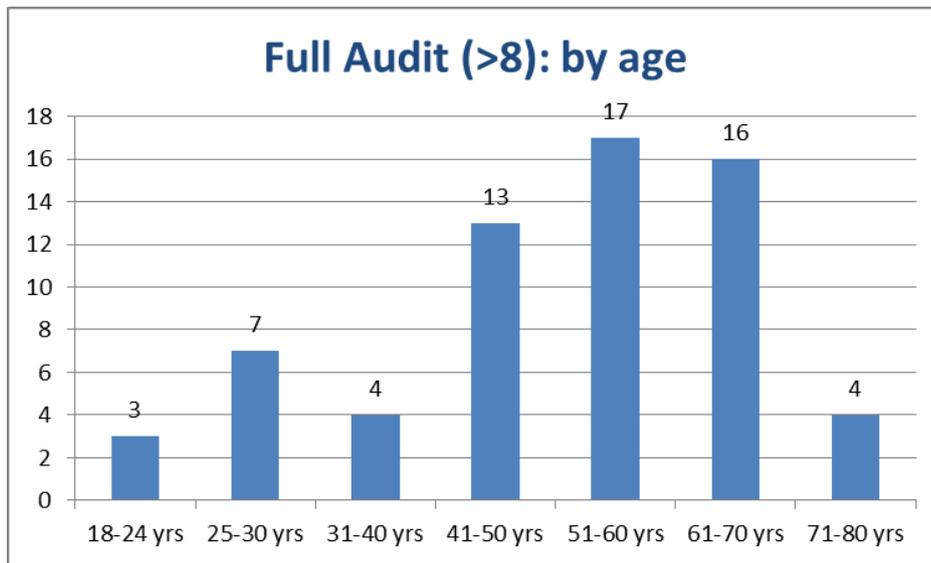


Gender and Age

Interestingly, although the gender split for patients being assessed by AUDIT-C were generally balanced (46% female to 54% male), less than a quarter (23%) of those patients receiving a full audit was female. This could be due merely to the small numbers involved in the pilot or could be a reflection of a possible wider difference in alcohol behaviour between men and women.

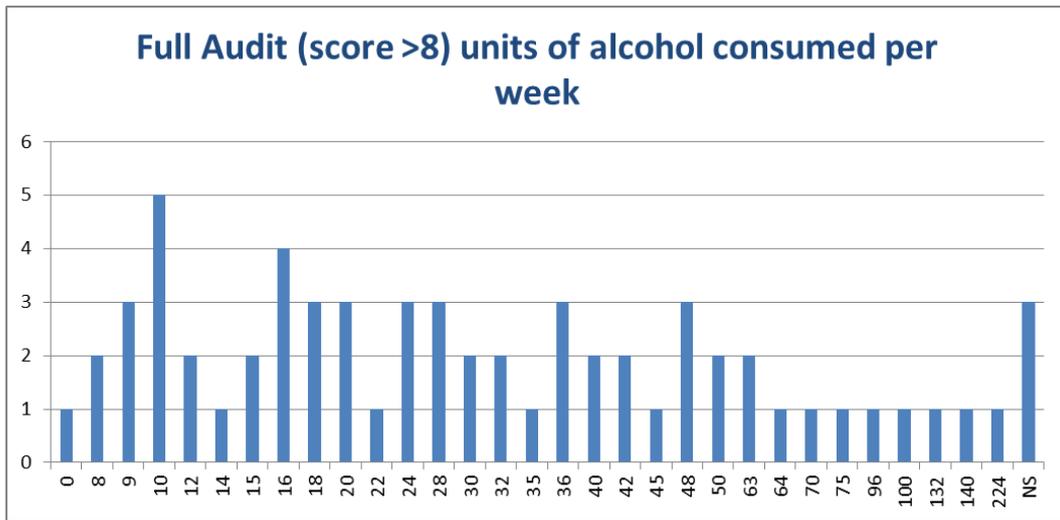


As would be expected, mirroring the AUDIT-C results, the majority of those patients identified for the full audit were aged between 41-70 years (72%) which supports published evidence around the demographics of those most likely to be hazardous drinkers.



Alcohol consumption

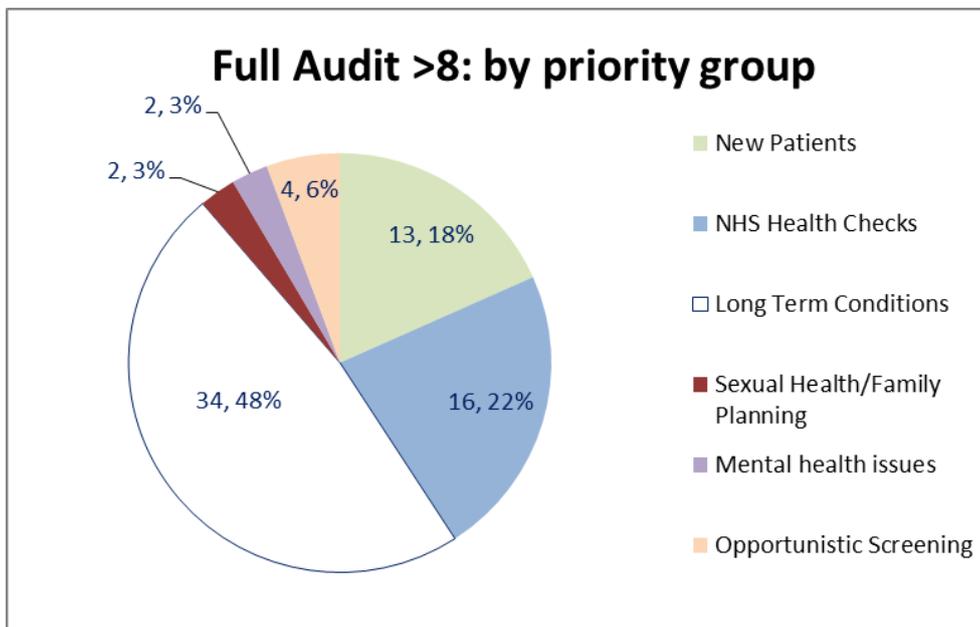
In terms of the weekly alcohol consumption of this group of patients, it varied enormously from 0 to 224 units a week and included 4 patients who stated they drank 100 or more units a week. Excluding the two outliers of 0 and 224, the mean weekly consumption was 33 units a week. The full breakdown for alcohol consumption was:



Priority Groups

Almost half, 34 patients (48%), of all Full Audit scores >8 came from patients with long-term conditions as part of their regular six monthly check. We did not explore the breakdown of these long term conditions but it is significant that many of those identified as having hazardous drinking also had a long-term condition.

NHS Health Checks, which is targeted at those patients aged between 40 and 74 years of age, was another priority group from which patients had a Full Audit score of >8. Over a fifth (22%) came into this category, suggesting that doing IBA as part of the NHS Health Check could be a useful approach. More surprisingly, only 2 patients in the full audit were identified as having mental health issues, given that evidence would suggest that alcohol problems are more common among people with more severe mental health issues.



Recommendation

All new patient reviews, long term condition reviews and NHS Health Checks should incorporate IBA.

Results: Signposting and referral

Leaflets

Guidance suggests that patients who have Full Audit scores between 16-19 should be signposted to other services and/or referred to tier 2 services. In the Full Audit, 36 (56%) of patients accepted a leaflet. From the questionnaires, three staff felt the leaflets were useful; one person stated that they took the view that they handed them out but it was up to a patient if they read it.

Signposting

Staff were also asked whether they were able to signpost patients. Most staff indicated they were able to do this but one staff member felt that they were limited in options or pathways. They made the point that not every audit risk outcome has the associated appropriate service to signpost to, e.g. extended IBA. This suggests that further work around increasing the knowledge about local services to which patients could be signposted, would support staff in the practice.

Referral to specialist services

Largely due to the short timescale of the pilot, only seven patients were identified as being referred into specialist services and, on further investigation two were coded incorrectly so leaving five patients – 4 males and 1 female - who were referred to tier 3 services. All five patients were aged between 34 and 55 years and had an average Full Audit score of 28 out of 40 (range was 24-37). Of these five patients, 2 people failed to make appointments for assessment and were subsequently discharged. Of the 3 people seen all 3 cases were alcohol dependent with complex social and health issues; in all 3 cases engagement was poor. All had audit scores over 27.

Staff were asked their views about specialist services and their ability to refer patients to these services. Four of the respondents said they were able to refer to specialist services but one staff member indicated there was no proforma to use for this purpose, *“despite repeated promises”*. Another staff member said they usually referred to Plummer Court and this was echoed by one of the HCAs in a in-depth interview,

“I’ve offered support and a referral to Plummer Court but everyone said no.”

One of the staff interviewed explained a possible perception from clients in explaining,

“One man said he would not go to Plummer Court they are nasty, they are horrible and I would never go back, he said I am still an alcoholic and I will never go back”.

Recommendation

A proforma for referral to specialist services should be available for staff in primary care.

Results: Staff involvement

During the period of the pilot, 9 out of 11 health care professionals in the practice undertook IBA to patients from the following professions:

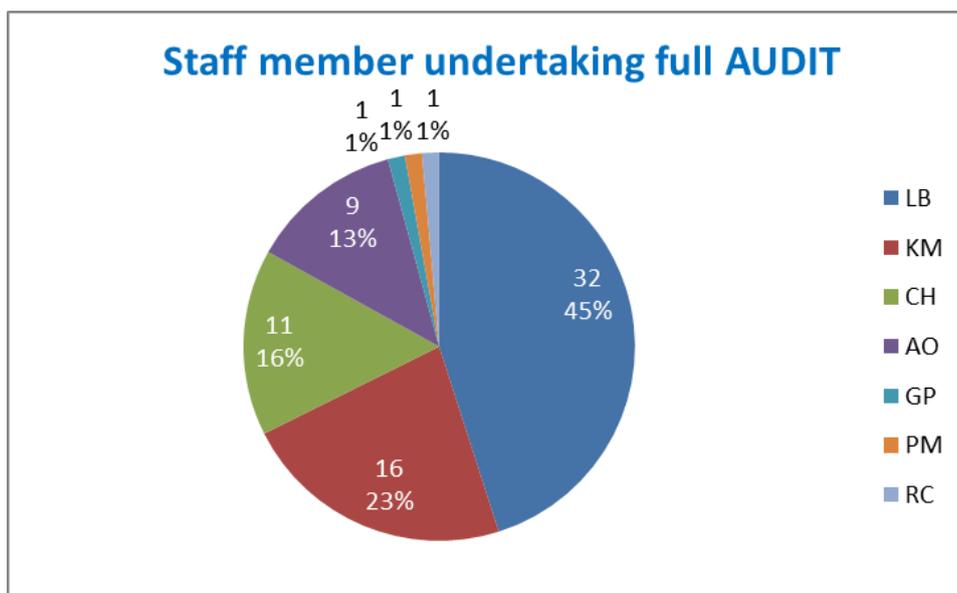
- 2 health care assistants
- 2 practice nurses
- 5 GPs

Data is not available for the staff breakdown of AUDIT-Cs undertaken but in relation to staff members undertaking the Full Audit, almost two-thirds (61%) were undertaken by HCAs (LB & CH); practice nurses (KM & AO) did 36% and GPs accounted for 3%.

HCAs in the practice are the most likely practice staff member to undertake patient reviews, e.g. new patient appointments, long term condition reviews and NHS Health Checks, so it is expected that these staff would see the majority of patients. Nevertheless, despite five GPs having been trained in IBA, they only undertook Full Audits with 3 (3%) patients. A possible explanation, outlined below, is the time factor in undertaking a Full Audit, which is likely to impact disproportionately on GPs.

All those who responded to the questionnaire had been undertaking IBA for more than six months with four out of five undertaking them for more than a year.

The breakdown for staff undertaking Full Audits is as follows:



Results: Staff views

Important health issues

In the questionnaire, practice staff were asked to rank four behaviours – exercising regularly, staying within recommended alcohol limits, eating a healthy diet and not smoking - in terms of promoting the health of their patients. As might be expected, the majority (4/5) ranked “not smoking” as the best way to promote their patients’ health with “staying within recommended alcohol limits” as their second ranking. The fifth person ranked alcohol above smoking and in all cases exercise and a healthy diet were ranked lower.

This would suggest that all staff who returned the questionnaire were very aware of the health consequences of alcohol.

Importance of IBA

All five staff surveyed indicated that it was very important that IBA was offered in the practice. Their reasons to support this included,

“Some patients aren't aware that they are hazardous drinkers until it is brought to their attention. These are a particular target of mine as usually it shocks them into cutting down on unit intake.”

“a major public health, personal health, family & community health issue”

“One guy had a health check and his cholesterol was up, he was drinking most days, now he has cut out drinking through the week. I told him his attitude was great. He had never thought about it until he came to the GP, he is sleeping better, he feels better. He thanked me and it made me feel good.”

All five respondents also considered that IBA should be part of a lifestyle review but there was no consensus around who should undertake the IBA; two staff identified HCAs as best placed to do them while two people felt that everyone should do them.

However, most staff who responded (4/5) identified some limitations of undertaking IBAs were identified. These included time constraints and the issue of patients with complicated problems presenting with a number of issues. One staff member commented,

“Sometimes it can become repetitive for the patient particularly during chronic disease management.”

All five staff took the view that it was feasible to incorporate brief interventions into routine clinical practice and that the practice should continue doing brief interventions.

Recommendation

IBA should continue in the practice and be incorporated into routine clinical practice.

Difficult Conversations

Four out five staff who responded to the questionnaire indicated that they did feel comfortable raising the issue of alcohol with patients. One member of staff felt slightly uncomfortable in the context of some patients who try to hide their alcoholism and may be in denial. This staff member also raised the issue of patients who do not drink, in that they can find the initial questions about alcohol offensive.

In the in-depth interviews, the HCAs said that prior to undertaking the training, the only time patients were asked about their alcohol consumption was when they registered with the practice,

“Only time we would talk about alcohol with the patients was when they joined the practice. How much they drink and how many units - that's the only time we talked about it”

One of the HCAs also identified that before the IBA training she felt apprehensive about asking patients about their alcohol intake *“in case people think I am delving into things”*.

As they became more familiar with using the IBA tools, they felt more comfortable with asking patients questions about their alcohol consumption.

Time to conduct IBAs

Time to undertake IBAs was an issue for some of those surveyed. Three staff members, all nursing and HCA staff who had undertaken the bulk of the assessments, felt there was insufficient time to do IBAs. One person commented,

“It [alcohol] can become the main issue of the consultation and side-track from the original reason the patient attended”

Another staff member when interviewed explained,

“Sometimes the timing is an issue, for people who screen mid way it’s not too bad, but if people score high you need to spend more time with them. It takes a double appointment – about 20 minutes. Or I add it into an annual check it takes an extra five minutes. It’s hard to judge how long it will take until you ask the questions. You definitely need longer – especially if they need to discuss the issues more, you don’t want to hurry people if they are listening.”

The alternative view was put forward by the GP respondents who acknowledged that it varied day by day but that once familiar with the audit tools, there was sufficient time. Nevertheless, it could be the case that as GPs did very few IBAs in the pilot, that their view is based on a limited number of IBA consultations.

Recommendation

Consideration should be made about the extra time required to incorporate IBA into routine clinical practice.

Results: Training

Research has suggested²¹ that healthcare professionals seem to have a generally negative attitude towards people with alcohol-use disorders, but this perception may be improved with education and training.

Prior to the pilot, all staff participating in the pilot received training to ensure a consistent approach in undertaking the IBA. This training provided an understanding of the AUDIT tools and the agreed referral pathway and comprised:

- One half day, whole team training session
- 4 hour Brief Interventions course (level 3) which covered:
 - all aspects of the IBA strategy
 - IBA observations
 - exercises to identify triggers, cycle of change activity and screening practice

All practice staff attended the whole team session and 9 staff in total (5 GPs, 2 HCAs and 2 practice nurses) received the four hour Brief Intervention course. It may be most cost-effective that full training should be concentrated on key staff in practices, namely those staff that undertake regular appointments with patients. As one HCA said in her interview,

“Everyone should have training (in IBA) – it’s the most important thing”

Recommendation

Consideration should be made about whether all staff, or key staff, should receive full IBA training.

Knowledge of alcohol issues

From the five questionnaires, no staff considered that they had a great deal of experience of alcohol issues prior to the training. One felt they had no experience while two each felt that they had little or moderate experience. Comparing this with their perception of their current knowledge - one considered they now knew slightly more; three felt they knew moderately more and one said they felt they knew extensively more than prior to the training.

In the in-depth interviews, both HCAs identified that their knowledge of alcohol issues was greater after the training and the overwhelming view was that the training was essential both for the knowledge gained and in providing staff with the confidence to support IBA. As one HCA explained,

“I think I thought more about how alcohol affected your liver, not your brain as well”

Both HCAs also identified the usefulness of the training, in particular:

“I was apprehensive before the training”

It really did help me to be aware of it”

“Once you do training obviously you’re more aware of the effects” (of alcohol)

This suggests that the training had a positive impact on all staff who attended.

Use of AUDIT tools

All staff completing the questionnaire considered the audit tools easy to use; all five staff members indicated that the Full Audit, especially, was easy to use. This was emphasised by the HCAs who said that, following the training, they found the audit tools straightforward to use.

In the interviews with the HCAs, the issue was raised about confusion between drinks and units. She explained that in the new patients’ consultation the question is framed in terms of drinks whereas the audit tools uses units so initially she had to keep checking on the amount of units in a particular drink and remember that she was talking about units rather than drinks.

Recommendations

Develop a consistent approach between the new patients’ consultation and the IBA consultation, e.g. using units as the agreed measure.

Results: Roll-out of pilot

Four practice staff considered that it was feasible to incorporate brief intervention into routine clinical practice and a number of suggestions were provided to support it's wider roll-out. The main emphasis was on a need for commitment from the practice as it was suggested that this was the case in this practice and that is why it has worked. As one staff member stated,

"It needs to be embedded and part of the routine."

Another suggestion given to promote the roll-out of IBA across other practices was that IBA should added to all chronic disease management templates instead of separate templates.

Recommendations

IBA should be added to all chronic disease management templates.

7. Recommendations

In this evaluation a number of recommendations have been suggested in the light of responses from practice staff involved in the pilot. These are listed below.

Recommendation

Protocols should be developed for practice electronic patient record systems to ensure that health professionals are prompted to the appropriate outcome once a patient's score is entered.

Recommendation

Consideration should be made about what intervention, if any, is offered to patients who score 5+ on AUDIT-C but who have a score of <8 in the Full Audit.

Recommendation

All new patient reviews, long term condition reviews and NHS Health Checks should incorporate IBA.

Recommendation

A proforma for referral to specialist services should be available for staff in primary care.

Recommendation

IBA should continue in the practice and be incorporated into routine clinical practice.

Recommendation

Consideration should be made about the extra time required to incorporate IBA into routine clinical practice.

Recommendation

Consideration should be made about whether all staff, or key staff, should receive full IBA training.

Recommendations

Develop a consistent approach between the new patients' consultation and the IBA consultation, e.g. using units as the agreed measure.

Recommendations

IBA should be added to all chronic disease management templates.

References

¹Funk M, Wutzke S, Kaner E, Anderson P, Pas L, McCormick R, et al. A multicountry controlled trial of strategies to promote dissemination and implementation of brief alcohol intervention in primary health care: findings of a World Health Organization collaborative study. J Stud Alcohol 2005; 66:379-88.

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⁷ NICE (2014) Alcohol-use disorders: preventing harmful drinking: Evidence Update, March 2014

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⁹ Babor, T.F. and Biggins-Hiddle, J.C. (2001) Brief interventions for hazardous and harmful drinking: A manual for use in primary care, Department of Mental Health & Substance misuse, World Health Organisation: Geneva.

¹⁰Ballesteros, J., Duffy, J. C., Querejeta, I., Arino, J. & Gonzalez-Pinto, A. (2004). Efficacy of brief interventions for hazardous drinkers in primary care|: systematic review and meta-analysis. Alcoholism: Clinical & Experimental Research, 28, 608-618.

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¹²Bertholet, N., Daepfen, J.-B., Wietlisbach, V., Fleming, M. & Burnand, B. (2005). Brief alcohol intervention in primary care: systematic review and meta-analysis. Archives of Internal Medicine, 165, 986-995.

¹³Babor, T.F. and Biggins-Hiddle, J.C. (2001) Brief interventions for hazardous and harmful drinking: A manual for use in primary care, Department of Mental Health & Substance misuse, World Health Organisation: Geneva.

¹⁴ The Index is a widely used and well researched index that is based on the premise that deprivation is made up of multiple dimensions or 'domains' which reflect different aspects of deprivation - Income deprivation, Employment deprivation, Health deprivation and disability, Education, Skills and Training deprivation, Barriers to housing and services, Living environment deprivation, and Crime. The Index has been produced at Lower Super Output Area level, of which there are 32,482 in the country and 173 in Newcastle.

<http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/>

¹⁵ The GP Patient Survey (2013) <http://practicetool.gp-patient.co.uk/Ccg/Search?id2=CRUDDAS%20PARK%20SURGERY%20%7C%20NE4%207JT&index=0>

¹⁶<http://practicetool.gp-patient.co.uk/Ccg/Search?id2=CRUDDAS%20PARK%20SURGERY%20%7C%20NE4%207JT&index=1>

¹⁷<http://practicetool.gp-patient.co.uk/Ccg/Search?id2=CRUDDAS%20PARK%20SURGERY%20%7C%20NE4%207JT&index=1>

¹⁸ Life expectancy at birth can be interpreted as the number of years a baby born in a particular area in a particular time period could be expected to live if it experienced the mortality rates in that area and time period throughout its life.

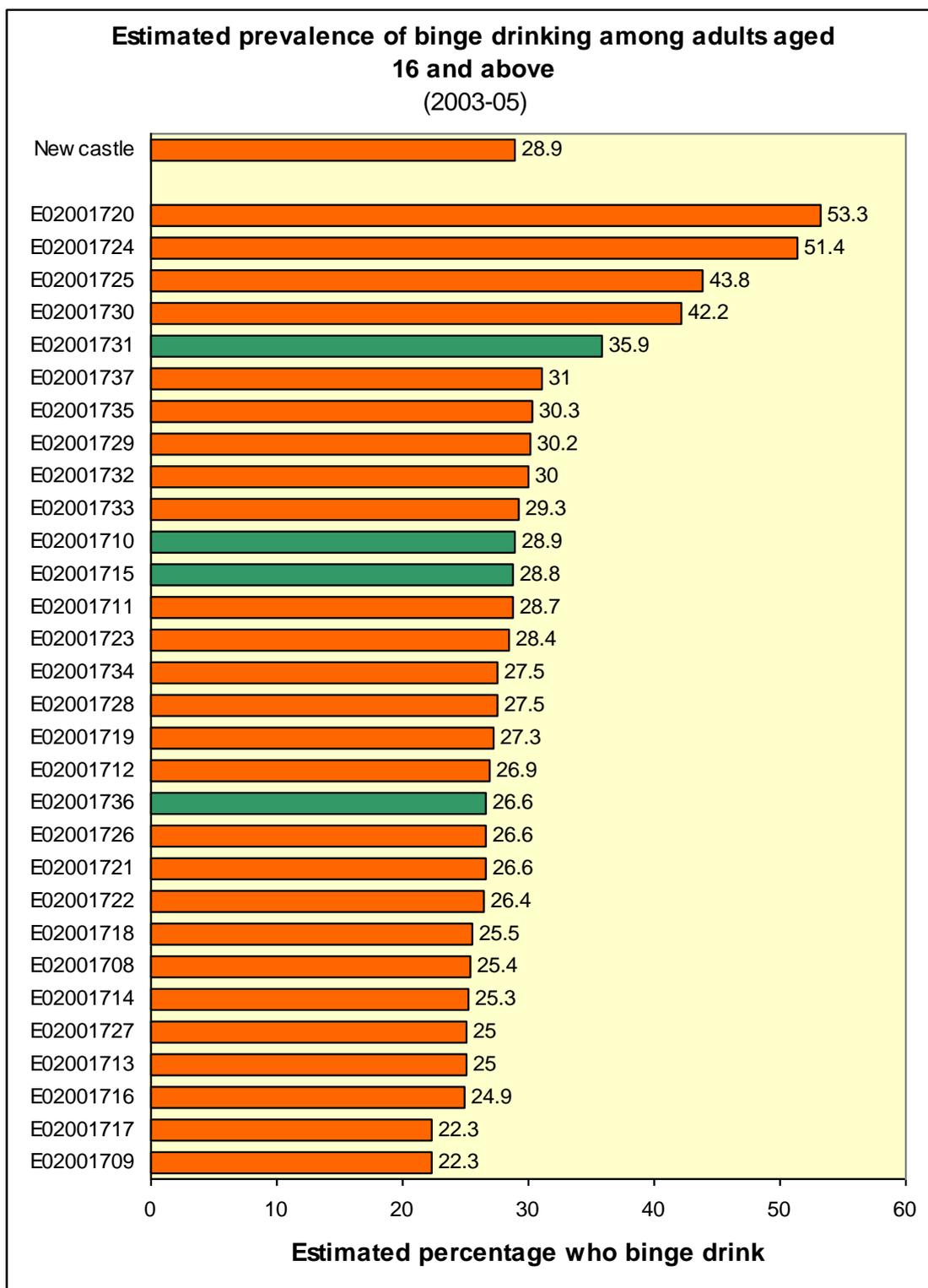
¹⁹ National General Practice Profiles (2013) <http://fingertips.phe.org.uk/profile/general-practice/data#mod,2,pyr,2013,pat,19,par,00H,are,A86017,sid1,2000005,ind1,639-4,sid2,-,ind2,->

²⁰The admissions included in this dataset have been taken from Department of Health Hospital Episode Statistics (HES) data. The cost of alcohol related hospital admissions have been aggregated into broad age and gender groups for wholly attributable and partially attributable conditions based on the patient registered GP practice. Using a national average tariff for each of the 47 alcohol attributable conditions a cost has been assigned to each admission which is then multiplied by the corresponding alcohol attributable fraction to provide an estimate of the cost of the admission.

²¹ van Boekel LC, Brouwers EPM, van Weeghel J et al. (2013) Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. Drug and Alcohol Dependence 131: 23–35

APPENDIX 1: Estimated Prevalence of binge drinking, Newcastle

The Office for National Statistics (ONS) produces model-based prevalence estimates for Middle Layer Super Output Areas that take into account the social and demographic characteristics of the population. These estimates must be used with caution, as they are relatively imprecise and do not represent the actual prevalence for the area in question, but provide an indication of the likely prevalence in the area.

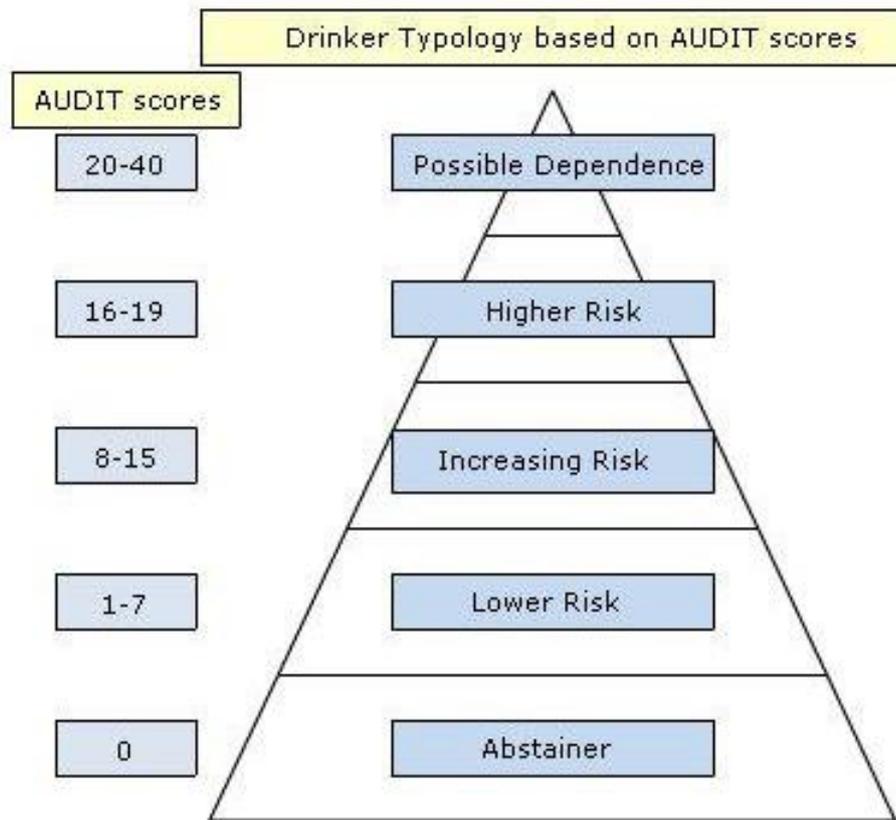


APPENDIX 2: Alcohol Use Disorders Identification Test (AUDIT) and AUDIT-C tools

AUDIT- C Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	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 :						<input type="text"/>

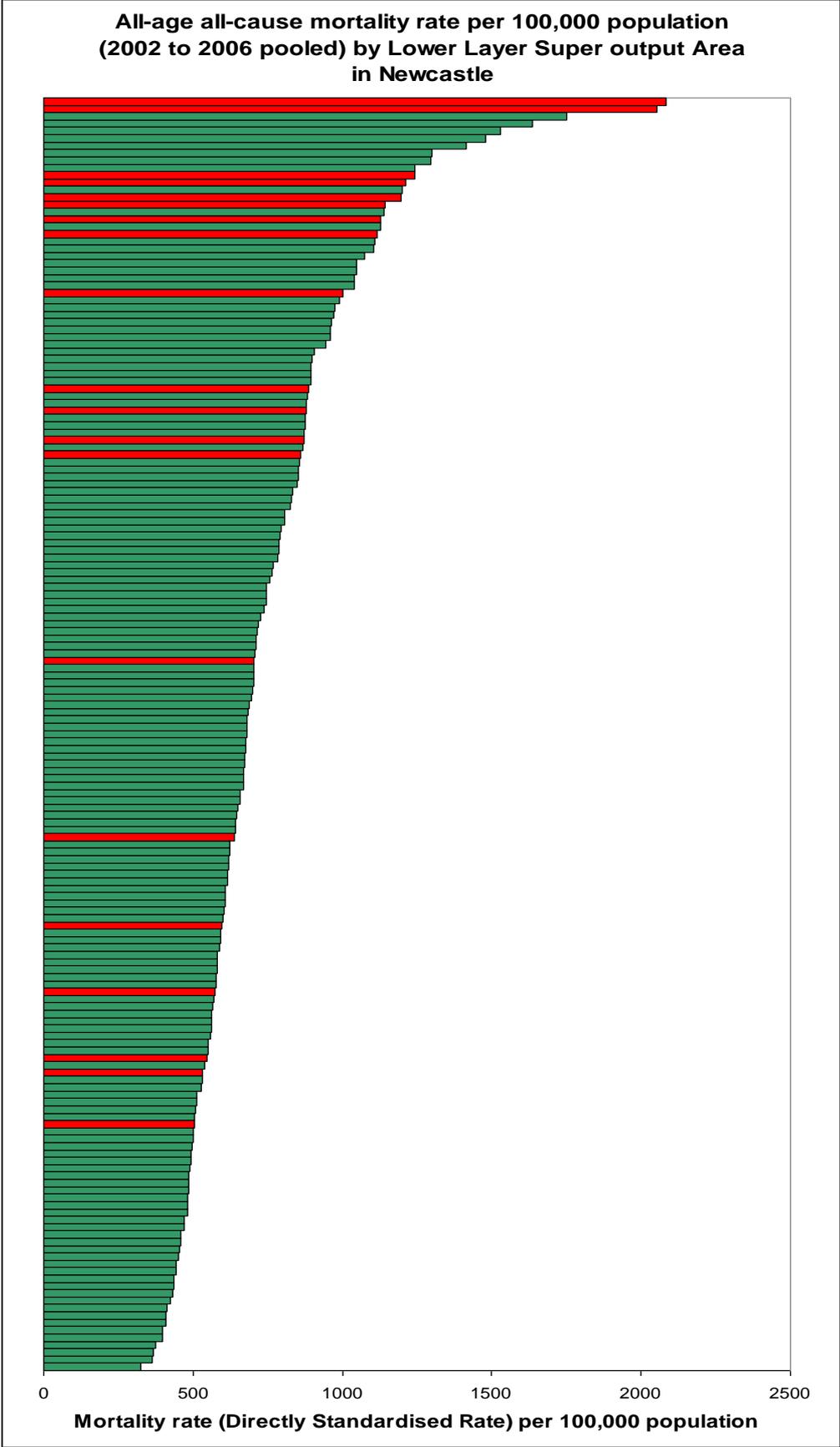
AUDIT Questions (after completing 3 AUDIT-C questions above)	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
TOTAL						<input type="text"/>

APPENDIX 3: Drinker typology based on AUDIT scores



Source: WHO Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care

APPENDIX 4: Newcastle all-age all-cause mortality by lower layer SOA



APPENDIX 5: PILOT PROPOSAL MEASURES

Baseline data collection	Provide a current assessment of practice operating in Cruddas Park
Pre questionnaires	To assess staffs: <ul style="list-style-type: none"> • <u>Current practice</u> delivering messages about alcohol • <u>Confidence</u> in completing alcohol screening and brief advice with patients • Perceived level of <u>importance</u> regarding alcohol as a priority topic • <u>Knowledge</u> of alcohol • <u>Confidence</u> to refer patients to appropriate services
Training	<ul style="list-style-type: none"> • Alcohol awareness • Using the AUDIT tool • Holding a structured brief conversation with a patient about alcohol • Future state pathway shared • Safeguarding issues • Data template • Use of standard health promotion literature
Post questionnaires	To assess staffs: <ul style="list-style-type: none"> • <u>Current practice</u> delivering messages about alcohol • <u>Confidence</u> in completing alcohol screening and brief advice with patients • Perceived level of <u>importance</u> regarding alcohol as a priority topic • <u>Knowledge</u> of alcohol • <u>Confidence</u> to refer patients to appropriate services • Feedback on electronic data capture template • Feedback on integrating alcohol screening and brief advice <u>into practice</u> • Feedback on <u>target audience</u>
Output measures	<ul style="list-style-type: none"> • Baseline measures <ul style="list-style-type: none"> - Number of current patients with an AUDIT score - Number of current patients scoring 8+ on AUDIT receiving an appropriate intervention - Proportion of practice staff completing training • An agreed electronic data template • AUDIT scores of patients from 7 priority groups • Proportion of patients scoring 8 – 15 on AUDIT receiving brief advice • Proportion of patients scoring 16 – 19 on AUDIT being signposted/referred to tier two service • Proportion of patients scoring 20+ being referred to tier three service • Proportion of patients returning for 4 week review appointment • Proportion of patients with second AUDIT score • A finalised adult alcohol care pathway for primary care to be promoted across West CCG
Primary outcome measures	<ul style="list-style-type: none"> • Number of patients with a reduced AUDIT score following intervention • Number of patients referred and attending structured treatment for alcohol