HEAT Standard: Alcohol Brief Interventions

National Guidance: 2014-15

Purpose

This note sets out national guidance for the Alcohol Brief Interventions (ABI) HEAT standard for 2014-15. It is anticipated that 2014-15 will be the final year of the HEAT standard. NHS Boards and ADPs should use this year 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. This supplements the LDP Guidance, provided to NHS Boards, for all HEAT targets and standards in 2014-15.

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 NHSScotland, as well as developing the evidence base. The delivery of ABIs remains a key priority for 2014-15.

The 2014-15 HEAT standard will support 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. In addition, the standard will build on the ABI HEAT target and support implementation of the Quality Alcohol and Treatment Support (QATS) report recommendation, that NHS Boards and their ADP partners should continue to embed and sustain delivery of ABIs as a key early intervention which should form part of any local ADP strategy to reduce alcohol misuse and related harm.

Standard definitions

The ABI HEAT standard for 2014-15 states that:

*NHS Boards and their Alcohol and Drug Partnership (ADP) partners will sustain and embed alcohol brief interventions (ABI) in the three priority settings (primary care, A&E, antenatal), in accordance with the SIGN74 Guideline. In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.*

NHS Boards and their ADP partners should maintain the same total level of delivery of ABIs under the ABI HEAT standard in 2014-15 as under the HEAT standard for 2013-14 (i.e. 61,081 ABIs nationally). It is expected that at least 90% of delivery (i.e. a minimum of 54,973 ABIs) will continue to be in the priority settings. The remainder can be delivered in wider settings in accordance with this guidance.
A brief intervention

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 A. 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 intervention. Delivery should be evidence-informed and while the evidence base for the three priority settings is outlined in the SIGN74 Guideline, there is a need to develop the evidence base for wider settings.

Evidence Reviews

Knowledge and evidence on delivering ABIs in wider settings has continued to be gathered and NHS Health Scotland has commissioned an evaluation project which is to contribute to this. The project will assess the feasibility and acceptability of ABIs being delivered in two wider settings (young people and social work) using mixed methods and is planned to report in February 2014. Health Scotland evidence briefings on ABI delivery in wider settings are already available for dentistry and community pharmacy and a briefing is forthcoming on young people. Of note also is a recent evidence review of Computer Based Alcohol Interventions [www.healthscotland.com/uploads/documents/18603-ComputerBasedAlcoholInterventions.pdf]. A final briefing on sexual health will be published in 2014.

Management and delivery of ABIs at local level

Taking into account the findings from the ABI national evaluation ‘An evaluation to assess the implementation of NHS delivered Alcohol Brief Intervention’, [http://www.healthscotland.com/documents/5438.aspx] the evidence papers produced for ABI delivery in various settings, the scoping exercise undertaken of ABIs in non-HEAT settings, the evaluation of the national ABI training programme and building on the nationally funded ABI pilots, Scottish Government and NHS Health Scotland have developed a ‘checklist of good practice requirements’ to ensure appropriate delivery of ABIs in practice.

This outlines what should be considered when planning, delivering and evaluating ABIs in order to develop and strengthen the evidence base. It is therefore applicable to all ABI delivery. Any ABIs delivered outwith 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.
This ‘checklist of requirements’ is contained in Annex B and provides details of the three stages for consideration, namely Planning the service, Implementing the service and Monitoring/evaluating the service. Questions include:

- Who are you aiming to reach?
- What outcomes are you hoping to achieve through the delivery of ABIs?
- Who/which staff groups will deliver the intervention and what are their training needs?
- What other organisations, agencies or groups will be involved in helping you to achieve these outcomes?
- What are you aiming to do to help you achieve these outcomes?
- How will you know who has been reached by the intervention and with what impact?

Appropriate ABI delivery fully supports the Healthcare Quality Strategy in that ABIs are evidence-based, proven to be clinically effective in reducing alcohol consumption, and delivered in a person-centred way following individual consent for their delivery.

**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 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.

**Primary Care**

Interventions delivered by doctors and nurses in the general practice setting. Interventions associated with health promotion checks (such as Keep Well) conducted outwith 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.

**A&E Care**

Interventions delivered by doctors and nurses as part of a patient’s care initiated in an 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.

Recent ABI Leads network events (27th August and 4th December 2013) have 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 C 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 embedding, Leads and relevant acute setting colleagues may wish to consider self-sustaining these approaches informally in the future.
It is recognised that ABIs can be delivered in acute settings other than A&E, which would constitute part of the wider settings outlined below. Health Boards are encouraged to consider how the scope of the Health Promoting Health Service (HPHS) Revised CEL [issued in January 2012: http://www.sehd.scot.nhs.uk/mels/CEL2012_01.pdf] fits with local arrangements, taking into account the Annual Report Summary Briefing for Year 1 [CEL (1) 2012 Action 18.2 published September 2013: http://www.healthscotland.com/uploads/documents/22106-BpAlcohol.pdf]

Antenatal Care

Antenatal care 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 based on in-pregnancy alcohol consumption will be considered as part of the standard.

Wider settings

NHS Boards and their ADP partners are encouraged to appropriately evaluate ABI delivery, in order to develop the evidence base within the Scottish context through this HEAT standard.

ABIs delivered outwith the priority settings, by any professional, will constitute wider setting delivery. Any delivery in the priority settings by a trained 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 the research has not been undertaken.

ADPs have been increasingly ‘owning’ ABI delivery and innovating new routes of delivery. This is evident from the findings from the Scoping exercise to ascertain the current and planned range of settings for Alcohol Brief Intervention delivery in non-HEAT settings by NHS Health Scotland (November 2011) [http://www.healthscotland.com/documents/5603.aspx]. This is supported, with the HEAT standard making allowance for the remainder of ABIs (above the expected 90% in the priority settings) to be delivered in wider settings in accordance with this guidance.

For those delivering in non-NHS settings, consideration should be given to the presentations outlined in the SIGN74 Guideline [http://www.sign.ac.uk/guidelines/fulltext/74/annex2.html], notably the social and psychiatric presentations.

The NICE Public Health (PH) Guideline 24 Alcohol use disorders - preventing harmful drinking (June 2010) [http://www.nice.org.uk/PH24] 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. 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 B** 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.

**Annex D** outlines the recommendations of this NICE Public Health (PH) Guideline 24 *Alcohol use disorders - preventing harmful drinking* (June 2010) [http://www.nice.org.uk/PH24](http://www.nice.org.uk/PH24) which may be considered by NHS Boards and their ADP partners for ABI delivery in wider settings.

**Repeat Delivery**

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 levels, then a repeat ABI would be appropriate. These ‘repeat’ ABIs can be considered 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 year.

**Who**

As outlined above, delivery in the priority settings should be undertaken by doctors, nurses and midwives.

Any ABIs delivered outwith the priority settings, by any trained professional, following the SIGN74 Guideline approach, will constitute wider setting delivery. Any delivery in the priority settings by a trained professional other than doctors, nurses and midwives will also be considered as wider setting delivery. Details of how to report this delivery are contained in the mandatory data reporting requirements section.
Training

The SIGN74 Guideline highlights that ‘training is required in order to deliver effective brief interventions’. Full guidance on competencies required to deliver ABIs are outlined in the *Delivery of Alcohol Brief Interventions Competency Framework* available on the NHS Health Scotland website [http://www.healthscotland.com/documents/4120.aspx].

This framework is intended to clarify 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.

The competencies can also be used as a guide for the content of awareness raising sessions. Part of the process of embedding ABIs will require the continued delivery of alcohol awareness training to staff across the public and community and voluntary sector to maximise opportunities for clients to be directed to appropriate support and information.

In recent years a number of key documents emphasise the importance of understanding the wider influences on health behaviour change and health inequalities and the importance of the role of practitioners in working in partnership with other services to signpost and refer individuals appropriately (The Health Behaviour Change Competency Framework (2010) [http://www.healthscotland.com/documents/4877.aspx] endorsed in the Alcohol and Drugs Workforce Statement (2010) [http://www.scotland.gov.uk/Publications/2010/12/AandD] and the Marmott Review [http://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals]. In response to this change in emphasis NHS Health Scotland have created a suite of Health Behaviour Change e-modules to support this approach. The suite of e-modules can be accessed by all practitioners but it is recommended that this is done through the guidance and support of local trainers in health behaviour change topics / Alcohol.

The suite of Health Behaviour Change resources including raising the issue of alcohol and alcohol brief interventions can be found here: [http://elearning.healthscotland.com/category_selector/index.php?view=cat&expand=108]

There are ABI trainers in all NHS Board areas across Scotland who have been trained to deliver flexible courses to primary care, A&E and antenatal staff. Some trainers are also able to offer training in wider settings. There are also trainers in generic Health Behaviour Change in most boards and they are also able to assist with training. Guidance on planning, workforce development and delivering behaviour change interventions along with a list of trainers, training coordinators, and local ABI leads can be found at the NHS Health Scotland Virtual Learning Environment (VLE): [http://elearning.healthscotland.com/category_selector/index.php?view=cat&expand=104]

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 (continuing) 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 B, as part of *Implementing the service*.
Resources

As part of national support for the implementation of ABIs by NHS Boards, reference material on screening and ABIs has been produced by NHS Health Scotland. The *Alcohol Brief Interventions: Professionals Pack* includes key terms relating to ABIs and sets out advice for practitioners on how to deliver interventions [http://www.healthscotland.com/documents/3273.aspx].

In addition, practitioner resources have also been published for the A&E setting [http://www.healthscotland.com/documents/4062.aspx] and the Antenatal setting [http://www.healthscotland.com/documents/4096.aspx]. These materials should be read in conjunction with the SIGN74 Guideline and this guidance.

Evidence papers have been and will be 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]

The evidence base on the relationship between alcohol and offending behaviour was also captured from 2009-2011 through a collaborative research programme between ISD and NHS Health Scotland and can be accessed online: [http://www.healthscotland.com/topics/health/alcohol/offenders.aspx]

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 HEAT standard and ADP core indicators.

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 HEAT standard) can act as an aid to future planning and development of policy and strategy.

NHS Boards and ADPs will be aware that the guidance for ADPs on planning and reporting arrangements 2013-15: [http://www.scotland.gov.uk/Resource/0042/00429713.pdf] includes the collection of number of screenings as a Core Indicator, as well as the number of ABIs delivered. Collection of screening information can help to provide an overall picture of activity, identifying those with alcohol use disorders and potential demand for services.
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 (included in Annex E), in addition to the mandatory reporting requirements, can 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 can help assess what impact, if any, alcohol brief interventions are having on health and health inequalities.

If a NHS Board or ADP decides to collect supplementary data for a given ABI Setting (or Service within that setting), and is able to pull together these 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.

Mandatory data reporting requirements, 2014-15

The mandatory reporting requirement and performance measure for the ABI HEAT standard in 2014-15 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 HEAT standard, ADP core indicators as part of the revised governance & accountability arrangements for ADPs and reporting to their Community Planning Partnerships (CPPs). 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 and the number of alcohol brief interventions delivered in accordance with the HEAT Standard guidance, have been ADP core indicators since 2012/13.

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 2014-15.

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 as currently being used to report on the 2013-14 ABI HEAT Standard. All reported ABI delivery will require to be in accordance with the ABI HEAT standard guidance.

This information will be made available in the HEAT reporting system for 2014-15 (with arrangements put in place to share this performance management information with ADPs) and through ADP reporting arrangements.

Scottish Government will monitor the delivery in all settings to ensure it accords with the planned national guidance.
It is strongly advised that, where possible, data reports are more detailed (e.g. with breakdown of who/where delivering and demographics of who receiving) and are compiled more frequently than quarterly by NHS Boards and their ADP partners to help manage delivery.

**Timescales for mandatory reporting**

**Quarterly returns** should be submitted by email to Stephen Simmons (Health Improvement Team, ISD) at stephen.simmons@nhs.net by the following dates:

- First quarter (01 April to 30 June 2014): by Friday 25 July 2014
- Second quarter (01 July to 30 September 2014): by Friday 31 October 2014
- Third quarter (01 October to 31 December 2014): by Friday 30 January 2015
- Fourth quarter (01 January to 31 March 2015): by Friday 24 April 2015

In addition, the **total number of alcohol brief interventions** delivered during 2014-15 for the HEAT standard (1 April 2014 – 31 March 2015) should be submitted by email to Stephen Simmons stephen.simmons@nhs.net at Information Services Division (ISD) no later than 29 May 2015.

Only ABIs delivered between 1 April 2014 and 31 March 2015 can be reported for the purposes of the HEAT standard. Any retrospective data subsequently discovered for ABIs delivered under the previous HEAT standard (between 1 April 2013 and 31 March 2014) **cannot** be included in returns for 2014-2015.

**Publication of data**

As part of the HEAT standard, ISD will publish an annual figure of ABI delivery. This information will be made available on the ISD website: [http://www.isdscotland.org/Publications/index.asp](http://www.isdscotland.org/Publications/index.asp) and Scottish Government’s Scotland Performs website: [http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/alcoholbriefinterventionsStandard](http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/alcoholbriefinterventionsStandard).

This will be broken down by NHS Health Board, delivery in each of the three priority settings (namely 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’.

Any additional data provided by NHS Boards, and their ADP partners, will not be routinely published.

**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 HEAT standard. This will include supporting evaluation, training and data collection, the development of resources and encourage the sharing of good practice and the evidence base, seeking to provide opportunities to build on current ABI delivery programmes and inform emerging delivery.

In anticipation of this being the final year of the Standard and the long term aim to embed ABI delivery in routine practice, NHS Boards and ADPs are encouraged to develop local
and regional support networks to share learning. This could include continuation of the Action Learning Sets as facilitated by NHS Health Scotland with an A&E focus. This approach will continue through ABI Leads events and Leads are encouraged to sustain this to facilitate ongoing discussion of challenges and potential local solutions.

Resources you may also find of help are listed below:

- Outcomes Framework and Logic Model: [http://www.healthscotland.com/OFHI/alcohol/content/tools.html](http://www.healthscotland.com/OFHI/alcohol/content/tools.html)


Public Health Division
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KEY COMPONENTS OF AN ALCOHOL BRIEF INTERVENTION (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 interventions.

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 national clinical guideline, SIGN74 Guideline [http://www.sign.ac.uk/guidelines/fulltext/74/index.html], was published in 2003 recommending the delivery of ABIs for harmful and hazardous drinkers in primary care and also highlighting 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 and are based on recommendations made in SIGN Guideline 74. This highlights the use of motivational interviewing approaches and FRAMES [Feedback, Responsibility, Advice, Menu (of options), Empathetic interviewing, and Self-efficacy for the delivery of an effective ABI].

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 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.

*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.

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IMPLEMENTING ALCOHOL BRIEF INTERVENTIONS (ABIs) IN WIDER SETTINGS:
CHECKLIST OF GOOD PRACTICE REQUIREMENTS TO CONSIDER WHEN
PLANNING THE DELIVERY AND EVALUATION OF YOUR SERVICE

The following are a series of questions to consider if you are planning to introduce Alcohol Brief Interventions (ABIs) into a new wider setting. This could include a health setting beyond one of the three priority settings (i.e. primary care, A&E and antenatal), or a non-health setting. 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.

The questions cover Planning the Service, Implementing the Service and Monitoring and Evaluating the Service. The aim is to help support the implementation of effective interventions and develop the ABI evidence base.

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?
- 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?

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**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: http://www.healthscotland.com/documents/4120.aspx]
• 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?
• 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?
ANNEX C

Delivering Alcohol Brief Interventions (ABIs) in A&E: Common Challenges and Potential Solutions Identified Through Action Learning

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 now on two 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
- Practicabilities 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
- Staff acceptance that it is 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
- Use of CEL (01) [http://www.sehd.scot.nhs.uk/mels/CEL2012_01.pdf] – provides opportunity to focus on ABI delivery in A&E in partnership with Health Promoting Health Service colleagues.
- 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

Ongoing learning from these processes will continue to be collated and shared in 2014-15.
Consideration for ABI delivery in wider settings: NICE Recommendations

The following outlines recommendations from the NICE Public Health (PH) Guideline 24 Alcohol use disorders - preventing harmful drinking (June 2010)\(^2\) [http://www.nice.org.uk/PH24] 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 hypertension and gastrointestinal or liver disorders)
- with relevant 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.

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.


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.