

*Assessing IBA quality in
Primary Care: is recorded
'IBA' really IBA?*

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Background

Evidence base for IBA in reducing high risk alcohol consumption is strong:

- Over 50 peer reviewed publications
- 1- 8 people who receive advice will reduce their drinking to within lower risk levels

Significant scope to develop improved methods of IBA delivery and reporting in primary care practice:

- Known difference between quality of support in smoking cessation vs. alcohol reduction programmes (Brown, 2014)
- Observed difference between expected number of patients receiving brief intervention or specialist services referral and actual number

What do we know about IBA delivery and reporting in primary care practice?

1. IBA pathway

Taken from Public Health England

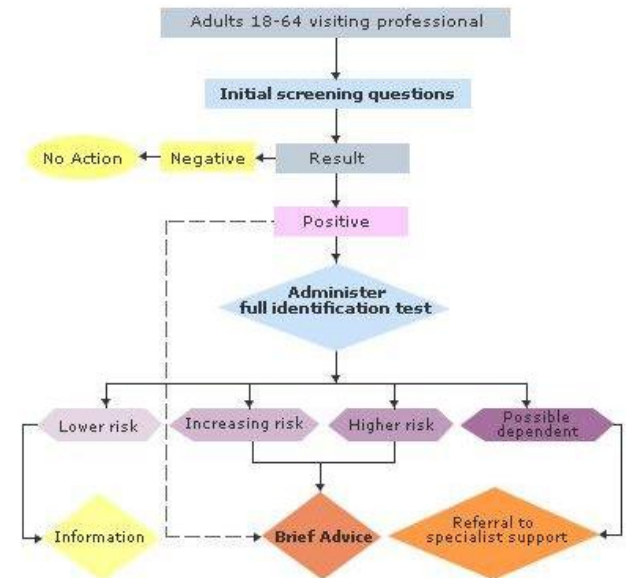
Alcohol Learning Resources Primary Care e-Learning

Stages:

Initial Simple Screening Test

Using validated questionnaire (AUDIT C or FAST).

Result is negative, no action is taken. Result is positive, a full identification test offered.



The Full Identification Test

Questions to help identify between lower risk, increasing risk, higher risk and possible dependency (full AUDIT).

Brief Advice

Conclusions from full identification test determine the action to be taken dependent on score:

- Lower risk drinkers given an information leaflet on maintaining lower risk drinking level
- Increasing risk and higher risk drinkers are offered brief advice
- Possibly dependent drinkers are offered referral to alcohol specialist support

2. Guidelines

Taken from 'Alcohol-use disorders: preventing harmful drinking' and relevant to Primary Care Practice

When to: 'new patient registrations, when screening for other conditions and managing chronic disease or carrying out a medicine review'

Who to: '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 and with relevant mental health problems'

How to: 'when broaching the subject of alcohol and screening, ensure the discussions are sensitive to people's culture and faith and tailored to their needs. Complete a validated alcohol questionnaire. Use AUDIT to decide whether to offer them a brief intervention or whether to make a referral.

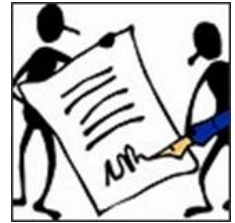
Offer a session of structured brief advice on alcohol. If not immediately, offer an appointment as soon as possible thereafter.

Use a recognised, evidence-based resource that is based on FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy). It should take 5–15 minutes.

Routinely monitor the individual's progress in reducing their alcohol consumption to a low-risk level. Offer an additional session of structured brief advice or an extended brief intervention.'

Why? 'work on the basis that offering an intervention is less likely to cause harm than failing to act where there are concerns.'

3. Commissioning and Contracts



National Alcohol Direct Enhanced Service (DES) (up until the 31st March 2015)

Collated information on:

- Number of newly registered patients aged 16+ screened using AUDIT-C/FAST**
- Number of AUDIT-C/FAST positive patients screened with full AUDIT
- Number of AUDIT positive (score 8+) patients receiving BA / BI;
- Number AUDIT positive (score 20+) patients referred to specialist services

Collated through reported read code information (entered by clinical practice staff)

Payment (of approx. £2.38) for each **newly registered patient aged 16+ screened using AUDIT-C/FAST**

Pay for performance reports indicate number of screens/ IBA pathways being delivered:
sample of Alcohol DES returns for **financial year 2013-2014** gave a count of **22,708** newly registered patients completing Alcohol screening (across 32 GP practices in South London)

This data was shared by NHSE local area team

Since 1st April 2015 absorption of Alcohol DES into the GP contract:

'it will be a contractual requirement for all practices to identify newly registered patients aged 16 or over who are drinking alcohol at increased or higher risk levels' and they will continue to monitor that this is achieved'

(NHS employers, 2014)

Local Enhanced Services and Service Level Agreements: two such examples are models in Bolton and Kingston that aim to tackle, through pay for performance (and other methods) aspects of National guidelines not covered by the GP contract



All patients over the age of 16 invited for screening once every 2 yrs
Health Trainers support individuals to reduce their drinking
Information on numbers of patients with raised AUDIT C, AUDIT10, signpost to services etc. collated (via read codes) and shared with all practices (to drive reporting and increase support)



For existing patients
Distinct payments made for completing each part of the IBA pathway (AUDIT C, Full Screen Audit and Brief or Extended intervention) measured through read code reporting

4.a. Clinical practice of delivering and reporting IBA- expected

Task: in groups map the expected process of IBA delivery and reporting (as a part of the new patient or health check)

Scenario: Patient X attends the GP surgery for a new patient/ health check

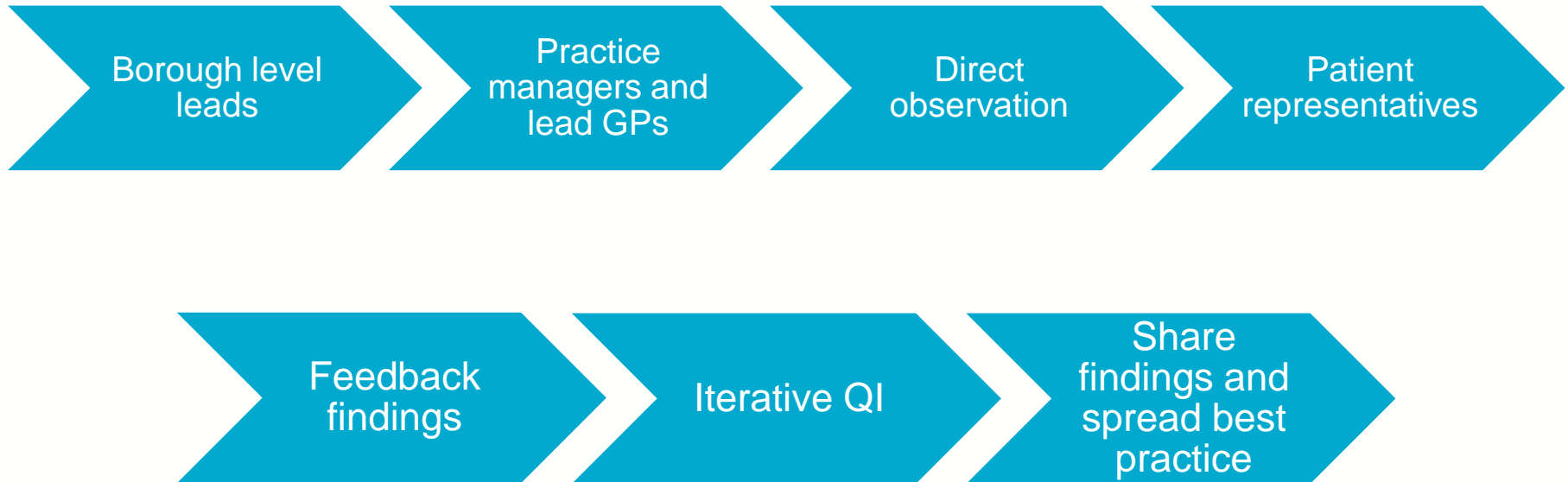
Think about the individual's interaction with members of the surgery at each stage of the consultation (pre, during and post) and explore *who, what, where, why, how and when* different parts of the IBA pathway are enacted

Resources:

- Large pieces of paper
- Marker pens
- Coloured cardboard shapes (explanation to be given)
- Blue tack
- Flip charts (for feedback)

Timing: 10-15 minutes group work followed by feedback

4.b. Clinical practice of delivering and reporting IBA- actually observed



***Task:* What are the contributing factors that lead to a difference between expected and observed IBA delivery and reporting?**

Discuss in groups

Consider the question within the framework of:

- Patients/ individuals
- Personnel (both clinical and support staff)
- Organisational aspects

Timing: 10-15 minutes group work followed by feedback

**By understanding the pathway,
guidelines, contracts and actual
practice how can we ensure recorded
IBA is quality IBA?**

Suggestions to mitigate against factors that cause differences between IBA recording and quality IBA delivery



Delivery: accredit teaching, links with specialist services, mandate in curriculum

Reporting: mandate/ develop templates, simplify read codes, 'Ready for consultation' approaches

Commissioning and contracts: toolkit for practice level requirements to set up quality processes and pay against standards, specialist services

Any questions?

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References

PHE Alcohol Learning Centre eLearning (2015)

<http://www.alcohollearningcentre.org.uk/eLearning/IBA/platforms/ALC/>

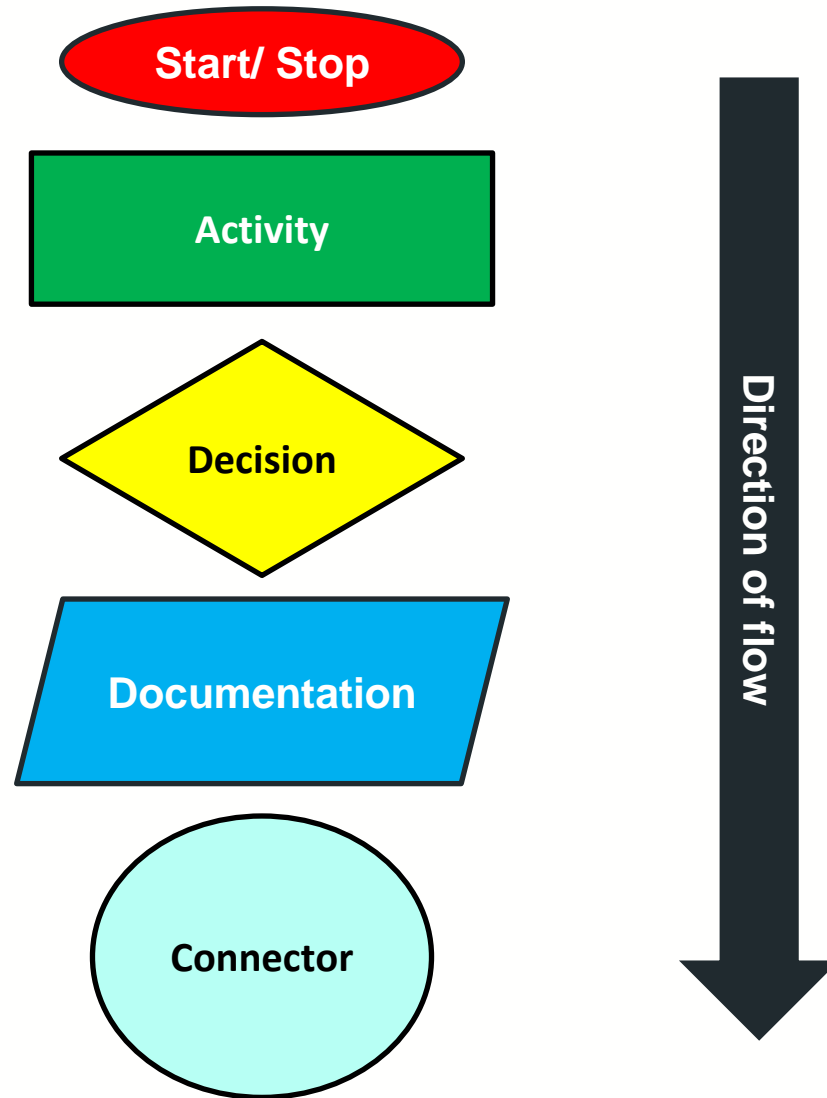
NICE guidelines (2010) <http://www.nice.org.uk/guidance/ph24>

Brown, J. (2014) Brief interventions in primary care on smoking and excessive alcohol consumption in England: Findings from a population survey

NHS employers (2014) <http://www.nhsemployers.org/>

Khadjesari, Z. et al (2013) Alcohol consumption screening of newly-registered patients in primary care: a cross-sectional analysis

Process Mapping



A simple process map

