Understanding and optimising an identification/brief advice (IBA) service about alcohol in the community pharmacy setting

Executive Summary

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Understanding and optimising an identification/brief advice (IBA) service about alcohol in the community pharmacy setting

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i Dr Gray was at the School of Pharmacy and Biomedical Sciences at UCLan when the project began.

ii Dr Cook was in the Centre for Public Health at Liverpool John Moores University when the project began.

iii Professor Heim was in the School of Psychology at UCLan when the project began.

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Copyright information

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Disclaimer

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Background

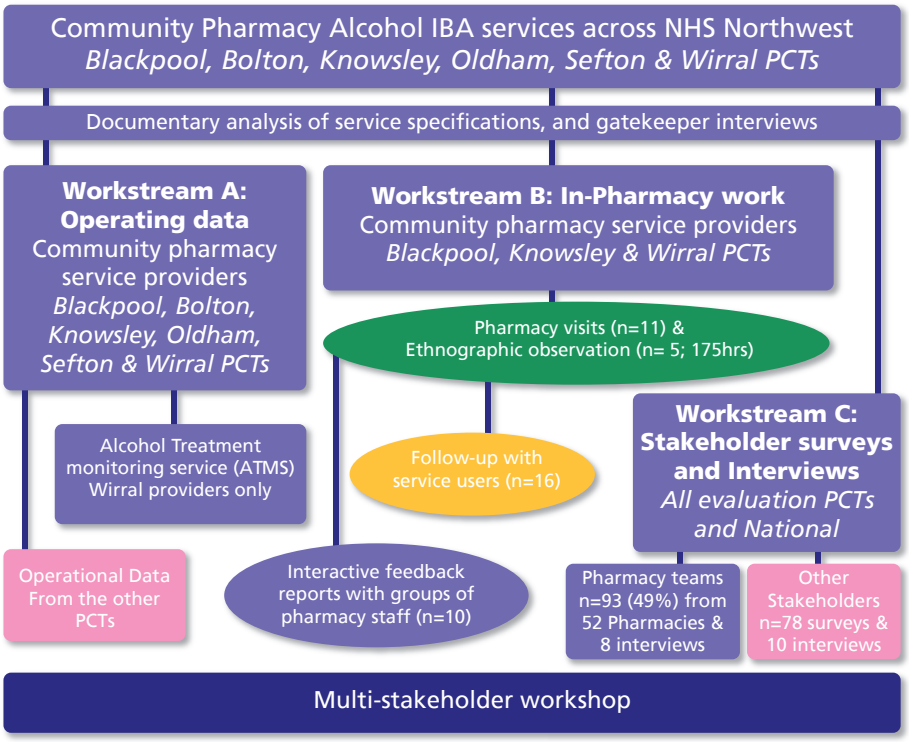
Since 2007, a number of Primary Care Trusts in the North West have, at some point, commissioned an identification and brief advice (IBA) service for alcohol in the community pharmacy setting and almost 100 pharmacies have been involved in providing the service. The alcohol IBA has a track record in other primary care settings, and this evaluation sought to understand how the service had been adapted for, and implemented in, the community pharmacy setting and how its potential to reduce alcohol-related problems might be maximised. It was not designed to demonstrate the effectiveness of the service: rather, it was designed to describe the type of service that should be tested in further outcome-based evaluative work.

Aims

1. To characterise, consolidate and optimise both the constant and variable elements of the pharmacy alcohol identification/brief advice (IBA) service in NHS Northwest, and

2. To inform planning for current and future pharmacy based services promoting safe consumption of alcohol.

Evaluation Design



We explored, in some detail, the assumed and actual processes used to provide this service. Data from this multi-strand design have provided us with a better understanding of which elements of the service are at its core, replicable across pharmacies, and which might be adapted to best fit the environment and people involved to generate the best health outcomes for the public.

Results

Data obtained from each workstream were mapped across service domains to triangulate findings.

1 Identification: Pharmacies appeared to be screening a group that was broadly representative of their customers. There was great variability in the numbers of screens undertaken by different pharmacies: a small number of pharmacies were prolific, and others performed few screens. A customer waiting for a prescription presented a good opportunity for opening a conversation. There were conflicting data from pharmacy staff who felt that approaching customers about alcohol consumption was difficult, but that they had received sufficient training and felt confident about providing the service: this might be limiting their interactions to people that they know well. The existing literature - and providers and stakeholders in this evaluation - identify community pharmacy as an appropriate setting for providing the alcohol IBA service, but the evaluation suggests that pharmacy to date is not capitalising on its potential to reach people who do not engage with other health services. Linking alcohol screening to other pharmacy services, like weight management and MUR, was suggested as a positive move. There was some interest in the possibility of instigating the alcohol screening in a more congenial way.

2 Screening: There were few consistent messages about screening across workstreams, as each one had addressed a different aspect of the screening process. Few studies to date have documented the verbatim conversations between pharmacy staff and customers, and it was valuable to have the opportunity to do this within the current evaluation. Recordings of the screening process indicated that pharmacy staff are not always neutral in their delivery of the assessment. There was some discomfort among staff with the content and tone of the questions in the AUDIT tool.

The majority of people screened had low risk AUDIT scores (scoring 0-7) (71% for Wirral and 79% for the rest of the North West), and yet many were still given an intervention. The demographic profile of people offered an intervention was in line with the expected target groups: more males, younger people and those from more deprived areas.

3 Brief Intervention: There were some consistent messages across workstreams. The nature of the intervention offered to customers was not always clear with regard to whether it could be considered information or a full brief advice intervention. Suggestions for different formats of interventions were forthcoming from stakeholders: there was no strong consensus about the best format. The environment for the intervention was noted: a private area was felt to be essential, but some observations were provided at the counter and users did not express discomfort with this. Support materials were seen as useful: calorie counters and unit wheels were seen as a good focus for a service where no 'product' is available (in contrast with smoking cessation and nicotine replacement therapy).

4 Referral: There were strong consistent messages across workstreams about the challenges of making effective referrals with higher risk drinkers. Pharmacy was not seen as integrated into the wider alcohol service team by stakeholders. The Wirral operational data pointed to some overlap between records of pharmacy IBA screens and acceptance of structured treatment, but those treatment users were not identified as higher risk drinkers in the pharmacy so it is difficult to know whether the pharmacy engagement had any bearing on their entry to treatment.

5 Follow-up: Despite its inclusion in service specifications, follow-up with service users was not being undertaken - as shown by several of the evaluation workstreams. Yet stakeholders felt that it would be a useful tool for determining outcomes, and thus building a good business case for the service. There was some evidence that the alcohol IBA service had a positive impact on the drinking behaviour of some customers. In two of the sixteen cases that were followed up in the evaluation, service users indicated they had significantly cut down their drinking and made other positive lifestyle changes. Some had also shared the information given at the pharmacy with people in their social circle. A number of respondents reported an increased awareness of units in different drinks and recommended limits, and of other lifestyle services offered at the pharmacy.

6 Monitoring: There were no strong, consistent themes about monitoring across workstreams. Interlinked key findings suggest, however, that a more robust and streamlined electronic data recording service is needed. The nature of the intervention lacked clarity and agreement, and this was affecting the operational data quality.

7 Training/Support: The training of providers was a common issue across several strands of the evaluation. Most staff reported that they had had sufficient training to provide the service, and stakeholders did not express any concerns about pharmacy staff training for the service, yet the in-pharmacy feedback revealed that staff would like 'refresher' training and ongoing support. The presentation of the AUDIT questions, revealed through the recordings of consultations, suggested a lack of emphasis on keeping a standardised, neutral approach to their delivery during training. Issues of missing/ ambiguous operational data also suggested a lack of training on how to achieve consistency of recording. Appointing a service 'champion', both within each pharmacy and at a strategic local level, was another support mechanism identified by providers and stakeholders.

8 Infrastructure: Pharmacy workload was identified as a barrier to meeting the potential of the service. Some pharmacies prioritised this service and undertook many screens, and others did not. There were some issues raised that were consistent with previous evaluations of other enhanced pharmacy services. Competing pressures affected identification practices, and strategies were employed to accommodate the extra demands of the service – such as engaging with customers who were waiting for prescriptions. Widespread adoption of a framework where the community pharmacy culture would shift to proactively maximise every customer's health and wellbeing would assist in this goal. Healthy Living Pharmacy pathfinder sites may help us to explore a change in culture.

9 Commissioning: The challenges of delivering the service within the confines and turbulence of the commissioning structure, such as imposed caps on numbers screened and time-limited pilots, resulted in uneven delivery. There was consensus among stakeholders that commissioners would need more outcome-based evidence from the pharmacy service to secure its continued funding. Further work would be needed to demonstrate benefit and to underpin an effective business case.

The table overleaf details our recommendations for practice. We have identified four main stakeholder groups – pharmacy providers, pharmacy leaders/organisations, commissioners, and service users (including groups that represent the service user perspective like Alcohol Concern). In the table, we have indicated which group/s we think could progress each recommendation.

Recommendations for Practice

Recommendation	Stakeholder Group			
	Pharmacy Providers	Pharmacy Leaders	Commissioners	Service users/ groups
Develop a common specification with a degree of flexibility to enable local adaptations.		●	●	●
Increase pharmacy staff confidence in proactively approaching customers and increasing their reach to people who do not engage with other health services.	●	●		
Build on initial training with "refresher" sessions and buddying of staff to enhance confidence.	●	●		
During initial and refresher training, emphasise the importance of asking the screening questions as written, consistent data collection, effective referral, and comprehensive follow-up.	●	●		
Empower pharmacy staff to support users in consultations and make effective referrals.	●	●	●	
Improve appropriate targeting of customers through other pharmacy services, such as smoking cessation, weight management, and MURs.	●			
Share good practice regarding in-pharmacy display and promotion of alcohol services.	●	●		●
Ensure a private space is offered to service users for the conversation.	●			
Clarify the elements of the 'intervention', with reference to existing evidence.		●		●
Support pharmacy staff to engage the majority of users in follow-up to determine the frequency and characteristics of behaviour change.	●	●		●
Simplify data collection moving from paper to IT.		●	●	
Require each pharmacy to have a service champion.	●	●	●	
Explore the use of new promotional tools' to engage customers.		●		●
Review the use of the AUDIT screening tool within the pharmacy service, both in terms of whether it is the most suitable tool for the setting, and the method of completion (self-completion vs. short interview).		●		●
Share and provide effective resources to use in the IBA e.g. alcohol unit wheels and calorie counters.	●	●		
Work towards a common minimum dataset that is acceptable to service users.		●	●	●
Devise better methods for tracking health outcomes over time.		●	●	
Improve data collection and optimise the service to build a strong business case.	●	●		●
Make best use of the diversity of community pharmacy settings to extend reach and to cascade information.	●	●	●	
Improve integration of pharmacy into patient referral pathways, both for individuals who are at risk and those who might be affected by the alcohol use of other people.	●	●	●	
Engage with local health professionals and other alcohol services to raise awareness of the pharmacy services.	●	●	●	●
Identify a local "champion of champions" to co-ordinate sharing of good practice and feedback.		●	●	
Devise a fair and stable remuneration system, recognising the adverse effects of capping and suspension of services.		●	●	
Work to build public health work into the "core business" of community pharmacy in future contractual frameworks.	●	●	●	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