

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



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Published September 2012

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This report should be referenced as follows

Gray NJ, Wilson SE, Cook PA, Mackridge AJ, Blenkinsopp A, Prescott J, Stokes LC, Morleo MJ, Heim D, Krska J, Stafford L. Understanding and optimising an identification/brief advice (IBA) service about alcohol in the community pharmacy setting. Final report. Liverpool PCT; 2012.

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Acknowledgements

We would like to thank Peter Gaylard (Being Influential Limited), Yvonne Imrie and Ian Bruce (Lundbeck Limited), Steve Morton (NHS Blackpool) and Vic Standing (Liverpool PCT) for their contributions to the project through attending team meetings and responding to calls for information and advice.

We would also like to thank our market researchers Martyn Bristow, Amanda Wright and Mark O'Keefe for their comprehensive and thoughtful work on the project.

We are very grateful to all the service users, pharmacy staff, gatekeepers and stakeholders who participated in the project.

We would also like to acknowledge a number of individual stakeholders who participated in different aspects of the evaluation:

Simone Arratoonian
Charlotte Bowen
Bertha Brown
Ian Canning
Melanie Carroll
Mary Edwards
Deirdre Doogan
Christine Hartley
Nigel Hughes
Fin McCaul
Eileen Neilson
Phil Ramsell
Pamela Soo
Mike Ward
Gary Warner
Tee Weinronk
Ali Wheeler
Cate Whittlesea

British Liver Trust
British Liver Trust
NHS Knowsley
NHS Sefton
Wirral LPC
Balance North East
Pharmacy Voice
Help Direct Lancashire
West Yorkshire HLP
Independent Pharmacy Federation
Willow Consulting
NHS Bolton
NHS Wirral
Alcohol Concern
Hampshire & Isle of Wight LPC
NHS Wirral
Our Life
Kings College London School of Pharmacy

Funding Declaration

This evaluation was funded by Liverpool PCT using an unrestricted educational grant from Lundbeck Limited.

Disclaimer

The views and opinions expressed therein are those of the authors and do not necessarily reflect those of Liverpool PCT or Lundbeck Limited.



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Glossary & Abbreviations

Acronym	Term	Description, if necessary
	100-hour pharmacy	An extended hours pharmacy that is contracted to open for at least 100 hours per week.
ABIS	Alcohol Brief Intervention Service	Both describe a service where people are screened to determine their alcohol risk and then action is taken according to their 'score', which may be a brief educational intervention or referral to specialist alcohol services.
ASBI	Alcohol Screening and Brief Intervention	
ASK	Alcohol Service Knowsley	
ATMS	Alcohol Treatment Monitoring Service	The ATMS collected data on non-structured (tier 1/2) and structured (tier 3/4) alcohol treatment services in the Cheshire and Merseyside area (McCoy <i>et al.</i> , 2007; McCoy <i>et al.</i> , 2010).
AUDIT	Alcohol Use Disorder Identification Test	WHO devised screening tool to describe the drinking risk of an individual.
AUDIT-C	Alcohol Use Disorder Identification Test (Consumption questions)	Shortened AUDIT tool focusing on alcohol consumption questions.
BI	Brief Intervention	Educational intervention about alcohol use risks, including explanation of daily amounts, units, different types of drinkers and providing an educational leaflet.
CPPE	Centre for Pharmacy Postgraduate Education	Continuing education body for registered pharmacists and technicians in England.
CVD	Cardiovascular Disease	
DoB	Date of Birth	
FAST	Fast Alcohol Screening Test	A screening tool to identify alcohol risk.
GIS	Geographic Information Systems	Systems designed to manage and interpret geographical information
HLP	Healthy Living Pharmacy	A pilot initiative to facilitate advice for the public about health and wellbeing.
IBA	Identification and Brief Advice	A service where people are screened to determine their alcohol risk and then action is taken according to their 'score', which may be a brief educational intervention or referral to specialist alcohol services.
IMD	Index of Multiple Deprivation	The index contains ward-level data and allows comparison of levels of social and economic deprivation across wards
LJMU	Liverpool John Moores University	
LPC	Local Pharmaceutical Committee	Local negotiating body for pharmacy contractors.
MCA	Medicines Counter Assistant	A member of pharmacy staff who works on the front counter and who has completed, or is studying for, a qualification recognised by the General Pharmaceutical Council (regulator).
MR	Market Researcher	
MRC	Medical Research Council	
MUR	Medicines Use Review	An advanced pharmacy contract service, specified nationally, where pharmacists invite patients to discuss what their medicines are for.

Acronym	Term	Description, if necessary
NMS	New Medicines Service	A pilot advanced pharmacy contract service, specified nationally, where pharmacists offer education and advice to patients presenting their first prescription for a medicine on a specified national list e.g. statin.
ONS	Office for National Statistics	
OTC	Over-the-counter (medicine)	Non-prescription (medicine) that can be bought or supplied in a pharmacy, like many cough remedies and painkillers.
PCT	Primary Care Trust	
RCT	Randomised controlled trial	
RPS	Royal Pharmaceutical Society	Professional body for pharmacists in Great Britain.
SATINS	Sefton Alcohol Treatment and Interventions Nursing Service	
SIGN	Scottish Intercollegiate Guidelines Network	SIGN develops evidence based clinical practice guidelines for the National Health Service (NHS) in Scotland.
SIPS	Screening and Intervention Programme for Sensible Drinking	
SOP	Standard Operating Procedure	Detailed written instructions to ensure consistency of delivery
SPoC	Single Point of Contact	One named point of contact, rather than multiple
	Tier 1 services	Non-substance misuse specific services providing minimal interventions for alcohol misuse.
WHO	World Health Organisation	



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Executive Summary

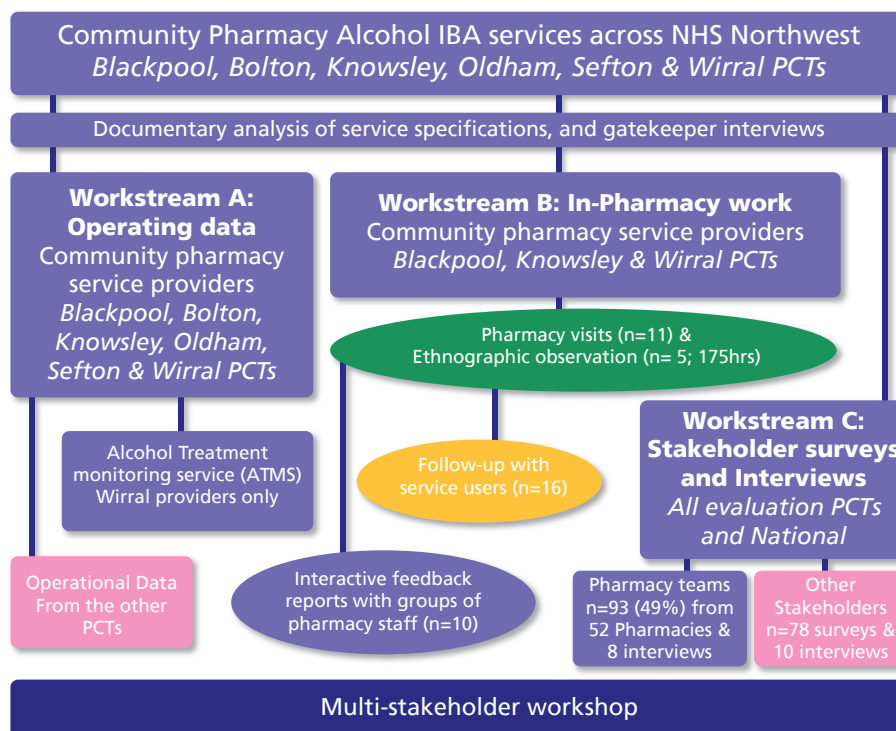
Background

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 buddy-ing 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.	●	●	●	

Chapter 1

Introduction

1.1 Alcohol use and misuse in England

In England, it has been estimated that over a quarter of adults aged 16-64 years regularly drink more than the recommended alcohol levels (Drummond *et al.*, 2005). A recent systematic review of research relevant to the trends in alcohol consumption over the last 20 to 30 years suggests that there has been an increase in drinking amongst women of all ages and amongst men 35 years and older, as well as a rising consumption in adolescent drinkers over the last decade (Smith & Foxcroft, 2009). Indeed, recognising the increasing consumption of alcohol in British culture, the UK Government in March 2012 published 'The Government Alcohol Strategy', which aimed to tackle violence caused by binge drinking. Current NHS guidelines state that men should not regularly exceed three to four units per day and women, two to three units (NHS, 2011). However research suggests that both men and women regularly exceed these unit guidelines (Fuller, 2009) and that many people are unaware of the recommended guidelines (Lader & Steele, 2010). General motivations for drinking are with food and for socialising (Morleo *et al.*, 2010) and drinking alcohol is generally recognised as part of British culture (Fuller, 2009; Department of Health, 2010).

Harmful levels of alcohol are associated with a range of health, crime and economic harm issues. Excess alcohol consumption is a major causal factor in a wide range of health conditions including mouth, throat, stomach, liver and breast cancers, hypertensive disease and cirrhosis (Rehm *et al.*, 2010). It is also linked to mental ill-health, accidental injury, violence and sexually transmitted diseases (Taylor *et al.*, 2010). Hazardous drinking is defined as the '*regular consumption of more than the recommended upper limit of alcohol*' (Scottish Intercollegiate Guidelines Network, 2003), whereas harmful drinking has been defined as '*a pattern of drinking that causes damage to physical health (e.g. liver) or mental health (e.g. episodes of depression secondary to heavy consumption of alcohol)*' (WHO, 1992).

It was estimated in 2003 that alcohol-related harm cost the economies of England and Wales £20billion annually through impacts on the workplace, health, and criminal justice system (Prime Minister's Strategy Unit, 2003). According to 2004 data from the Canadian Centre for Addiction and Mental Health (Rehm *et al.*, 2012), 14% of the UK adult population drank more than five drinks several times a week and 20% drank five or more drinks once a week. The report suggested that 3.9% of women aged 18-64 and 9.3% of men aged 18-64 living in the UK were alcohol dependent. Since then, alcohol-related harms have increased significantly: recent data show a 65% increase in alcohol-related admissions to hospitals in England between 2003/04 and 2008/09 (North West Public Health Observatory, 2010). For many countries alcohol represents one of the biggest challenges facing public health and health care systems. Figures for England suggest that, in 2006, 3.2% of deaths (16,236) were attributable to alcohol. In 2007/08 annual alcohol-related admissions to hospital exceeded 850,000; up 69% since 2002/03 (North West Public Health Observatory, 2010). In 2009 there

were 8,664 alcohol-related deaths in the UK (Office for National Statistics [ONS], 2011). According to the ONS males accounted for approximately two-thirds of the total number of alcohol-related deaths in 2009. The North West of England has the highest percentage of both male and female alcohol related deaths across England per year, for the years 2000-2009 inclusive (ONS, 2011).

1.2 Brief interventions about alcohol in the health care setting

The World Health Organisation defines alcohol related Brief interventions as “those practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it.” (Babor & Higgins-Biddle/WHO, 2001). A brief intervention usually consists of a short, one-to-one discussion of a person’s drinking habits.

Brief intervention has been found to be effective in reducing drinking when delivered in a primary care setting (SIGN, 2003 and 2004). The national clinical guidance in the UK (NICE, 2010) recommends that:

- General practitioners (GPs) and other primary healthcare professionals should opportunistically identify hazardous and harmful drinkers and deliver a brief (ten minute) intervention.
- Motivational interviewing techniques should be considered when delivering brief interventions for harmful drinking in primary care.
- Primary care workers should be alerted by certain presentations and physical signs, to the possibility that alcohol is a contributing factor and should ask about alcohol consumption.

Brief interventions are an effective means of targeting at-risk drinkers in settings such as primary care (Babor *et al.*, 2003; Watson & Blenkinsopp, 2009). A review of the literature on brief interventions in general practice reveal significant reductions in alcohol consumption (Kaner *et al.*, 2007; 2009) and provide strong evidence in support of brief intervention in reducing alcohol consumption. For every eight people who receive alcohol advice, research suggests one person will reduce their drinking to within low-risk levels (Moyer *et al.*, 2002). However variations have been found to exist with a Cochrane systematic review questioning the effectiveness of brief interventions in women (Kaner *et al.*, 2007).

There are several screening tools available to underpin the brief intervention; the most often cited being the AUDIT and FAST tools.

The **Alcohol Use Disorders Identification Test (AUDIT)** was developed by the World Health Organization in 1982 as a simple way to screen and identify people who are at risk of developing alcohol problems. The AUDIT test focuses on identifying the preliminary signs of hazardous drinking. It is used to detect alcohol problems experienced within the last year. The test contains 10 multiple choice questions on quantity and frequency of alcohol consumption, drinking behaviour and alcohol-related problems or reactions. The answers are scored on a 5-point Likert scale; a score of more than eight indicates an alcohol use problem. The AUDIT-C is a short 3-item screen developed from the 10 question AUDIT instrument concentrating on questions about consumption. It is scored on a 5-point Likert scale from 0 to 4, with scores of 4 or more for men and 3 or more for women considered positive and harmful drinking. It is used in a wide range of settings.

The **FAST alcohol screening test** was developed specifically to be used by health professionals to screen patients for hazardous drinking, although it has also been used effectively in the general population. The FAST test was developed by taking four key questions from the AUDIT test and arranging them into a short, two-phase test. Depending on the response to the first question of the test, the other questions may not need to be asked. If a person answers “never” on the first question, they are not a hazardous drinker and the remaining questions are not necessary. The maximum score is 16. A total score of 3 indicates hazardous drinking.

The one item **Single Alcohol Screening Question (M-SASQ)** asks ‘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?’ rated on a 4-point Likert scale from 0 never to 4 daily or almost daily. A score of 0-1 indicated lower risk drinkers and a score of 2-4 indicates increasing or high risk drinkers.

Recent research by the Screening and Intervention Programme for Sensible Drinking (SIPS) alcohol screening and brief intervention research programme (2012) has looked into alcohol screening and brief intervention in Emergency departments, the probation service and primary health care. The research found it feasible to implement alcohol screening and brief advice in all three settings, however, it was highlighted that necessary support and the most appropriate screening instrument differed between the settings. With regards to the primary health care setting, the SIPS research found the Fast Alcohol Screening Test to be the most efficient and effective tool and the patient information leaflet to be the more cost effective when compared to delivering brief advice in this setting.

There has been little evaluation of the long term effects of brief interventions with the exception of a study by Wutzke and colleagues (2002). They conducted a 9 month and 10 year follow up of a cohort of 554 hazardous or harmful drinkers recruited in primary care and health screening services in Australia. The study found that at 9 months the intervention had significantly lowered alcohol consumption but at 10 years there was no significant reduction. Johnson *et al.* (2011) conducted a systematic review investigating the barriers to implementing an alcohol brief intervention with studies conducted, in the main, in primary care. The study found barriers to engaging with the service to include; lack of financial incentives, lack of managerial support and staff workloads. The review also found evidence that there was a perceived lack of knowledge and confidence by health professionals in providing advice on alcohol use. Some felt the topic of alcohol was a difficult one to raise, due to the potential of upsetting patients. Interestingly, the review found that generally patients prefer to discuss alcohol related issues with their GP or a nurse rather than a specialist provider, suggesting alcohol brief intervention may be a suitable service delivered in other primary and secondary care settings, such as community pharmacy.

1.3 Brief interventions about alcohol in the community pharmacy setting

Community pharmacy is increasingly considered for inclusion in primary care and community pathways for the identification, signposting and treatment of people with alcohol

problems. The 2008 white paper 'Pharmacy in England' pledged to develop the public health role of the pharmacist (Department of Health, 2008), and the current government echoes this intent (Department of Health, 2010). There is insufficient research, however, about the impact of such services or their acceptability to pharmacy service users (RPSGB, 2008; Mackridge *et al.*, 2010a). A systematic review found few published studies of community pharmacy-based alcohol services (Watson & Blenkinsopp, 2009). However, brief interventions have been shown to be effective in wider primary care settings for other public health issues, such as smoking cessation and coronary heart disease (Blenkinsopp *et al.*, 2003). Watson and Blenkinsopp (2009), in a review of the literature on brief alcohol interventions in pharmacy, found three feasibility studies which included 14 pharmacies and 500 customers. These researchers found little existing empirical evidence of the effectiveness of community pharmacy based services for alcohol misuse and identified this as an important area of future study. Two of the three studies reviewed found no significant reductions in alcohol consumption after brief intervention. Dhital's (2004) study of a single pharmacy in London and Fitzgerald *et al.*'s (2008) of eight pharmacies in Glasgow found no significant reductions. A third study by Goodall and Dawson (2006) of six pharmacies in Leeds did find evidence of a reduction. The review authors concluded that community pharmacy could be an appropriate setting for alcohol services, and that brief intervention may be an appropriate and clinically useful tool for use in the community pharmacy setting (Watson & Blenkinsopp, 2009).

Although Watson and Blenkinsopp's review suggests that brief alcohol interventions in community pharmacy settings are feasible, the authors argue that large-scale studies are needed to evaluate the short and long term effects and cost-effectiveness of alcohol interventions to service users. Goodall and Dawson (2006) investigated the feasibility of screening for hazardous drinking with brief interventions in community pharmacy in Leeds. The prevalence of hazardous drinking detected in this study was consistent with other reports and described a major health issue. Findings revealed that all pharmacists that participated in the study were highly motivated and wanted to implement the service, and highlighted the potential value of the service. The study found that the feasibility of introducing such a service into pharmacies was dependent on factors such as the involvement of all pharmacy staff and access to a private consulting area. The authors suggested that Medicine Use Review (MUR - an 'advanced service' in the Community Pharmacy Contract in England & Wales), with revised funding, could provide the vehicle for such a service.

Fitzgerald and colleagues' (2008) study of eight community pharmacies in Glasgow recruited 70 service users in a 3-month period, with 19 of the service users taking part in a follow up study. The research found patients were primarily recruited from service users seeking smoking cessation advice, from the poster/displays, because they were feeling run down/tired/lethargic, seeking multi-vitamins/herbal remedy, seeking sleep aids and those seeking emergency hormonal conception. Pharmacists felt service users viewed the service as valuable, as many of the service users were unaware of some of the alcohol information and advice they received. From follow-up telephone interviews with service users, service users were pleased to have taken part in the service and viewed the experience positively. Privacy was acknowledged as an important factor for service users. Again this study points to the feasibility of trained community pharmacists to recruit, screen and intervene with patients/service users on alcohol issues. Both pharmacists and service users/patients that participated in the study were positive about the service.

Other work from Glasgow also supports the view that pharmacy staff considered it feasible to provide an intervention in the field of alcohol use (Fitzgerald *et al.*, 2009). This study involved the development of a two-day training course focussing on; consequences of problem alcohol use, attitudes, sensible drinking, familiarity with client screening using the Fast Alcohol Screening Tool (FAST), brief interventions and motivational interviewing. The course resulted in increases in staff knowledge and self-related competence. Educational packages tailored for community pharmacists are available from both the Centre for Pharmacy Postgraduate Education (CPPE) and the Alcohol Learning Centre.

From the current literature, it would appear that pharmacists in the UK are leading the initiative to become involved in providing alcohol advice and interventions. Formal studies are currently ongoing throughout the UK, including in Lambeth and Grampian, while a number of PCTs have commissioned services, for which no published data are available. The former study, conducted in the London borough of Westminster, trained 29 pharmacists who carried out 134 screenings over 5 months, of whom 35 (26%) were low risk, 72 (54%) increasing risk, and 21 (16%) high risk (Dhital *et al.*, 2012). This study also involved interviews with service users from four pharmacies, concluding that regardless of drinking status, most people were willing to utilise the service and were positive about pharmacists' involvement. Dhital *et al.* acknowledged, however, that these views "*would need to be verified in a larger study with a representative sample of participants*" (Dhital *et al.*, 2010, p601).

Two areas have embraced screening using a specially produced scratchcard, which enables pharmacy customers to assess their score utilising AUDIT-C (Alcohol Use Disorder Identification Test (Consumption Questions), WHO 1982). In Portsmouth, pharmacies have been carrying out screening using AUDIT-C since September 2010 with the aid of a scratchcard. To date (August 2012), 7482 interactions have taken place in 22 pharmacies, with 57 people identified as high risk accepting referral, while a further 381 were also high risk and accepted a brief intervention. A further 405 scored increasing risk and also accepted brief intervention, but 2581 respondents refused and 4058 were low risk.

In the Isle of Wight, 4587 screenings have been delivered using the same method in 2 years in 27 pharmacies, with 3072 scored as low risk.

Outside the UK, only work from New Zealand has been identified. Sheridan and colleagues' 2008 and 2010 studies found that community pharmacists' knowledge of the alcohol content of drinks and recommended safe drinking limits was poor, and, although they were generally well motivated towards undertaking this role, pharmacists lacked knowledge, skills and confidence. However, a follow-up study of 43 pharmacies found there to be scope for community pharmacists in New Zealand to deliver brief interventions and that customers found this advice acceptable (Sheridan *et al.*, 2012). In this study, questionnaires were handed out to pharmacy customers about alcohol consumption and they explored the views of pharmacists providing brief advice. The study gained 2,427 completed questionnaires, indicating that this is a good method of obtaining information on the prevalence of drinking among community pharmacy customers and to explore the acceptability of providing the service in an area. They also reported in this study that 30% of the study population would be considered 'risky drinkers'.

1.4 Brief interventions about alcohol in pharmacies in the North West of England

The North West has received recent attention due to its disproportionate incidence of alcohol-related problems (North West Public Health Observatory, 2010). Community pharmacy as a provider of alcohol services began in Wirral in 2007 and grew progressively throughout the North West such that, in 2011, 94 pharmacies across Blackpool, Bolton, Knowsley, Oldham and Sefton PCTs had also been commissioned to provide alcohol screening and advice services: although - with the exception of Sefton - no external evaluation had been conducted. This area thus provided by far the largest opportunity to evaluate a pharmacy alcohol service.

Recently Mackridge *et al.* (2010b) conducted an evaluation of a screening and brief intervention pilot for encouraging safe alcohol consumption in five community pharmacies in Sefton PCT, based on the results from a developmental project involving potential providers, commissioners and the public (Mackridge *et al.*, 2010a). The pilot confirmed the suitability of pharmacy to offer a screening and intervention service for safe alcohol consumption, with some caveats, relating to privacy and broaching the topic with clients. This study again showed that pharmacies had the capacity to identify drinkers across the spectrum of risk according to the AUDIT screening tool. Moreover pharmacies, unlike other primary care providers, could provide an all-encompassing approach to alcohol screening, and targeting of a wider population would identify individuals further downstream from those requiring referral to specialist alcohol services. This would enhance awareness about safe alcohol consumption through simple yet cost-effective public health messages that can be tailored towards the individual but then easily passed onto friends and family. Both pharmacy providers and service users were found to view the service positively (Mackridge *et al.*, 2010b) as was found in London (Dhital *et al.*, 2010).

1.5 Summary

Provision of an alcohol brief intervention in the primary care and wider health care settings has been found to be of potential value to public health, It can be delivered successfully in the community pharmacy setting and is accepted by service users. It is also beneficial in that it provides knowledge and raises general awareness of the issue of alcohol use. There has been a growing interest in recent years in introducing the service into the community pharmacy setting, but relatively little research or evaluation. Small-scale studies have shown that providing this service in the community pharmacy setting is generally viewed positively by service providers (community pharmacists and staff), the customers who had received the service, and the general public. However there is a need for a large-scale evaluation of screening and brief advice on alcohol delivered in the community pharmacy setting.



Chapter 2

Aims, Objectives and Evaluation Overview

2.1 Evaluation rationale

Following recommendations for best practice, the project team concluded that exploring the potential of alcohol services in community pharmacies should follow the Medical Research Council Framework for complex interventions (Campbell *et al.*, 2000). Indeed the framework cites alcohol intervention as a multi-faceted service which is difficult to evaluate using a traditional randomised controlled trial (RCT). Community pharmacy alcohol services - as a public health intervention - are still at an early stage of development, and further modelling and feasibility work is required to further increase effectiveness. The MRC framework advocates the initial characterising, consolidation and optimisation of both constant and variable components of a replicable intervention, followed by the development of a feasible protocol for comparing the intervention with an appropriate alternative. The project described in this report relates to the initial stage of this process – defining a replicable intervention.

The project team have been explicit about their intent to seek out the best practice of experienced pharmacy providers across the North West Region in order to describe the features of the alcohol IBA service that *would be best suited to the community pharmacy setting*.

2.2 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.

2.3 Objectives

1. To identify and quantify opportunities for providing the service, and how/whether pharmacy might maximise its impact through opportunistic provision.
2. To characterise the service elements, and to link process to appropriate outcomes.
3. To obtain the views of all key stakeholders on the most suitable service for community pharmacy and whether further development/modification would enhance its acceptability and spread.
4. To evaluate the user and provider experience by direct observation of the service, interview and involvement of potential users in gathering data.
5. To quantify service outcomes from up to 200 pharmacies, including interrogation of public health datasets.

2.4 Evaluation Design

2.4.1 Overview of Evaluation Design

In order to meet the evaluation aims and objectives, the following design was agreed (Figure 2.1):

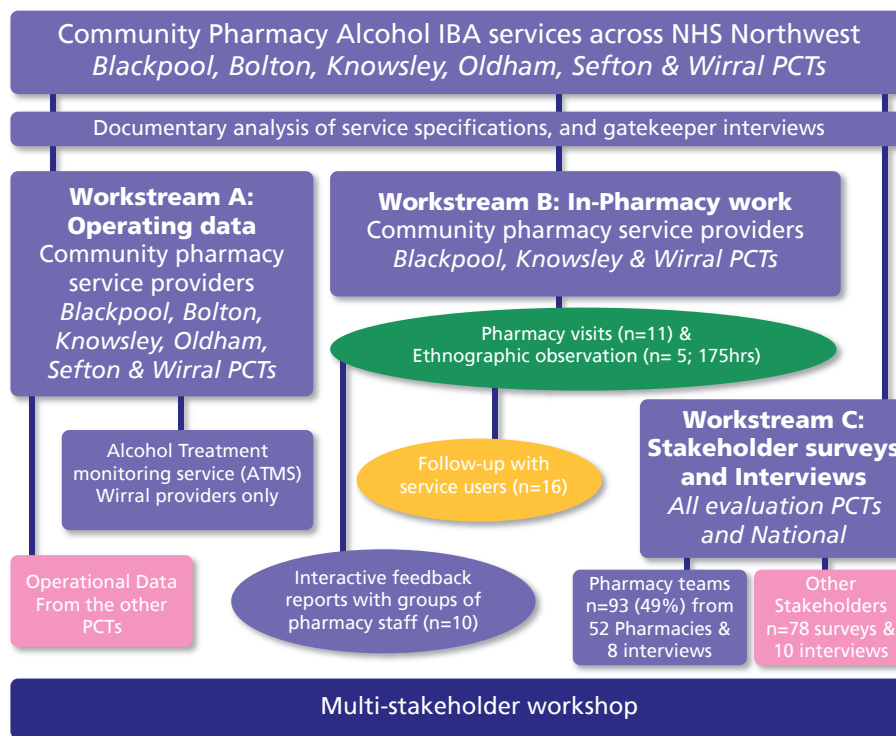


Figure 2.1 – Evaluation design overview

We explored, in some detail, the assumed and actual processes used to provide this service. We studied the service documentation, and talked to stakeholders about its development and progress. We interrogated the data provided by pharmacies about the service, and – with the Wirral data - explored links to outcomes for users with other public health datasets. We observed the service in action in pharmacies, and undertook follow-up with users and providers. From this multi-faceted approach, we now have 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.

The evaluation combined quantitative and qualitative methods appropriate to the objectives addressed. These methods were:

- Documentary analysis of service specifications;
- Descriptive and comparative statistical analysis of pharmacy operating data;
- Structured observation of pharmacy engagement with customers;
- Qualitative analysis of recorded pharmacy consultations between pharmacy staff and service users
- Qualitative analysis of telephone interviews with service users, pharmacy staff and pharmacy stakeholders;
- Thematic analysis of face-to-face group feedback interviews with pharmacy staff;
- Quantitative analysis of self-completion postal surveys to pharmacy staff and online surveys to stakeholders.

Table 2.1 shows how data from each workstream addressed the evaluation objectives. The evaluation design produced data that contributed, in combination, to a better understanding of this complex intervention.

Objective	Documentary analysis	Operating data	In-Pharmacy observation, service user interviews and provider feedback	Stakeholder surveys / interviews	Stakeholder Workshop
1. To identify and quantify opportunities for providing the service, and how / whether pharmacy might maximise its impact through opportunistic provision.	X		X	X	X
2. To characterise the service elements, and to link process to appropriate outcomes.	X	X	X	X	X
3. To obtain the views of all key stakeholders on the most suitable service for community pharmacy and whether further development / modification would enhance its acceptability and spread.			X	X	X
4. To evaluate the user and provider experience by direct observation of the service, interview and involvement of potential users in gathering data.			X		
5. To quantify service outcomes from up to 200 pharmacies, including interrogation of public health datasets.		X	X		

Table 2.1 – Mapping workstreams to the evaluation objectives

2.4.2 Ethical and R&D Approvals

This service evaluation was not subject to review by a NHS local research ethics committee. Fieldwork was, however, submitted for appropriate approval by institutional ethics committees and local R&D organisations as follows:

- Workstreams A and B: Ethical approval was granted by Liverpool John Moores University Research Ethics Committee. R & D approvals were given by NHS Blackpool, NHS Knowsley, NHS Sefton, NHS Wirral, and Greater Manchester Primary Care Research Governance Partnership (ReGrouP) for NHS Bolton.
- Workstream C: Ethical approval was granted by the Science, Technology, Engineering and Medicine (STEM) Research Ethics Committee at the University of Central Lancashire.

2.5 Structure of this Report

The following chapters will combine the methods, results and initial discussion for each workstream:

- Documentary analysis of service specifications, and gatekeeper conversations;
- Exploration of operating data
- In-pharmacy observation and interviews with service users
- Stakeholder surveys and interviews
- Stakeholder workshop

A further chapter will then triangulate and discuss the data across workstreams as a basis for proposing recommendations to inform planning for current and future pharmacy based services promoting safe consumption of alcohol.



Chapter 3

Existing pharmacy alcohol IBA services in the North West

The first part of the evaluation included a series of gatekeeper interviews, conducted by JP in Summer 2011, and collection of documentation associated with each service.

3.1 Gatekeeper context-setting interviews (Summer 2011)

A number of common issues, and some notable differences, were identified during these context-setting interviews.

3.1.1. Common issues discussed by gatekeepers

- **Outcome measures:** There was a general consensus among PCT gatekeepers regarding the outcomes to measure the success of the brief interventions. Success would be measured by the number of people who received an IBA, and the number of people then attending specialist services. Follow-up engagement about the service was also viewed as an important and helpful measure of success: it was recognised, however, that patients/customers were not always willing to sign up for follow-up. Other useful outcome measures would include customer satisfaction and feedback from pharmacists and pharmacy staff on their views of the service.
- **Training: All PCTs** required pharmacists and staff delivering the service to attend at least a half-day training session, run by an outside organisation (most often by specialist alcohol services).
- **Facilities:** A private consultation area was felt to be important for the service.
- **Variability:** The PCTs who were currently running the service all commented that the number of IBAs delivered varied considerably across pharmacies in their area, with some pharmacists embracing the service and doing many whilst others did few, if any.
- **Other IBA services:** All PCTs had a number of other services across health and social services providing IBAs, viewing pharmacy as another access point with the potential to reach a different cohort.
- **Benefits of including pharmacy:** All the PCTs considered community pharmacies to have the potential to reach a different cohort of people than the other services providing IBAs. Pharmacists were viewed as more accessible and more convenient, for reasons such as: no appointment needed, being on the high street, and having extended opening hours.

- **Funding:** The future of the service, and one of the major challenges of the service for the PCTs, centred on the availability of funding.
- **Recording of data:** Pharmacists needed a less labour intensive data recording system.
- **Approach to customers:** A common barrier faced by those delivering the service is how to approach customers. Effective marketing materials for the service might support the approach.

3.1.2 Differences identified between PCTs

- **Adaptation of other pharmacy services:** Blackpool and Knowsley PCTs had based their service on the Wirral PCT model. Bolton PCT was undertaking a very different service.
- **Screening vs IBA service:** Bolton only provided the AUDIT-C screening tool, thus did not use the full AUDIT or provide an IBA.
- **GP Involvement:** Bolton was the only PCT that involved the GP in the pharmacy service.
- **Payment for the IBA service:** Only Sefton provided a tiered payment system dependent on the level of risk of patients screened.
- **Follow-up:** Some PCTs specified follow-up with service users, and others did not as the intervention itself was evidence-based i.e. underpinning research showed that behaviour change did result in a percentage of the population following intervention. Payment for follow-up was not always forthcoming.
- **Pilot:** Sefton was conducting two pilots: pharmacy staff in one area were receiving increased training, and in another area they were receiving increased help with publicity for alcohol IBAs.
- **Capping:** Wirral had a capping system in place which only allowed pharmacists to conduct a fixed number of screenings per month, dependent on funding, and the number of screenings permitted might change each month.

3.2 Service Specification Analysis

Table 3.1 summarises the key features of the documentation associated with each service. Most of the service specs are in fact SOPs rather than service specs. They show the variation in all elements of the service across PCTs. They place less emphasis on setting out the intended learning outcomes of training and on the content of any intended behavioural change element of the service.

Area / Date of Documentation	Service model	Training	Targeting	Referral & follow up	Remuneration	Other Notes
Wirral 2007 33 pharmacies	Alcohol awareness + behavioural change Alcohol screening using AUDIT tool, then Brief Intervention (BI) if score is 8-15 a. Explain daily amounts & what a unit is b. Category of drinker c. Leaflet content	Includes behavioural change Pharmacists and staff	"Any customer that the pharmacist / staff member identifies as needing advice / support, and any patient that has not completed AUDIT in the last 12 months" Mentions MUR, smoking cessation, symptoms associated with alcohol misuse including gastric problems, high blood pressure and falls.	16+ refer to Wirral's Alcohol Service (WAS) Harm Reduction or Dependent Drinkers Teams 8 & 52 week follow up after IBA	£10 + VAT per intervention	Pharmacy records client details Information shared – initials, DoB, age, gender, 'First part plus one' of postcode
Blackpool Pilot service spec Mar 2010 18 pharmacies	AUDIT + information leaflet + IBA BI if AUDIT score is 7-15 Content as for Wirral To be provided in pharmacy consultation room	All staff involved in service to complete training. Pharmacist + technicians	"Any customer that the pharmacist / staff member identifies as needing advice / support" Mentions MUR, smoking cessation	16+ specialist treatment 4 week follow up, 3 questions. Telephone follow up acceptable.	£10 per intervention including 4 week follow up	30 days notice of max. number of IBAs.
Bolton May 2011 7 pharmacies	Pharmacy screening only. All forms with consent go to GP practice. Invited to health trainer at practice if AUDIT score is 5+.	Pharmacist + 2 others 1.5hr evening session	Patients with a prescription from a Bolton GP	Client consent sought. If consent given – form shared with GP. If not, leaflet only.	£2 per Audit C completed – up to 80 per 4 weeks	

Area / Date of Documentation	Service model	Training	Targeting	Referral & follow up	Remuneration	Other Notes
Knowsley SOP Aug 2010 17 pharmacies	AUDIT + information leaflet + IBA BI if AUDIT score is 7-15 Units of alcohol Daily limits Leaflet content	e learning No staff category specified	"Any patient who drinks alcohol" Mentions MUR, smoking cessation "Care needs to be taken not to alienate existing patients by targeting indiscriminately"	16+ refer to Alcohol Service Knowsley ASK 4 week follow up, telephone contact is acceptable	£10 + VAT per intervention	"No signs or advertising without prior agreement" Data recording on RPS database
Oldham SOP Oct 2010 9 pharmacies	AUDIT + information leaflet + IBA BI if AUDIT score is 8-15 Content as for Wirral To be provided in pharmacy consultation room	Alcohol Learning Centre e learning & PCT event Pharmacists and staff	"Any patient over 16 yrs of age who drinks alcohol and has not completed AUDIT in the last 12 months" Mentions MUR, smoking cessation	16+ Refer to local Single Point of Contact for Community Alcohol Services in Oldham 4 week follow up; 3 questions	£10 + VAT per intervention 2 per week; max 104 per year	Data recording on RPS database
Sefton SOP & SLA June 2011 10 pharmacies	AUDIT + information leaflet + IBA BI if AUDIT score is 8-15 Content as for Wirral To be provided in pharmacy consultation room	PCT event Pharmacists and staff	"Any patient over 16 yrs of age who drinks alcohol and has not completed AUDIT in the last 12 months" Mentions Prescriptions for long term conditions e.g. hypertension MUR, smoking cessation, CVD screening	16+ refer to Sefton Alcohol Treatment and Interventions Nursing Service SATINS 4 week follow up Telephone acceptable	Linked to AUDIT score: 0-7 = £8 8-15 = £10 16+ = £12	Data recording on Servicepact "No signs or advertising without prior agreement"

Table 3.1 – Summary of key features of service documentation

Chapter 4

Workstream A: Analysis of Operational Data

4.1 Methods

This workstream used intervention data recorded by providers, with a focus on data collected from Wirral pharmacies because: i) the Wirral system had been established for the longest period, and the model for many of the others; ii) it had the largest number of records, and iii) the recording system links to structured treatment monitoring systems, allowing estimations of the number of people accessing pharmacy screening prior to attending structured treatment.

Wirral data

Between 2008 and 2011, pharmacies participating in the brief intervention programme in Wirral submitted data to the Alcohol Treatment Monitoring System (ATMS). The ATMS collected data on non-structured (tier 1/2) and structured (tier 3/4) alcohol treatment services in the Cheshire and Merseyside area (McCoy *et al.*, 2007; McCoy *et al.*, 2010). The system collected pseudo-anonymised identifiers, which allowed tracking of individuals between services. Thus, the overlap between individuals screened in pharmacy settings and presenting to structured treatment was measured using methodologies developed elsewhere (Sanderson-Shortt *et al.*, 2010).

Pharmacy screening data from the Alcohol Treatment Monitoring System (ATMS) were extracted for 2008 to 2010 and the three quarters of 2011 (to 30/09/2011). The extract had been stripped of any patient identifiers. Data refer to the number of screenings rather than the number of individuals screened (thus one individual may have been screened more than once in a given year). It is not known to what extent improved monitoring over the course of the study period may have contributed to increases in recorded screenings.

Routine data from Wirral pharmacies were analysed to describe the demographics of all those screened (and compare this to the target groups recommended in the SOP); screening scores; and referral data. Demographic data comprised age and gender. Partial postcode was also provided, which enabled mapping to Index of Multiple Deprivation (2007) scores¹. Univariate general linear models were used to identify factors related to higher AUDIT scores, and logistic regression was used to identify predictors of having received an intervention. All analysis was carried out on SPSS ver 20.

¹ 'Postal sector' data were available; that is, the first part of the postcode and the leading numeric of the second part of the postcode. This level of postcode information does not map to population demographic data, therefore in order to estimate the deprivation level of the area of residence, GIS techniques were used to estimate deprivation scores for postcode sectors by interpolating values from a database of IMD scores at Lower Super Output Area level.

Data from other areas

All areas with pharmacy schemes contributed anonymised data, either directly (Blackpool, Bolton, Sefton) or via the Royal Pharmaceutical Society's online databases (Knowsley, Oldham). Because each dataset collected different variables, and areas differed in their commissioning and operation of the pharmacy screening service, it was not possible to analyse all areas together. Basic demographics are presented for other areas.

4.2 Results

4.2.1 Basic service activity in Wirral

In total, 10,907 records were retrieved. Table 4.1 shows the distribution of records by month and year. There were relatively few records for the first few months of the scheme, with screenings increasing in August 2008, and high numbers were maintained until the end of the collection period, September 2011.

		Month												Total
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Year	2008	-	-	-	9	2	1	31	138	181	137	320	154	973
	2009	254	134	196	178	245	243	166	167	126	102	186	39	2036
	2010	288	321	259	240	421	333	409	280	360	438	414	367	4130
	2011	240	421	333	394	538	645	652	404	297	-	-	-	3768
Total														10907

Table 4.1: Wirral service activity by month and year from April 2008 – September 2011

The amount of activity varied widely between the participating pharmacy groups, with over half of participating pharmacies (16/30) screening fewer than 50 individuals during the 42 months of the data collection period (Figure 4.1). The five most active organisations accounted for 72% of all screenings (7,895 individuals).

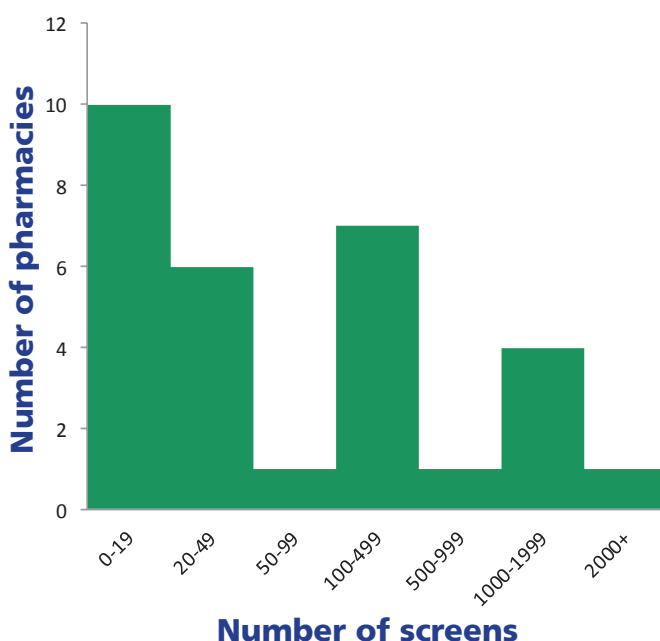


Figure 4.1: The distribution of screenings among Wirral pharmacies

4.2.2 Demographics of the screened population

Table 4.2 shows the demographics of the screened population as a function of age and gender. More women (59%) than men were screened, and those aged 60 years or older were disproportionately represented in the screening population, especially in the male screened population, of whom 35% were aged 60 years or over. However, age varied significantly by pharmacy group, from 14% aged 60 years or over, to 59%. A small number of records were retrieved that apparently related to individuals aged under 14 years of age. We assume these represent data entry errors since the service is unlikely to be offered to those aged less than 16 years therefore these records were excluded from further analysis.

	Age group											Total (100%)
	0-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	
Female	5 0.1%	193 3.0%	542 8.4%	565 8.7%	541 8.4%	606 9.4%	655 10.1%	662 10.2%	561 8.7%	526 8.1%	1621 25.0%	6477
Male	1 0.0%	87 2.0%	326 7.4%	331 7.5%	289 6.5%	308 7.0%	377 8.5%	389 8.8%	421 9.5%	340 7.7%	1561 35.2%	4430
Total	6 0.1%	280 2.6%	868 8.0%	896 8.2%	830 7.6%	914 8.4%	1032 9.5%	1051 9.6%	982 9.0%	866 7.9%	3182 29.2%	10907

Table 4.2: Age and gender characteristics of the screened population in Wirral

4.2.3 AUDIT scores and outcome of screening in Wirral

Table 4.3 shows the AUDIT category and whether or not individuals received an intervention. It was not always clear what constituted a brief intervention in the records (i.e. whether simple feedback was given or the full IBA), since there was no structured way of differentiating these actions within the data. For 5924 records, the intervention was recorded as a brief intervention. A further 4891 records were blank, and interpreted in Table 4.3 as having received no intervention. A combination of 'leaflets', 'advice' and 'information' was recorded for 85 screenings. Of these 85 records, the majority (81%) reached the AUDIT criteria to receive a brief intervention and, since these formed a relatively small proportion, they have been included in 'intervention' category in table 4.3. Likewise, 91 records stated 'counselling' or 'structured counselling'. These were incorporated into the intervention category. Seven screenings were recorded as having resulted in being 'referred' or 'referred into structured treatment'. All seven had the highest category of AUDIT score (>19), and these records have been included with the intervention group. Of those who received an intervention, 61% scored less than 8 on AUDIT (i.e. lower than the threshold to trigger an intervention).

Overall, AUDIT scores were missing for 5.5% of screenings (Table 4.3). During the first two years, 2008 and 2009, the proportion of individuals with unknown AUDIT scores was high (12.4% and 16.2% respectively). In 2010 and 2011 this was much lower (4.2% and 0.5%).

		Audit category					Total (100%)
		0–7	8–15	16–19	20–40	missing	
No intervention	Female	2612 86.9%	209 7.0%	15 0.5%	17 0.6%	153 5.1%	3006
	Male	1509 80.0%	197 10.0%	26 0.0%	35 0.0%	118 10.0%	1885
	Total	4121 84.3%	406 8.3%	41 0.8%	52 1.1%	271 5.5%	4891
Intervention	Female	2271 65.4%	826 23.8%	62 1.8%	64 1.8%	248 7.1%	3471
	Male	1412 55.5%	841 33.0%	75 2.9%	94 3.7%	123 4.8%	2545
	Total	3683 61.2%	1667 27.7%	137 2.3%	158 2.6%	371 6.2%	6016
Total		7804 71.6%	2073 19.0%	178 1.6%	210 1.9%	642 5.9%	10907

Table 4.3: AUDIT score category, gender and intervention status of individuals screened in Wirral

Cross-matching between pharmacy and structured treatment databases revealed that there were eight individuals received structured treatment^{vi} within 3 months of a pharmacy visit. None of these had 'referral' as the outcome in their pharmacy record; five records were blank for outcome, and three stated 'Brief intervention'. Four individuals were recorded as having AUDIT scores <20. It is not possible to determine whether these individuals sought alcohol treatment as a result of their screening in pharmacy.

Wirral pharmacy data were used to describe the characteristics of those with high AUDIT scores. Males had higher AUDIT scores than females in every age category and for both males and females the average AUDIT score dropped with age (Figure 4.2). Those from more deprived backgrounds had higher AUDIT scores ($r=0.14$, $P<0.001$). Full details of the general linear model are given in Appendix 4.1.

^{vi}Structured treatment is personalised to the individual's situation and gives them strategies to resume a structure to their life through time management and life coaching.

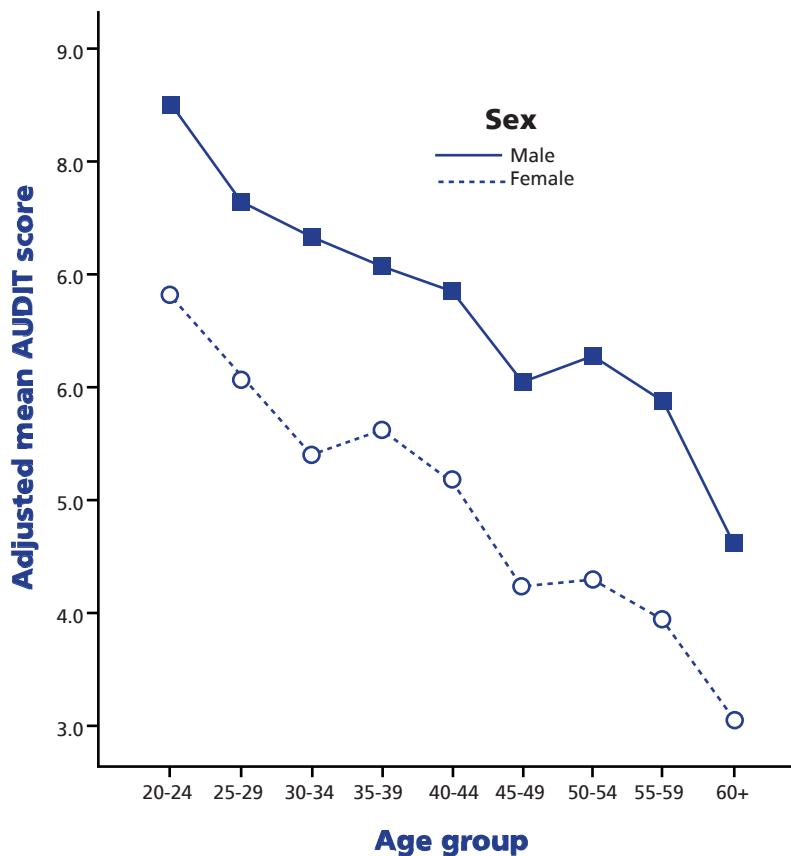


Figure 4.2: Mean AUDIT score of males (solid line) and females (dashed line) by age group. Means are adjusted taking into account age, gender and IMD in a multivariate analysis (General Linear Model: IMD was a covariate evaluated at IMD=32.2)

Figure 4.3 shows the odds of receiving an intervention by age group, gender, IMD and AUDIT score. If all pharmacies were operating according to the SOP (i.e. screen using AUDIT and offer IBA to all those scoring 8 or more), and if all individuals offered an intervention accepted it, then an AUDIT score of 8 or more would be the only significant predictor in the model, and this would correctly predict 100% of interventions. However, this was not the case. For any given AUDIT score, those aged 25 to 49 years had a 1.4 to 1.5 times higher odds of receiving an intervention compared to the youngest age group (20-24 year olds, $P < 0.001$). After controlling for the other variables, males were no more likely to receive an intervention than females, and the deprivation score of the area of residence of the individual was not related to the probability of receiving an intervention. As expected, AUDIT score was related to the probability of receiving IBA, with each one point increase in AUDIT score leading to a 1.16 times higher odds of receiving an intervention ($P < 0.001$). Despite this statistical significance, this is a relatively weak effect: in the multivariate model, between them these variables predicted only 10% of the variation in receipt of an intervention (full model details are given in Appendix 4.2). The model's inability to explain the variation in IBAs delivered is due in large part to the lack of a consistent AUDIT score criterion. Pharmacists may have differed in how they chose to offer the service, and this will have contributed to the variation. The lower tendency for younger people (20-24y) to receive an intervention could be due to pharmacists being less likely to offer it to this age group, or these individuals being less likely to take up the offer, or a combination of both these factors.

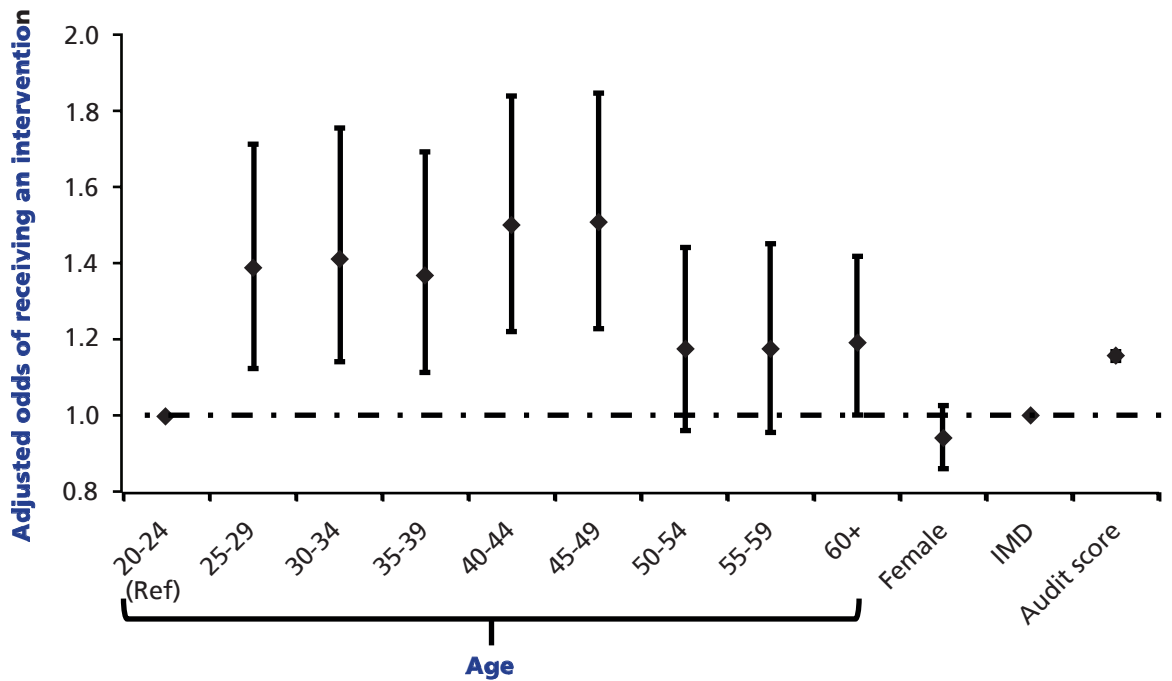


Figure 4.3: Adjusted odds of individuals receiving an intervention by age group, gender, IMD and AUDIT score. Odds with confidence intervals that do not overlap 1 (dashed line) are statistically significantly different to the reference category. Odds are adjusted taking into account age, gender and IMD in a multivariate analysis

4.2.4 Data from other areas of the North West

Blackpool, Bolton Sefton and Knowsley provided data on their pharmacy IBA services. As was the case with the Wirral, data from other areas suggest that relatively few pharmacies involved contribute the majority of screenings. For example, Blackpool recorded 570 screenings on their database, with two out of the ten participating pharmacies accounting for almost half of these (Appendix 4.3). Similarly for Bolton, seven pharmacies contributed data on 1035 screenings, half of which were carried out by a single pharmacy (Appendix 4.4).

Blackpool, Sefton and Knowsley provided information on the ages of screened individuals (Table 4.4). Similar to Wirral, the age group most commonly screened was the 60 years or more category. Sefton had the greatest proportion in this age category, at 38%, and Blackpool the lowest at only 19%.

Age (year)	Location ^a							
	Sefton		Knowsley		Blackpool		Total	
	n	%	n	%	n	%	n	%
16-19	6	1.5	55	2.2	7	1.4	68	2.0
20-24	27	6.8	187	7.6	41	8	255	7.6
25-29	21	5.3	184	7.5	53	10.4	258	7.7
30-34	14	3.5	120	4.9	49	9.6	183	5.4
35-39	24	6.0	200	8.1	67	13.1	291	8.6
40-44	39	9.8	294	11.9	51	10	384	11.4
45-59	45	11.3	297	12.1	62	12.1	404	12.0
50-54	42	10.6	268	10.9	46	9	356	10.6
55-59	30	7.5	232	9.4	40	7.8	302	9.0
60+	150	37.7	625	25.4	95	18.6	870	25.8
Total	398	100	2462	100	511	100	3371	100

^aAge data were missing for Bolton

Table 4.4: Age profile of persons screened in North West pharmacies

The range of AUDIT scores was similar across participating areas in the North West (Table 4.5), with 79% screening negative (scoring below 8), compared to 71% for Wirral (Table 4.3). However, the area with the highest percentage of low risk scores, Bolton (85%), used AUDIT-C rather than the full AUDIT. The other areas, which used full AUDIT, had comparable percentages of low risk drinkers to Wirral (72%). Sefton had by far the highest proportion of screenings in the highest AUDIT category (4%, compared to 2% in Wirral and fewer than 1% everywhere else).

Location	AUDIT category								Total (100%)
	0-7		8-15		16-19		20-40		
	n	%	n	%	n	%	n	%	
Blackpool	380	72.8	124	23.8	9	1.7	9	1.7	522
Bolton	876	84.6	159	15.4	0	0.0	0	0.0	1035
Knowsley ^a	1660	67.0	700	28.2	61	2.5	58	2.3	2479
Sefton	297	74.6	79	19.9	5	1.3	17	4.3	398
Total	3213	72.5	1062	24.0	75	0.5	84	1.9	4434

^a5 excluded due to missing data

Table 4.5: AUDIT scores of persons screened in North West pharmacies

The service in Bolton differed from the Wirral model that had broadly been used by the other areas. Bolton pharmacies aimed to screen and refer into primary care for an IBA. As part of the data collection for the referral, patient's GP details as well as postcode of residence was collected. This allowed mapping of a geo-demographic classification (Figure 4.4; P² People and Places by Beacon Dodsworth, www.beacon-dodsworth.co.uk). The most common categories of people referred by participating Bolton pharmacies were 'Mature Oaks' (17% of all those referred), 'Suburban Stability' (18%) and 'Urban Producers' (13%). The pharmacy service appeared to appeal to a range of population types: Mature

Oaks are the most affluent P² category, tending to be older, married professionals living in large detached properties. Suburban Stability is an averagely affluent group, tending to live in semi-detached or terraced properties that they are buying and working in manufacturing. Urban Producers live in terraced council housing and tend to be younger, single parents. Income in these areas is low and unemployment is high. See www.beacon-dodsworth.co.uk for further profile descriptions.

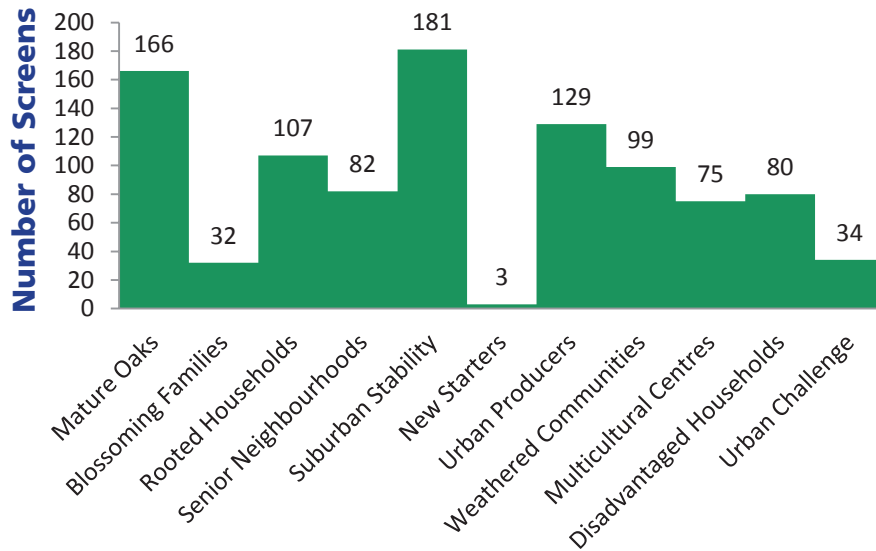


Figure 4.4: Population classification of persons screened in Bolton, based on Lower Super Output Area of residence (P2 People and Places, Beacon Dodsworth)

Two areas collected information on employment status. Of those screened in Sefton, 38% were employed, 25% were retired, and 27% not working (Appendix 4.5). Similarly, in Blackpool, 40% were working and 16% were retired (Appendix 4.3).

Further breakdown of the routine data provided by North West pharmacies are given in Appendices 4.3-4.6.

4.3 Summary of key messages from operational data

Across all screening areas, pharmacy screenings were most common among older people (aged 60 years or more).

In Wirral pharmacies, many interventions were delivered to people who have screened negative on AUDIT. This appears to be contrary to the service specification. That said, there was evidence that services were more likely to be provided to those most in need: those from poorer backgrounds were more likely to screen positive on AUDIT, and those who screened positive were more likely to receive an intervention.

There were some issues with the data collected. Outcome data were inconsistently coded. Collection of complete postcodes would enable accurate deprivation and other social variables to be attached, which would allow pharmacists to demonstrate the range of people attracted to the service. Data from different areas differed in terms of variables collected, making comparison between areas difficult. There were data quality issues with individual datasets which limited the extent of the analysis possible.

Using the Wirral exemplar, pharmacies would need to screen 10,000 people in order to identify 400 people drinking in higher risk categories (AUDIT 16+), eight of whom would be expected to be seen in structured treatment within three months.



Chapter 5

Workstream B: In-Pharmacy observation, service user engagement and provider feedback

5.1 Methods

Pharmacies in each of the three PCTs providing an alcohol IBA service in the North West during the fieldwork period, January to April 2012 were involved in this part of the study. Participating pharmacies within NHS Wirral, NHS Knowsley and NHS Blackpool were purposively selected to represent a range of settings, such as within/adjacent to health centres and various retail locations, and because of their high alcohol IBA service activity levels. This workstream involved four data collection activities designed to investigate the characteristics of a good pharmacy alcohol IBA service, highlight best practice and explore user perspectives. The phases of work were as follows:

5.1.1 Phase 1: User perspective observation

The aim of this phase was to ascertain the extent to which customers entering the pharmacy would be aware of the availability of the service and gather some insight as to how the service may be experienced. With prior permission (consent materials are at Appendices 5.1-5.3), Market Researchers (MRs) - acting as potential service users - visited 11 pharmacies (four in Wirral, four in Knowsley and three in Blackpool) covertly. They completed a structured checklist (Appendix 5.4) as well as making field notes concerning the pharmacy environment and promotion of the alcohol IBA service. During these visits, MRs approached the pharmacy counter and asked for a hangover cure to stimulate possible provision of the service (Appendix 5.5). Where the service was offered, MRs made a subsequent written record relating to their experience of the service, including any sense of discomfort and the location and nature of service provision.

5.1.2 Phase 2: Observation of staff-customer interactions

At five purposively selected pharmacies within the participating PCTs (two in Wirral, two in Knowsley and one in Blackpool), MRs directly observed all interactions between pharmacy staff and customers that took place at the pharmacy counter during observation periods (in-store poster at Appendix 5.6). Between 30 and 43 hours of observations were completed across the opening hours of each pharmacy, tailored to the pharmacy to provide an overview of typical customers. MRs completed checklists of key features of each interaction (Appendix 5.7) and made field notes of any other salient points. The checklist comprised: customer demographics; reason for visiting the pharmacy (prescription; over-the-counter (OTC) sale; access a service; advice; non-medicine sale; other); alcohol IBA offered, reaction to offer of IBA and outcome. Times of interactions were categorised as: morning (9:00-11:59); lunch (12:00-13:59); afternoon (14:00-17:59) and evening (18:00-19:00). In the NHS

Wirral pharmacies, alcohol IBA service provision that took place in the consultation room was also audio recorded with patient consent (in-store poster and consent materials are in Appendices 5.8-5.11) and transcribed. These transcripts were then examined for the quality of the screening and intervention and for service user reaction during the consultation. Data from this phase were used to pinpoint staff training needs and provide a detailed understanding of how the consultation may be experienced from a user perspective. They also provided a detailed overview of the nature and frequency of customer interactions at each site as a marker for possible opportunities to provide the service.

5.1.3 Phase 3: Follow-up telephone interviews with service users

Semi-structured interviews were conducted with sixteen service users at around 2 weeks and then at 3 months following receipt of the pharmacy IBA service (Consent materials and interview schedules are in Appendices 5.12-5.15). Participants were presented with strongly favourable and strongly negative views of the topic to stimulate consideration of both the positive and negative aspects of the service. Interviews at two weeks focused on perceptions of the service, while those at three months focused on perceived impact that the service had on service users' behaviour in relation to alcohol. In the latter interview the possibility of a 'cascade' effect, whereby the service user initiates or contributes to a discussion with a third party as a result of receiving the service, was also explored. Interviews lasted approximately 5-10 minutes and audio recordings were transcribed verbatim with participant consent. Transcripts were analysed thematically through the identification of core themes based on the research aims as well as those emerging from the interviews themselves. Data in this phase provided insight into the quality of service provision and the impact on sustained behaviour change, as well as assessing the feasibility of obtaining follow-up data with pharmacy-based alcohol IBA service users.

5.1.4 Phase 4: Interactive feedback with service providers

Individual feedback reports were compiled for each pharmacy participating in Phases 2 and 3 and these were presented to participating staff at an informal, interactive feedback meeting with the one of the research team (LCS) (Discussion guide is at Appendix 5.16). During these sessions, pharmacy staff involved in delivering the service were also asked to comment on other related issues including: operational data and processes for payment by the PCT; training received; their experience of delivery (e.g. targeting of customers and their level of confidence in service provision), as well as considering what advice they might proffer to pharmacy staff about to begin providing the service. Written reports summarising the results of user perspective observations, including of areas available for alcohol IBA service delivery and, were offered, and MRs' experience of the consultation were sent to the 6 pharmacies that only participated in Phase 1. This aim of this phase was to give staff an opportunity to comment on the findings and to add clarity and context to facilitate appropriate interpretation of the findings.

5.2 Results

5.2.1 Participating pharmacies

A total of 11 pharmacies took part in Workstream B, with 5 participating in all phases and 6 participating in phase 1 only. Details of the pharmacies are shown in Table 5.1.

Code	Pharmacy type	Opening hours	Setting	Proximity to GP surgery	Phases of involvement
PH1	Nationwide multiple of >100 pharmacies	Mon-Fri: Open over lunch Sat: Open Sun: Closed	Town high street/shopping centre	2 practices within 0.1 mile	Phase 1 only
PH2	Small group with 2-5 pharmacies	Mon-Fri: Open over lunch Sat: Open am only Sun: Closed	Health Centre	Same site	Phase 1 only
PH3	Single independent	Mon-Fri: Closed over lunch Sat: Closed Sun: Closed	Among local neighbourhood shops (a small parade)	1 practice at 0.2 miles away; 2 practices at 0.4 miles away	All phases
PH4	Single independent; 100 hour contract	Mon-Fri: Open early morning to late night Sat: Open early morning to late night Sun: Open	Health Centre	Same building	All phases
PH5	Nationwide multiple of >100 pharmacies	Mon-Fri: Closed over lunch Sat: Open am only Sun: Closed	Among local neighbourhood shops (a small parade)	Same site	Phase 1 only
PH6	Small group with 2-5 pharmacies	Mon-Fri: Closed over lunch Sat: Closed Sun: Closed	Out of town shopping centre	Same site	All phases

Code	Pharmacy type	Opening hours	Setting	Proximity to GP surgery	Phases of involvement
PH7	Small group with 2-5 pharmacies	Mon-Fri: Closed over lunch & Wed afternoon Sat: Closed Sun: Closed	Health Centre	Same building	All phases
PH8	Nationwide multiple of >100 pharmacies; health-based with multiple consultation rooms	Mon-Fri: Open Sat: Closed Sun: Closed	Among local neighbourhood shops (a small parade)	1 practice at 0.25 miles away	Phase 1 only
PH9	Nationwide multiple of >100 pharmacies	Mon-Fri: Open Sat: Open Sun: Closed	Health Centre	Same building	Phase 1 only
PH10	Nationwide multiple of >100 pharmacies	Mon-Fri: Open Sat: Open am only Sun: Closed	Village high street/centre	1 practice at 0.6 miles away	Phase 1 only
PH11	Nationwide multiple of >100 pharmacies	Mon-Fri: Open Sat: Open Sun: Closed	Among local neighbourhood shops (a small parade)	1 practice at 0.5 miles away; 1 practice at 0.6 miles away	All phases

Table 5.1: Details of pharmacies participating in Workstream B

5.2.2 Opportunities to provide the alcohol IBA service

A higher proportion of females (59%) than males were recorded as visitors to the pharmacies (Figure 5.1). This gender difference was consistent across all age groups but more marked in the 'under 25 years' and '25 to 34 years' age groups, where females represented 76% and 71% of the sample respectively.

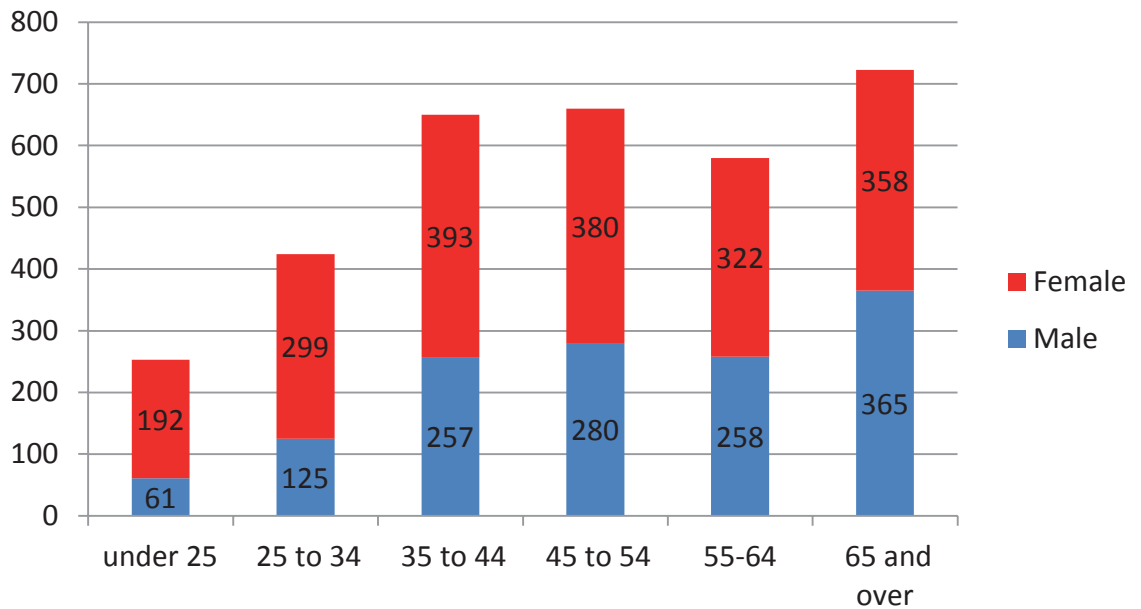


Figure 5.1: Demographic profile of customers visiting the pharmacy during observation (n = 3299; missing = 9; hours observed across all pharmacies = 171)

Both hours of opening and the location and nature of the pharmacy appear to impact on customer numbers and characteristics. Pharmacy counter interactions were broadly similar in morning and afternoon sessions, but lunchtimes were quieter in one pharmacy co-located with a GP surgery, which may relate to surgery appointment times and also in those pharmacies which closed for lunch (Figure 5.2).

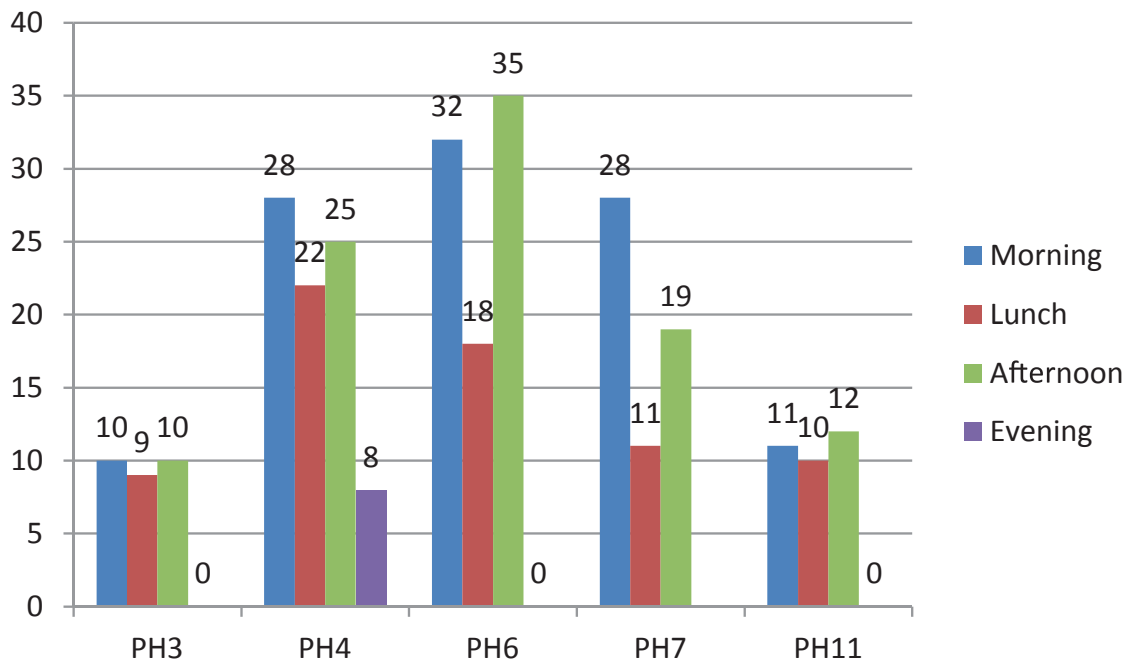


Figure 5.2: Pharmacy counter interactions by pharmacy and time of day: mean number of customers per hour observed for each time period

The demographics of the customer base described above give an indication of the diversity of possible opportunities to initiate an IBA screening/consultation. Although there was a slight bias towards females and the elderly, customers of both sexes and of all ages visited the pharmacies, but males under 34 years were least well represented.

Around three-quarters (76%) of all counter interactions observed were associated with prescriptions, ranging from 55% to 87% across the participating pharmacies (Figure 5.3). Purchases of over-the-counter (OTC) medicines and other items accounted for a further 23% of interactions at the counter, while customers visiting the pharmacy to seek advice or to access a service were a less frequent occurrence, with only 4% and 5% of interactions relating to these respectively.

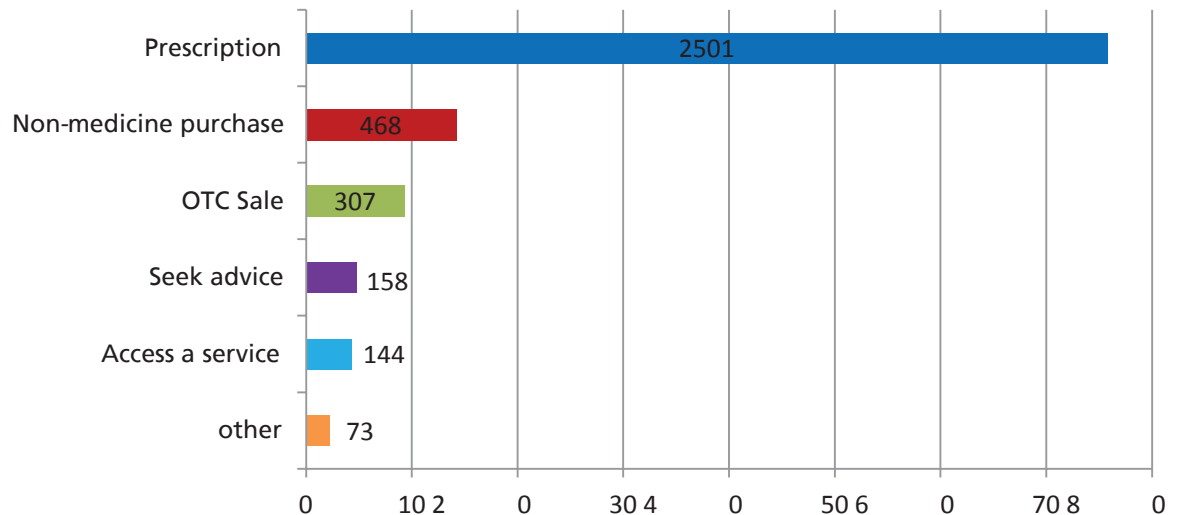


Figure 5.3: Number of customers by reason for visiting the pharmacy (n=3299; some customers visited for multiple reasons)

Services accessed by customers during the observation period are shown in Figure 5.4, with supervision of methadone, Care at the Chemist (free of charge OTC medicines provision without prescription) and smoking cessation services being most common. One instance was recorded of an individual visiting the pharmacy to attend a pre-booked alcohol IBA consultation.

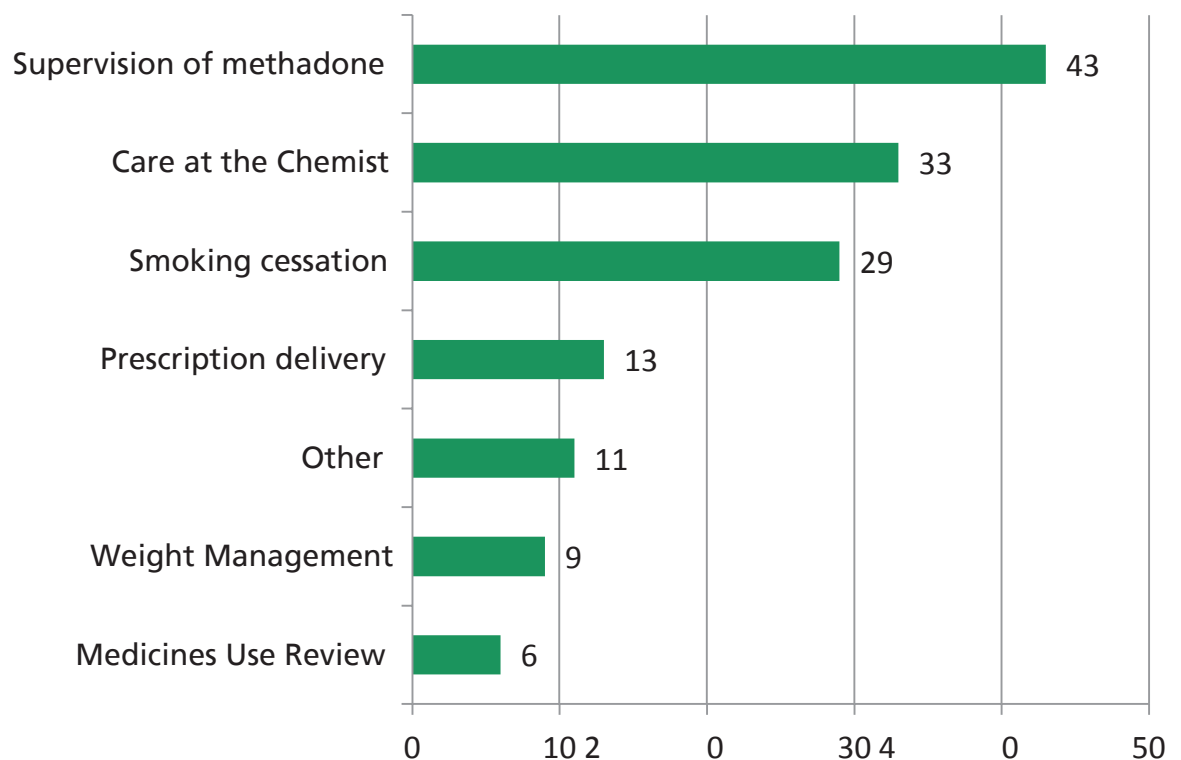


Figure 5.4: Number of customers visiting the pharmacy for services (n=144)

Although staffing levels and skill mix varied between pharmacies, approximately two-thirds (63%) of the interactions observed at the counter were with a Medicines Counter Assistant (MCA) (Figure 5.5). At two of the pharmacies MCAs handled almost all of the customer interactions, referring only occasionally to a pharmacist or dispenser/technician if the customer required expert advice. During the feedback interviews, one pharmacist reported that delivering the alcohol IBA service had shifted the mindset of the MCAs in his pharmacy to proactively approaching and engaging customers. He also added that this learning might be replicable across other enhanced service provision. These data suggest that training for alcohol IBA services need to be appropriate and available to all pharmacy staff groups.

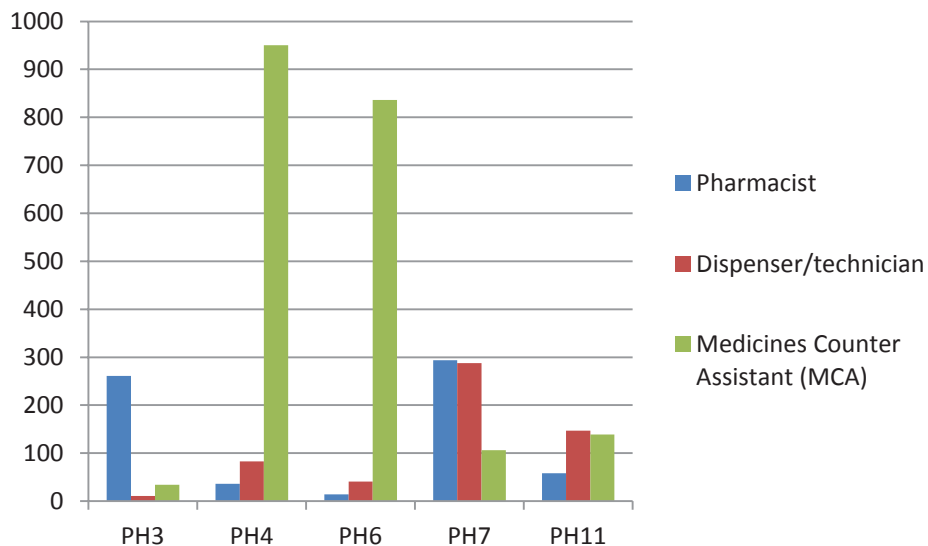


Figure 5.5: Counter interactions handled by each staff group by pharmacy (n=3298; missing =1)

Due to staffing and commissioning restrictions, the alcohol IBA service was not available in all pharmacies during all of the observation periods. However, 112 customers were offered the service during the observations. Figures 5.6 & 5.7 summarise the demographics of those offered the service. Middle aged (aged 35-44 and 45-54 years) and female customers were most commonly targeted and around two-thirds (66%) of those offered the service accepted and continued through the IBA screening process. Of those offered the service, younger customers (aged under 34 years) were marginally more likely to accept, although this was not statistically significant (χ^2 , $p=0.258$). Reasons given by customers who declined the service primarily centred on not drinking alcohol or not having time.

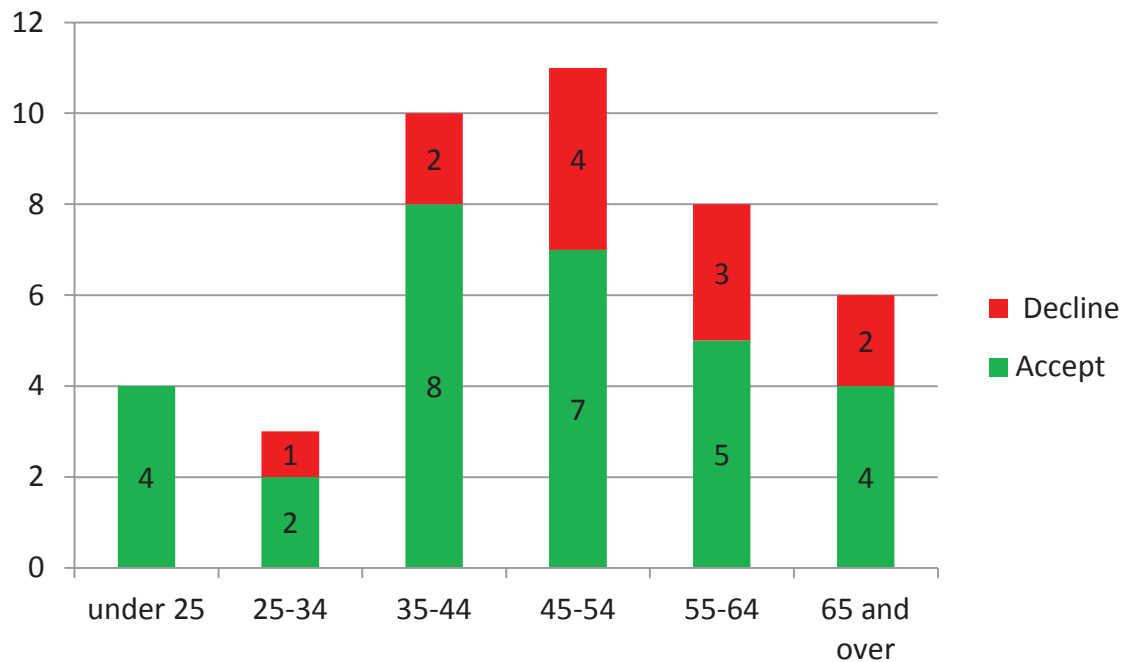


Figure 5.6: Numbers of male customers accepting and declining the offer of alcohol IBA service during observation (n=42)

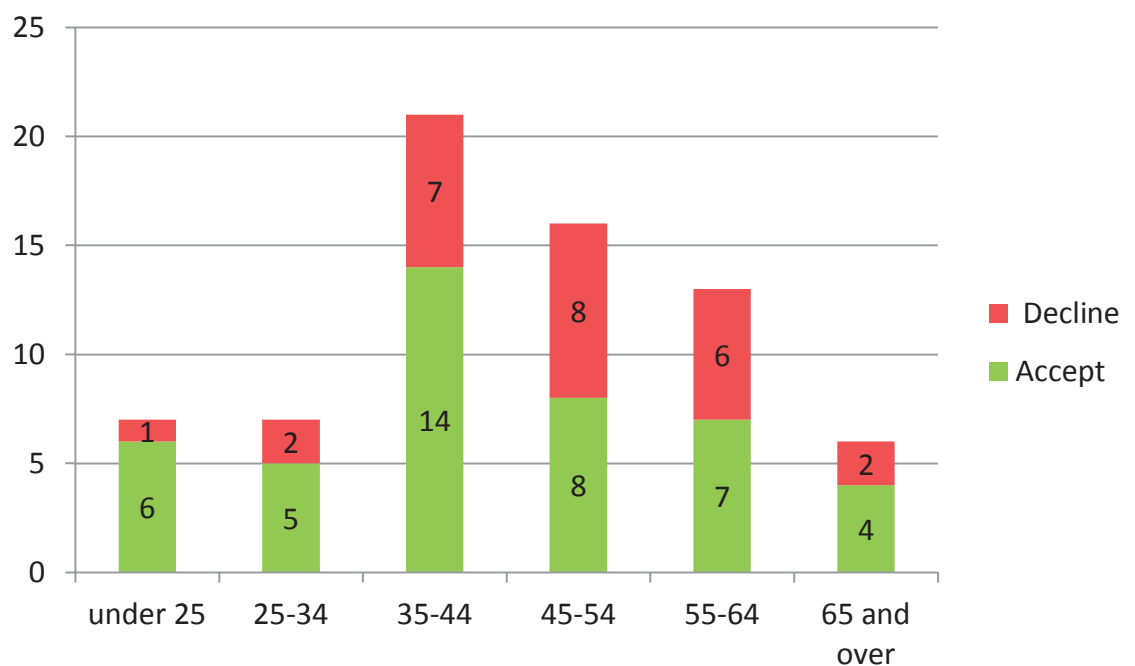


Figure 5.7: Numbers of female customers accepting and declining the offer of alcohol IBA service during observation (n=70)

Pharmacy staff regularly took the opportunity to offer the intervention to people waiting for prescriptions to be dispensed or those collecting a regular prescription. Indeed, in 89 of the 112 (79%) occasions where the service was offered, this was the customer's reason for visiting the pharmacy. Pharmacy teams highlighted that this client base could be most easily approached about the subject of alcohol and this formed part of the service specification in one of the participating PCTs. However, this approach resulted in a possible plateau of service provision since staff in pharmacies that had provided the service for a number of years reported that most of their regular customers had now been screened. The intervention was also offered following OTC and non-medicine sales in some pharmacies, but was less likely to be offered to customers accessing a service or seeking

advice (accounting for just seven and five of the cases observed respectively). On reflection during feedback sessions, some pharmacy staff felt that the IBA service could augment other services offered such as smoking cessation, weight management and Care at the Chemist. This highlights a possible training need in terms of recognising opportunities to offer the service beyond those waiting for prescriptions to be dispensed.

5.2.3 Service delivery

Standardised procedures for delivering the alcohol IBA service had been adopted at each pharmacy. At all pharmacies an initial approach was made to the customer at the counter. Staff reported that asking people to take part in a 'quiz' about alcohol or alcohol awareness audit was an effective and, they considered, non-judgemental way to broach the subject and this was consistent with promotional material about the service provided by PCTs. Analysis of intervention transcripts suggests that the manner in which the session was initiated did not appear to have a significant bearing on how the conversation developed. At four of the five pharmacies, staff completed the questions with the customer, while - at the remaining pharmacy - questions were self-completed by the service user prior to review with the staff. Interventions were usually delivered in the consultation room in NHS Wirral, while in NHS Knowsley and NHS Blackpool the counter or a quiet area of the pharmacy were predominantly used. Consultations were interrupted by staff taking phone calls on a number of occasions.

During service provision, staff typically posed the AUDIT questions in turn, although a minority of pharmacy staff also urged respondents to be truthful in their responses. The majority of consultations were carried out with staff using discursive strategies that appeared to be designed to manage conversations to minimise the potential of conversational discomfort for both staff and clients alike. For example, staff frequently pre-empted answers to questions:

"A lot of these [questions] won't apply to you probably but I'll check them with you anyway" (Case 5, M, 55-64; also in Case 6: M, 65+).

In a similar vein, staff members rephrased questions in a manner consistent with expectations regarding how clients may answer:

"Okay, um, I take it that you've never failed to do something that was expected because of drinking?" (Case 7: F, < 25)

"Take it you've never needed a drink in the morning to get yourself going?" (Case 1: M, < 25).

The use of these linguistic practices suggests that additional training may be required to help minimise the use of leading questions. Another conversational strategy employed was for staff to make use of laughter or personal disclosure as a means of mitigating the potential for conversational uneasiness. For example, in a conversation following on from the AUDIT question about memory loss, the Medicines Counter Assistant delivering the service remarked:

"We get rubbish [at drinking] as we get older" (Case 9: F, 55-64).

In another case, after a client replied 'never' to the question regarding feelings of remorse as a consequence of drinking alcohol, the staff member proclaimed:

"No, don't feel guilt or remorse after drinking! (laughter)" (Case 11: F, < 25)

During feedback sessions a number of pharmacy staff admitted finding these questions difficult to address with customers since they do not seem applicable or worded in the most appropriate way.

While such conversational practices may illustrate individual differences in the manner in which staff seek to build rapport with clients, they also exemplify challenges associated with delivering standardised IBA interventions. Staff employed a variety of rhetorical devices with the aim of making personal connections with clients yet this may have been at the cost of professionalism and standardised delivery of the intervention. In terms of training needs, this highlights the requirement for staff to be made aware of the need to strike the appropriate balance between being personable and professional.

As part of the service specification for all pharmacies, service user's AUDIT score and risk level ('low risk', scoring up to 7; 'increasing risk' 8 to 15 or 'high risk' 16 and over) should be fed back to the service user at the conclusion of the alcohol IBA screening/consultation and in all cases this was done. Additionally, appropriate advice and literature regarding safe alcohol consumption were handed out in most cases. During feedback, one pharmacy reported having a checklist accessible in the consultation room as an aide memoire for staff delivering the service of the advice applicable to a drinker at each risk level and materials which could be given, including unit and calorie counter wheels and drink diary leaflets. Efforts were made by pharmacy staff both to ensure that service users knew general guidance about units in different drinks and recommended limits and to tailor advice to the individual. One pharmacist reported that they usually invited customers to select one message from the advisory leaflet that they consider applicable to them and make a change accordingly.

5.2.4 Service Implementation

During feedback sessions with pharmacy staff, a number of contextual issues which act as barriers and facilitators to service delivery were pinpointed (Table 5.2). Key facilitating factors included training to develop and maintain staff confidence in their ability to deliver the service and the nomination of a staff member to 'champion' the service. In a number of instances the latter had developed informally among the staff group originally trained and proved beneficial. Fluctuations in the numbers of alcohol IBA consultations pharmacies could carry out per month, as a function of caps dictated by PCT funding constraints, were reported across all pharmacies as a limitation. In the context of securing payment, easy to record operational data, preferably in electronic format, for payment of those completed was identified as important. True referral, as opposed to signposting, customers screened as 'high risk' to alcohol services, and follow-up of others in-pharmacy where relevant, remained largely problematic. In some PCT areas, there was a lack of formal referral pathways but pharmacy staff considered these could be helpful. However, pharmacies in other areas where referral pathways were established reported resistance to being referred by customers screened as 'high risk', suggesting that issues around referral may need further consideration prior to more widespread rollout.

Barriers	Facilitators
Changeable funding constraints meaning that caps for number of interventions allowable per month fluctuate and can be limiting.	Clearly visible promotional material indicating how to access the service (inside & outside media) and supporting material about safe drinking.
Time pressures and impact on existing workload, particularly preparation and dispensing of prescriptions (a priority), therefore need to take a 'grab it when you can' approach.	Private space for confidential conversation of drinking habits – consultation room favoured for in-depth discussion.
Alcohol consumption can be a difficult subject to broach with customers, particularly those who may be at higher risk.	Training for staff, including periodic refreshers, to allow pharmacy staff to develop and maintain confidence in their ability to deliver service.
Service users seeming reluctance to tell the truth about their drinking habits and resistance to change.	Having a nominated member of staff who 'champions' the service.
Some of the questions on the full AUDIT questionnaire are difficult to address with customers and did not, to providers, seem applicable or worded in the most appropriate way.	Using an informal, friendly approach to introduce the idea of completing the screening to customer e.g. asking people to take part in the alcohol 'quiz' has been effective and doesn't look like you're targeting them specifically.
Lack of formal referral pathways into alcohol treatment services, or where these are established, resistance by customers screened as 'high risk' to being referred.	Building a rapport with the service user and taking an empathic, non-judgemental approach within alcohol IBA consultations and normalising drinking behaviour. Emphasising the health benefits of safe drinking, and finding a stimulus that is relevant to them.
	Easy to record operational data for submission of records of interventions completed to PCT for payment and - where relevant follow-up - with client.

Table 5.2: Factors affecting service implementation in pharmacies as perceived by providers

5.2.5 User experience

User perspective observations highlighted variability in the promotional materials and resources available to the service user. Promotional posters related to the alcohol Identification and Brief Advice (IBA) service were visible on approaching the pharmacy at three pharmacies visited (n=11) and inside at five of the pharmacies (n=11). Market Researchers reported that - in most cases - posters clearly guided customers to talk to a member of staff if they would like a consultation, although some referred more generally to how to access NHS specialist alcohol treatment services. Information leaflets on drinking, with detailed information about alcohol and its effects on illnesses, were on show at nine and seven pharmacies respectively (n=11). Unit and calorie counters were also widely available, while drink diary leaflets and glasses showing unit measures were offered by a few pharmacies visited. The display of these and other health promotional materials, laid out prominently on a central table, at one pharmacy visited was highlighted by Market Researchers as particularly accessible to pharmacy users; other pharmacies were reported as making use of counter space and 'information areas', though these were sometimes cluttered.

In some pharmacies, Market Researchers (MR) reported that the layout did not provide sufficient privacy, even where 'quiet areas' were utilised.

"It did not feel very private or confidential as I was speaking in front of the other customers. [Speaking] about my results in a public setting deterred me from speaking openly about my drinking." (MR2, M, 25-34)

All five occasions in which MRs received a full IBA consultation in the consultation room were positively evaluated regarding the private space and this provided for an open discussion of their drinking habits:

"The separate room gave total privacy. I felt I could open up and answer honestly." (MR1, M, <25)

Table 5.3 below, and an expanded version in Appendix 5.17, summarise 17 cases where the alcohol IBA consultation was observed and service users were followed up post-intervention. While privacy concerns were not widely reported by these service users, it is likely that they were a factor as reported elsewhere (Mackridge et al., 2010b) and as supported by the above findings from Phase one.

Case no	Details	Alcohol IBA consultation	Follow-up 1	Follow-up 2
1	Male, < 25, non-medicine purchase	<ul style="list-style-type: none"> Drinks only rarely, a couple of pints once a month. AUDIT score 4; low risk; informed of recommended guidelines; given alcohol awareness literature 	<ul style="list-style-type: none"> Thought service was good idea which raises awareness and could see the value for others who drink excessively Felt should have been more honest about how much he drank – more than told pharmacist, describing himself as a 'binge drinker' Would recommend service to friends and family as a source of non-judgemental support about alcohol 	<ul style="list-style-type: none"> Thought consultation had made him more aware of what help and support was available if he needed it His drinking habits have not changed and had drunk a lot this weekend Had spoken to a friend who he thinks needs help with his drinking and tried to get him to go to pharmacy but the friend is adamant he is fine so has not accessed alcohol service
2	Male, 55-64, waiting for prescription to be dispensed	<ul style="list-style-type: none"> Drinks 2-4 times a month; drinks up to 4 pints on a night out Staff seeks to find out if he knows what a unit is; calculate unit consumption (half pint = 1 unit) Reduction in drinking due to medical condition + financial issues AUDIT score 3; low risk 	<ul style="list-style-type: none"> Felt at ease having discussion about drinking habits in consultation room Because not a big drinker discussion had not changed way thought about alcohol & received minimal advice Would recommend service to others as perceived as informative and up to individual if take advice. 	<ul style="list-style-type: none"> Found service informative and thought staff made it very user friendly and easy to understand His drinking habits have not changed as does not drink to excess as is diabetic Has not had need to recommend service to family/ friends
3	Female, 35-44, waiting for prescription to be dispensed (10 min wait)	<ul style="list-style-type: none"> Completed questionnaire at counter with MCA Informed of AUDIT score and risk level Given info leaflet on safe alcohol consumption 	<ul style="list-style-type: none"> Felt had enough privacy at the counter as at one end away from other customers Found info given useful esp. chart re units in different drinks but was unsure what score at end meant Would recommend service to family & friends, mentioning good existing rapport with pharmacy staff 	<ul style="list-style-type: none"> Mentioned service to family & friends who also thought it was a good idea Her drinking habits have changed: reduced drinking so instead of drinking 3-4 times a week now twice a week; switching to non-alcoholic drinks with dinner in week More aware of services available in pharmacy but not accessed – Lipotrim weight management not needed
4	Female, 35-44, prescription	<ul style="list-style-type: none"> Completed questionnaire at counter with MCA Informed of AUDIT score and risk level – low risk Given info leaflet on safe alcohol consumption 	<ul style="list-style-type: none"> Felt had enough privacy at the end of counter, service well-run by nice staff Found info given useful & thought discussed had changed way thought about intake and health impacts Would recommend service to family and friends; commented could show leaflet given to someone else, though hadn't done so yet. 	<ul style="list-style-type: none"> Found pharmacy staff helpful but couldn't remember anything particular about consultation Her drinking habits have changed: reduced and felt opportunity to talk during consultation had helped Has started attending gym every night to occupy evenings instead of pub

Table 5.3: Summary of service user cases: alcohol IBA service consultation; 1-2 weeks post intervention interview (Follow-up 1); and 3 month interview (Follow-up 2)

Follow-up interviews with 16 service users revealed that the service was positively received, with the most prominent emergent theme being perceived usefulness of the service to individuals considered 'at risk'. Respondents typically distanced themselves from the possibility that they might benefit personally from an IBA service but readily subscribed to the view that the service was a good idea - in particular for other/ younger people.

"If it helps someone to, you know, if they've got a drinking problem, if you can stop it going further, it's going to save money for the National Health and it's going to save their life" (Case 8: M, 65+).

Another service user felt that the service should be targeted at those aged under 50 years and that it would be a good idea to "let the pharmacy know" (Case 5: M, 55-64) if a relative has an alcohol problem. A minority of respondents, however, felt that GPs might be more appropriate for discussion regarding personal alcohol consumption. Only one respondent at follow-up felt that the service was "a bit pointless" and primarily applicable to other people.

"I don't think it'd change anyone's life. I don't think it would change the way they drink 'cos of doing that." (Case 12: F, 35-44)

Service users were generally happy with the manner in which the service was delivered and staff felt that this was, in part at least, related to their existing rapport with customers.

At 3 month follow-up with 14 users, six of the respondents remarked that they had talked to others about their drinking habits and safe drinking since the consultation (two within a work context) while three respondents had discussed the service with family and friends, with two of these proposing to a significant other that they should attend it. This demonstrated the potential for a 'cascade' effect, with impact reaching beyond service users alone. Almost all respondents stated that they would recommend the service to family and friends.

In all but two cases respondents reported that the intervention had not affected their personal alcohol consumption. This was consistent with the aforementioned perception that excessive consumption was an issue for others but not for themselves. However, in two cases, service users reported significant lifestyle changes, which they attributed to receiving the IBA service. In one case the respondent reported that, together with their partner, they had cut alcohol consumption from approximately four days per week to about 2 days a week (Case 3: F, 35-44). In another case a respondent reported cutting alcohol consumption very significantly and attending the gym on a daily basis following the consultation (Case 4: F, 35-44).

5.3 Summary of key messages from in-pharmacy work and user interviews

A wide range of opportunities to provide alcohol IBA screenings and consultations were available at community pharmacies. The customer base is of a broad demographic: customers visiting the pharmacies observed throughout the day were of both sexes and of all ages. The majority of staff interactions with customers observed at the counter were associated with prescriptions and these encounters were shown to be well-utilised by staff as an opportunity to offer the service. Customers visiting the pharmacy for other reasons, particularly for OTC sales and to access other enhanced services offered, form a further group of potential service users which pharmacy staff could target for the intervention.

Initiating the discussion by asking customers to participate in an alcohol quiz or alcohol awareness audit was a popular approach to a non-confrontational conversation opener. The majority of customers offered the alcohol IBA service during the observation period accepted the screening and the service was positively received by the service users interviewed post-intervention. Those interviewed perceived the service to be informative and a good idea, particularly for individuals drinking at higher risk levels, with most reporting that they would recommend it to family and friends if appropriate. Providing a consultation room for a more in-depth discussion addressed issues of privacy.

There was some evidence that the alcohol IBA service has a positive impact on the drinking behaviour of some customers. In two of the sixteen cases that were followed up, service users indicated they had significantly cut down their drinking and made other lifestyle changes. A number of respondents also reported an increased awareness of units in different drinks and recommended limits, and of other lifestyle services offered at the pharmacy.



Chapter 6

Workstream C: Provider and Stakeholder engagement

6.1 Methods

6.1.1 Pharmacists/staff survey and interviews

All pharmacists and a staff member in each of the 94 pharmacies participating in the Northwest IBA service were invited to take part in a survey between March and May 2012. The number of pharmacies by area contacted to take part in the study was; Knowsley =17, Oldham = 9, Bolton = 7, Wirral = 33, Blackpool = 18 and Sefton =10. Each pharmacy was sent two copies of the postal survey (one for the pharmacist and one for a staff member who had delivered the service) to complete. Ninety-three surveys were returned, from 52 pharmacies, giving a response rate of 49%. The survey sought information about pharmacist and pharmacy staff experiences of delivering the service, with a focus on understanding the challenges and successes of delivering this service in the community pharmacy setting (Appendices 6.1 and 6.2). At the end of the survey participants could indicate if they would like to be contacted to take part in a short telephone interview.

Three pharmacists and four pharmacy staff members in five different pharmacies who had delivered the service volunteered to take part in a short telephone interview in order to gain a deeper understanding about their experience of delivering the service (Appendices 6.3 and 6.4). Interviews took between 5 and 20 minutes: all were digitally recorded and transcribed verbatim. They were conducted in May/June 2012. Consent forms were received from all interviewees prior to interview (Appendix 6.5).

6.1.2 Stakeholder survey and interviews

An online stakeholder survey was conducted in March 2012 in order to explore inter-professional relations and potential common ground for future service development (Appendix 6.6). The gatekeeper interviews in Phase 1 and Workstream B (users and providers) informed the online survey questions and the stakeholder interview format. The sample inclusion criteria for the stakeholder interviews and online survey was purposive, in that individuals identified by the research team as being stakeholders were invited to take part in the study. However a snowball sampling was also implemented in the study design, in that, the invitation email encouraged identified stakeholders to forward the information to other potentially interested individuals. Electronic mail shots were distributed to relevant parties including Drink Wise North West, Alcohol Concern, all the PCT alcohol leads in the North West, and all the LPCs in England and Wales. The study design involved an online survey which was available at <https://www.surveymonkey.com/s/StakeholderWSC>. Anonymity and confidentiality was assured. Seventy-eight stakeholders nationwide completed the survey.

For the qualitative element, ten nationwide stakeholders were identified and interviewed by telephone in order to gain a deeper understanding of their views and perceptions of the alcohol IBA service being delivered in the community pharmacy setting (Appendices 6.7 and 6.8). Interviews took between 15 and 35 minutes, were digitally recorded and transcribed verbatim. They were conducted in May/June 2012. Consent forms were received from all interviewees prior to interview (Appendix 6.9). Commissioners and policy makers were asked about current and future commissioning of alcohol services, and their experience/perceptions of the advantages/disadvantages of different service models.

6.1.3 Data analysis

Qualitative Data - with participants' consent, all the interviews from all workstreams were recorded for transcription and then imported into QSR NVivo software for thematic analysis. Researchers responsible for conducting the interviews coded the transcripts, and categories were compared to check for consistency and in order to identify the relevant sub-themes.

Quantitative Data – all survey data were imported into, and analysed using SPSS version 19. Descriptive and inferential statistics were used dependent on the data.

6.2 Results

6.2.1 Service provider survey

Ninety-three pharmacists and pharmacy staff, from 52 pharmacies who had provided or were still providing the service, completed a postal survey: this gave a response rate of 49%. Nearly half of participants were from the Wirral area (46%, n=43). More pharmacists (60%, n=56) than pharmacy staff (40%, n=44) completed the survey. Participants most frequently identified themselves as pharmacy managers (33%, n=31), followed by medicines counter assistants (17%, n=16). Participants were fairly equally represented across the range of years they had worked in community pharmacy. The location of the pharmacy for the majority of participants was among local neighbourhood shops (28%, n=26) followed by a village high street or centre (19%, n=18). The majority, 91% (n = 85) of the participants worked in a pharmacy which was part of a chain. The number of staff trained in delivering the IBA alcohol service ranged between 1 to 10, with the majority between 2 and 4. The number of enhanced services delivered by the pharmacies ranged from none to 9, with a fairly even distribution between 1 and 5. 50% (n=46) of participants stated that the pharmacy in which they worked dispensed more than the average of 6,340 NHS items per month.

The majority of participants, (58%, n= 54) had been delivering the service for 12 or more months. A one-way ANOVA found a significant difference between the priority given to the service by the provider (their priority choices were given as high, medium or low), and the number of months (under 11/ 12 plus) the service had been delivered ($F(3, 81) = 6.519, p=.001$). Those that had been conducting the service for a longer period of time placed more value on the service. ANOVA analysis found no significant effect of the number of IBAs done per month and the priority given to the service.

The most commonly stated way in which participants identified customers for the alcohol IBA service was through customers presenting specific prescriptions (n=20), which was similar to data collected in the other workstreams. However 54 participants stated they had no particular target and asked everyone. From the free comment box other ways that

customers were identified included; waiting for prescriptions, part of MUR or smoking cessation conversation, part of the NHS health check, or through talking with people concerned about their weight. The majority of participants stated the service took between 6-10 minutes (56%, n=51), although some took only 1-5 minutes (24%, n=22), and 20%, n=18 took 11 plus minutes to complete. Participants tended to conduct the alcohol IBA service over the counter and then take the customer into a consultation room (44%, n=39). The main reason for providing the service this way was due to confidentiality (n =11).

Participants were asked to indicate the extent they agreed/disagreed with a number of statements about the IBA service (Table 6.1 overleaf). For ease of read the majority response has been highlighted for each statement. It can be seen that the majority of participants agreed with all statements apart from the statement 'Other professionals (like GPs) referred people to us for this service'. The majority of participants disagreed with this statement.

Statement	Strongly agree % (n)	Agree % (n)	Neither agree nor disagree % (n)	Dis-agree % (n)	Strongly disagree % (n)	Don't know % (n)	M	SD
Community pharmacies are appropriate locations for alcohol IBA services to be delivered	29.0 (27)	48.4 (45)	14.0 (13)	4.3 (4)	4.3 (4)	-	2.06	.998
Community pharmacists can reach a wider range of people than other alcohol services	39.8 (37)	41.9 (39)	12.9 (12)	2.2 (2)	2.2 (2)	1.1 (1)	1.88	.987
A supportive working environment helped us to provide the alcohol IBA service	22.6 (21)	51.6 (48)	16.1 (15)	5.4 (5)	2.2 (2)	2.2 (2)	2.19	1.056
The way the data for the IBA service were recorded was not time consuming for pharmacists and staff	13.2 (12)	50.5 (46)	16.5 (15)	14.3 (13)	3.3 (3)	2.2 (2)	2.51	1.129
Support from colleagues helped us to provide the service	21.5 (20)	50.5 (47)	18.3 (17)	4.3 (4)	3.2 (3)	2.2 (2)	2.24	1.077
Time constraints prevented this service being fully adopted by this pharmacy	16.7 (15)	35.6 (32)	15.6 (14)	23.3 (21)	6.7 (6)	2.2 (2)	2.74	1.294
There is a need for this service in this area	26.9 (25)	45.2 (42)	16.1 (15)	6.5 (6)	5.4 (5)	-	2.18	1.073
Workload pressures prevented this service being fully adopted by this pharmacy	20.7 (19)	30.4 (28)	12.0 (11)	23.9 (22)	10.9 (10)	2.2 (2)	2.80	1.408
There is always enough time to talk with customers about issues like alcohol	9.7 (9)	35.5 (33)	8.6 (8)	34.4 (32)	11.8 (11)	-	3.03	1.255
The pay the pharmacy received for providing this service was appropriate	12.0 (11)	51.1 (47)	16.3 (15)	6.5 (6)	2.2 (2)	12.0 (11)	2.72	1.470
There was a general lack of awareness about this service by our customers	28.0 (26)	48.4 (45)	10.8 (10)	10.8 (10)	2.2 (2)	-	2.13	1.076
The training I received was adequate to deliver this service	25.8 (24)	59.1 (55)	9.7 (9)	-	-	5.4 (5)	2.05	1.107
It is useful for the community to have community pharmacies deliver this service	26.9 (25)	52.7 (49)	11.8 (11)	3.2 (3)	-	5.4 (5)	2.16	1.236
We told other professionals (like GPs) that we were providing this service	7.6 (7)	29.3 (27)	17.4 (16)	26.1 (24)	3.3 (3)	16.3 (15)	3.37	1.531
Other professionals (like GPs) referred people to us for this service	5.4 (5)	13.0 (12)	5.4 (5)	43.5 (40)	17.4 (16)	15.2 (14)	4.00	1.367
I enjoyed providing this service	16.1 (15)	41.9 (39)	22.6 (21)	10.8 (10)	5.4 (5)	2.2 (2)	2.37	1.240

Table 6.1: Provider responses to statements about the alcohol IBA service

Participants were asked to indicate the extent they agreed/disagreed with a number of statements about their own experience of the IBA service (Table 6.2). It can be seen that, for all statements, 'sometimes' was the most common response. There is an interesting juxtaposition that many staff felt that it was at least sometimes difficult to approach customers about their alcohol use, but also that they at least sometimes felt confident when approaching customers about their alcohol use.

Statement	Always % (n)	Often % (n)	Sometimes % (n)	Rarely % (n)	Never % (n)	Don't know % (n)	M	SD
The service received a good response from our customers	19.4 (18)	26.9 (25)	34.4 (32)	14.0 (13)	2.2 (2)	3.2 (3)	2.62	1.197
It was difficult to approach customers about their alcohol use	14.0 (13)	21.5 (20)	53.8 (50)	5.4 (5)	3.2 (3)	2.2 (2)	2.69	1.032
I felt confident when approaching customers about their alcohol use	17.2 (16)	32.3 (30)	35.5 (33)	6.5 (6)	3.2 (3)	5.4 (5)	2.62	1.250
It was easy to engage with other alcohol services about referrals	12.9 (12)	19.4 (18)	29.0 (27)	14.0 (13)	5.4 (5)	19.4 (18)	3.38	1.641
Finding an appropriate way to start the conversation about alcohol use with an individual was difficult	5.4 (5)	18.3 (17)	49.5 (49)	14.0 (13)	9.7 (9)	3.2 (3)	3.14	1.099

Table 6.2: Provider responses to statements about their experience of the alcohol IBA service

The majority (72%, n = 67) of participants surveyed did not follow up with customers in order to see if their alcohol use or perceptions had changed. Almost three-quarters (74%, n = 69) of participants felt the service was a success and 83% (n = 77) would be willing to continue the service. In general the service was viewed positively with comments on why participants would continue the service focussing on the benefits of the service in providing knowledge about alcohol.

6.2.2 Service provider interviews

The majority of participants worked in a chain pharmacy, with only one participant working for a small independent pharmacy; all had previously delivered or currently deliver the alcohol IBA service. There was a mix with regards to the prescription throughput of the pharmacies, with some pharmacists reporting delivering well above the NHS average of 6,340 NHS prescriptions per month, others meeting the average per month, and others well under this average. All the pharmacies delivered between three and six other enhanced services and had between three and eight members of staff.

Delivering the alcohol IBA service

There was a general consensus among pharmacists and pharmacy staff that the service was useful for the community in their area and all said that they would conduct the service again (if they were not already offering the service) if funded. Participants also stated that they enjoyed delivering the service, citing a variety of reasons including; easy service to deliver, enjoyed engaging and talking with patients and staff felt the service was received well by customers who appreciated the information and advice.

"It made work more enjoyable or something different to do". (Interview 2, pharmacy staff)

"I actually enjoyed doing it. I think it helped you know cause people didn't realise just how many units there was in the drinks what they were having they thought one glass was one unit and obviously it's not is it, or one can one unit and they were quite surprised how many units there was in a can". (Interview 3, pharmacy staff)

"It was quite fun. I love the wheel as a way of they had an alcohol wheel and nobody really knew how many units they were taking so it was quite a shock to them so that was good". (Interview 7, pharmacy staff)

Difficulties experienced

Difficulties experienced in service delivery centred upon approaching customers about their alcohol consumption and starting the conversation about alcohol consumption.

"A barrier is that some people aren't comfortable with actually talking about their alcohol consumption". (Interview, 5, pharmacist)

"Many customers thought alcohol consumption was something very personal to them and they didn't want to discuss it with any health care professional, they felt that they were competent enough to make that decision whether it was going to do them harm or not". (Interview 6, pharmacy staff)

"I think it is the broaching it with patients really, they're sort of you know gauging your audience really whether you're going to get you know receptive patients really". (Interview 1, pharmacist)

Feedback to providers

Not much feedback had been received from service users: two of the participants interviewed, however, had received generally positive feedback.

"The people that actually took part did benefit and all of them have come back to us and saying the actual material that we gave out was helpful as well. So they've used it then with their family members, certainly people that had teenagers and so on they used the actual material with them to say you know, "Have you looked at this?" and they found them really, really useful". (Interview 1, Pharmacist).

6.2.3 Stakeholder survey

About the participants

Seventy-eight participants completed the online stakeholder survey. Respondents were asked to describe their involvement with alcohol services, participants were from various roles across the UK however the majority (64%, n =46), described themselves as pharmacy provider representatives (e.g. LPC). Participants to the survey were from across England with the majority being in the North West (44%, n= 30). Five participants stated that they had a national remit. The majority of participants were aware of an alcohol IBA service being delivered in the community pharmacy setting either in their own PCT (38%, n=29) or in another PCT (38%, n=29). 18 were not aware of it at all (24%).

Participants' perceptions and experience of the alcohol IBA

Participants were asked to indicate the extent they agreed/disagreed with the following statements (Table 6.5). Only 72 of the 78 participants that completed the survey completed this section. For ease of reading, the majority response has been highlighted for each statement.

Statement	Strongly agree % (n)	Agree % (n)	Neither agree nor disagree % (n)	Disagree % (n)	Strongly disagree % (n)	Don't know % (n)	M	SD
Community pharmacies are appropriate locations for alcohol IBA services to be delivered	69.9 (51)	23.3 (17)	4.1 (3)	2.7 (2)	-	-	1.397	.702
Community pharmacists can reach a wider range of people than other alcohol services	68.5 (50)	28.8 (21)	2.7 (2)	-	-	-	1.343	.533
We have good data about the pharmacy IBA service on which to base future commissioning	5.6 (4)	33.3 (24)	30.6 (22)	18.1 (13)	1.4 (1)	11.1 (8)	3.097	1.344
Pharmacists engage well with other alcohol service providers	15.3 (11)	31.9 (23)	30.6 (22)	16.7 (12)	2.8 (2)	2.8 (2)	2.681	1.172
There is a need for this service in this area	57.7 (41)	31.0 (22)	8.5 (6)	-	-	2.8 (2)	1.620	.991
This pharmacy service should be a high priority for commissioners	45.8 (33)	38.9 (28)	13.9 (10)	-	1.4 (1)	-	1.722	.809
The local community benefits from having this service in community pharmacies	55.6 (40)	33.3 (24)	5.6 (4)	2.8 (2)	-	2.8 (2)	1.667	1.035
Pharmacists will need a lot of extra training to deliver this service properly	4.2 (3)	25.0 (18)	22.2 (16)	38.9 (28)	9.7 (7)	-	3.250	1.071
I am confident that community pharmacists provide this service well	34.7 (25)	47.2 (34)	9.7 (7)	2.8 (2)	2.8 (2)	2.8 (2)	2.000	1.126
My area has a well-integrated service provision for alcohol	4.2 (3)	18.3 (13)	35.2 (25)	19.7 (14)	8.5 (6)	14.1 (10)	3.521	1.382
Pharmacists are an integrated part of the alcohol service provider network	13.9 (10)	13.9 (10)	25.0 (18)	29.2 (21)	16.7 (12)	1.4 (1)	3.250	1.319

Table 6.5: Stakeholder responses to statements about the alcohol IBA service

The majority of participants felt the service should be commissioned nationally (79%, n=57), with the remainder responding that it should be a locally commissioned service (21%). The vast majority (82%, n=37) of pharmacy provider representatives, 75% (n=9) of commissioners of primary care services, 50% (n= 3) of policy makers, and all of the research/ education stakeholders felt the service should be commissioned nationally.

Participants were asked to comment on what they thought pharmacists can contribute in providing this service. This question received a large number of responses, all of which were in support of the alcohol IBA service being delivered in the community pharmacy setting. The responses fell into three main areas.

1. The appropriateness of the pharmacy setting delivering this service (n=46). The main reasons for this service being delivered in the community pharmacy setting include; accessibility, a non-judgemental environment, informal, long open hours, and confidential.
2. The opportunistic nature of pharmacists being able to deliver this service (n=35). Pharmacists were viewed as being able to offer this service as part of their role and through advising on other matters such as smoking cessation. There was also the perception that pharmacists can reach a wider demographic compared to other health professionals
3. Increasing knowledge & awareness (n=24). Pharmacists were viewed as an appropriate resource for advice and support, and as being in a position to raise the awareness of alcohol within the community setting.

The only negative aspect of the service was around staff confidence in approaching and engaging the customers about their alcohol use.

6.2.4 Stakeholder interviews

Interviews were conducted with ten pharmacist stakeholder representatives, including the Chairs of five Local Pharmacy Committees from across the UK, Health and Wellbeing leads, and representatives from the National Pharmacy Association. All of the stakeholders interviewed had a thorough knowledge about the service and experience of the service being delivered in the community pharmacy setting or the potential of it being delivered in this setting. The five LPC stakeholders interviewed had local level involvement with the service whereas the other five had a national role and a nationwide look on the service.

The delivery of the alcohol IBA in the community pharmacy setting

All of the ten stakeholders interviewed were very positive and supportive about an alcohol IBA service being delivered in the community pharmacy setting. In general pharmacists and pharmacy staff were viewed as being able to deliver the service, once trained, and should deliver the service due to their position as health professionals within the community.

"I think it's a good setting to have it delivered in, obviously community pharmacists see patients or customers who come in every day."(Interview 1)

"you know the value of your community pharmacy is it's there, you know in many cases 7 days a week, and often for long hours and so people can access it outside of you know 9 to 6 or whatever some of the other agencies offer Monday to Friday". (Interview 3)

The alcohol service was viewed as being able to fit in with other services pharmacists currently deliver and advice giving was seen as already a part of a pharmacist's role and therefore another viable reason as to why they are in a good position to provide this service.

"Pharmacists for years now have been delivering stop smoking services which are in one way fairly similar in terms of you know advising people on effects of the habit, you know providing information on these you know changing habits you know and actually effecting change and helping people to make the change". (Interview 2)

In support of the stakeholder online survey finding, those stakeholders interviewed felt that community pharmacies delivering this service could reach a wider demographic, people who may not be reached through other service providers through the opportunity to deliver the service whilst providing advice on other issues such as weight, hypertension and sexual health.

"I think community pharmacy sees a lot of well patients or people who believe they're well but may have issues that aren't going to their GP surgery or other agency so I think you know community pharmacy is often the front line where you know there's opportunity to get this lifestyle messaging across to people". (Interview 3)

"The fact that you know they're open very long hours so you know people don't have to make appointments they just walk in and they could be coming in like I said, they could be coming for something else and then through conversation you know about...it could lead to these sort of subjects being broached much more easier and it's just generally raising awareness". (Interview 2)

"you have opportunities in a pharmacy when you're doing MUR's and you're talking to patients you have the opportunities to get into the conversation, you know and you know, "Can you tell me say a little bit about your alcohol use?" and then we can you know we can then do the audit and see whatever and move them along and give them some lifestyle advice and refer them if necessary". (Interview 3)

Indeed a number of interviewees commented on the added value of pharmacists delivering this service compared to GPs. The community pharmacy setting was viewed as a more practical and opportunistic setting than that provided by GPs.

"I think pharmacy will have more time, they can tie into things like whether they do reviews on medication don't they. So it's having that time to sit through and take a bit of time with individuals which GP's don't have really, so I think it's good." (Interview 7)

"people access pharmacies...community pharmacies much more regularly than say maybe their GP practice and in fact well people who don't have any reason to go anywhere near a medical practice go in for other things even shopping, even if it's not anything to do with prescriptions they go in to buy over the counter medicines etc. So I think in terms of face to face interaction it's very possible " (Interview 2)

"It's the different environment that they offer, it's not a clinical environment it's a socio-clinical environment so it's a less threatening, certainly less judgemental type of environment where people feel more comfortable to have those sorts of conversations than they would do in a more clinical environment like a hospital or a GP practice". (Interview 5)

In order for the service to reach its full potential, there was a consensus that the service needs to become embedded within community pharmacy. This view was also expressed in the pharmacist/staff survey. Two stakeholders specifically thought it could become part of the 'Healthy Living Pharmacy' framework:

"I think in order to make it routine one of the things that I think contributes to success, well a string of success in IBA is where it's...where audit is actually included within whatever electronic screening assessment systems that the practitioners are actually using so that it becomes a no brainer so they don't have to think, "Shall I do this?" it is just automatically done as part of all the routine questioning so for instance in A&E its most successful where its built in to the electronic triage system that way it can't not happen and it does happen and that sets off the whole...sets the whole thing in motion so it's about imbedding it in the existing system so it becomes completely routine mainstream and run of the mill that's the identification bit. They've then got to be trained in delivering the brief advice of course". (Interview 8)

"The difficulty initially was to use the service in isolation, in isolation it was hard to convince fellow colleagues...and I know sometimes the wider audience in terms of the patients, how this fits in but as a suite of lifestyle interactions like I say in terms of smoking cessation, in terms of alcohol screening and in terms of weight management all three are very strong public health messages and they actually compliment quite well and it fits ideally in the role of health champions and healthy living pharmacies." (Interview 6)

Feedback about the service

With regard to receiving feedback about the service a few of the stakeholders had received some feedback from pharmacists and pharmacy staff, but little feedback had been received from service users, stakeholders or other healthcare providers. The feedback that had been received was generally positive especially in terms of pharmacists and pharmacy staff experiences of delivering the service and their experience of service user responses.

"Certainly from pharmacists and pharmacy staff are all very positive despite some concerns about opening that conversation with people when they actually get down to it and learn the language to use and the way to approach it, it's never a problem". (Interview 5)

"I've spoken to staff about it the kind of feedback that they've been getting and it seems to be very well received, people are quite happy to fill out the cards and have a quick chat". (Interview 4)

Integration with wider alcohol services provision

There was a mix of responses with regards to how well pharmacists were integrated with other alcohol related services. Participants from the LPC saw services as being less integrated than the other stakeholders. Despite this current lack of integration, the view was expressed that delivery of the IBA service would greatly improve integration.

"At the moment very low but we hope to improve that... Yeah improve it through the IBA service, raise the awareness of pharmacists". (Interview 3)

"I've experienced varying degrees with integration you know from it being completely isolated and there being no awareness in primary care of the fact that it's going on to areas where they've got really clear pathways into which IBA in pharmacy is quite well integrated but you know it's like everything else it's very, very patchy and different in...differs from area to area". (Interview 8)

What could be improved/changed?

Despite the stakeholders feeling confident and satisfied with the service being delivered in a community pharmacy setting, a number of changes to the service were suggested. These included increasing the level of engagement by some of the pharmacists delivering the service, issues around time and workload pressure, the training needs of service providers, and the difficulty some service providers find with broaching the subject. Scratch cards were viewed by two of the interviewees who had been involved in service delivery as a way to make the approach of the subject of alcohol easier.

“Now a little bit of training on how to broach difficult subjects and conduct conversations in those sort of subjects and you know sexual health is another one like alcohol it would have probably helped.” (Interview 2)

“Increasing that level of engagement locally so that people are referring to pharmacy and getting other providers to understand that pharmacies are a good place to do that ...keeping it simple, recording appropriate levels of activity and outcomes but keeping it very simple, keeping it very smart and allowing health champions to deliver that..” (Interview 5)

“...the difficulty we’ve found is with pharmacists being uncomfortable I suppose with raising the issue of alcohol. We’ve been using the alcohol scratch cards in Berkshire and that has certainly helped.” (Interview 1)

Future commissioning and measures of success

There was support to see this service commissioned at a national level by all ten interviewees. Having the service commissioned nationally was viewed as a way forward in standardising the service and embedding the service as part of community pharmacy practice. However there was acknowledgment that the restructuring of the PCTs was going to have a significant impact on the future of commissioning.

Measures of success tended to focus at the individual level, in that the service would be viewed a success if it captures people who are potentially high risk drinkers getting referred to other alcohol services or indeed if there is evidence that the service changes people’s behaviour through the advice they received. Patient follow up was viewed as a good measure of success by a number of stakeholders from varying roles since the follow up may provide evidence of behaviour change. There was also some suggestion that the service needs to be measured in terms of its impact on other services and evaluating the service in terms of value for money.

6.3 Summary of key messages from service providers and stakeholders

Community pharmacy is regarded as an appropriate environment for the delivery of an alcohol IBA service.

There is a lot of added value of community pharmacy delivering this service, including; the informal setting, the opportunity to reach a wider demographic than other health professionals such as GPs with the potential to raise awareness and knowledge about alcohol.

Service providers enjoyed delivering the service and it was received well by the community.

Pharmacists and pharmacy staff lacked confidence in approaching the subject of alcohol.

The service would be improved by greater integration with other alcohol service providers.

The service would benefit and be utilised to its full potential from being embedded within community pharmacy or as part of the Healthy Living Pharmacy framework.



Chapter 7

Multi-Stakeholder workshop

In this chapter, we present the outputs from the workshop with stakeholders. Key stakeholders were identified by the core research team and project advisors. In total 48 stakeholders were invited including service commissioners, service users, alcohol charities, community pharmacy and other alcohol service providers from national, regional and local levels. Eighteen attendees across all key stakeholder groups were represented on the day, along with eight members of the research team.

Prior to the workshop, the research team sent stakeholders a briefing paper (Appendix 7.1) containing a summary of findings. Building on the briefing paper, two stimulus presentations were made at the workshop (Appendices 7.2a and 7.2b) and participants worked in groups to address two topics **“What needs to be done to continue to improve the delivery, quality and sustainability of the service?”** and **“What needs to be done to maximise the opportunity and impact of service delivery in the pharmacy setting?”**. The groups were then asked to give feedback on preliminary recommendations and to prioritise actions needed as a result of the evaluation findings. This chapter begins with the identified priorities then goes on to explore outputs from the group work.

7.1 Priorities for action

Stakeholders were asked, in reviewing our preliminary recommendations, to identify their top five priorities, and also to put any forward additional recommendations that they felt were warranted by the data. The following emerged as the highest priorities:

- 1. Greater standardisation** of the service with core elements and some that can be localised.
- 2. Demonstrating value** – strengthen the evidence base on: *“Is the pharmacy service as/more/less cost-effective than other Tier 1 services?”*
- 3. Engaging the public** – through increased awareness of the service and increased staff confidence to deliver
- 4. Change pharmacy culture** – from illness to wellness
- 5. Produce a plan for stakeholder engagement**

7.1.1 Greater standardisation

Stakeholders recognised that the direction of travel in commissioning was largely away from national service specifications and that to pursue this would be unrealistic. However they felt that the current differences in service specifications revealed by the evaluation meant that service users in neighbouring areas might receive different interventions and that variation in data being collected made it more difficult to monitor process and outcomes. At one extreme was a PCT where the pharmacy service consisted only of screening questions with all service users identified as needing a brief intervention referred to the general practice. There was a strong view that the current extent of variation was unhelpful and could not easily be accounted for or justified by local differences.

“More standardisation needed of training, data collected, audit, and information provided in Brief Interventions”

The data that pharmacies were required to record varied from area to area, both in terms of the data items and the records themselves. Stakeholders felt that without a minimum dataset it was difficult to monitor and audit the service:

“Minimum dataset: Gender, age (not D.O.B), initials, first 4 or 5 letters of postcode”

Collecting postcode data was viewed as valuable because it could enable pharmacy data to contribute to local identification of other service needs.

“Inclusion of postcode in dataset would allow “hotspot management” – knowledge of where heavy drinkers are – this intelligence could feed other services”

Paper records made it more difficult to analyse service data and, even where there was an option for the use of IT, uptake across all pharmacies was not guaranteed:

“Pharmacy organisations need to take some responsibility to allow pharmacy to submit data on IT”

Stakeholders also saw potential for efficiencies in greater sharing of promotional materials, tools to support brief interventions and information for service users. Sharing of good practice (based on evidence, for example, from service user feedback) was also viewed as important and potentially leading to a more consistent identity for the service. Stakeholders thought that pharmacy could work with local commissioners to capitalise on the potential for greater standardisation of these materials while still allowing some flexibility for local variation.

7.1.2 Demonstrating value

Stakeholders thought that the evaluation had produced valuable findings and had addressed its key objectives. The findings were regarded as a useful addition to the evidence base in their own right and could be used to support the design of future studies. In particular the participants whose areas were currently designing and commissioning pharmacy alcohol services could use and build upon the learning from existing services.

While data on the numbers of interventions provided are useful, stakeholders thought that pharmacy now needs to move to the next level of evaluation.

“Outcome data that can prove the benefit not just intervention data”

In comparison to other Tier 1 services, stakeholders said that the pharmacy service is less well supported by evidence and commissioners will expect data that can be used to compare different services. Pharmacy needs to build the business case for the service.

“Is pharmacy cost effective as against other IBA venues?”

The importance of agreeing with commissioners the sorts of outputs that showed the service was delivering to target was raised.

“Outputs (need) to be of mutual value”

A number of suggestions were made about other data sources that might be used to track effects of interventions made in pharmacies.

“Demonstrate the effect (? A & E attendances down? – survey, people’s level of concern as an indicator)”

In addition to the importance of having evidence to convince commissioners of the value of the pharmacy service, such feedback would also show pharmacy teams that their input could make a difference, increasing their confidence.

“Robust evidence base to provide confidence in pharmacy staff and commissioners”

It was not always clear exactly what was being delivered in pharmacy interventions and the service specifications did not make this clear. Although the information content of interactions was usually specified, any behavioural change content was less clear.

“What is “raising awareness” and what is an intervention?”

The workshop heard that a RCT of a community pharmacy brief intervention is currently being undertaken in Lambeth & Southwark, will complete recruitment by the end of the year, and should report in summer 2013. This RCT intervention has an explicit behaviour change element. Stakeholders viewed this as an important study, and also suggested that future studies needed to include an element of economic analysis.

“Talking to commissioners about value for £ rather than service cost. Economic evaluation needed”

7.1.3 Engaging the public

Data from the evaluation indicated that the majority of service users were visiting the pharmacy with or about a prescription, and most were aged 60 years or over. The profile of service users was thus dominated by people who were already interacting with the health service. Pharmacy teams arguably felt more comfortable talking with these customers and introducing the subject of the alcohol service. Stakeholders thought the new data from the evaluation were helpful in identifying, for the first time, the profile of service users.

“Understanding the demographic reached by the pharmacist – expanding the programme to reach those not engaged”

Stakeholders suggested ways of building IBA into daily work in the pharmacy by using other prescription-related services to introduce it - “Link to MURs / NMS”. These services were also seen to have potential for “Targeting for cascading to those who do not visit the pharmacy”. Stakeholders also wanted pharmacies to target other patients visiting the pharmacy, such as drug misusers and those with mental health problems.

“Need to improve targeting by including mental health problems since dual diagnosis is a massive issue”

Pharmacy staff were thought to be reluctant to raise alcohol use with patients in these groups, and this was identified as a future training need.

Extending the reach of the service, however, was seen as essential to maximise the opportunities afforded by the community pharmacy setting. A two-pronged approach was thought to be needed: external promotional activity to raise public awareness and increase the number of potential service users visiting pharmacies, and adaptation of training for pharmacy staff to reduce their threshold for beginning conversations about alcohol with individuals who are not regular customers.

“Opportunities – if not prescription-related, how to operationalise?”

Promotion and advertising external to the pharmacy were seen as essential, and a number of suggestions were made for possible methods.

“Advertising the service in different settings used by people (eg hairdresser)”

“Social marketing (including “scary” marketing: liver disease)”

“Events – eg target everyone in one day”

Having raised awareness - and brought more people into the pharmacy - the importance of maximising those new opportunities was stressed. The training that pharmacy staff receive needed to include ways of introducing and “selling” the service, including to people who were not regular customers and may only be making a brief visit to the pharmacy. This would include explaining why monitoring data - such as postcodes - were essential, and providing assurances about confidentiality and anonymity.

“Increasing pharmacy staff confidence in proactively approaching customers”.

“Having answers to barriers & ways of approaching delivery at each organization to encourage “busy people” to see where they fit in”

Training also needed to include strategies for being flexible and tailoring behavioural approaches to the individual’s situation.

“Sensitivity to where people are at / their understanding eg target parental responsibility rather than work-based responsibility”

“Language, not “what is your score?” but “now how do you feel about your score?”

Cultural awareness and understanding of the role of alcohol in different religions was an area that stakeholders felt needed to be tackled more effectively through training.

“Awareness that some religious groups do not drink: may need improved knowledge & training for service deliverers”

Having user friendly materials for pharmacy staff to use to engage with the public was also crucial.

“Use of quiz/wheel & other tools to make it easier to talk (scratch cards / case study cards etc)”

“Different ways to communicate with different people eg paper questionnaire / App for iPad/Phone”

A potential difficulty for staff was that the alcohol service did not involve a medicine or treatment, unlike services such as smoking cessation. There was no therapy that could be offered as a tangible support.

“Information service rather than product service (more difficult than smoking cessation service which had OTC product to offer)”

One suggestion was to have a “product” that pharmacy staff could give to service users: *“could give a drinking glass/unit calculator”*

Alcohol Concern has been working on the use of a single sentence following the screening questions², and stakeholders thought this approach could be tried in pharmacies.

“Do screen and then give one sentence – really brief BI – would this iron out the differences in pharmacists’ interpretation of health info?”

7.1.4 Changing the community pharmacy culture

Like many services in community pharmacy that are not part of the “Essential” list within the current contractual framework, the alcohol IBA service tended to be an add-on for most pharmacies. Achieving reach beyond prescription customers would mean a fundamental change in community pharmacy culture.

“Culture change – staff buying into ethos of the message & promoting services provided by the pharmacy”

Stakeholders identified the need for work to build public wellbeing work into the core business of community pharmacy. The Healthy Living Pharmacy movement was seen as a possible means of achieving this, and the delegates were made aware that changes in the community pharmacy contractual framework were forthcoming next year. In the meantime a number of suggestions were made.

An in-pharmacy champion for this and other public health services was identified as a way of motivating pharmacy teams, a channel for communication / updating staff, and to embed training.

“Require pharmacies to have a service champion”

“Having an individual in each pharmacy who leads on the service and can provide a focus beyond training when staff are back in day to day work”.

“Use of champions. Focus on making a difference, train the trainer. Service continues even when champion is not there”.

²Examples include “In the long term drinking alcohol every day can contribute to a number of health issues”, “You are much more likely to have an accident when you’ve been drinking” and “Mixing alcohol and medication can have serious side effects.”

Several measures to support staff to promote the service were put forward. The importance of training as a means of inculcating service quality was emphasised, as was the need for more standardisation of training. Some improvements were identified to existing training, to increase its fitness for purpose.

- *training support staff*
- *leadership / public health training (being proactive)*
- *training for the transition from counter to consultation room*
- *training to include the importance / impact of the service*
- *training /communicating to pharmacies that they are part of the integrated pathway*

On a practical level, some pharmacy staff were unsure where service users could be referred, and how referrals could and should be done. The “Lack of referral processes = barrier” and there was a need for “*Consistent signposting – need the tools and confidence to do so*”.

Another suggestion was to identify pharmacies that could act as role models for the vision of a culture that supported health and wellbeing:

“Getting pharmacies at the higher end of delivery on board with championing the service through training & networking”

“Sharing good practice, opportunities for refresher training”.

7.1.5 Producing a plan for stakeholder engagement

There were indications within the evaluation data that pharmacies were not yet part of local patient pathways for alcohol use. Working with other stakeholders to produce a plan for the future was seen as a key next step towards the goal of “*Integration of pharmacy into (the) local pathway*”.

The plan would enable “*a clear focus about what pharmacy can achieve with IBA & how it fits in with wider services*” and “*a medium term (3 yr) vision for delivery & to commit*”

Stakeholders called for more “*Joined-up working eg voluntary sector / pharmacy*”, and suggested that pharmacy needed to become more proactive in “*Getting out in the community (to achieve) joined-up working*”.

7.2 Summary of the Contribution of the Stakeholder Workshop

Feedback and input from the stakeholder workshop have formed the basis for identifying priorities for the future. In addition to forming an integral part of the research process and findings, the stakeholder event was the starting point for disseminating the study findings and its outcomes will further inform the dissemination of the research.



Chapter 8

Synthesis of the Findings

8.1 Introduction

The previous methods and results chapters have highlighted a number of common themes and issues within the pharmacy alcohol IBA service. In this chapter, we will consider consistent cross-cutting themes from triangulated data, and highlight areas where any conflict exists. We will use this synthesis of the workstream data to underpin our recommendations. *This will ensure that we address our study aims, to:*

- i) characterise, consolidate and optimise both the constant and variable elements of the pharmacy alcohol identification/brief advice (IBA) service in NHS Northwest, and
- ii) inform planning for current and future pharmacy based services promoting safe consumption of alcohol.

The Wirral-format service specifications in the North West describe six elements within the service:

1. Identification
2. Screening
3. Brief Intervention
4. Referral
5. Follow up
6. Monitoring of the service

We will use these elements to structure our discussion. Table 8.1 overleaf shows the relevant key findings from each workstream relating to each of these service elements.

8.2 Limitations of the evaluation

This evaluation has drawn upon a number of different data resources to explore and cross-validate its findings, but it is subject to several important limitations:

- There was inevitable self-selection bias within the respondents to surveys and interviews;
- Pharmacists predominated among the stakeholders engaged;
- There was a smaller number of service users engaged with the project than initially envisaged and desired.
- Some of the measures were based on self-report.

8.3 Triangulation of Data from the Evaluation Workstreams

Element		Workstream Data		
		Operational data*	In-Pharmacy observation, service user interviews and provider feedback	Stakeholder & Provider surveys / interviews
1. Identification	<p>Customers targeted included many people aged 60 and over, which may reflect pharmacy footfall</p> <p>A small number of pharmacies accounted for the majority of screens in Wirral and other areas</p>	<p>Customers targeted were mostly those bringing prescriptions</p> <p>There were a significant number of opportunities for engagement across all demographic groups</p> <p>Staff needed further training to identify appropriate individuals and be able to initiate conversations</p> <p>Staff responded positively to the suggestion that alcohol IBA could be linked to other pharmacy services</p>	<p>Customers targeted were mostly those bringing prescriptions</p> <p>Community pharmacy is an appropriate environment for the delivery of an alcohol IBA service</p> <p>Conflicting data regarding the confidence of pharmacy staff to approach customers about their alcohol use – provider survey results suggest high overall confidence and enjoyment, but stakeholders assert that this is a challenge for staff</p> <p>The service should be embedded within community pharmacy and/or as part of the Healthy Living Pharmacy framework – it could be linked to other topics, such as weight, hypertension and sexual health</p>	<p>The profile of service users is dominated by people who were already interacting with the health service</p> <p>Link the IBA service to other pharmacy services, such as MURs and NMS</p> <p>Should also target drug misusers and people with mental health problems – pharmacy staff would need support and training to do this, as they showed reluctance to engage with these groups</p> <p>External promotion is needed to raise public awareness of the service</p> <p>In the pharmacy, the service needs to be 'sold'</p>
2. Screening	<p>Most people screened had an AUDIT score of 0-7</p> <p>Men tended to score higher than women on AUDIT</p> <p>People from more deprived areas tended to score higher on AUDIT</p>	<p>Pharmacy staff were not always presenting the AUDIT questions to customers in an unbiased way</p> <p>Some staff felt that the AUDIT questions were awkward to use with customers, and that some questions did not seem applicable</p>	<p>Some stakeholders felt that alcohol 'scratch cards' may be a useful tool for screening</p>	

Operational data*		Workstream Data		Stakeholder Workshop
Element	In-Pharmacy observation, service user interviews and provider feedback	Stakeholder & Provider surveys / interviews		
4. Referral	<p>Seven interactions resulted in 'referral' from the pharmacy data – none of these individuals presented to structured treatment within three months</p> <p>Eight other individuals from the Wirral pharmacy service presented to structured treatment within the time period of the data. None of them had 'referral' as their in-pharmacy intervention, nor particularly high AUDIT scores</p>	<p>Formal referral pathways are desired by staff, but they may not be universally successful owing to service user acceptance</p>	<p>Stakeholders felt that there was a lack of integration of community pharmacy with other alcohol service providers</p> <p>Most provider survey respondents felt that it was easy to engage with other services about referrals, but only 'sometimes' (rather than 'all the time' or 'often')</p> <p>Providers did not feel that they got referrals from other health care staff (like GPs), but many did not tell such staff they were providing the service</p>	<p>Pharmacy needs to be integrated into the local alcohol pathways for effective referral to take place</p> <p>Some staff do not know how/where to refer</p> <p>Consistent signposting is needed</p>
5. Follow up	There were no data on follow-up	Follow-up interviews are feasible	<p>Most providers did not follow up with customers</p> <p>Stakeholders felt that follow-up was important to explore behaviour change</p>	Follow-up is an important issue
6. Monitoring of the service	<p>Data quality needs to be improved</p> <p>Postcode data capture may expand opportunities for understanding the alcohol consumption patterns in a local area</p>	Data recording should be simple, electronic and linked directly to payment (no multiple recording)	<p>Most provider survey respondents felt that data recording was not time consuming for staff</p>	<p>A minimum dataset for alcohol services may be needed, which may include postcode data</p> <p>Electronic data input systems were needed</p> <p>Outcome data are now needed, with mutual value for providers and commissioners, in order to build an effective business case</p>

*Operational data conclusions largely drawn from analysis of Wirral data

Table 8.1: Mapping key findings across the workstreams to each element of the Pharmacy Alcohol IBA service description

Chapter 9

Implications for Practice, and Recommendations

9.1 Implications for Practice

The results of the present investigation add weight to the assertion that provision of alcohol IBA services in the community pharmacy setting appears feasible, reaches relevant sections of the population, and is regarded by key stakeholders as desirable. The results do not provide robust evidence of benefit in terms of reduced drinking, or that services do reach people not using other health services, but they do create a solid basis on which further work can build.

Staff in community pharmacies in the North West identified a significant proportion of people at increasing and high risk: these groups represented 19-20% and 1-2% of their screened customers respectively. Sheridan and colleagues (2012) estimated that, in New Zealand, 30% of pharmacy users could be considered risky drinkers: if the UK figures were broadly similar, then the screening was penetrating that at-risk population.

Commissioners reported that there have been some prolific service providers and others who have recorded few, if any, interventions. This is not unusual with pharmacy enhanced services, and the primary reason for variable individual pharmacy activity has been suggested to be the level of service funding (Blenkinsopp *et al.*, 2007). Even in pharmacies that were more active service providers, there was evidence that clients who were approached did not extend beyond prescription clientele. Hesitation to push beyond this familiar group might undermine the consensus among all stakeholder groups that community pharmacy has a unique opportunity to reach people who might not otherwise engage with public health services. People collecting repeat prescriptions, however, (of whom the over-60s form the primary group) may still have their wellbeing issues overlooked, despite regular contact with health services focused upon the management of long-term conditions. Pharmacies in different settings (e.g. supermarket, health centre, high street) have a different customer base: by making the service available across the network, a broad cross-section of people can be engaged.

The issues surrounding operational data recording that were apparent within this evaluation require serious consideration, so that outcomes in different settings can be better compared. There were a number of different methods of routine recording of data (including paper-based and online systems), and data items collected, across PCTs. The quality of the operational data was not exemplary: for example, it was difficult to determine the exact nature of the intervention provided to customers from the Wirral database. In order to monitor both process and outcomes for the service, it will be necessary to clarify the dataset needed and then to train providers to report it accurately and completely from their consultations.

The issue of follow-up is complex, especially as this activity potentially serves two purposes – exploring behaviour change with individual users, and providing outcome data for the service. The IBA employed by community pharmacies is evidence-based, from past work in other settings, and thus follow-up is not considered necessary to prove its effectiveness. It is notable that our evaluation follow-up with service users reported an effect very similar to that of Moyer *et al.* (2002) in that one in eight of our evaluation user sample reported an impact on their alcohol use. Existing service providers and commissioners seemed not to value follow-up data as it was not included in some service specifications and, even if it was, providers did not routinely collect it. Stakeholders involved in the evaluation, however, felt that it would be necessary to provide outcome data from the pharmacy service, through follow-up with users, to underpin the case for commissioning. Providers should, therefore, incorporate follow-up strategies into their services.

The alcohol IBA service is one of a 'suite' of pharmacy public health services, and there was support among providers and stakeholders for a common approach to a range of services within an overarching framework. This would represent a change in pharmacy culture and training so that pharmacy staff take every opportunity to explore public health issues with customers, providing strategies and support for behaviour change. There is evidence in this evaluation that staff are, themselves, naturally making links between pharmacy services (such as smoking cessation and weight management) to offer tailored and relevant advice and thus open up these opportunities. These linkages actually help staff to broach a sensitive personal lifestyle issue. A redesigned pharmacy alcohol IBA service could serve as a template for other services in this 'suite'. The 'Healthy Living Pharmacy' framework has been piloted at 20 pathfinder sites across England (PSNC, 2011), and may be an appropriate vehicle for this culture change if found to be successful.

Beyond integration of services within the pharmacy, the operation and referral processes for the alcohol IBA service may be affected by the level of integration of the pharmacy service with other alcohol use support services in the area. Our provider survey suggested that the majority of pharmacists had not told other local health professionals (like GPs) about their alcohol IBA service, and had not received referrals from local health professionals. Cross-service provider engagement may therefore be of crucial importance.

The specification for the service has varied significantly across PCTs, despite operating across a relatively small geographical region. There is a strong argument that an evidence-based common specification would improve consistency of delivery and provide a robust dataset from which to monitor outcomes. Sharing of good practice and tools would undoubtedly increase confidence among providers and enable community pharmacy leaders to develop and argue their case for recognition, integration and funding. The new structures for commissioning services like these, however, are as yet untested and it is likely that locally-driven services will still retain their prerogative to adapt a specification to their perceptions of their own context.

The Government's Alcohol Strategy aims for large-scale awareness-raising of risky alcohol consumption and supporting everyone to make informed choices about responsible drinking (2012: p21). This Strategy asserts that there is no 'one size fits all' solution to the problem: this invites diversity of service providers who can reach a large proportion of the adult population. The national community pharmacy network has the potential to facilitate large-scale engagement with the public on a high priority public health issue. Effective provision of a pharmacy alcohol IBA service - with a commitment to the 'industrialisation' of both service provision and outcome-orientated follow-up, underpinned by a robust common specification / dataset and ongoing research - could yield long-term benefit to individuals, to the public, and to the wider health service.

9.2 Recommendations for Further Research

We recommend that a further study is conducted, in the form of a randomised, controlled trial, informed by the findings of this evaluation. A trial could usefully incorporate some or all of the following aspects:

- Comparison of screening using AUDIT–C (using scratch cards or other means) versus full AUDIT
- Comparison of different degrees/types of intervention, such as brief advice, behaviour change counselling, motivational interviewing, norm-based interventions
- Targeted screening to specific client groups or to all customers during specific periods
- Computerised methods of recoding data and supporting staff to follow-up clients
- Use of mystery shopper methodology to assess fidelity of the intervention
- Use of standard outcome measures, such as the Alcohol Problems Questionnaire (Williams & Drummond, 1994)
- Impact on the wider public, through pharmacy users survey covering Extended AUDIT, awareness of personal risk, knowledge of safe drinking levels
- Economic evaluation

9.3 Recommendations for Practice

The team’s reflections on this evaluation have resulted in a number of recommendations for practice, in order to address our objective “To inform planning for current and future pharmacy based services promoting safe consumption of alcohol”.

These recommendations are first presented here as a structured list that reflects different aspects of the service: initial and ongoing training; service specification and delivery; service development; service integration, and contracting/commissioning issues.

General recommendation:

- Develop a common specification with a degree of flexibility to enable local adaptations.

Initial and ongoing training:

- 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.

Service specification & delivery:

- 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.

Service development:

- 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.

Service integration:

- 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.

Contract/commissioning aspects:

- 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.

Table 9.1 overleaf details our recommendations for practice. We have identified four main stakeholder groups – pharmacy providers, pharmacy leaders, 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 help to 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.	●	●	●	

Table 9.1 – Recommendations for Future Practice

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