

**NORTH EAST QUALITY OBSERVATORY SERVICE
(NATIONAL COLLABORATING CENTRE
FOR INDICATOR DEVELOPMENT)**

FOR

**NATIONAL INSTITUTE FOR HEALTH AND CARE
EXCELLENCE**

INDICATOR DEVELOPMENT PROGRAMME

Feedback report on piloted indicators

Topic area: Alcohol

Pilot period: 13th December 2018 – 31st March 2019

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Output: Recommendations for NICE indicator menu

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Summary of recommendations

The recommendations have been summarised by indicator type rather than for each individual indicator due to the overlap in key issues reported.

There were three alcohol screening indicators and four alcohol brief intervention indicators tested in the pilot (see Appendix B).

Acceptability assessment (summary)

75% of practices support inclusion of indicators in this topic area.

Implementation assessment (summary)

Minor problems identified by some practices during piloting, potentially resolvable by further discussion and the actions in tables 1 and 2.

Acceptability assessment of alcohol screening indicators:

Indicator 1: Alcohol screening for newly diagnosed hypertension patients

The percentage of patients with a new diagnosis of hypertension in the preceding 12 months who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the 3 months before or after the date of entry on the hypertension register.

Indicator 3: Alcohol screening for patients with a new diagnosis of depression or anxiety

The percentage of patients with a new diagnosis of depression or anxiety in the preceding 12 months who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the 3 months before or after their diagnosis being recorded.

Indicator 6: Alcohol screening for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia

The percentage of patients with one or more of the following conditions: CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the preceding 2 years.

Support for individual indicators ranged from 72% of practices for Indicators 1 and 6, to 88% of practices for Indicator 3. Views from practices were split on whether all patient groups in Indicator 6 should be included; there were concerns raised about Indicator 1 being addressed at newly diagnosed patients (as opposed to at review); and the strongest support was for Indicator 3.

Implementation assessment of alcohol screening indicators:

Minor problems identified by some practices during piloting, potentially resolvable by further discussion and the actions in table 1.

Table 1 Alcohol screening indicators: Issues to be resolved prior to implementation

Issue	Detail	Mitigating activity
Alcohol screening method	Alcohol consumption is generally recorded in units rather than as a score from a screening tool	For discussion – can either / both be acceptable as screening methods?
Timing of screening	Identified as an issue for hypertension but not for depression/anxiety At new diagnosis is identified as a good opportunity to screen and intervene regarding alcohol, however there are appointment time pressures	For newly diagnosed hypertension patients, propose that alcohol screening and brief intervention could take place at a review appointment
Frequency of screening	For Indicator 6, practices requested that screening should only be required every few years	Piloted indicator 6 states every 2 years for screening, however the NHS Health Check is done on the appropriate patient group every 5 years
Alignment with existing local schemes	Current risk of overlap with local scheme requirements.	To include aligning with the requirements of the acute sector's 2019/20 CQUIN scheme ¹ .

¹ <https://www.england.nhs.uk/publication/ccg-cquin-2019-20-indicators-specifications/>

Acceptability assessment of alcohol brief intervention indicators:

Indicator 2: Alcohol brief intervention for newly diagnosed hypertension patients

The percentage of patients with a new diagnosis of hypertension in the preceding 12 months with a FAST score of ≥ 3 or AUDIT-C score of ≥ 5 who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

Indicator 4: Alcohol brief intervention for patients with a new diagnosis of depression or anxiety

The percentage of patients with a new diagnosis of depression or anxiety with a FAST score of ≥ 3 or AUDIT-C score of ≥ 5 who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

Indicator 5: Alcohol brief intervention for patients with schizophrenia, bipolar affective disorder and other psychoses

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a FAST score of ≥ 3 or AUDIT-C score of ≥ 5 who have received a brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

Indicator 7: Alcohol brief intervention for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia

The percentage of patients with one or more of the following conditions: CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia with a FAST score of ≥ 3 or AUDIT-C score of ≥ 5 who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

Support for individual indicators ranged from 69% of practices for Indicators 5 and 7, to 78% of practices for Indicator 2, and 82% of practices for Indicator 4. The brief intervention indicator for patients with newly diagnosed hypertension (Indicator 2) appeared to be preferred over the screening indicator for these patients (Indicator 1).

Implementation assessment of alcohol brief intervention indicators:

Minor problems identified by some practices during piloting, potentially resolvable by further discussion and the actions in table 2.

Table 2 Alcohol brief intervention indicators: Issues to be resolved prior to implementation

Issue	Detail	Mitigating activity
Lack of alcohol screening indicator for mental health in QOF	The brief intervention indicator (Indicator 5) would currently exist in isolation	Discussion required – to be resolved prior to implementation
Follow up of impact of brief intervention	While practices were aware of the evidence base for the effectiveness of brief intervention, they were unable to track the impact of the intervention in individual patients	
Alignment with existing local schemes	Current risk of overlap with local scheme requirements	To include aligning with the requirements of the acute sector's 2019/20 CQUIN scheme ¹ .
Lack of services available to support people with reducing their drinking	Unlike for smoking cessation, there are no services available for alcohol that are similar to 'stop smoking' clinics.	

Background

As part of the NICE indicator development process, all clinical and health improvement indicators for general practice proposed for inclusion in the NICE Indicator Menu are piloted, using an agreed methodology, in a representative sample of GP practices across England.

The aim of piloting is to test whether indicators work in practice, have any unintended consequences and are fit for purpose.

A list of piloted indicators for this topic is shown in Appendix B.

Practice recruitment

Number of practices recruited	30
Number of practices withdrawing	4
Final number of practices in the pilot	26
Number of practices participating in feedback	25

Feedback was obtained via interviews and survey, and it was possible for individuals to participate in both the survey and the interviews.

Feedback participation by role and method

Staff role	Survey	Interview	Interviews for Alcohol topic
GP	14	18	10
Practice Manager	13	15	6
Other senior management	3	4	1
Admin staff (including finance, IT, performance)	2		
Number of participants	32 (25 practices)	37 (25 practices)	17 (13 practices)

Assessment of feasibility, reliability and acceptability

Feasibility and reliability

It was possible to develop Business Rules to support this topic and all indicators within it. Related to the piloted indicators 3 and 4, one practice (1/13) noted that a lot of people with anxiety or depression may not be coded with these conditions in general practice systems because this could be considered to be a vague diagnosis which is 'not so 'clear cut'.

Acceptability

Topic views

There was general agreement from the survey respondents (75%, 24/32) that the topic of alcohol represents what is important to patients, families and carers. There was also a common view that this represents what it is important to clinical staff (72%, 23), with 7 people being unsure (22%, 7/32) and the remaining 2 disagreeing.

"It goes without saying that when you're managing diabetes, AF and so on, it's great to have that prompt to ask about alcohol. You've got so many other things to ask about that sometimes that, the most important thing, gets missed out". (GP, interview)

"Alcohol is a difficult topic as it is often more important to the family and carers than to the patient". (Practice manager, survey)

"I still don't think the general population are aware of the importance of following drinking guidelines, and the potential harm done. Perhaps a national campaign would help here". (GP, survey).

"Alcohol is so endemic that clinical staff find it hard to focus on it when there are more pressing matters". (Practice manager, survey)

"The alcohol (tool) is only useful to use as a nag for the excessive casual drinker to almost scare them into realising what they are doing. However, alcohol abuse people need to engage themselves". (GP, survey)

"Any prompt for all clinical staff could have a positive benefit". (Practice manager, survey)

One practice (1/13) expressed concerns during their interview regarding the suitability of including alcohol as an indicator topic.

“... I think it would be very difficult because it’s not like, “I have blood pressure today.” Firstly, the patients always underestimate and lie about their intake of alcohol and secondly they could be teetotal today and an alcoholic tomorrow. I don’t think we are going to get a true answer from patients full stop....Blood pressure is ours and we can control it or not control it but at least we can govern it by checking the blood pressure. From that point of view I would probably say that it isn’t a good indicator”. (GP, interview)

The majority of survey respondents were supportive of the indicators being financially incentivised (75%, 24/32), a view which was also reflected in the interviews from 10 of the 13 practices (77%). There were mixed opinions in terms of the indicators being suitable for quality improvement (without incentivisation). Only 34% of those responding to the survey (11 participants) were in favour of this, with 12 people (38%) not supportive and the remaining 9 being unsure. One practice thought that asking the patient about alcohol consumption was just part of the opportunistic questions relating to lifestyle.

Six survey respondents (6/32, 19%) stated that there were existing schemes in their local area, with four of these declaring that the pilot had had a positive impact, one stating no impact and the final respondent saying the pilot indicators may have had a negative impact.

“All the indicators would improve the quality of care for patients. We already have this screening included in the templates for these indicators”. (Practice senior manager, survey)

Ten of the 13 practices interviewed (77%) were undertaking practice-specific work relating to alcohol, with 8 of these describing this in further detail. Six (out of 10 reporting schemes) were referring to the inclusion of alcohol screening as part of the new patient registration process, and three practices referred to the inclusion of alcohol screening in the NHS Health Check. Three practices (3/13, 23%) also included the topic of alcohol in chronic disease and mental health reviews, acknowledging that their approach may be ‘unstructured’. The core contract of one practice contained the

topic of alcohol and one practice (which did not think the pilot was useful because of this) participated in the Local Enhanced Services (LES) scheme in their area.

“Okay. I didn’t find the domain particularly helpful. We’ve got an alcohol LES in our area and so the questions here that were being piloted were ones that we were already asking and more in our area. So we found that in most cases we’ve actually done what was being asked for, or it was getting into very sort of time-consuming territory with the clinicians”. (GP, interview)

In terms of potential impact of the alcohol indicators on other existing alcohol-related work within the practice, the general view seemed to be that they would have no impact or no negative impact, with one practice suggesting the indicators would have a positive impact by providing more structure.

“Before this it was just new patients really and a limited amount of non-structured information gathering in our chronic disease template but I have added your template to our chronic disease template. It’s a bit more structured I think since the pilot is going on and doing... the information gathering is a little bit more structured”. (GP, interview)

Suggested amendments to indicator definitions (summary for all indicators)

Six practices (6/13, 46%) agreed that all four patient groups in the pilot should be included if alcohol became a topic within a primary contract, with three others (3/13, 23%) stating that all chronic diseases should be included.

“I think generally in terms of alcohol, I think it’s important for all patient groups...because the nursing staff have multiple things to work on when they do all their quality management of new patients, health checks, I think it is important.....” (GP, interview)

Proposals from the remaining four practices (4/13, 31%), varied between focusing on just two patient groups rather than four, or limiting the indicators to patients with low mood, depression, anxiety or serious mental illness, or to patients with diabetes, hypertension and CVD, or with dementia.

"I think dementia is quite interesting. It would be useful for dementia probably because you're actually asking the carers more, more information from the carer like alcohol". (GP, interview)

Three of the 13 practices suggested that it was important to include patients with atrial fibrillation.

"For any of the chronic diseases, alcohol is normally one of the questions we have on the system. the AF group..... we do ask that at diagnosis, because you want to know what triggered it. But maybe not at follow-up. But weirdly, the AF people, we know which are our alcohol problem because their warfarin goes crazy". (GP, interview)

Another practice suggested alcohol screening should be done *"more broadly than in the people you would expect to be asking, such as the newly diagnosed depressives and the mental health patients". (GP, interview)*

There were mixed views on whether alcohol screening should occur at diagnosis, with some supportive comments including two practices who thought that alcohol screening should take place following a new diagnosis only and a range of other comments suggesting that screening at diagnosis is not appropriate (an example of which is provided) .

"New diagnoses of anxiety or hypertension are a great time to screen and intervene with alcohol". (GP, survey)

"It's easy to have the FAST or the Audit C in long term condition clinics but I don't think we should be using that when the GP first diagnoses someone with hypertension. You want to just be asking, "Right, how much alcohol do you drink?" You don't want to have to be going through that FAST and I think they won't remember to do it". (GP, interview)

"I think sometimes at diagnosis (it) might be worthwhile doing. But leaving it sort of sitting there, say, for every time you see the same person, it gets quite embarrassing to keep repeatedly asking the same questions." (GP, interview)

"I think generally in terms of alcohol, I think it's important for all patient groups. I think the balance between the work we do and the amount of outlay we do and because the nursing staff have multiple things to work on when they do all their quality management of new

patients, health checks, I think it is important. We do do a lot anyway. So it's balancing between how many checks we do and seeing is there any evidence to say if we're doing more, is it beneficial or not". (GP, interview)

In terms of exclusions, three practices (3/13, 23%) noted that their preference was to exclude those with mental health conditions due to difficulties in getting the patients to attend (although one practice described their solution to this), and one of these practices suggested this was because anxiety and depression could be a 'vague diagnosis and possibly short-term'.

"We've got a lady that we identified as a champion to really try to get them (patients with mental health problems) in for their yearly reviews..... once you've got them in, trying to tease out of them information that they don't want to give anyway does make it difficult. I think the only thing we try to do is just to be honest with them and just say that we're trying to get this information to make sure they get the best care that they can". (Practice manager, interview)

Feedback on alcohol screening indicators (indicators 1, 3 and 6)

Seven of the practices interviewed (54%, 7/13) used the AUDIT-C screening tool, with a further 3 practices (3/13, 23%) using FAST. One practice used both tools and two practices were unsure as to which tool had been used by their staff.

With regard to the alcohol screening indicators (as opposed to the topic as a whole) as measures of the quality of care for patients, six practices spontaneously mentioned that they preferred to use the number of units as a quantitative value for alcohol consumption rather than the score from an alcohol screening tool.

"The other thing was, there's no quantitative value, you know. When you actually ask people, "How much do you drink?" and they tell you how much they drink, then you can sit there and judge it. And next time round you sit there and, "Are you still drinking the same amount or has it gone up?" But when you're just asking the FAST screens, you then get this sort of number and you then do a brief intervention. And it then doesn't tell you how much they've actually had....."

'....then you've got to convert every unit that they give you into the drinks that they actually drink, "But I only drink whiskies at weekends, Doc."And then you have to go through it all ..., to then translate it back into FAST. Rather than just saying, "How much do you drink?"

and then sitting there saying, "Well, you drink a lot. Shall we just see how much you are drinking, how often you're doing it?" ". (GP, interview)

"The other thing is, the DVLA probably don't particularly like a FAST result. They do like to know how many units people are having, and so do the insurance companies. (GP, interview)

"So I do think that alcohol is important.... However, if I'm honest, I don't particularly like the idea of using FAST.... why we can't just ask people how many units they use as a starting point because that's much easier and quicker for people to ask that question.... Then if you realise that they're over the recommended limit, then go on to ask FAST. It's quite difficult for people to remember to do FAST and I don't think GPs are particularly great at using it.". (GP, interview)

Regarding the use of the specific shortened screening tools referred to in the practice handbook for the pilot, comments from practices included:

(The FAST tool) "...as a screening tool, it wasn't a very good screening tool. Because either they drank a lot, drank regularly, and so you knew that anyway. Or it was zero, but you've still got to ask four questions to discover that they don't drink anything". (GP, interview)

(The AUDIT C tool) "I think as you get better at using it... the faster you get with it" (GP, interview)

"Not all patients are happy to be questioned in as much detail of AUDIT C re alcohol". (GP, survey)

A question was also raised about whether it was really screening that was being undertaken at diagnosis in some patients:

"But when you're at the initial consultation, it (FAST) is not a really useful screening tool, because we're not screening, we're asking direct questions for problems at that point. If you've got anxiety, "How much are you drinking? Is that causing it?" We're not asking them whether they're over-drinking, we are deliberately seeking out a cause for it". (GP, interview)

Feedback on alcohol brief intervention indicators (indicators 2, 4, 5 and 7)

Views from practices relating to the alcohol brief intervention indicators as measures of the quality of care for patients included concerns from a minority about not knowing if the intervention has worked for the patient.

"I understand the reason for asking the question and offering brief intervention. How successful it is going to be in making an improvement, I don't know. I know it's meant to be by NICE but I think in practicality I'm not so sure". (GP, interview)

"I don't think we've got enough time to follow them up because you give the intervention, how do you know if it's worked or not?" (GP, interview)

"I think brief intervention, just a couple of sentences like decreasing your alcohol intake. I mean it's difficult with alcohol, isn't it, because people are much more guarded than they are about smoking really so it's more difficult to make an intervention and then see whether it's been acted on or not. It's not like the stop smoking services that are set up so you can't refer people (for alcohol) as easily". (Practice manager, interview)

Regarding the importance of providing advice about alcohol "...Although I am conscious that when that message comes from the doctor it carries more weight than coming from somewhere else. So we still need to do it, but I do agree it takes a lot of time". (GP, interview)

"I think it's always very useful to be able to tie that with a blood result. If you've seen that there are changes in their MCV (Mean Corpuscular Volume as an alcohol biomarker). It gives it much more weight than just seeing the questionnaire result". (GP, interview)

There was a general point from one practice about the use of terminology for brief intervention and whether this could be simplified.

"I mean the whole thing is people worry about your terminology at NICE, what is brief intervention... but it is just basically just saying you're drinking too much, have you thought of cutting down. It's not anything complicated. It's like stopping smoking cessation advice. That's often the problem when these things are given. People think they've got to do a lot of work and it's just really documenting that you've told the patient to cut down on your drinking, "As you know you're drinking harmful amounts". That doesn't take time if that's what you're asking for". (GP, interview)

Other indicator-specific feedback

The views of survey respondents (n=32) in terms of the impact on quality of care for patients were obtained for each of the seven alcohol indicators and a summary of the findings is shown in Table 3. Indicators relating to patients with a new diagnosis of depression or anxiety had the greatest level of support (although one respondent did state that the brief intervention indicator may make quality of care worse), followed by those with newly diagnosed hypertension.

Twenty-two respondents (69%) thought that alcohol brief intervention for patients with mental health conditions (indicator 5) would improve quality of care; however one practice noted the removal of the alcohol screening indicator from the mental health section of QOF for 2019/20.

“There is definitely a close link between alcohol and mental health, thus worth incorporating into review process”. (Practice senior manager, survey)

“It was felt alcohol questioning and recording could be taken out of MH (Mental Health) this year for QOF so why put it back in?” (Practice senior manager, survey)

Although the indicators for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia were supported (69-72%), this was overall to a lesser degree than the other patient groups, with one survey respondent (1/32) commenting that the denominator was too large (Practice senior manager) and another suggesting that this was not a suitable opportunity for change in this patient group.

“Routine questioning of alcohol use in chronic disease I don't believe provides the impetus for alcohol change”. (GP, survey)

For two of the four patient groups (patients with anxiety and depression and those with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia) there was greater support for the screening indicator than the brief intervention indicator.

“Being asked to add an intervention task to an already crowded agenda for these patients causes its own risks - such as reducing their engagement”. (GP, survey).

With the newly diagnosed hypertension patient group, a greater number of respondents thought that brief intervention could make the quality of care for patients better (78%) than for the screening indicator in this group (72%).

Table 3: Views on quality of care for patients for each alcohol indicator: Do you think that each listed indicator could make the quality of care for patients....

	Better	No effect	Unsure	Worse	Total
Indicator 1: Alcohol screening for newly diagnosed hypertension patients	23 72%	8 25%	1 3%	0	32
Indicator 2: Alcohol brief intervention for newly diagnosed hypertension patients	25 78%	5 16%	2 6%	0	32
Indicator 3: Alcohol screening for patients with a new diagnosis of depression or anxiety	28 88%	3 9%	1 3%	0	32
Indicator 4: Alcohol brief intervention for patients with a new diagnosis of depression or anxiety	26 82%	3 9%	2 6%	1 3%	32
Indicator 5: Alcohol brief intervention for patients with schizophrenia, bipolar affective disorder and other psychoses	22 69%	4 12%	6 19%	0	32
Indicator 6: Alcohol screening for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia	23 72%	5 16%	4 12%	0	32
Indicator 7: Alcohol brief intervention for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia	22 69%	7 22%	3 9%	0	32

Assessment of implementation:

Assessment of piloting achievement

The baseline extraction covers a 12 month time period and the final extraction a 4 month time period.

Indicator 1: Alcohol screening for newly diagnosed hypertension patients

% newly diagnosed hypertension patients screened	Baseline	Final
Practices	26	26
Practice population	321,651	321,815
Generated (new HTN)	6,825	2,667
Excluded: existing ALD diagnosis before HTN diagnosis	124	55
Excluded: existing ALD diagnosis before screen	1	5
Exception: declined	9	0
Exception: new registration	112	46
Exceptions as percentage	1.81%	1.76%
Denominator	6,579	2,561
Numerator	323	294
Numerator as percentage	4.91%	11.48%

Indicator 2: Alcohol brief intervention for newly diagnosed hypertension patients

% newly diagnosed hypertension patients given brief intervention	Baseline	Final
Practices	26	26
Practice population	321,651	321,815
Generated (new HTN)	6,825	2,667
Generated (new HTN + high score)	136	192
Excluded: existing ALD diagnosis before Dep/Anx diagnosis	Nil *	Nil *
Excluded: existing ALD diagnosis before intervention	Nil *	Nil *
Exception: declined	Nil *	Nil *
Exception: new registration	Nil *	Nil *
Denominator	136	192
Numerator	9	10
Numerator as percentage	6.62%	5.21%

*Rejection rules failed

Indicator 3: Alcohol screening for patients with a new diagnosis of depression or anxiety

% patients newly diagnosed with depression or anxiety screened	Baseline	Final
Practices	26	26
Practice population	321,651	321,815
Generated (new depression/anxiety)	5,384	2,663
Excluded: existing ALD diagnosis before Dep/Anx diagnosis	227	90
Excluded: existing ALD diagnosis before screen	0	0
Exception: declined	22	1
Exception: new registration	387	187
Exceptions as percentage	7.93%	7.31%
Denominator	4,748	2,385
Numerator	7	7
Numerator as percentage	0.15%	0.29%

Indicator 4: Alcohol brief intervention for patients with a new diagnosis of depression or anxiety

% patients newly diagnosed with depression or anxiety given brief intervention	Baseline	Final
Practices	26	26
Practice population	321,651	321,815
Generated (new depression/anxiety)	6,818	4,112
Generated (new depression/anxiety + high score)	786	493
Excluded: existing ALD diagnosis before Dep/Anx diagnosis	Nil *	Nil *
Excluded: existing ALD diagnosis before intervention	Nil *	Nil *
Exception: declined	Nil *	Nil *
Exception: new registration	Nil *	Nil *
Denominator	786 **	493 **
Numerator	19	16
Numerator as percentage	2.42%	3.25%

**Rejection rules failed*

***Discrepancy: Indicator 4 denominator is higher than the numerator for Indicator 3.*

Indicator 5: Alcohol brief intervention for patients with schizophrenia, bipolar affective disorder and other psychoses

% patients with schizophrenia, bipolar affective disorder and other psychoses given brief intervention	Baseline	Final
Practices	26	26
Practice population	321,651	321,815
Generated (existing SMI)	4,138	3,387
Generated (existing SMI, not in remission)	1,015	2,053
Generated (existing SMI, not in remission + high score)	128	128
Excluded: existing ALD diagnosis before Dep/Anx diagnosis	Nil *	Nil *
Excluded: existing ALD diagnosis before intervention	Nil *	Nil *
Exception: declined	Nil *	Nil *
Exception: new registration	Nil *	Nil *
Denominator	128	128
Numerator	5	3
Numerator as percentage	3.91%	2.34%

**Rejection rules failed*

Indicator 6: Alcohol screening for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia

% patients with CHD, AF, CHF, stroke or TIA, diabetes or dementia screened	Baseline	Final
Practices	26	26
Practice population	321,651	321,815
Generated (existing conditions)	24,568	26,063
Excluded: existing ALD diagnosis before other diagnosis	343	357
Excluded: existing ALD diagnosis before screen	64	82
Exception: declined	113	69
Exception: new registration	346	240
Exceptions as a percentage	1.90%	1.21%
Denominator	23,702	25,315
Numerator	2,761	2,755
Numerator as percentage	11.65%	10.88%

Indicator 7: Alcohol brief intervention for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia

% patients with CHD, AF, CHF, stroke or TIA, diabetes or dementia given brief intervention	Baseline	Final
Practices	26	26
Practice population	321,651	321,815
Generated (existing conditions)	24,568	26,063
Generated (existing conditions + high score)	261	120
Excluded: existing ALD diagnosis before other diagnosis	Nil *	Nil *
Excluded: existing ALD diagnosis before intervention	Nil *	Nil *
Exception: declined	Nil *	Nil *
Exception: new registration	Nil *	Nil *
Denominator	261	120
Numerator	30	14
Numerator as percentage	11.49%	11.67%

**Rejection rules failed*

Practices' views on implementation issues and impact

Training requirements

When asked if they thought it would be advisable to undertake additional training if the topic of alcohol was introduced nationally, 44% of the survey respondents (14/32) said yes, with a further 34% (11/32) stating that no further training was required, and the remaining 7 respondents were unsure. Refresher training relating to interventions was suggested by one practice.

"Alcohol just requires reading around the subject if knowledge lacking". (GP, survey)

"Alcohol is simply questioning although the screening questions are only useful as a prompt about alcohol". (GP, survey)

Workload, resource utilisation and costs

With regard to additional clinical workload during the pilot, half (16/32) of survey respondents considered there to be no extra or acceptable extra workload during the pilot. Seven respondents were unsure (22%, 7/32) and the remaining 9 stated that the clinical workload was heavy (25%, 8/32) or prohibitive (3%, 1/32). For this latter group of 9 it was reported that both GP (5/9) and non-GP (5/9) clinical roles were affected.

Almost 72% (23/32 survey respondents) considered there to be no extra or acceptable extra administrative workload during the pilot. Three respondents were unsure and the remaining six stated that the administrative workload was heavy (13%, 4/32) or prohibitive (6%, 2/32).

Within the interviews, a number of practices raised concerns about the alcohol screening tool being time consuming, particularly if done opportunistically, if these indicators were introduced into primary care contracts. In some cases the patient was asked to book another appointment in order to provide them with adequate advice and guidance.

"But I also agree with the amount of time you spend doing it (screening tool), and then you can allocate that to the Healthcare Assistant who asks the alcohol questions. And you almost risk de-skilling the GPs in normal recording of alcohol consumption". (GP, interview)

Regarding the AUDIT-C tool *"It's manageable if you just do the first part, but then when you get into the second part it gets very long". (GP, interview)*

“.... then those patients needing more input would have been advised to come back for further input rather than trying to fit it in in that... depending on the appointment and depending whether it was a nurse with a half an hour diabetes appointment or a GP just doing a quick blood pressure check or something..... So there were options to either try and do it then if you had the time or to get the patient to come back”. (GP, interview)

“To try and then feed back to people, it’s just, that is ten minutes on its own, absolutely. Unless they’re a non-drinker, or they’re coming in for that problem themselves. But otherwise, it hijacks the entire consultation”. (GP, interview)

“The quality of alcohol support for patients depends on the quality of the community support services and their capacity to cope with increase of patients should there be an increase following identification”. (Practice manager, survey)

Another practice talked about how they had used the pilot to improve existing templates.

“I think what we have is we tend to use the national templates that are developed by EMIS when they come out to us. Then amongst those templates we will then edit them to help us.....So it had an alcohol consumption question..., alcohol intake, alcohol consumption, so that was it. There was a question there to prompt clinicians to ask but there was nothing structured”. (GP, interview)

Five practices expressed concerns about onward referrals to alcohol services in the community.

“They (the alcohol service) actually want patients to make the phone call themselves ... We get our staff to give them a number, we talk to them about the benefits and disadvantages or issues they are going to have with the level of alcohol they are drinking and sometimes if our gut feeling is that they aren’t quite listening then we might back it up with a blood test. We will then shove the blood test under their noses to show them what effect it is having”. (GP, interview)

“If you just refer people who drink a lot but aren’t alcoholics for example,...all your alcohol services, don’t want to support them, so there’s nothing that you can send them to like the stop smoke clinics”. (Practice manager, interview)

“Even though we have a service, I’m not sure how adequate it is for our patients...we have got (to have) something to refer these patients to rather than just giving them, “Well you’re drinking too much,” because I think if they need to be referred on to somewhere...”. (Practice manager, interview)

“Understand asking re alcohol (is) important (for) lifestyle/health promotion intervention, however clinical pathways / patient engagement with onward referral for intervention is poor”. (GP, survey)

Changes in practice organisation

In the interviews, some practices described how they had included the clinical system templates provided in the pilot into their existing long term condition review clinical templates. One GP mentioned that he had developed a protocol to flag patients in the four condition groups who had no alcohol screen code recorded.

One practice (1/13) suggested that the availability of a consistent, national template would be helpful.

“I think what would be useful is if it could be coordinated nationally in terms of the templates that we get.often a new target is introduced but then the IT follow up for it takes a year or more to come through. So I think what would be useful is if EMIS Web was given the opportunity to create a template which had the right things on it from the word go and were delivered to practices from the word go, then it would be a much smoother transition”. (GP, interview)

As alcohol screening usually takes place within an appointment, rather than being the specific reason for the appointment, some practices stated that this took place with a GP in a standard 10 minute appointment, whereas others mentioned that this would be done by a nurse, in a 30 minute appointment with the patient.

“Difficult to ascertain full information in short 10 minute appointment on emotive subject”. (Practice manager, survey)

One practice highlighted the appointment time pressures associated with a newly diagnosed patient and suggested alcohol screening did not take place at this point, with a further practice proposing that with newly diagnosed hypertension specifically,

recognising the importance of this and suggesting that alcohol screening could take place at a patient review appointment.

Barriers to implementation

One practice noted that the Read codes which they used locally to record information relating to the newly registered patient questionnaire were different to those proposed in the pilot handbook.

Another practice suggested that if the alcohol indicators did get introduced, that the achievement thresholds for payment were set relatively low and that financially this was worthwhile so that practices would focus on obtaining the information.

Assessment of exception reporting (or future Personalised Care Adjustment)

Given the short time period available for the pilot, we are unable to comment upon likely levels of exception reporting.

Assessment of overlap with and/or impact on existing QOF indicators or local schemes

As described on pages 9 to 10, it is possible that there are various schemes and services already in existence in local areas which overlap with the requirements of these indicators.

Other overall views on implementation of the indicators (including unintended consequences)

Other views reported by respondents included:

“However, there is a discrepancy between what people perceive should be done and what is feasible”. (GP, survey)

“.....patients won't necessarily always come in to tell you that they are drinking. So it's usually they come in for one thing and then you begin to probe into that area. So they come in not sleeping, how do you cope with that? So ones that come in with depression, low mood and stuff like that, how do you cope if you go into that? They come into see the nurse with these

conditions and...., it's embedded in these templates. They will not always be forthcoming with this kind of information unless you have something to actually remind you or prompt you to ask those questions.” (GP, interview)

Three of the 32 survey respondents (9%) reported positive things that they didn't expect to experience during the pilot, with one of these providing further detail to say that this resulted in better screening for alcohol.

Five of the survey respondents (16%) stated that there were negative things that they didn't expect to experience, with three providing further detail (although two of these comments related to issues already highlighted earlier in the paper, on overlap with an existing alcohol LES and on whether the screening tool added anything to just counting units).

“Difficult to undertake opportunistically. Need to start at beginning of QOF year during to make part of routine review. Nurses feedback is that Audit-C is achievable in time frame however if need to progress to further screening / intervention will make current routine clinics over run”.
(GP, survey)

Suggested amendments to indicator wording

The Indicator Advisory Committee may wish to discuss the comments from a number of practices who stated that they preferred to use the number of units as a quantitative value rather than the score from an alcohol screening tool.

No other amendments to indicator wording are suggested.

Appendix A: Practice recruitment

A sample of 30 GP practices from across England was recruited by the NCCID to participate in the indicator pilot for 2018/19. Practices were to be representative of England in terms of the range of practice list sizes² and level of deprivation³. An additional aim was that there was practice coverage with regard to three of the four principal clinical system suppliers.

There were 4 of the 30 practices who subsequently withdrew from the pilot, one just prior to the commencement of the pilot, two practices mid-pilot and one close to the end. One of the remaining practices underwent a merger just prior to the start of the pilot which resulted in a change in the stratum for this practice due to the practice population more than doubling in size.

Final practice numbers in each stratum of practice list size and level of deprivation participating in the pilot are shown in the table below. When compared to the distribution of practices initially planned to target (in order to be fully representative of practices in England on these dimensions), there is over-recruitment in one stratum (large list size, least deprived) and under (no) recruitment in one stratum (small list size, least deprived); however, in this case, there is a practice categorised with medium list size and low deprivation where the list size (5,518 registered patients) is close to the lower end of the range.

Broadly speaking, based on this and other background data available to characterise the pilot practices, they appear to be fairly representative of GP practices in England.

Table 1: Participating pilot practice numbers by stratum

	IMD score ³			
List size ²	Least	Medium	Most	Total
Large	8	2	4	14
Medium	3	4	2	9
Small	0	2	1	3
Total	11	8	7	26

² 2016/17 registered population taken from NHS Digital QOF 2016/17 <https://digital.nhs.uk/>

³ Index of Multiple Deprivation (IMD 2015) Public Health England <https://fingertips.phe.org.uk>

Appendix B: Indicator development

The NICE Indicator Advisory Committee (IAC) in March 2018 considered a review undertaken by NCCID of all of the previous NICE indicator work on alcohol, which suggested some areas that could be revisited and also some new areas for potential indicator development. IAC agreed to proceed to piloting and consultation on indicators focused on alcohol screening (using a short screening tool, to address problems identified by a previous pilot using the long tools) and provision of brief advice in a number of primary care populations, as detailed below. (To note that a screening indicator for patients with schizophrenia, bipolar affective disorder and other psychoses was not included in the pilot due to the existence of indicator MH007 in QOF up to 2018/19. However, by the point the pilot was undertaken, during 19/20, this indicator had been removed from QOF).

Indicator wording as piloted

Indicator 1: Alcohol screening for newly diagnosed hypertension patients

The percentage of patients with a new diagnosis of hypertension in the preceding 12 months who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the 3 months before or after the date of entry on the hypertension register.

Indicator 2: Alcohol brief intervention for newly diagnosed hypertension patients

The percentage of patients with a new diagnosis of hypertension in the preceding 12 months with a FAST score of ≥ 3 or AUDIT-C score of ≥ 5 who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

Indicator 3: Alcohol screening for patients with a new diagnosis of depression or anxiety

The percentage of patients with a new diagnosis of depression or anxiety in the preceding 12 months who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the 3 months before or after their diagnosis being recorded.

Indicator 4: Alcohol brief intervention for patients with a new diagnosis of depression or anxiety

The percentage of patients with a new diagnosis of depression or anxiety with a FAST score of ≥ 3 or AUDIT-C score of ≥ 5 who have received brief intervention to help them

Indicator 5: Alcohol brief intervention for patients with schizophrenia, bipolar affective disorder and other psychoses

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a FAST score of ≥ 3 or AUDIT-C score of ≥ 5 who have received a brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

Indicator 6: Alcohol screening for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia

The percentage of patients with one or more of the following conditions: CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the preceding 2 years.

Indicator 7: Alcohol brief intervention for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia

The percentage of patients with one or more of the following conditions: CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia with a FAST score of ≥ 3 or AUDIT-C score of ≥ 5 who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

Appendix C: Acceptability and implementation recommendations

Acceptability recommendations

In order to provide recommendation to the Indicator Advisory Committee, the degree of acceptability of the indicators to practices is assessed and reported in the 'Summary of Indicators' section as follows:

- a) A summary of the percentage (of respondents to the survey) responding to the survey questions which relate to whether indicators within the topic should be financially incentivised and their impact on the quality of care for patients;
- b) Relevant indicator- specific comments reported descriptively.

Implementation recommendations

Implementation recommendations in the 'Summary of Indicators' section are based on a judgement of the findings reported by pilot practices relating to workload, training, set up and preparation, taken from surveys and interviews/focus groups. A narrative overview of the ease of implementation from these findings, forms the basis of the implementation category used for the recommendations in the topic reports.

The implementation categories are:

- No problems (with implementation)
- Minor problems (resolvable)
- Major problems (potentially resolvable)
- Major problems (not resolvable)