Primary Care Needs Assessment tool: indicator review

Google Chrome is advised to ensure this page displays/ functions as intended.

ⓘ You are now reviewing the PCNA indicator(s) for: **Prevalence of alcohol misuse**

ⓘ **Caution**: The information on this page is provided for testing purposes and may be subject to amendment. It may contain errors or not be fully reflective of consensus public health advice or relevant services, therefore should only be used with care.

Strategic context

ⓘ Consider the national strategic context for prioritising improvement action in this area (in conjunction with your health board's IMTP and Regional Partnership Board's Area Plan):

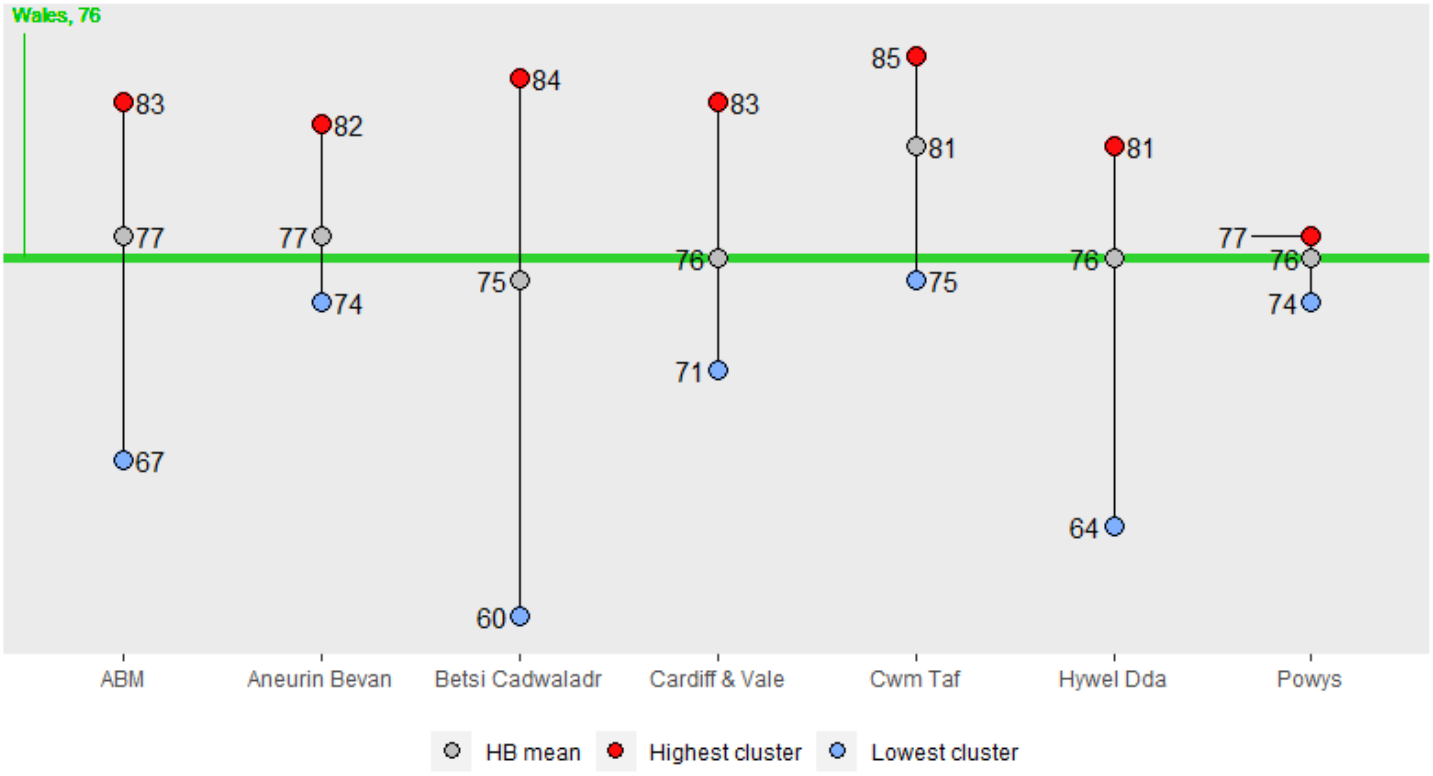
- Alcohol consumption is associated with mental ill health, liver, neurological, gastrointestinal and cardiovascular conditions and several types of cancer; it is also linked to accidents, injuries and poisoning and social problems such as crime, assault and domestic violence (*Making a difference*; PHW 2016; link).
- Alcohol (along with drug use and high BMI) is one of the top three identified risk factors for disability-adjusted life years (DALYs) among adults under 50 years in Wales (*Health and its determinants in Wales*; PHW 2018; link).
- *Working together to reduce harm* was published by the Welsh Government in 2008 (link); this 10-year substance misuse strategy has been supported by a series of substance misuse delivery plans (link).
- Data indicate that those living in the most deprived areas of Wales are more than three times as likely than those in the least deprived areas to be admitted for alcohol-specific conditions (PHW 2018; link)
- A combined strategy comprising brief advice; random breath-testing; reduced access; better control of advertising and increased price is estimated to save 10-20% of the alcohol burden on the individual, society and economy in *Making a difference* (PHW 2016; link).
- The *Public Health (Minimum Price for Alcohol) (Wales) Act 2018* (link) introduces introducing a minimum price for alcohol, targeting harmful drinking through restricted availability of low cost, high strength products.
- Indicators for this topic are reported via Primary Care Measures.

▼ PCM national variation

ⓘ Primary Care Measures (PCM) are a set of care quality indicators for primary care in Wales. The charts

below emphasise variation between and within health boards; for further information see here. Beneath the charts are improvement action options that may inform cluster IMTPs. Variation is a natural phenomenon and can be healthy e.g. it can be a deliberate result of innovation in primary care settings that seeks to test improvements in processes or deliver better care outcomes. Variation that is observed in a healthcare context may be referred to as *inequality*; inequality that is judged to be both avoidable and socially unjust is termed *inequity* (sometimes alternatively described as *unwarranted variation*).

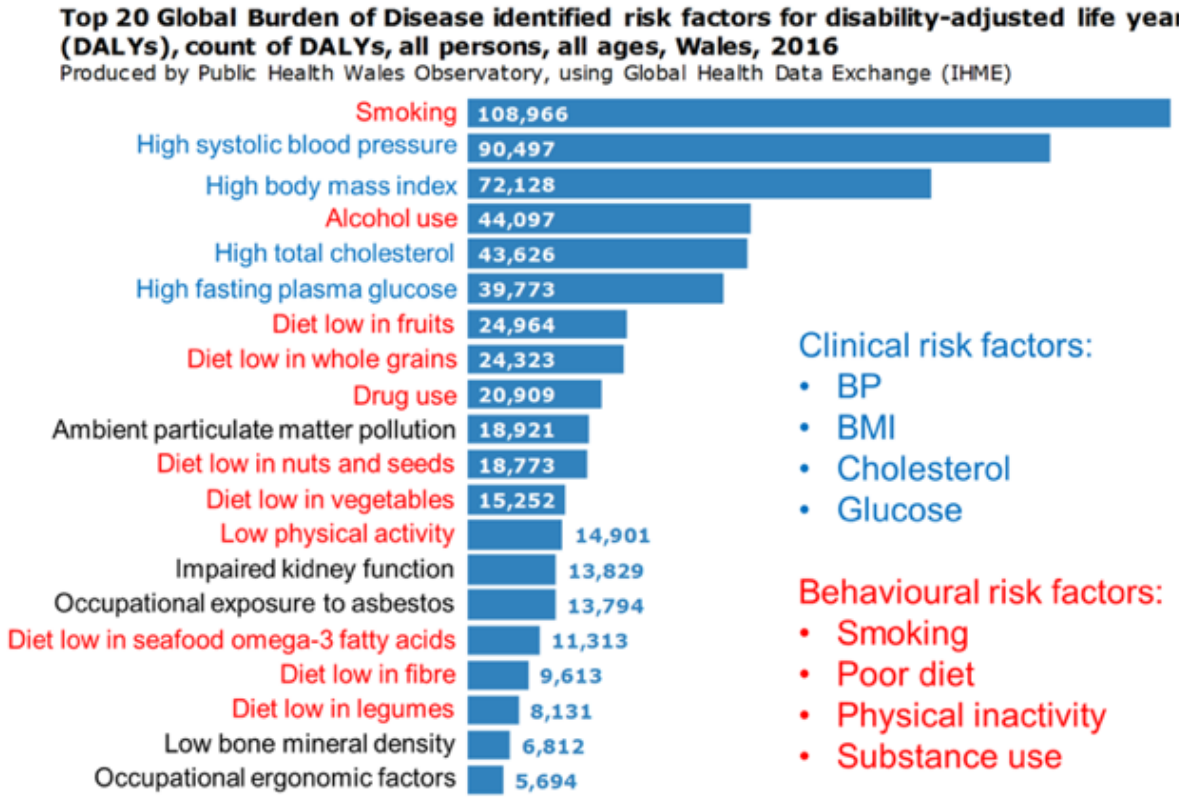
Variation in proportion of people aged 16+ years with a record of alcohol intake, by cluster within each health board, Q3 2017/18 (*Source*: PCIP, Nov 2019):



▼ ⓘ Tell me about: DALYs

What are DALYs?

- Disability-adjusted life years (DALYs) are a combined measure of early deaths (i.e. premature mortality) and disability-weighted impact on quality of live from living with poor health.
- Because DALYs capture both what kills us and what makes us ill, they describe the overall 'burden of disease' (reported by risk or condition) more effectively than mortality or disability prevalence does alone.
- The relative contribution of known risk factors for DALYs is illustrated in the figure below (*Health and its determinants in Wales*, PHW 2018).



Behavioural risk factors for DALYs:

- Behavioural risk factors for DALYs relate to both individual behaviours and the choice environment (i.e. the people and things around a person that influence their health choices).
- Four behaviours—smoking, substance misuse (alcohol and drugs), inactivity and unhealthy diet contribute considerably to identified risk factors for DALYs in Wales.
- Behavioural risk factors are generally reduced via mix of population and targeted approaches, with the aim of preventing or reversing health-harming behaviours that contribute to DALYs.

Clinical risk factors for DALYs:

- Four clinical risk factors are among the top five ranked risks for DALYs, these being: high systolic blood pressure (i.e. hypertension); high body index (i.e. overweight and obesity); high total cholesterol; high fasting plasma glucose (a prelude to diagnosis of diabetes).
- Clinical risk factors may be secondary (in part) to behavioural risk factors.
- Clinical risk factors are generally reduced via targeted approaches.

▼ ⓘ Tell me about: Prevention

Definitions:

- Zola's river analogy is a useful way of thinking about prevention of ill health (Zola 1970). It describes **primary** prevention (stopping everyone from falling into a river and coming to harm e.g. never smoking), **secondary** prevention (ensuring any individuals at risk who do fall in get to safety quickly; minimising the chance of complications through early identification and intervention e.g. screening) and **tertiary** prevention (search-and-rescue for those taken downstream; mitigating the

worst consequences of established disease e.g. vascular surgery).

- The Welsh Government definition of prevention is broader: working in **partnership** to co-produce the best outcomes possible, utilising the strengths and **assets** people and places have to contribute.

Building a healthier Wales (Feb 2019) sets out six key principles for implementing prevention in Wales:

- Adhere to the **five ways** of working (as outlined in the Well-being of Future Generation Act).
- Commit to investing in **evidence-based** interventions (where available or evaluate small and scale up if appropriate).
- Ensure evidence-based interventions have sufficient **scale** and **reach** to make a measurable population impact and to reduce inequalities.
- Ensure services are provided to a sufficient **quality** to achieve the best possible **outcomes** for each intervention; continually improve by drawing upon quality improvement techniques.
- Balance intervention benefits for **short and long-term** outcomes (including investing in one sector to realise a return in another).
- Optimise **value** by taking an agile approach to evaluating interventions and approaches and disinvesting in those that do not yield benefit/ value.

Improvement actions for GP practice cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ **Make every contact count by opportunistically asking about alcohol consumption**

- Making Every Contact Count (MECC) is an all-Wales approach to behaviour change, utilising day-to-day interactions, to support people to make positive changes that improve their physical and mental health and well-being.
- MECC is focussed on behavioural risk factors, vaccination uptake and mental health and well-being.
- Consider encouraging practice staff to acquire MECC skills. For MECC e-learning (to level 1), see here [ESR or other login/ registration required]. For MECC training contacts by health board, see here [intranet].
- Brief intervention by practice staff in regular contact with people at risk (e.g. due to behaviours or socio-demographic characteristics) is promoted in NICE guidance (PH49); this involves discussion, negotiation or encouragement often given opportunistically, and could support an informed choice to consider reducing alcohol consumption.
- *Making a difference* (PHW 2016; link) cites evidence from the WHO that offering brief advice for

hazardous drinking is quite cost-effective (relative to very cost-effective population-level strategies).

- Record or update alcohol use on the clinical system.

▼ Make every contact count by asking about other risk behaviours

- When asking about alcohol consumption, consider also asking about smoking (BRF-001), physical inactivity (BRF-003) and physical inactivity (BRF-004).
- Evidence indicates the clustering (co-occurrence) of risk behaviours, whereas services in the UK tend to focus on changing behaviour to address a single risk factor (*J Public Health* (Oxf). 2018 Sep 6).
- Clustering of behavioural risk factors is more frequent in areas of higher deprivation (compared to the general population) indicating the need for proportionately greater attention to multiple risk factors among people living in areas of deprivation (*Health Place*. 2017 May;45:189–198).

▼ Ensure staff confidence to offer simple alcohol consumption advice

- MECC cite the UK Chief Medical Officer's recommendation that adults should not regularly drink more than 14 units of alcohol a week (link). People who drink as much as 14 units a week are advised to spread their drinking over three or more days in the week. Women who are pregnant, or who think that they could be, are advised that it is safest not to drink at all.
- Drink Wise Wales advocate having several "drink free" days is a good way to cut down (link). They advise Go low: Choose lower alcohol drinks or have more soft drinks; Go slow: Drink more slowly or with food; Go small: Choose smaller glasses, bottles rather than pints, and avoid multi-buy offers.

▼ Consider selective use of an alcohol harms "screening" tool

- Consider utilising a "screening" test that can be used by health professionals as a tool to assess a service users level of risk for alcohol harm, such as AUDIT C (link).
- Where screening everyone is not feasible or practicable, consider focussing on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. This includes people: with relevant physical conditions (such as hypertension and gastrointestinal or liver disorders), relevant mental health problems (such as anxiety, depression or other mood disorders), who have been assaulted, at risk of self-harm, who regularly experience accidents or minor traumas, who regularly attend GUM clinics or repeatedly seek emergency contraception.
- Scoring may suggest the need for further assessment for and delivery of a community-based assisted withdrawal, or referral for assessment and management by specialist alcohol services.

▼ Audit the follow-up of abnormal liver function tests

- QOF guidance for 2017/18 identified liver disease as a national clinical priority; proposed quality improvement action focussed on management of abnormal liver function tests (see here). An audit cycle within GP practices is described with the goal "to facilitate appropriate management of abnormal ALT tests and, thereby, more timely diagnosis of patients with liver disease."

▼ **Ensure awareness and implementation of NICE guidance/ quality standards**

- *Behaviour change: individual approaches*. Public health guideline [PH49] (Published date: January 2014) includes recommendations suitable for healthcare professionals. This guideline covers changing health-damaging behaviours among people aged 16 and over using interventions such as goals and planning, feedback and monitoring, and social support. It aims to help tackle a range of behaviours including alcohol misuse, poor eating patterns, lack of physical activity, unsafe sexual behaviour and smoking.

- *Alcohol-use disorders: prevention*. Public health guideline [PH24] (Published date: June 2010) includes recommendations suitable for healthcare professionals. This guideline covers alcohol problems among people over 10. It aims to prevent and identify such problems as early as possible using a mix of policy and practice.

- *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence*. Clinical guideline [CG115] (Published date: February 2011) includes recommendations suitable for healthcare professionals. This guideline covers identifying, assessing and managing alcohol-use disorders (harmful drinking and alcohol dependence) in adults and young people aged 10â€“17 years. It aims to reduce harms (such as liver disease, heart problems, depression and anxiety) from alcohol by improving assessment and setting goals for reducing alcohol consumption.

- *Alcohol-use disorders: diagnosis and management of physical complications*. Clinical guideline [CG100] (Published date: June 2010; Last updated: April 2017) includes recommendations suitable for healthcare professionals. This guideline covers care for adults and young people (aged 10 years and older) with physical health problems that are completely or partly caused by an alcohol-use disorder. It aims to improve the health of people with alcohol-use disorders by providing recommendations on managing acute alcohol withdrawal and treating alcohol-related conditions.

- *Alcohol-use disorders: diagnosis and management*. Quality standard [QS11] (Published date: August 2011) sets out 13 quality statements, any of which could form a focus for collective local improvement action. This quality standard covers identifying and supporting adults and young people (aged 10 and over) who may have an alcohol problem, and caring for people with alcohol-related health problems, such as alcohol dependence or Wernicke's encephalopathy. It also covers support for their families and carers. It describes high-quality care in priority areas for improvement.

Improvement actions for wider cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ Make every contact count by opportunistically asking about alcohol consumption

- Making Every Contact Count (MECC) is an all-Wales approach to behaviour change, utilising day-to-day interactions, to support people to make positive changes that improve their physical and mental health and well-being.
- MECC is focussed on behavioural risk factors, vaccination uptake and mental health and well-being.
- Consider encouraging practice staff to acquire MECC skills. For MECC e-learning (to level 1), see here [ESR or other login/ registration required]. For MECC training contacts by health board, see here [intranet].
- Very brief intervention by staff in contact with the general public is promoted in NICE guidance (PH49), in the form of "ask, advise, assist" to inform people about services or interventions that can help them improve their general health and well-being; this could support an informed choice to consider reducing alcohol consumption.
- *Making a difference* (PHW 2016; link) cites evidence from the WHO that offering brief advice for hazardous drinking is quite cost-effective (relative to very cost-effective population-level strategies).

▼ Make every contact count by asking about other risk behaviours

- When asking about alcohol consumption, consider also asking about smoking (BRF-001), physical inactivity (BRF-003) and physical inactivity (BRF-004).
- Evidence indicates the clustering (co-occurrence) of risk behaviours, whereas services in the UK tend to focus on changing behaviour to address a single risk factor (*J Public Health* (Oxf). 2018 Sep 6).
- Clustering of behavioural risk factors is more frequent in areas of higher deprivation (compared to the general population) indicating the need for proportionately greater attention to multiple risk factors among people living in areas of deprivation (*Health Place*. 2017 May;45:189–198).

▼ Ensure staff confidence to offer simple alcohol consumption advice

- MECC cite the UK Chief Medical Officer's recommendation that adults should not regularly drink more than 14 units of alcohol a week (link). People who drink as much as 14 units a week are advised to spread their drinking over three or more days in the week. Women who are pregnant, or who think that they could be, are advised that it is safest not to drink at all.
- Drink Wise Wales advocate having several "drink free" days is a good way to cut down (link). They advise Go low: Choose lower alcohol drinks or have more soft drinks; Go slow: Drink more slowly or with food; Go small: Choose smaller glasses, bottles rather than pints, and avoid multi-buy offers.

▼ Consider selective use of an alcohol harms "screening" tool

- Consider utilising a "screening" test that can be used by health professionals as a tool to assess a service users level of risk for alcohol harm, such as AUDIT C (link).

- Where screening everyone is not feasible or practicable, consider focussing on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. This includes people: with relevant physical conditions (such as hypertension and gastrointestinal or liver disorders), relevant mental health problems (such as anxiety, depression or other mood disorders), who have been assaulted, at risk of self-harm, who regularly experience accidents or minor traumas, who regularly attend GUM clinics or repeatedly seek emergency contraception.

- Scoring may suggest the need for further assessment for and delivery of a community-based assisted withdrawal, or referral for assessment and management by specialist alcohol services.

▼ Ensure awareness and implementation of NICE guidance/ quality standards

- *Behaviour change: general approaches*. Public health guideline [PH6] (Published date: October 2007) includes recommendations suitable for a broad audience. This guideline covers a set of principles that can be used to help people change their behaviour. The aim is for practitioners to use these principles to encourage people to adopt a healthier lifestyle by, for example, stopping smoking, adopting a healthy diet and being more physically active.

- *Behaviour change: individual approaches*. Public health guideline [PH49] (Published date: January 2014) includes recommendations suitable for a broad audience. This guideline covers changing health-damaging behaviours among people aged 16 and over using interventions such as goals and planning, feedback and monitoring, and social support. It aims to help tackle a range of behaviours including alcohol misuse, poor eating patterns, lack of physical activity, unsafe sexual behaviour and smoking.

- *Community pharmacies: promoting health and wellbeing*. NICE guideline [NG102] (Published date: August 2018) includes recommendations suitable for a broad audience. This guideline covers how community pharmacies can help maintain and improve peopleâ€™s physical and mental health and wellbeing, including people with a long-term condition. It aims to encourage more people to use community pharmacies by integrating them within existing health and care pathways and ensuring they offer standard services and a consistent approach. It requires a collaborative approach from individual pharmacies and their representatives, local authorities and other commissioners.

- *Alcohol-use disorders: prevention*. Public health guideline [PH24] (Published date: June 2010) includes recommendations suitable for a broad audience. This guideline covers alcohol problems among people over 10. It aims to prevent and identify such problems as early as possible using a mix of policy and practice.

- *Alcohol: school-based interventions*. Public health guideline [PH7] (Published date: November 2007) includes recommendations suitable for a broad audience. This guideline covers school-based interventions to prevent and reduce alcohol use among children and young people. It aims to encourage children and young people not to drink, delay the age at which they start drinking and reduce the harm to those who do drink.

- *Alcohol: preventing harmful use in the community*. Quality standard [QS83] (Published date: March 2015) sets out four quality statements, any of which could form a focus for collective local improvement action. This quality standard covers preventing and identifying alcohol problems in the community. It includes policy and practice approaches to prevent harmful alcohol use in adults, young people and children. It is particularly relevant to local authorities, the police, and schools and

colleges. It describes high-quality care in priority areas for improvement.

What is happening in Wales?

ⓘ Consider whether shared learning/ local experience might guide your own implementation of the evidence:

▼ **Placeholder project description**

- *What problem was being addressed?* Placeholder.
- *What was done to address it?* Placeholder.
- *How does this evidence good practice?* Placeholder.
- *What key learning can be shared?* Placeholder.
- *Who did it or who can be contacted in the event of queries?* Placeholder.

ⓘ Have something to share? Please let us know here.

ⓘ **Caution**: Any text entered into the following sections will not be saved if you navigate away from this page, or close the browser window before selecting PRINT.

What do you know about community views on this?

ⓘ Consider any relevant citizen/ community voice information (e.g. from surveys, complaints, engagement events, or your health board's well-being or population needs assessments). Summarise this into the following box:

Type here

What assets or partnership opportunities can you identify?

ⓘ Consider any relevant local assets or potential partner organisations that might facilitate co-production. Summarise this into the following box:

Type here

Do you need more data before making a decision?

ⓘ If relevant, consider any additional data (or information) requirements that might ensure a more informed decision on determining action. Summarise this into the following box:

Type here

What is your provisional decision?

ⓘ Having reviewed indicator data on local needs and considered evidence-informed quality improvement options, please record initial thoughts on proposed actions. You may also wish to record related thoughts around potential service models, capacity requirements, workforce development or financial considerations. Ideally, discuss these with both the wider cluster and with your local public health team (LPHT). Summarise your proposals for action into the following box:

Type here

ⓘ Now PRINT this page (e.g. to PDF) so you have a record of your entries (Steps E-H). You may then close the Print view browser window and return to the PCNA workbook to review another indicator.