Strategies for Implementation of ABIs in A&E and Antenatal Settings in Scotland: A Qualitative Interview Study

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About this Study

* **Aim: To capture learning on ABI implementation in A&E and antenatal settings in the Scottish national ABI programme**
* Evidence for efficacy in A&E and antenatal settings is less convincing than in primary care.
* 366,184 Scottish ABIs delivered to 31st March 2013; In 2012/13, 31% of ABIs were delivered outside of primary care.
* No comparable published study to identify implementation issues in large scale national ABI programmes of this kind

Methods

* 14 in-depth qualitative interviews with implementation leaders or senior clinicians in 9 Scottish mainland health boards.
  * 12 had been involved in ABI delivery for over 5 years
  * 8 were involved in implementation in both settings
  * High and low performing health boards sampled
* Interviews (~67 mins), recorded, notes written up, supplemented & checked with participants for accuracy.
* Inductive analysis, with framework method charting using CFIR headings.

Findings

* 5 main strategies important for supporting implementation.
* No obvious differences in strategies reported by more and less successful health boards except suggestion of earlier use of these strategies in more successful boards.
* Not a magic formula: implementation still challenging even when using these strategies.
* Use of strategies prior to expecting ABI delivery was considered best.
  * *"Need a whole range of supports in place. The developmental time to get up and running was huge"*

Five Helpful Strategies

1. The National ABI Target
2. Leadership for Implementation
3. Flexibility, Collaboration and Pragmatism in Intervention Design
4. Recording, Monitoring and Reporting
5. Engaging and Supporting Frontline Staff

1. The National ABI Target

* Mostly, but not universally, helpful in securing implementation in both settings.
  * Vital to draw attention at senior level, came with funding, implementation might disappear without it – except where local areas had their own targets.
* Lack of ownership: *"everyone thought that it was somebody else's target".*
* Unintended consequences included: distortions in recording; short-term solutions that did not achieve routine delivery; and staff resistance to feeling '*coerced*' by the target which was '*foisted upon them*'.

Quotes

* *The target was definitely important. Health boards take the target seriously. They are monitored on them… at the highest level… it probably wouldn't have happened without it being a target.*

Interview 3, Both settings

* *People get pressure fatigue and project fatigue… they have multiple demands and multiple targets to meet while also operating under financial constraints with less people to do the work. People get burnout and say 'I just can't. I just can't do any more' and it's really difficult to know how to overcome that.*

Interview 1, Both settings

2. Leadership for Implementation

* Identification of appropriately senior individuals to lead implementation
* Gaining support of other senior practitioners and staff from the start.
  * Very difficult to get that senior support, especially in A&E where some senior staff were unconvinced of merits of ABI on evidence/appropriateness grounds.
  * Approaching senior staff with an open mind and readiness to acknowledge existing related work was helpful.

Quotes re Senior Support

* *In hindsight if I was running this project again, I would have held that [first] meeting with very senior leads so hospital managers and senior medical leads. I would have rubber-stamped the initiative from very, very high up and I think that might have made things a wee bit faster perhaps.*

  Interview 7, A&E

* *There was a bit of 'I've got the 10 commandments here, it's a really good way to live, I don't understand why you're not taking them.' If I had my time again the approach would be different. I would probably have a discussion with senior managers about 'how we can develop the best practice that you're delivering at the moment?'*

  Interview 1, Both settings

3. Flexibility, Collaboration and Pragmatism in Intervention Design

* Balancing what is desirable with what is possible, to fit with existing practice.
  * Avoiding an overly rigid concept of what constitutes an ABI is important in new settings.
* Starting point= really good understanding of existing practice:
  * By working alongside frontline practitioners
  * By practice audits
  * Through prior knowledge
* Recognition that many practitioners were already asking about alcohol – used in efforts to '*win hearts and minds*', ABI design.

Quotes re Flexible ABI Design

* *A key lesson is not to be afraid to tweak the model. An ABI is a structured conversation. It can be structured around other processes that might make it easier for staff to incorporate in their daily work.*

  Interview 3, Both settings

* *We started off with the full FAST screening tool completed on every patient but it was too cumbersome, but now we've just gone for the first question and if yes then a conversation about alcohol would be helpful.*

  Interview 7, A&E

4. Recording, Monitoring and Reporting

* Establishment of robust and practical recording, monitoring and reporting was essential
* Needed to happen much earlier than had been achieved here
* Data was vital for reporting, for monitoring to support ongoing implementation efforts and for allowing comparisons of implementation between different staff and teams.

The Importance of Recording

* *Unless you can capture delivery then you can't report it or know about impact. Unless you've got recording in place, you can train until the cows come home but you can't evidence it.*

Interview 10, Both

* *If we had robust recording systems then I could say we're giving you reliable information month by month and… I can see exactly who's not delivering ABIS… it's a name and shame game and that's what you need before anybody is going to buy into it.*

A&E

Establishing Recording Systems was Very Difficult in Many Areas

* *There are four, five, six different systems depending on how patients come in and progress through the NHS*

  Interview 1, Both

* *We're still in the process of agreeing who has access to [the recording screens] because everybody has access to different levels of the system. So that makes it really difficult trying to negotiate. It shouldn't be difficult it should be dead easy. You should be able to say every nurse and doctor in A&E should have access to that screen but for some reason it's not easy. That's the biggest bane of my life, that's not easy.*

  A&E

Mandatory Recording

* *When the [IT system] was modified to create the mandatory field, it meant that you couldn't discharge a patient until you clicked either 'BI delivered yes/no' and that was the only thing that significantly increased the recording and now we are well in target.*

  Interview 7, A&E

* This carries a risk of data distortions if practitioners tick any box just to get past the screen.

5. Engaging and Supporting Frontline Staff

* Need to work closely with frontline staff during design, training and implementation stages.
* Practicalities of training were difficult and time consuming.
* Alcohol Liaison Nurses or similar staff roles were important both as champions and support for staff but caution re. them doing all the work!

Bite-Sized Training

* *We broke [the training] down into bite sizes of one and a half hours… I came in very early so that I could catch the staff starting when they were at their quietest period in the emergency department and each member of staff attended three sessions of one and a half hours. This carried on for ages until everyone was trained – death by a thousand cuts.*

Interview 7, A&E

ALNs & Routine Delivery by Frontline Staff

* *We kept offering support through the Alcohol Liaison Nurses. We focused on building up relationships… Across the hospital because of the ALNs work, some people know a bit about [alcohol], but the only people having conversations about alcohol are the ALNs.*

  Interview 2, Both settings

* *Part of [the alcohol nurse] role was to involve other staff in what she was doing and to show them how easy it was to do but it probably wasn't successful in terms of embedding anything into practice because it gave them a get-out.*

  Interview, A&E

How do these findings fit with prior research?

* Fit well with issues known to be important in implementation efforts more broadly as in CFIR.
* Similarly intensive and wide-ranging implementation efforts necessary for other high profile issues.
* Some strategies similar to earlier studies: support from senior staff; adapting the intervention; IT; training etc.
* In gen, more emphasis on system or higher level strategies than previous studies (e.g. Nilsen), less on individual - attitudes, skills or concerns about patient responses - partly because there was in effect a requirement to deliver.

Known Unknowns
(as in, you probably know these by now…)

* Adaptation of ABI design, to make it easier and more acceptable to implement, risks compromising effectiveness in ways that are currently unknown.
* Uncertainty about the required content of ABIs for effective delivery is a weakness.
* Stronger evidence of effectiveness in these settings should be helpful in gaining support of senior staff.

Conclusions

* Participants in this study were responsible for a high-profile national programme supported by considerable resources and funding.
* Even then, implementation was v. challenging in terms of winning hearts and minds, and re-structuring practice.
* Five helpful strategies identified, but still hard to achieve, time-consuming and complex.
* Implementation leaders did not benefit from prior knowledge or training in implementation science, so they learned these strategies 'the hard way', through trial and error.
* Overall this study emphasises the magnitude of the implementation challenge.

Thank You

* *Jim McCambridge, Lucy Platt, LSHTM,*
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* *Islington Borough Council*
* *All interviewees*

* *Questions/Queries/for Papers from this Research:*

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