Alcohol Strategy 2016-2019

Foreword

Rod and Karen to be inserted

Introduction

Drinking is part of our culture and is reflected in how we socialise, celebrate and sympathise with life's milestones. Whilst many people use it sensibly, regular drinking above medical guidelines can lead to a number of alcohol related health issues, including cancer, liver disease and premature death. It can also affect personal relationships between families and friends, heighten social isolation and physical capacity and being a victim of crime. Alcohol can also increase the likelihood of committing crime through reduced inhibitions and heightened aggression impacting on anti-social behaviour, and crime and disorder within communities. There is also a financial risk as it can also affect work and lost productivity.

There is also a clear relationship between high consumption, frequency and increased risk of disease, disability and death. Reducing alcohol related harm is a public health priority ranking among the top five risk factors for disease disability and death globally. Age, gender, socio-economic status and patterns of drinking all contribute to levels of alcohol related harm. Children, young people and the elderly are more vulnerable to alcohol related harm. Early initiation of drinking before the age of 14 years is a predictor for impaired health status and increased risk of alcohol dependence in later life. Furthermore when young people do drink they tend to consume larger amounts in a single drinking episode and are less risk adverse.

Whilst people tend to reduce their alcohol intake as they get older those that continue tend to drink more frequently than their younger counterparts. With ageing, people are unable to tolerate the same levels of consumption as previously leading to a high burden of unintentional injures such as trips and falls.

Whilst harmful use of alcohol is a significant risk factor in the premature deaths of men aged 15-59 there is growing evidence that women may be more vulnerable to alcohol related harms. Women's vulnerability is due to a range of factors in relation to physiology, lower weight, smaller livers and greater proportion of overall body fat. Breast cancer is one of seven cancers that can be attributed to alcohol and is particularly prevalent in women in comparison to men. Drinking during pregnancy can increase the risk of foetal alcohol spectrum disorder (FASD) and other preventable health conditions within new-borns. Women are also more at risk of interpersonal violence from male partners.

Regularly drinking can also affect family life and influence young people's own drinking behaviour and vulnerability to developing alcohol use related disorder. Harmful drinking can compromise parenting, subjecting children to mistreatment, neglect and abuse.

Tackling alcohol related harm has many different aspects and requires a multi-agency approach. No one agency can tackle alcohol on its own. To achieve the ambitions of this strategy we need public services to continue to work together, maintaining and developing relationships with regulatory and enforcement agencies, forging and strengthening relationships with primary and secondary care.

Our Approach

The purpose of this strategy is to stimulate partners (statutory, non-statutory, the community and businesses) to work together to reduce alcohol related harm in the county. It will build on the ongoing work to reduce alcohol related harm amongst the Partnership who recognises that reducing alcohol related harm requires a long term consistent approach if we are to succeed.

All public services are under considerable financial challenge. The current cost of alcohol misuse on society in England is estimated to be £21bn, of which £11bn is spent on crime, £7bn spent on lost productivity and £3.5bn spent on the NHS (PHE Why Invest?). Therefore, it is integral to the delivery of this strategy that all stakeholders work together to minimise costs and add value regardless of who benefits most.

There is a substantial body of evidence on how alcohol related harm can be reduced. Some of this evidence requires a central government response such as minimum unit price (MUP), however, a lot of activity can be, and is delivered and co-ordinated locally. The delivery of this strategy will be achieved using the evidence base to ensure interventions and activities undertaken are cost effective and produce the best outcomes No one agency can tackle alcohol related harm on their own, this is why this strategy needs to be adopted across the public service sector within Shropshire. All agencies need to maximise opportunities through their daily delivery of service to combat alcohol related harm.

Delivery of this strategy cannot just be the responsibility of public services. People also need to review their own relationship with alcohol and make adjustments as necessary. Changing drinking culture needs a multi-pronged approach. Only by raising awareness through social marketing, working with business to promote social responsibility, utilising powers to create the right environment and providing the right intervention at the right time, will the ambitions of this strategy be realised.

What we already do

Many partnership agencies already tackle alcohol related issues on a daily basis as part of their core business. Tackling underage sales, licence compliance, protecting communities from anti-social behaviour and managing patient care are just some of the activities undertaken. Since 2003 partners have being working together to co-ordinate activity to reduce alcohol related harm throughout the county. The 2012 to 2015 alcohol strategy was ambitious and set out a range of activities to reduce alcohol related harm. Implemented at a point of unprecedented restructure of the public sector and period of austerity key achievements include.

- Implementation of the Community Alcohol Project; in key areas of Shropshire
- Establishment the alcohol liaison nurse team within Royal Shrewsbury Hospital
- Evaluation of the ALN project
- Implementation of the Joint Working Protocol between Substance Misuse Services and Children and Family Services,
- Re-established Oswestry Pub watch.
- Recommissioned Alcohol Specialist services
- Increased the number of alcohol successful completions

Understanding the local profile

Shropshire is a large rural county that is sparsely populated, 54% of the population live in the main market towns which equates to 6% of the land. There are 306,100 people who live in Shropshire with a fairly equal gender split. As with many rural areas 98% of the population is White British. Shropshire is also home to round 2% of armed force personnel. Compared to the national average Shropshire's population is weighted towards the older age groups, with a greater proportion living in the county aged 45 and above. This is an important factor when planning health services as the negative effect of regularly drinking on health can take between 10 years and 20 years to appear.

Overall the county is fairly affluent with only 4% of the population living in the most deprived fifth areas in England. The electoral wards are Harlescott, Meole Brace, Monkmoor, Battlefields and Heathgates in the Shrewsbury area, Market Drayton East in the north of the County and Castle in the Oswestry area have the greatest levels of deprivation. Shropshire also has a low wage economy due to the nature of agriculture and small businesses. There is an adverse relationship between alcohol and deprivation known as the alcohol harm paradox. Areas of low socioeconomic status have a greater susceptibility to the harmful effects of alcohol despite little difference in consumption.

To understand how alcohol affects the population a needs assessment was undertaken during the summer of 2015 as part of the Joint Strategic Needs Assessment. The following information is derived from this work.

Night Time Economy

The night time economy is centred on the main five market towns of Shrewsbury, Oswestry, Whitchurch, Bridgnorth and Ludlow who offer a variety of pubs, bars, restaurants and night clubs. Shrewsbury is the main centre for entertainment within Shropshire, attracting people from around the county and from neighbouring areas further afield. Shropshire also attracts a large number of tourists.

The night-time economy also provides a number of employment opportunities from bar staff to those employed in the 17 microbreweries in Shropshire and workers who provide travel solutions.

As with all night-time economy activity, town centres can become tainted with drink related anti-social behaviour and violence, if unregulated and unplanned. A vibrant, diverse well planned night-time economy can produce many benefits to the community and should form part of local planning and licensing priority.

Drinking Behaviours

The health harms associated with alcohol consumption are measured on risks associated with units consumed over the course of a week. Following a review of the most recent evidence the Chief Medical Officer has published new guidance on regular drinking and its associated health risks. For both men and women who drink regularly the advice is to drink no more than 14 units over the course of the week, with alcohol free days between. People drinking at this level would be defined as lower risk drinkers. Increasing risk drinkers are those who regularly drink above the lower risk drinking levels but below 35 units a week. At this level people may not be experiencing any direct effect from alcohol consumption but their drinking is storing up potential health harms in the future. Higher risk drinking is defined as regular drinking that exceeds 35 units or more. Some people within this group may have dependency issues but not all.

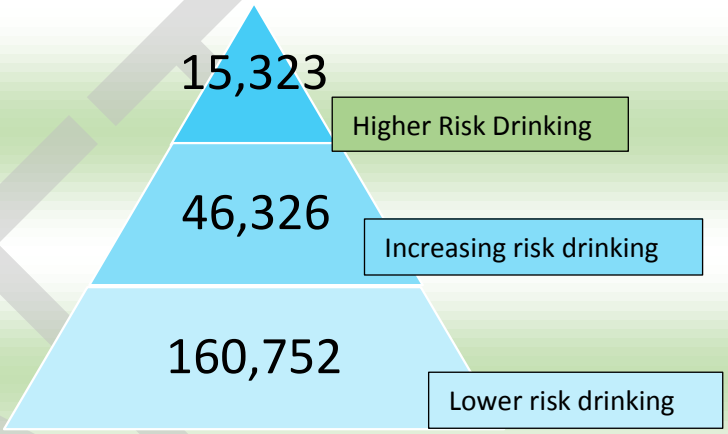
Many will be experiencing some level of harm whether health related, work or in personal relationships.

Understanding estimates of regular drinking behaviour helps to define what level of action is required at the population level to reverse the negative impact of alcohol related harm. Figure 1 opposite illustrates the estimated number of people drinking at the different levels of risk within Shropshire for the population aged 16 years plus based on 2014 synthetic population estimates. Please note these figures are an estimation based on the assumption that the proportion of those engaging in lower, increasing and higher risky drinking behaviour has not changed since 2008

Other measures on alcohol consumption include estimates on those who abstain from drinking. In Shropshire it is estimated the proportion of people aged 16 years and over who abstain from drinking alcohol is lower than in the West Midlands.

Binge drinking is a behaviour associated with the night-time economy and mainly young people. Binge drinking is defined as any consumption of alcohol that doubles the daily unit allowance using unit guidelines of 2-3 per day for women and 3 - 4 units of alcohol for men in any one drinking session. The focus of the recent Chief Medical Officers recommendations is on the significant risk of harm and injury that can be experienced in a single drinking episode from drinking just 5-7 units of alcohol over a three to six hour period.

Figure 1Synthetic population estimates of drinking behaviour in all people aged16 years and older.



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Alcohol Related Crime

Since 2010/2011 Shropshire's recorded alcohol related crime rate, including violent crime, has consistently fallen below the national average.

Despite this in 2013/2014 over a fifth (22%) of rapes reported to the police involved either alcohol or drugs.

In the same year, 37% of domestic abuse cases reported to the police recorded alcohol as a factor in the offence for either the victim or the perpetrator.

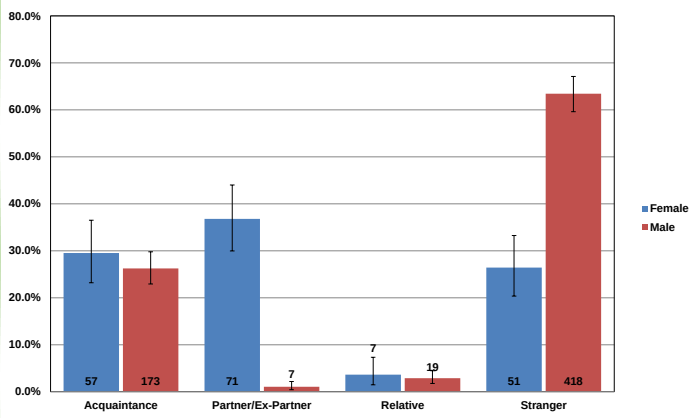
As well violent crimes reported to the police the LYNX system within both sites of the Shrewsbury and Telford Hospital Trust records violent incidents that result in an A&E presentation. Between 2011 and 2014 there were a total of 1424 incidents of violent crime reported to the system of these, just over 68% (974) reported alcohol as a contributing factor to the incident.

The data shows a clear gender split in attendees, with over three quarters of incidents reported by males compared to females. Not surprisingly the 16 - 24 year old age group were the largest group recording violent crime followed by the 25 - 34 year olds. There was no significant gender difference within these age groups.

The majority of males reported the crime was perpetrated by a stranger compared to

females who were more likely to be a victim of a crime committed by someone they knew. Over a third of all incidents reported by women were caused by a partner and a further third by an acquaintance (see graph 1 below).

Graph 1: Percentage of alcohol related violent incidents reported at A&E by gender and perpetrator



Source: LINX dataset SATH 2011-2013

As well as violent crime, another criminal offence directly linked to alcohol is drink driving. Shropshire has a higher proportion of road traffic accidents, where at least one driver failed a breath test following an accident, where someone was either killed or injured compared to both the West Midlands and England average.

Table 1: Alcohol Related Road Traffic Accidents per 1000

Period	Count	Shropshire	West Midlands	England
2010 - 2012	91	44.2	37.5	27.7
2011-2013	88	45.3	36.1	27.6
2012-2014	78	41.8	33.1	26.4

Source: Local Alcohol Profiles for Shropshire and England 2015

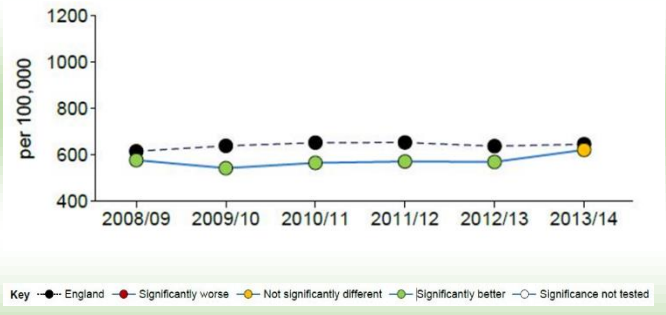
Alcohol Health Harms

The impact of alcohol consumption on health is well documented. At the national level there has been a 100% increase in the number of people attending A&E for alcohol poisoning between 2008/009 and 2013/2014. Alcohol specific emergency admissions have also increased by just under 54%, inpatient admissions by around 64% and for planned admissions the increase is over 143%. When comparing admission rates to hospital from A&E attendance, 1 in 3 people was admitted to a ward when alcohol was a factor of presentation, compared to 1 in 5 of all other attendances.

Nationally there are also significant differences in A&E presentations for alcohol poisoning between age groups. There have been large increases in the number of younger people aged 15 to 24 years attending A&E over the last few years. Broken down further the data illustrates there has been a 76% increase in presentations for those in the 15 – 19 year age group and a 93% increase in those aged 20 -24 years. However, the highest attendance rates of all groups are within older men aged between 45 – 65 years. The pressures caused by alcohol on the health service are not just experienced by the acute sector, 3 out of 4 attendances at A&E for alcohol poisoning arrived by ambulance in 2013/2014 (Nuffield, 2015).

The rate of hospital related admissions in Shropshire has been better than the England average since 2008. However, the latest data available (Chart 1 below) shows between 2012/2013 to 2013/2014 the rate of hospital admissions increased at a rate that put Shropshire on the same levels as the England average.

Chart 1: Rate of hospital related alcohol admissions per 100,000.



Source: Local Alcohol Profiles for Shropshire and England 2015

Alcohol is also directly attributed to seven types of cancer, mouth, throat, larynx,

oesophagus, breast, liver and bowel accounting for 4% of all cancers in the UK. After smoking, alcohol is one of the most preventable causes of cancer.

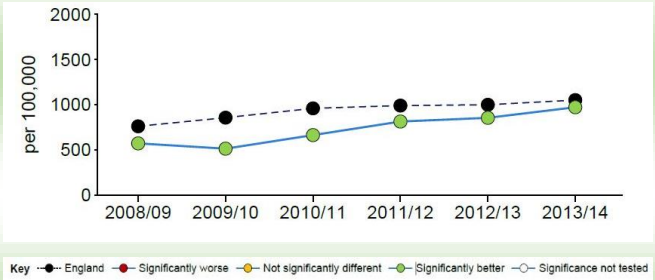
Unfortunately the rate of hospital admissions for alcohol related cancers in Shropshire has been higher than the England average for a number of years. Whereas England alcohol related cancer rates appear to have stabilised there has been a further increase in the rate of cancer related hospital admissions in Shropshire between 2012/2013 to 2013/2014 (Chart 2).

Chart 2: Rate of Hospital Admissions per 100,000 for alcohol related cancers

Source: Local Alcohol Profiles for Shropshire and England 2015

As well as cancer, alcohol is also attributable for other chronic health conditions, hypertension, cardiovascular disease and liver disease. It is estimated nationally that 12% of all hypertension is due to regular drinking. Whilst these specific health conditions fall below the England average in Shropshire levels of harm is increasing. Cardiovascular disease is a particular problem locally increasing at a faster rate than the England average (Chart 3).

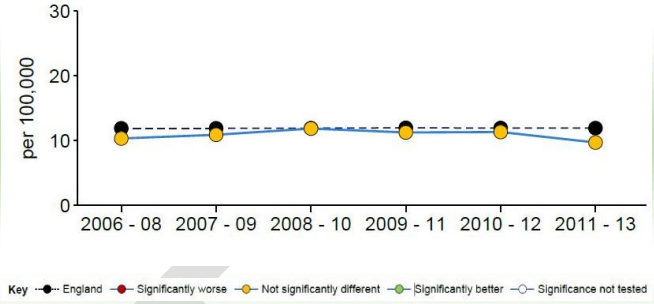
Chart 3 Rate of hospital admissions per 100,000 for cardiovascular disease.



Source: Local Alcohol Profiles for Shropshire and England 2015

Alcohol related deaths in the county remain lower than the England rate, decreasing between 2010 and 2011 despite rises in some health conditions (Chart 4).

Chart 4: Rate of alcohol related deaths per 100,000 of the population.

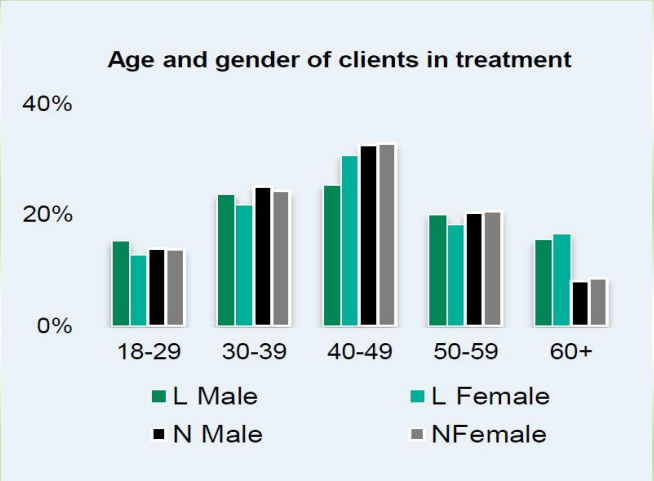


Source: Local Alcohol Profiles for Shropshire and England 2015

Alcohol Treatment

Alcohol treatment is available throughout the county and can be accessed either through a self-referral or third party referral. The majority of people self-refer. As Chart 5 illustrates the majority of people in treatment during 2013/2014 was in the 40 -49 age group. Chart 5 also compares the proportion of people in treatment locally compared to the national. Shropshire has a higher proportion of older people (aged 60 +) in treatment, than the national average.

Chart 5



Source: Joint Strategic Needs Assessment Support Pack for Alcohol and Drugs in Shropshire 2013/14, Public Health England

Successful completion of treatment is measured by the proportion of treatment exits who do not return to treatment within six months

Table 2 percentage of people who successfully completed treatment and did not return within 6 months

Year	Shropshire	National
2012	30%	36%
2013	45%	36%
2014	56%	38%

Treatment is a protective factor for families. As people seek help the risks associated with parental alcohol misuse are reduced. In 2013/2014 just over a quarter of the treatment population were living with children, either their own or other people's children; a further 29% were parents not living their children.

Policy Drivers

The Governments Alcohol Strategy 2012

The 2012 National Alcohol Strategy set out the government's ambition to 'radically' tackle alcohol related harm by stemming the availability of cheap alcohol and changing people's attitudes and drinking behaviour. The expected outcomes:

- A change in behaviour so that people's think it was not acceptable to drink in ways that it causes harm to them and others.
- A reduction in the amount of alcohol fuelled violent crime.
- A reduction in the number of people drinking above recommended guidelines.
- A reduction in the number of people binge drinking
- A reduction in the number of alcohol related deaths.
- A sustained reduction in number of 11-15 year olds drinking and the amounts consumed.

The Governments Drug Strategy 2010 Reducing demand, restricting supply, supporting people to live a drug free life.

This strategy was seen as a step change in preventing and tackling drug misuse with clear outcomes around enforcement and recovery. The strategy aimed to put more responsibility on individuals to seek help and overcome dependence. It also placed emphasis on a more holistic approach to tackling drug dependency by addressing other issues such as offending, housing and employment. The strategy ambition would be realised by achieving the following outcomes:

- Freedom of dependence on drugs and/ or alcohol;
- Prevention of drug related deaths and blood borne viruses;
- A reduction in crime and re-offending
- Sustained employment and the ability to access and sustain suitable accommodation;
- Improvement in mental and physical health and wellbeing;
- Improved relationships with family members, partners and friends;
- The capacity to be an effective parent

Health and Social Care Act 2012

Under the provisions of the Act the public health function was moved to local authority's to maximise opportunities to build on the population approaches to secure better health for all. Other aspects of the Act included the establishment of Health and Well Being Boards, bringing together a range of partners with statutory responsibility to improve population health and well-being and reduce health inequalities.

To measure improvement the Public Heath Outcome Framework (PHOF) together with the ring-fenced budget provide the framework for local authorities to target resources accordingly.

Licensing Act 2003

The Licensing Act 2003 established a single integrated system for licensing premises that serve alcohol and late night food outlets. Through their operating policy applications for license have to demonstrate how under the Act their business will meet the four licensing objectives:

- ❖ The prevention of crime and disorder;
- ❖ Public safety;
- ❖ The prevention of public nuisance;
- ❖ The protection of children from harm.

These objectives form the basis on which the licensing authority determines what is in the public interest when carrying out its functions.

High Impact Changes (2009)

The Department of Health published guidance for local areas in 2009 on activities that would support reducing alcohol related harm. These activities still hold firm today and whilst many have been introduced they still underpin the direction of this strategy.

- ❖ Work in Partnership
- ❖ Develop activities to control the impact of alcohol misuse in the community.
- ❖ Improve the effectiveness and capacity of specialist treatment.
- ❖ Appoint an alcohol worker.
- ❖ IBA – provide more help to encourage people to drink less.
- ❖ Amplify national social marketing priorities.

Outcomes

The aim of the strategy is to reduce the burden of alcohol related harm across the life course. To do this we need to have a consistent approach to promote sensible drinking and deter behaviour that can do most harm. This strategy will encorporate both environmental approaches to reducing harm and promoting opportunities to address individual risks.

Promote Safer Communities	Improve Health and Well-being	Protect Children and Young People	Create capacity
• Reduce the incidence of alcohol related crime and anti-social behaviour. • Improve the management and planning of the night-time economy. • Extend support for alcohol misusing offenders	• Promote sensible drinking • Prevent further increases in levels of chronic and acute ill health caused by alcohol	• Reduce alcohol related harm among children and young people • Reduce alcohol related harm among children and young people	• Strengthen data collection, and utilisation across stakeholders to support the development of future plans • Increase capacity through workforce planning and development

Implementation of the Strategy

As with previous strategies, these ambitions will require a multifaceted approach and whilst this strategy sets out a framework for action, delivery can only be strengthened through close links with other partnerships. Working together will strengthen resource efficiencies and reduce duplication within the system through key strategic links.

The Safer Stronger Communities Board, accountable to the Health and Well Being Board, will provide the strategic overview of the implementation of the action plan and make the strategic links across the partnerships. The governance structure is illustrated below (Figure 1).

Alcohol Strategy Governance Structure:

- The coordination of the strategy will be carried out by the Alcohol Strategy Group. The group will meet bi-annually. The strategy will be reviewed yearly to monitor the progress and agree priorities for the following year. The group will provide a yearly report to the Safer Stronger Communities Board (and other relevant Partnership Boards as requested).

- Commissioning decisions to support treatment improvements and preventative services will be decided through the Substance Misuse Commissioning Group.

- Task and Finish groups will be established to undertake specific time limited pieces of work to support the delivery of the strategy

Outcome: Promoting Safer Communities

- Improve the management and planning of the night-time economy.
- Reduce the incidence of alcohol related crime and anti-social behaviour.
- Extend support for alcohol misusing offenders

Alcohol related crime can be divided into two categories, either defined offences such as drink driving or drunk and disorderly offences or where alcohol was a contributing factor in the offence such as alcohol related violent crime and disorder. Shropshire's overall crime rate is low when compared to other areas with similar demographics, socio-economic status and geographic characteristics. Recorded alcohol related crime, including violent crime, has consistently fallen in Shropshire, and is below the national average. However, Shropshire as a significantly higher proportion of drink driving offences that resulted in injury than other areas in the West Midlands.

The relationship between alcohol, crime and disorder is complex and is linked to both environmental and individual risk factors. A number of studies have shown the association between alcohol related crime and density of licensed premises. As the night-time economy plays an important part of town centre life, creating jobs and bolstering local economies, it is important local areas have an agreed approach to the night-time economy. Statutory partners have an important role in helping to shape the night-time economy through licensing and planning.

As well as the environment, individual characteristics, age and gender can increase the risk of being a victim or perpetrator of alcohol related violence. Men are more likely to be victims or perpetrators of violent crime involving strangers; whereas women are more likely to know their attacker.

Once in the criminal justice system perpetrators of alcohol related crime need to be supported to access appropriate support to reduce the risk of re-offending.

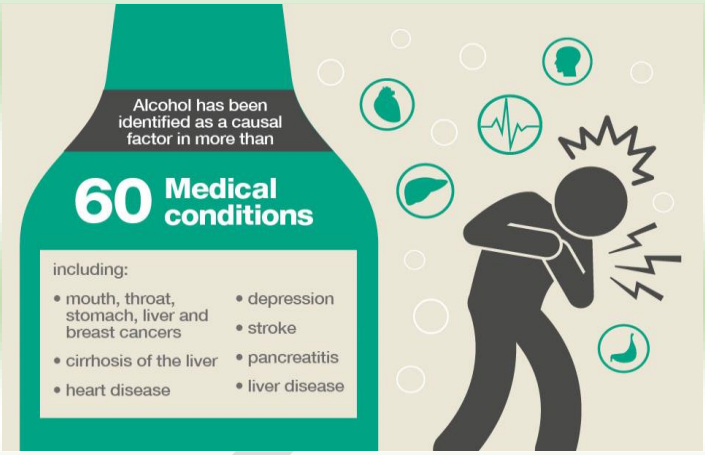
What we will do to reduce the incidence of alcohol related crime and disorder.

- Work with the licensing committee to utilise the powers under the Licensing Act 2003 to create a safe and vibrant night –time economy.
- Develop a systematic approach to tackle alcohol related crime, including drink driving.
- Where alcohol is a contributing factor ensure appropriate disposal of the offence and referral into treatment compliments other criminal justice interventions.
- Improve support to victims of alcohol violent crime, including cases of domestic abuse.

Outcome: Improving Health and Well-Being

- Promote Sensible Drinking

- Prevent further increase in levels of chronic and acute ill health caused by alcohol



Alcohol, after smoking and obesity is one of the three biggest lifestyle risk factors and accounts for 10% of the UK burden of disease and death.

Recent guidelines from the Chief Medical Officer has recommended both men and women should not drink more than 14 units a week over a minimum period of three days, with alcohol free days in between. Many people are unaware their drinking is at levels that may be doing them harm and find it difficult to understand units in relation to the volume of alcohol they drink

What we will do to promote sensible drinking

To help people to understand more about safe drinking levels we will use national campaigns to promote sensible drinking, using the strength of the partnership to support implementing these across a range of services.

We will build on our work with businesses to create an off and on licensed trade that supports a sensible approach to the sale of alcohol and deters excessive consumption.

What we will do to prevent further increase in levels of chronic and acute ill health caused by alcohol.

Identification and brief advice (IBA) are proven to be effective interventions in reducing consumption in a range of settings.

The Health Check for 40 – 70 year olds and new GP referrals provides an opportunity to assess people's current level of drinking and take appropriate action. We want to extend this within other areas of health, and social care, to ensure we are able to identify risks early.

We will achieve this by:

- Encouraging all statutory partners to have a systematic response for managing alcohol issues as part of their service delivery.
- Identifying champions within partner organisations to lead delivery of the strategy and be responsible for its implementation.
- Targeting IBA at those within primary and secondary care who are already demonstrating physical conditions such as hypertension, gastrointestinal and liver disorders; mental health around anxiety and depression, as well as victims of assault and risk of self-harm.
- Implementing Audit C across a range of services to support early identification and brief intervention.
- Responding to 'treatment resistant' drinkers and dual diagnosis systematically to support the individual's needs.

Outcome: Protecting Children and Young People from alcohol related harm

- Reduce alcohol related harm among children and young people.
- Support and protect children and young people affected by parental substance misuse.

Young people can be affected by alcohol related harm through the behaviour of a parent or sibling or through their own consumption.

Over the last decade young people are less likely to take drugs and alcohol than their counterparts did in 2001. Whilst this is encouraging, England still ranks amongst the countries with higher levels of young people's alcohol consumption. For those young people who do drink, they are more likely to binge drink than our European neighbours. Problematic drug and alcohol use in young people rarely happens in isolation, and is usually a symptom of other issues in the young person's life. It can often present with other risk factors such as truancy, offending and mental health.

It is important young people are supported to build resilience and effectively managed to prevent further harm.

What we will do to reduce alcohol related harm amongst young people.

- Build resilience through partnership work with schools and colleges.
- Ensure sanctions are fully applied to business that break the law in respect of under-age and proxy sales.
- Undertake validated screening, such as Audit C, for young people aged 16 - 17 to determine support required.
- Introduce brief interventions and extended interventions into a range of young people's settings to manage harmful drinking behaviour.

Unfortunately children and young people exposed to problematic drinking by parents suffer a range of poor outcomes. These can range from low self-esteem and poor educational attainment to behaviour and psychological problems. There is also a greater risk of exposure to domestic abuse, sexual exploitation, self-harm and developing alcohol related problems in later life.

What we will do to support and protect children and young people affected by parental substance misuse.

- Ensure all frontline workers are able to properly assess families affected by problematic alcohol use.
- Strengthen commissioning arrangements between adult mental health, domestic abuse and children and family services.

Outcome: Creating Capacity

- Strengthening of data collection, sharing and utilisation across stakeholders to support the development of future plans
- Increasing capacity through workforce planning and development

Shropshire has a long and established history for good partnership working across the public sector. This strategy has been developed recognising this strength but also acknowledging there is more that needs to be done to ensure there is the capacity and knowledge to direct resources appropriately.

The changes that have occurred across the public sector since 2013 mean new relationships need to be forged with agencies and organisations that have changed their status.

It is recognised across the partnership that in order to use scarce resources effectively decisions need to be informed by robust data and intelligence.

What we will do to strengthen data collection, sharing and utilisation across stakeholders to support the development of future plans

- Work together to identify an agreed process for the collection and sharing of data, including agreeing local common definitions to support analysis.
- Implement PHE minimum data set for hospitals as part of response.

The level of increasing and higher risk drinking within the county far outstrips anything a local specialist service could support. There is substantial evidence that supports the implementation of IBA as a tool to effectively reduce alcohol related health harms. To roll IBA out effectively there needs to be a skilled workforce of people who can use opportunistic moments to deliver essential advice and information.

What we will do Increase capacity through workforce planning and development.

- Develop a workforce strategy to support implementation of IBA across the partnership.
- Identify workforce champions to support roll out of IBA.